Unofficial Copy **1996 Regular Session**
SB0273/397438/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL NO. 273
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, strike in their entirety lines 2 and 3 and substitute "Health Care Consumer Information and Education Act"; strike beginning with the first "prohibiting" in line 4 down through "circumstances" in line 6 and substitute "requiring, under certain circumstances, certain carriers to disclose certain information concerning the carriers operating practices in a certain manner to enrollees, prospective individual purchasers, employers, and providers; specifying the information that carriers are required to disclose; prohibiting certain carriers from preventing providers from disclosing certain information; specifying the application of this Act; requiring certain carriers to file certain information with the Insurance Commissioner; authorizing the Commissioner to adopt regulations; defining certain terms; and generally relating to requiring certain carriers to disclose certain information about the carriers operating practices to certain persons under certain circumstances"; and strike in their entirety lines 7 through 16, inclusive, and substitute:

"BY adding to
Article 48A - Insurance Code
Section 490FF
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-706(i)
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)".

(Over)

AMENDMENT NO. 2

On pages 1 and 2, strike in their entirety the lines beginning with line 19 on page 1 through line 29 on page 2, inclusive, and substitute:

"Article 48A - Insurance Code

490FF.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A COMMUNITY HEALTH NETWORK;

(V) A DENTAL PLAN ORGANIZATION; OR

(VI) ANY PERSON OR ENTITY ACTING AS A THIRD PARTY ADMINISTRATOR.

(3) "CONTRACT" MEANS ANY WRITTEN AGREEMENT BETWEEN A PROVIDER AND A CARRIER FOR THE PROVIDER TO RENDER HEALTH CARE SERVICES TO ENROLLEES OF THE CARRIER.

(4) "ENROLLEE" MEANS ANY PERSON ENTITLED TO HEALTH CARE BENEFITS FROM A CARRIER.

(5) "HEALTH CARE SERVICES" MEANS A HEALTH OR MEDICAL CARE

PROCEDURE OR SERVICE RENDERED BY A PROVIDER THAT:

(I) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION; OR

(II) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR MEDICAL GOODS FOR THE TREATMENT OF A HUMAN DISEASE OR DYSFUNCTION.

(6) "PRINCIPAL OPERATING PRACTICES" MEANS THE PROCESSES BY WHICH CARRIERS MAKE DECISIONS ABOUT WHAT SERVICES TO COVER AND PAY FOR, INCLUDING THE TITLES OF KEY ADMINISTRATIVE AND EXECUTIVE STAFF WHO MAKE THE DECISIONS.

(7) (I) "PROVIDER" MEANS A PERSON OR ENTITY LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE OR THE HEALTH - GENERAL ARTICLE TO PROVIDE HEALTH CARE SERVICES.

(II) "PROVIDER" INCLUDES:

1. A HEALTH CARE FACILITY;

2. A PHARMACY;

3. A PROFESSIONAL SERVICES CORPORATION;

4. A PARTNERSHIP;

5. A LIMITED LIABILITY COMPANY;

6. A PROFESSIONAL OFFICE; OR

7. ANY OTHER ENTITY LICENSED OR AUTHORIZED BY LAW TO PROVIDE OR DELIVER PROFESSIONAL HEALTH CARE SERVICES THROUGH OR ON

BEHALF OF A PROVIDER.

(B) THIS SECTION APPLIES TO A CARRIER THAT PROVIDES HEALTH CARE SERVICES TO ENROLLEES OR OTHERWISE MAKES HEALTH CARE SERVICES AVAILABLE TO ENROLLEES THROUGH CONTRACTS WITH PROVIDERS.

(C) (1) EACH CARRIER SHALL DISCLOSE ITS PRINCIPAL OPERATING PRACTICES, AS IDENTIFIED IN PARAGRAPH (2) OF THIS SUBSECTION:

(I) TO A PROVIDER:

1. IN THE FIRST YEAR OF A CONTRACT BETWEEN THE CARRIER AND THE PROVIDER; AND

2. AT ANY TIME, ON THE PROVIDER'S REQUEST;

(II) TO AN ENROLLEE OF THE CARRIER:

1. ON ENROLLMENT OF THE ENROLLEE;

2. DURING THE ENROLLEE'S OPEN ENROLLMENT PERIOD; AND

3. AT ANY TIME, ON THE ENROLLEE'S REQUEST;

(III) TO A PROSPECTIVE INDIVIDUAL PURCHASER OF A HEALTH BENEFIT PLAN THROUGH A CARRIER, ON REQUEST; AND

(IV) EXCEPT FOR A SMALL EMPLOYER UNDER § 698(Q) OF THIS ARTICLE, TO AN EMPLOYER, AT LEAST 30 DAYS BEFORE ENROLLING AN EMPLOYEE OF THE EMPLOYER UNDER A HEALTH BENEFIT PLAN SPONSORED BY THE EMPLOYER, FOR PURPOSES OF DISTRIBUTING THE DISCLOSURES TO THE EMPLOYER'S EMPLOYEES.

(2) THE PRINCIPAL OPERATING PRACTICES REQUIRED TO BE DISCLOSED

IN PARAGRAPH (1) OF THIS SUBSECTION SHALL INCLUDE THE INFORMATION DESCRIBED IN SUBSECTIONS (D), (E), AND (F) OF THIS SECTION.

(D) (1) EACH CARRIER SHALL IDENTIFY AND DEFINE IN LAYMAN'S TERMS THE PREDOMINANT REIMBURSEMENT METHODOLOGY USED BY THE CARRIER TO REIMBURSE PROVIDERS FOR HEALTH CARE SERVICES RENDERED TO ENROLLEES, INCLUDING CAPITATION, CASE RATES, DISCOUNTED FEE-FOR-SERVICE, AND FEE-FOR-SERVICE REIMBURSEMENT METHODOLOGIES.

(2) A CARRIER THAT USES A CAPITATED REIMBURSEMENT METHODOLOGY TO PAY PROVIDERS SHALL PROVIDE A SUMMARY OF:

(I) THOSE HEALTH CARE SERVICES FOR WHICH CAPITATION APPLIES AND FOR WHICH PROVIDERS ARE AT FINANCIAL RISK;

(II) THE LEVEL OF FINANCIAL RISK THAT PROVIDERS ARE ASSUMING; AND

(III) THE PRESENCE OF ANY STOP-LOSS PROVISIONS THAT MITIGATE THE PROVIDER'S LEVEL OF FINANCIAL RISK.

(3) IN ADDITION TO PARAGRAPH (2) OF THIS SUBSECTION, THE CARRIER SHALL:

(I) PROVIDE A SUMMARY OF THE DEGREE TO WHICH A CAPITATED PROVIDER IS RESPONSIBLE FOR PAYING FOR PARTICULAR HEALTH CARE SERVICES, INCLUDING:

1. LABORATORY AND DIAGNOSTIC TESTING;

2. REFERRALS TO SPECIALTY PHYSICIANS;

3. HOSPITAL CARE; AND

4. PRESCRIPTION DRUGS; AND

(II) PROVIDE A BRIEF EXAMPLE OF HOW CAPITATED PAYMENT SYSTEMS OPERATE.

(E) (1) EACH CARRIER SHALL PROVIDE A SUMMARY OF:

(I) THOSE HEALTH CARE SERVICES FOR WHICH THE CARRIER PROVIDES COVERAGE AND PAYMENT; AND

(II) THE PROCESS THAT THE CARRIER FOLLOWS TO DETERMINE WHICH HEALTH CARE SERVICES FOR WHICH TO PROVIDE COVERAGE OR ELIMINATE COVERAGE.

(2) THE CARRIER SHALL:

(I) IDENTIFY THE TITLES OF KEY PERSONNEL OF THE CARRIER WHO ARE INVOLVED IN MAKING COVERAGE DECISIONS; AND

(II) DISCLOSE WHETHER OUTSIDE CONSULTANTS OR EXTERNAL RESOURCES, INCLUDING FEDERAL OR STATE AGENCIES, TRADE GROUPS, AND TECHNOLOGY COUNCILS, ARE USED BY THE CARRIER TO ASSIST THE CARRIER IN MAKING COVERAGE DECISIONS FOR INDIVIDUAL ENROLLEES OR FOR THE CARRIER'S ENTIRE ENROLLED POPULATION.

(F) (1) EACH CARRIER SHALL DISCLOSE THE DISTRIBUTION OF EACH $100 IT RECEIVES IN PREMIUM DOLLARS FROM ENROLLEES.

(2) THE DISCLOSURE SHALL BE IN THE FORM OF A PIE CHART OR BAR GRAPH WITH DESCRIPTIVE TERMS IN LAYMAN'S LANGUAGE THAT IDENTIFIES:

(I) THE PROPORTION OF EVERY $100 IN PREMIUM DOLLARS THAT THE CARRIER USES TO PAY PROVIDERS FOR THE DIRECT PROVISION OF HEALTH CARE SERVICES TO ENROLLEES, INCLUDING WHAT PROPORTION IS FOR DIRECT

MEDICAL CARE EXPENSES;

(II) THE PROPORTION OF EVERY $100 IN PREMIUM DOLLARS THAT THE CARRIER USES TO PAY FOR PLAN ADMINISTRATION;

(III) THE PROPORTION OF EVERY $100 IN PREMIUM DOLLARS THAT THE CARRIER USES TO PAY FOR THE MARKETING AND ADVERTISING ACTIVITIES OF THE CARRIER; AND

(IV) IF THE CARRIER IS A FOR-PROFIT PUBLICLY TRADED ENTITY, THE PROPORTION OF EVERY $100 IN PREMIUM DOLLARS THAT THE CARRIER OR ITS PARENT CORPORATION USES TO PAY FOR CASH DIVIDENDS DISTRIBUTED TO SHAREHOLDERS OF THE CARRIER.

(G) THE DISCLOSURES REQUIRED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE IN A FORM THAT INCLUDES:

(1) A GLOSSARY OF TERMS;

(2) AN EXECUTIVE SUMMARY;

(3) A SUMMARY DESCRIPTION OF THE PREDOMINANT REIMBURSEMENT METHODOLOGY THAT CARRIERS USE TO PAY FOR HEALTH CARE SERVICES;

(4) A SUMMARY DESCRIPTION OF THE METHOD OF DISTRIBUTION BY CARRIERS OF PREMIUM DOLLARS; AND

(5) THE LOSS RATIO FOR A HEALTH BENEFIT PLAN IN ACCORDANCE WITH § 490S OF THIS ARTICLE.

(H) EACH YEAR, A CARRIER SHALL:

(1) UPDATE THE DISCLOSURES REQUIRED UNDER SUBSECTION (C) OF THIS SECTION; AND

(2) FILE THE DISCLOSURES WITH THE COMMISSIONER.

(I) THE COMMISSIONER:

(1) SHALL ESTABLISH A PROCESS FOR:

(I) THE ANNUAL FILING OF THE DISCLOSURES REQUIRED UNDER SUBSECTION (C) OF THIS SECTION; AND

(II) MAKING THE DISCLOSURES AVAILABLE FOR INSPECTION AND REVIEW BY THE GENERAL PUBLIC; AND

(2) MAY ADOPT REGULATIONS TO CARRY OUT THIS SECTION.

(J) (1) A CARRIER MAY NOT PROHIBIT A PROVIDER FROM DISCUSSING OR COMMUNICATING INFORMATION TO AN ENROLLEE, PUBLIC OFFICIAL, OR OTHER PERSON THAT IS NECESSARY OR APPROPRIATE FOR THE DELIVERY OF HEALTH CARE SERVICES, INCLUDING:

(I) COMMUNICATIONS RELATING TO TREATMENT ALTERNATIVES;

(II) COMMUNICATIONS NECESSARY OR APPROPRIATE TO MAINTAIN THE PROVIDER-PATIENT RELATIONSHIP WHILE UNDER THE PROVIDER'S CARE;

(III) COMMUNICATIONS REGARDING AN ENROLLEE'S RIGHT TO APPEAL COVERAGE DETERMINATIONS OF THE CARRIER WITH WHICH THE PROVIDER OR THE ENROLLEE DOES NOT AGREE; OR

(IV) OPINIONS AND THE BASIS OF AN OPINION REGARDING PUBLIC POLICY ISSUES.

(2) THIS SUBSECTION DOES NOT PROHIBIT A CARRIER, AS A CONDITION OF A CONTRACT BETWEEN THE PROVIDER AND THE CARRIER, FROM PROHIBITING A

PROVIDER FROM COMMITTING, AGAINST THE CARRIER, A COMMERCIAL TORT RECOGNIZED UNDER MARYLAND LAW.

(K) THE COMMISSIONER MAY ISSUE AN ORDER UNDER THE PROVISION OF § 55A OF THIS ARTICLE IF THE COMMISSIONER FINDS A VIOLATION OF THIS SECTION.

Article - Health - General

19-706.

(i) The provisions of Article 48A, §§ 490U, 490AA, 490CC, [and] 490DD, AND 490FF of the Code shall apply to health maintenance organizations.".