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By: Senator Pinsky
Introduced and read first time: January 31, 1997
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance - Quality of Care - Requirements

FOR the purpose of prohibiting certain health insurance carriers from offering or paying bonuses or other incentive-based compensation to health care practitioners under certain circumstances; requiring certain health insurance carriers to maintain a certain provider panel that satisfies certain requirements related to the accessibility and provision of health care benefits to enrollees; requiring carriers to submit certain information to the Insurance Commissioner; requiring the Commissioner, in consultation with the Department of Health and Mental Hygiene or its designee, to make a certain determination related to the information provided by a carrier; requiring the Commissioner to adopt certain regulations; prohibiting certain health insurance carriers from penalizing a health care provider who makes certain reports to certain persons under certain circumstances; prohibiting a carrier and certain other persons from terminating or taking certain other adverse action against certain persons for certain actions taken for certain purposes; defining a certain term; and generally relating to prohibiting certain health insurance carriers from taking certain actions and requiring certain health insurance carriers to satisfy certain requirements in order to maintain certain quality of care standards.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-112, 15-113, and 15-116
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

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

Article - Insurance

15-112.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(3) "Enrollee" means a person entitled to health care benefits from a carrier.

(4) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(5) (i) "Provider panel" means the providers that contract with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee-for-service rate.

(b) A carrier that uses a provider panel shall establish procedures to:

(1) review applications for participation on the carrier's provider panel in accordance with this section;

(2) notify an enrollee of:

(i) the termination from the carrier's provider panel of the primary care provider that was furnishing health care services to the enrollee; and

(ii) the right of the enrollee, on request, to continue to receive health care services from the enrollee's primary care provider for up to 90 days after the date of the notice of termination of the enrollee's primary care provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

(3) notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider; and

(4) notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

(c) A carrier that uses a provider panel:

(1) on request, shall provide an application and information that relates to consideration for participation on the carrier's provider panel to any provider seeking to apply for participation;

(2) shall make publicly available its application; and

(3) shall make efforts to increase the opportunity for a broad range of minority providers to participate on the carrier's provider panel.

(d) (1) A provider that seeks to participate on a provider panel of a carrier shall submit an application to the carrier.

(2) (i) Subject to paragraph (3) of this subsection, the carrier, after reviewing the application, shall accept or reject the provider for participation on the carrier's provider panel.

(ii) If the carrier rejects the provider for participation on the carrier's provider panel, the carrier shall send to the provider at the address listed in the application written notice of the rejection.

(3) (i) Except as provided in paragraph (4) of this subsection, within 30 days after the date a carrier receives a completed application, the carrier shall send to the provider at the address listed in the application written notice of:

1. the carrier's intent to continue to process the provider's application to obtain necessary credentialing information; or

2. the carrier's rejection of the provider for participation on the carrier's provider panel.

(ii) The failure of a carrier to provide the notice required under subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to the penalties provided by § 4-113(d) of this article.

(iii) If, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, the carrier, within 150 days after the date the notice is provided, shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the address listed in the application.

(iv) The failure of a carrier to provide the notice required under subparagraph (iii)2 of this paragraph is a violation of this article and the carrier is subject to the provisions of and penalties provided by §§ 4-113 and 4-114 of this article.

(4) (i) A carrier that receives an incomplete application shall return the application to the provider at the address listed in the application within 10 days after the date the application is received.

(ii) The carrier shall indicate to the provider what information is needed to make the application complete.

(iii) The provider may return the completed application to the carrier.

(iv) After the carrier receives the completed application, the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) A carrier may charge a reasonable fee for an application submitted to the carrier under this section.

(E) (1) A CARRIER SHALL MAINTAIN A PROVIDER PANEL THAT IS SUFFICIENT IN NUMBERS AND TYPES OF PROVIDERS TO ASSURE THAT ALL COVERED HEALTH CARE BENEFITS THAT AN ENROLLEE IS ENTITLED TO RECEIVE UNDER THE ENROLLEE'S CONTRACT OR POLICY WITH THE CARRIER ARE ACCESSIBLE AND PROVIDED IN A TIMELY MANNER WITHOUT DELAYS.

(2) IN ORDER TO DETERMINE WHETHER A CARRIER HAS A SUFFICIENT PROVIDER PANEL TO MEET THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, ANNUALLY EACH CARRIER SHALL PROVIDE INFORMATION TO THE COMMISSIONER ON:

(I) THE NUMBER OF ENROLLEES OF THE CARRIER;

(II) THE NUMBER OF PRIMARY CARE PROVIDERS EMPLOYED BY OR UNDER CONTRACT WITH THE CARRIER;

(III) IF APPLICABLE, THE LOCATION FOR EACH PRIMARY CARE PROVIDER PRACTICE;

(IV) IF APPLICABLE, THE STAFFING AT EACH PRIMARY CARE PROVIDER LOCATION EXPRESSED IN FULL-TIME EQUIVALENCIES AND GROUPED BY MEDICAL SPECIALTY, INCLUDING:

1. GENERAL PRACTICE;

2. FAMILY PRACTICE;

3. INTERNAL MEDICINE;

4. PEDIATRICS;

5. OBSTETRICS AND GYNECOLOGY; AND

6. ADVANCED PRACTICE NURSING; AND

(V) ANY OTHER INFORMATION OR DOCUMENTATION THAT THE COMMISSIONER OR THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR ITS DESIGNEE CONSIDERS APPROPRIATE IN DETERMINING WHETHER A CARRIER'S PROVIDER PANEL IS SUFFICIENT TO PROVIDE ENROLLEES WITH TIMELY ACCESS TO HEALTH CARE SERVICES, INCLUDING:

1. THE WAITING TIME FOR TELEPHONE CALLS TO BE ANSWERED;

2. THE AVERAGE INTERVAL BETWEEN THE DATE AN ENROLLEE REQUESTS AN APPOINTMENT AND THE ACTUAL APPOINTMENT DATE; AND

3. OFFICE WAITING TIMES.

(3) (I) FROM THE INFORMATION PROVIDED BY A CARRIER UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE COMMISSIONER, IN CONSULTATION WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR ITS DESIGNEE, SHALL DETERMINE WHETHER THE CARRIER'S PROVIDER PANEL IS SUFFICIENT TO SATISFY THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION.

(II) IN REVIEWING WHETHER A CARRIER'S PROVIDER PANEL SATISFIES THE REQUIREMENTS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE COMMISSIONER SHALL ADOPT BY REGULATION:

1. SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, MAXIMUM PRIMARY CARE PROVIDER-TO-ENROLLEE RATIOS BROKEN DOWN BY THE MEDICAL SPECIALITIES LISTED IN PARAGRAPH (2) OF THIS SUBSECTION AND ANY OTHER MEDICAL SPECIALTY THE COMMISSIONER OR THE DEPARTMENT CONSIDERS APPROPRIATE; AND

2. APPOINTMENT GUIDELINES CONSISTENT WITH PARAGRAPH (5) OF THIS SUBSECTION.

(III) UNLESS THE CARRIER CAN DEMONSTRATE TO THE COMMISSIONER OR THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR ITS DESIGNEE THE CARRIER'S ABILITY TO SATISFY THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, A CARRIER MAY NOT HAVE A HIGHER PRIMARY CARE PROVIDER-TO-ENROLLEE RATIO THAN THAT ESTABLISHED BY THE COMMISSIONER BY REGULATION IN ACCORDANCE WITH SUBPARAGRAPH (II) OF THIS PARAGRAPH.

(4) REGARDLESS OF MEDICAL SPECIALTY, THE COMMISSIONER MAY NOT ADOPT BY REGULATION A HIGHER PRIMARY CARE PROVIDER-TO-ENROLLEE RATIO OF:

(I) FOR PHYSICIANS, WITH RESPECT TO ADULT ENROLLEES, 2,000 TO 1;

(II) FOR PHYSICIANS, WITH RESPECT TO ENROLLEES UNDER THE AGE OF 21 YEARS, 1,500 TO 1; AND

(III) FOR ADVANCED PRACTICE NURSES, 1,000 TO 1.

(5) IN DEVELOPING THE APPOINTMENT GUIDELINES REQUIRED UNDER PARAGRAPH (3)(II)2 OF THIS SUBSECTION, THE COMMISSIONER SHALL CONSIDER THE FOLLOWING:

(I) APPOINTMENTS FOR ROUTINE AND PREVENTIVE PRIMARY CARE SHALL BE SCHEDULED TO BE PERFORMED WITHIN 30 DAYS OF AN ENROLLEE'S REQUEST FOR AN APPOINTMENT;

(II) APPOINTMENTS FOR ROUTINE SPECIALIST FOLLOW-UP SHALL BE SCHEDULED TO BE PERFORMED WITHIN 30 DAYS OF THE INITIAL AUTHORIZATION, IF REQUIRED, FROM THE ENROLLEE'S PRIMARY CARE PROVIDER, OR SOONER AS DEEMED NECESSARY BY THE ENROLLEE'S PRIMARY CARE PROVIDER, WHOSE STAFF SHALL MAKE THE APPOINTMENT DIRECTLY WITH THE SPECIALIST'S OFFICE; AND

(III) AT THE DISCRETION OF THE NEWBORN'S PRIMARY CARE PROVIDER, APPOINTMENTS FOR NEWBORNS SHALL BE SCHEDULED TO BE PERFORMED:

1. WITHIN 14 DAYS AFTER DISCHARGE FROM A HOSPITAL IF NO HOME VISIT HAS OCCURRED; OR

2. WITHIN 30 DAYS OF DISCHARGE FROM A HOSPITAL IF A HOME VISIT HAS BEEN PROVIDED.

[(e)] (F) A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under Title 19, Subtitle 13 of the Health - General Article; or

(3) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection [(h)] (I) of this section.

[(f)] (G) (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license, certification, or other authorization of the provider to provide health care services if the carrier provides health care services within the provider's lawful scope of practice.

(2) Notwithstanding paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on its provider panel based on the participation on the provider panel of a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

[(g)] (H) A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection [(h)] (I) of this section; or

(2) filing an appeal under Title 19, Subtitle 13 of the Health - General Article.

[(h)] (I) Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel, including

grievances involving the termination of a provider from participation on the carrier's provider panel.

[(i)] (J) (1) For at least 90 days after the date of the notice of termination of a primary care provider from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the primary care provider shall furnish health care services to each enrollee:

(i) who was receiving health care services from the primary care provider before the notice of termination; and

(ii) who, after receiving notice under subsection (b) of this section of the termination of the primary care provider, requests to continue receiving health care services from the primary care provider.

(2) A carrier shall reimburse a primary care provider that furnishes health care services under this subsection in accordance with the primary care provider's agreement with the carrier.

[(j)] (K) (1) A carrier shall provide to prospective enrollees before enrollment and to existing enrollees at least once a year:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(2) The information provided under paragraph (1) of this subsection shall be updated at least once a year.

(3) A policy, certificate, or other evidence of coverage shall:

(i) indicate clearly the office in the Administration that is responsible for receiving and responding to complaints from enrollees about carriers; and

(ii) include the telephone number of the office and the procedure for filing a complaint.

[(k)] (L) The Commissioner:

(1) shall adopt regulations that relate to the procedures that carriers must use to process applications for participation on a provider panel; and

(2) in consultation with the Secretary of Health and Mental Hygiene, shall adopt strategies to assist carriers in maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

15-113.

(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 that provides health benefit plans subject to regulation by the State.

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

(b) A carrier may not reimburse 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 does not prohibit a carrier from providing bonuses or other incentive-based compensation to a health care practitioner if the bonus or other incentive-based compensation does not:

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

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

(C) (1) A CARRIER MAY NOT OFFER OR PAY BONUSES, INCENTIVES, OR OTHER FINANCIAL COMPENSATION, DIRECTLY OR INDIRECTLY, TO A HEALTH CARE PRACTITIONER OR CREATE ANY FINANCIAL DISINCENTIVES FOR A HEALTH CARE PRACTITIONER THAT WOULD, BY THEIR APPLICATION, INDUCE THE HEALTH CARE PRACTITIONER TO DENY, WITHHOLD, OR DELAY THE PROVISION OF MEDICALLY NECESSARY OR APPROPRIATE CARE TO AN ENROLLEE OR INSURED THAT THE ENROLLEE OR INSURED IS OTHERWISE ENTITLED TO RECEIVE UNDER THE ENROLLEE'S OR INSURED'S CONTRACT OR POLICY WITH THE CARRIER.

(2) THIS SUBSECTION DOES NOT PROHIBIT A CARRIER FROM USING CAPITATED RATES TO REIMBURSE A HEALTH CARE PRACTITIONER FOR HEALTH CARE SERVICES PROVIDED TO ITS ENROLLEES OR INSUREDS.

15-116.

(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 that provides health benefit plans subject to regulation by the State.

(3) "HEALTH CARE FACILITY" HAS THE MEANING STATED IN § 19-101(F) OF THE HEALTH - GENERAL ARTICLE.

[(3)] (4) "Health care provider" means an 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 provider or in any other manner, may not prohibit a health care provider from discussing with or communicating to an enrollee, subscriber, public official, or other person information that is necessary or appropriate for the delivery of health care services, including:

(1) communications that relate to treatment alternatives;

(2) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under the health care provider's care;

(3) communications that relate to an enrollee's or subscriber's right to appeal a coverage determination of a carrier with which the health care provider, enrollee, or subscriber does not agree; and

(4) opinions and the basis of an opinion about public policy issues.

(C) (1) IN ADDITION TO THE PROVISIONS OF SUBSECTION (B) OF THIS SECTION, A CARRIER MAY NOT PENALIZE A HEALTH CARE PROVIDER, WHO IN GOOD FAITH, REPORTS TO STATE OR FEDERAL AUTHORITIES ANY ACT OR PRACTICE BY THE CARRIER THAT JEOPARDIZES PATIENT HEALTH OR WELFARE.

(2) IN ADDITION TO PARAGRAPH (1) OF THIS SUBSECTION, A CARRIER OR HEALTH CARE PROVIDER OR HEALTH CARE FACILITY, EMPLOYED BY OR UNDER CONTRACT WITH THE CARRIER, MAY NOT TERMINATE OR TAKE OTHER ADVERSE ACTION AGAINST A HEALTH CARE PROVIDER OR AN EMPLOYEE OR GROUP OF EMPLOYEES OF A CARRIER FOR ACTIONS TAKEN BY THE HEALTH CARE PROVIDER, EMPLOYEE, OR GROUP FOR THE PURPOSE OF:

(I) NOTIFYING A CARRIER, HEALTH CARE PROVIDER, HEALTH CARE FACILITY, OR PATIENT OF CONDITIONS WHICH THE HEALTH CARE PROVIDER, EMPLOYEE, OR GROUP OF EMPLOYEES IDENTIFY IN THEIR COMMUNICATIONS WITH THE CARRIER, HEALTH CARE PROVIDER, OR HEALTH CARE FACILITY AS DANGEROUS OR POTENTIALLY DANGEROUS OR INJURIOUS TO:

1. PATIENTS WHO ARE CURRENTLY RECEIVING HEALTH CARE SERVICES FROM THE CARRIER, HEALTH CARE PROVIDER, OR HEALTH CARE FACILITY;

2. INDIVIDUALS WHO ARE LIKELY TO RECEIVE HEALTH CARE SERVICES FROM THE CARRIER, HEALTH CARE PROVIDER, OR HEALTH CARE FACILITY; OR

3. EMPLOYEES OF THE CARRIER, HEALTH CARE PROVIDER, OR HEALTH CARE FACILITY;

(II) NOTIFYING A FEDERAL OR STATE AGENCY OR AN ACCREDITATION AGENCY OF THE CONDITIONS IDENTIFIED IN ITEM (I) OF THIS PARAGRAPH;

(III) NOTIFYING OTHER INDIVIDUALS OF CONDITIONS THAT THE HEALTH CARE PROVIDER, EMPLOYEE, OR GROUP OF EMPLOYEES REASONABLY BELIEVE TO BE SUCH AS IDENTIFIED IN ITEM (I) OF THIS PARAGRAPH; AND

(IV) DISCUSSING THE CONDITIONS THAT ARE IDENTIFIED IN ITEM (I) OF THIS PARAGRAPH WITH OTHER HEALTH CARE PROVIDERS OR EMPLOYEES FOR THE PURPOSE OF INITIATING THE ACTION DESCRIBED IN ITEMS (I) THROUGH (III) OF THIS PARAGRAPH.

[(c)] (D) This section does not prohibit a carrier, as a condition of a contract between the carrier and a health care provider, from prohibiting tortious interference with a contract as recognized under State law.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1997.