SENATE BILL 624

Unofficial Copy 1996 Regular Session
C3 6lr2688

CF 6lr2573

By: Senators Astle and Dorman
Introduced and read first time: February 2, 1996
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Care Provider and Payor Communications Act

FOR the purpose of prohibiting certain insurers and health maintenance organizations from prohibiting health care practitioners from disclosing or communicating certain information to enrollees or subscribers under certain circumstances;prohibiting insurers and health maintenance organizations from requiring health care providers to indemnify or hold harmless the insurer or health maintenance organization from any liability arising from a coverage decision made by the insurer or health maintenance organization under certain circumstances; requiring health maintenance organizations that use a certain economic profile to evaluate a provider under contract with the health maintenance organization to disclose to the provider certain information concerning the economic profile prior to taking a certain action against the provider; prohibiting certain insurers and health maintenance organizations from withholding certain reimbursements regardless of the method of reimbursement used by the insurer or health maintenance organization; altering a certain provision of law related to developing certain forms to require that a certain study be performed by certain persons related to the feasibility of a certain uniform voucher form; making a certain technical correction; establishing a certain study group to evaluate the use and effectiveness of certain patient and provider grievance appeal procedures; requiring the study group to make a certain report by a certain date; providing for the application of certain provisions of this Act to health maintenance organizations; definingcertain terms; providing for the effective date of certain provisions of this Act; and generally relating to certain insurers and health maintenance organizations.

BY adding to
Article 48A - Insurance Code
Section 354RR, 470HH, 477RR, and 490FF
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 490DD
Annotated Code of Maryland

(1994 Replacement Volume and 1995 Supplement)

BY adding to
Article - Health - General
Section 19-706(l) and 19-710(r) and (s)
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Chapter 577 of the Acts of the General Assembly of 1995
Section 2 and 3

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article 48A - Insurance Code

354RR.

A NONPROFIT HEALTH SERVICE PLAN MAY NOT BY CONTRACT, OR IN ANY OTHER MANNER, REQUIRE A HEALTH CARE PROVIDER TO INDEMNIFY THE PLAN OR HOLD THE PLAN HARMLESS FROM OR AGAINST ANY LIABILITY ARISING FROM COVERAGE DECISIONS MADE BY THE PLAN OR FROM THE CONDUCT OF ANY OTHER PERSON OTHER THAN THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S AGENTS OR EMPLOYEES.

470HH.

A HOSPITAL OR MAJOR MEDICAL INSURER MAY NOT BY CONTRACT, OR IN ANY OTHER MANNER, REQUIRE A HEALTH CARE PROVIDER TO INDEMNIFY THE INSURER OR HOLD THE INSURER HARMLESS FROM OR AGAINST ANY LIABILITY ARISING FROM COVERAGE DECISIONS MADE BY THE INSURER OR FROM THE CONDUCT OF ANY OTHER PERSON OTHER THAN THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S AGENTS OR EMPLOYEES.

477RR.

A GROUP OR BLANKET HEALTH INSURER MAY NOT BY CONTRACT, OR IN ANY OTHER MANNER, REQUIRE A HEALTH CARE PROVIDER TO INDEMNIFY THE INSURER OR HOLD THE INSURER HARMLESS FROM OR AGAINST ANY LIABILITY ARISING FROM COVERAGE DECISIONS MADE BY THE INSURER OR FROM THE CONDUCT OF ANY OTHER PERSON OTHER THAN THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S AGENTS OR EMPLOYEES.

490DD.

(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 dental plan organization; or

(v) Any other person or organization that provides health benefit plans subject to State regulation.

(3) "Health care practitioner" means any individual who is licensed, certified, or otherwise authorized under the Health Occupations Articleto provide health care services.

(b) A carrier [that reimburses a health care practitioner on an aggregate fixed sum basis or on a per capita basis] may not reimburse [the] A health care practitioner in an amount less than the sum or rate negotiated in the carrier's provider contract with the health care practitioner.

(C) THIS SECTION APPLIES TO ANY METHOD OF REIMBURSEMENT USED BY A CARRIER TO REIMBURSE A HEALTH CARE PRACTITIONER, INCLUDING REIMBURSEMENT MADE ON A CAPITATED OR NONCAPITATED BASIS.

[(c)] (D) This section does not prohibit a carrier from providing bonuses or other incentive-based compensation to a health care practitioner if the bonusor other incentive-based compensation does not:

(1) Violate the provisions of § 19-705.1 of the Health - General Article; or

(2) Deter the delivery of medically appropriate care to an enrollee.

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 DENTAL PLAN ORGANIZATION; OR

(V) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO STATE REGULATION.

(3) "HEALTH CARE PRACTITIONER" MEANS ANY INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES.

(B) A CARRIER, AS A CONDITION OF A CONTRACT WITH A HEALTH CARE PRACTITIONER, OR IN ANY OTHER MANNER, MAY NOT PROHIBIT A HEALTH CARE PRACTITIONER FROM DISCUSSING OR COMMUNICATING TO AN ENROLLEE, SUBSCRIBER, OR OTHER PERSON INFORMATION THAT:

(1) IS NECESSARY OR APPROPRIATE FOR THE DELIVERY OF QUALITY HEALTH CARE SERVICES;

(2) RELATES TO TREATMENT ALTERNATIVES FOR THE ENROLLEE OR SUBSCRIBER, REGARDLESS OF THE PROVISIONS OR LIMITATIONS OF THE ENROLLEE'S OR SUBSCRIBER'S COVERAGE UNDER THE CARRIER'S HEALTH BENEFIT PLAN;

(3) IS NECESSARY OR APPROPRIATE FOR MAINTAINING THE PRACTITIONER-PATIENT RELATIONSHIP WITH THE ENROLLEE OR SUBSCRIBER; OR

(4) EXPRESSES OPINIONS REGARDING THE CARRIER OR THE HEALTH CARE PRACTITIONER'S EXPERIENCE WITH THE CARRIER.

(C) THIS SECTION DOES NOT PROHIBIT A CARRIER, AS A CONDITION OF A HEALTH CARE PRACTITIONER'S CONTRACT WITH THE CARRIER, FROM PROHIBITING A HEALTH CARE PRACTITIONER FROM:

(1) DISCLOSING THE TERMS OF THE CONTRACT BETWEEN THE CARRIER AND THE PRACTITIONER;

(2) COMMUNICATING OR ACTING IN A MANNER THAT WOULD TORTIOUSLY INTERFERE WITH EXISTING CONTRACTUAL RELATIONSHIPS TO WHICH THE CARRIER IS A PARTY; OR

(3) COMMUNICATING STATEMENTS OF FACT ABOUT THE CARRIER THAT ARE FALSE, THAT THE PRACTITIONER KNOWS TO BE FALSE, AND THAT CAUSE DAMAGE TO THE CARRIER.

(D) THIS SECTION DOES NOT PROHIBIT A HEALTH CARE PRACTITIONER FROM PROVIDING TO OR DISCUSSING WITH AN ENROLLEE OR SUBSCRIBER INFORMATION ABOUT THE RIGHT TO APPEAL OF THE ENROLLEE OR SUBSCRIBER COVERAGE DETERMINATIONS OF THE CARRIER WITH WHICH THE PRACTITIONER OR THE ENROLLEE OR SUBSCRIBER DO NOT AGREE.

Article - Health - General

19-706.

(L) THE PROVISIONS OF ARTICLE 48A, § 490FF OF THE CODE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19-710.

(R) (1) IN THIS SUBSECTION, "ECONOMIC PROFILE" MEANS A PROFILE, SUMMARY, OR ANALYSIS OF DATA CONCERNING SERVICES RENDERED OR UTILIZED BY A PROVIDER THAT IS UNDER CONTRACT WITH OR EMPLOYED BY A HEALTH MAINTENANCE ORGANIZATION IN THE PROVISION OF HEALTH CARE SERVICES BY THE PROVIDER TO ENROLLEES OR SUBSCRIBERS OF THE HEALTH MAINTENANCE ORGANIZATION.

(2) IF A HEALTH MAINTENANCE ORGANIZATION USES AN ECONOMIC PROFILE AS A FACTOR IN ITS PEER REVIEW, QUALITY ASSURANCE, CONTRACT REVIEW, OR OTHER PROVIDER REVIEW PROGRAM TO EVALUATE THE PROVIDER,

THE HEALTH MAINTENANCE ORGANIZATION SHALL DISCLOSE AND PROVIDE TO A PROVIDER ON REQUEST:

(I) THE DATA AND A DESCRIPTION OF THE CRITERIA USED TO COMPILE THE ECONOMIC PROFILE CONCERNING THE PROVIDER; AND

(II) THE MANNER IN WHICH THE ECONOMIC PROFILE IS USED TO EVALUATE THE PROVIDER.

(3) A HEALTH MAINTENANCE ORGANIZATION MAY NOT TERMINATE A PROVIDER CONTRACT OR THE PROVIDER'S EMPLOYMENT WITH THE HEALTH MAINTENANCE ORGANIZATION SOLELY ON THE BASIS OF AN ECONOMIC PROFILE WITHOUT INFORMING THE PROVIDER OF THE FINDINGS OF THE ECONOMIC PROFILE PRIOR TO THE TERMINATION.

(S) A HEALTH MAINTENANCE ORGANIZATION MAY NOT BY CONTRACT, OR IN ANY OTHER MANNER, REQUIRE A PROVIDER TO INDEMNIFY THE HEALTH MAINTENANCE ORGANIZATION OR HOLD THE HEALTH MAINTENANCE ORGANIZATION HARMLESS FROM OR AGAINST ANY LIABILITY ARISING FROM COVERAGE DECISIONS MADE BY THE HEALTH MAINTENANCE ORGANIZATION OR FROM THE CONDUCT OF ANY OTHER PERSON OTHER THAN THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S AGENTS OR EMPLOYEES.

Chapter 577 of the Acts of 1995

SECTION 2. AND BE IT FURTHER ENACTED, That the Insurance Commissioner, when developing [the uniform provider voucher form] the uniform laboratory referral form[,] and the uniform consultation referral form under Article 48A, § 490BB of the Code, shall consult with the Department of Health and Mental Hygiene, the Health Care Access and Cost Commission, the Office on Aging, Blue Cross and Blue Shield of Maryland, Blue Cross and Blue Shield of the NationalCapital Area, the Health Insurance Association of America, the League of Life and Health Insurers, the Maryland Hospital Association, the Medical and Chirurgical Faculty of Maryland, the Medical Group Management Association, a representative of the medical laboratory industry in the State, the Maryland Association of Health Maintenance Organizations, and a nonphysician health care provider association. The forms developed under this section shall be capable of electronic transfer.

SECTION 3. AND BE IT FURTHER ENACTED, That the Insurance Commissioner, when developing the forms in accordance with the requirements of Section 2 of this Act, shall assess any existing uniformity of forms currently being used within the health care delivery and finance industries, and shall examine any uniformity of forms that may be required in other states. IN ADDITION TO THE REQUIREMENTS OF SECTION 2 OF THIS ACT, THE INSURANCE COMMISSIONER, IN CONSULTATION WITH THE REPRESENTATIVES OF THE AGENCIES, ASSOCIATIONS, AND ORGANIZATIONS DESCRIBED UNDER SECTION 2 OF THIS ACT, SHALL STUDY THE FEASIBILITY OF A UNIFORM VOUCHER FORM FOR HEALTH CARE PROVIDERS.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) There is a Task Force to Study Patient and Provider Appeal and Grievance Mechanisms;

(b) The Task Force shall consist of the following members:

(1) Five representatives of the Medical and Chirurgical Faculty of Maryland, of whom two shall be nonphysician licensed health care providers;

(2) Five representatives of the insurance industry, appointed by the Maryland Association of Health Maintenance Organizations;

(3) Three members of the House Economic Matters Committee, appointed by the Speaker of the Maryland House of Delegates; and

(4) Three members of the Senate Finance Committee, appointed by the President of the Senate of Maryland;

(c) From among the members of the Task Force from the House of Delegates and the Senate of Maryland, one shall be designated the HouseChairman and one shall be designated the Senate Chairman;

(d) The members of the Task Force shall serve without compensation;

(e) The Task Force shall:

(1) Evaluate the use and effectiveness of patient and provider grievance and appeal mechanisms currently in law that are used to appeal decisions of health maintenance organizations, including appeal decisions related toenrollee or subscriber coverage, provider contract termination, and reimbursement determinations; and

(2) Based on the evaluation conducted, make recommendations concerning:

(i) The use and effectiveness of these appeal mechanisms; and

(ii) The need for legislative action; and

(f) On or before October 15, 1996, the House Chairman of the Task Force shall report the recommendations of the Task Force to the House Economic Matters Committee and the Senate Chairman of the Task Force shall report the recommendations of the Task Force to the Senate Finance Committee.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect June 1, 1996.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect October 1, 1996.