Unofficial Copy 1997 Regular Session
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By: Senators Young, Dorman, and Bromwell
Introduced and read first time: February 19, 1997
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Health Benefit Plans - Quality of Health Care Services

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 health care facilities to have a certain minimum staffing level; requiring the Secretary of Health and Mental Hygiene to adopt certain standards related to the minimum staffing level; prohibiting a private review agent and certain other individuals from denying certain health care services to a patient unless certain conditions are met; prohibiting a carrier from denying certain health care services to an enrollee unless certain conditions are met; prohibiting a carrier from terminating a provider from its provider panel for advocating the interest of a patient by reporting certain information to certain persons; requiring carriers to establish certain criteria related to authorizing or denying payment for health care services and for assuring a certain quality of health care services being provided; specifying the manner in which the criteria will be developed; requiring carriers to submit certain information to the Insurance Commissioner in regard to certain costs of the carrier; defining certain terms; and generally relating to prohibiting certain health insurance carriers and other persons from taking certain actions and requiring certain health insurance carriers and other persons to establish certain criteria or standards for purposes of assuring the provision of quality of health care services.

BY adding to
Article - Health - General
Section 19-127 to be under the amended part "Part II. Miscellaneous Provisions"; and 19-706(n)
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-1305.3
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, without amendments,

Article - Insurance
Section 15-112(a)
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)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-112(g), 15-113, and 15-605
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)

BY adding to
Article - Insurance
Section 15-121
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 - Health - General

Part II. MISCELLANEOUS PROVISIONS [Deficiencies in Services and Facilities].

19-127.

(A) ALL HEALTH CARE FACILITIES SHALL PROVIDE MINIMUM SAFE AND ADEQUATE STAFFING OF PHYSICIANS, NURSES, AND OTHER LICENSED AND CERTIFIED HEALTH CARE PRACTITIONERS.

(B) (1) THE SECRETARY SHALL ESTABLISH BY REGULATION, AND PERIODICALLY UPDATE, STAFFING STANDARDS DESIGNED TO ASSURE MINIMUM SAFE AND ADEQUATE LEVELS OF PATIENT CARE IN HEALTH CARE FACILITIES LICENSED BY THE DEPARTMENT.

(2) THE STANDARDS SHALL BE BASED ON THE FOLLOWING:

(I) THE SEVERITY OF PATIENT ILLNESS;

(II) FACTORS AFFECTING THE PERIOD AND QUALITY OF PATIENT RECOVERY; AND

(III) ANY OTHER FACTOR SUBSTANTIALLY RELATED TO THE CONDITION AND HEALTH CARE NEEDS OF PATIENTS.

(C) EACH HEALTH CARE FACILITY SHALL MAKE AVAILABLE FOR PUBLIC INSPECTION:

(1) THE DAILY STAFFING PATTERNS IT UTILIZES; AND

(2) ITS WRITTEN PLAN FOR ASSURING COMPLIANCE WITH THE STAFFING STANDARDS ESTABLISHED BY THE SECRETARY UNDER SUBSECTION (B) OF THIS SECTION.

19-706.

(N) THE PROVISIONS OF § 15-121 OF THE INSURANCE ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19-1305.3.

(a) Except as provided in subsection (b) of this section AND SUBJECT TO SUBSECTION (F) OF THIS SECTION, a private review agent shall:

(1) Make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within 2 working days of receipt of the information necessary to make the determination; and

(2) Promptly notify the attending health care provider and patient of the determination.

(b) A private review agent shall:

(1) Make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within 1 working day of receipt of the information necessary to make the determination; and

(2) Promptly notify the attending health care provider of the determination.

(c) If an initial determination is made by the private review agent not to authorize or certify a course of treatment, an extended stay in a health care facility, or additional health care services and the attending health care provider believes the determination warrants an immediate reconsideration, the private review agent shall provide the attending health care provider an opportunity to seek a reconsideration of that determination by telephone on an expedited basis not to exceed 24 hours of the health care provider seeking the reconsideration.

(d) For emergency inpatient admissions, a private review agent may not render an adverse decision or deny coverage for medically necessary covered services solely because the hospital did not notify the private review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining:

(1) The patient's insurance status; and

(2) The private review agent's emergency admission notification requirements.

(e) For an involuntary or voluntary inpatient admission of a patient determined by the patient's physician or psychologist in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, a private review agent may not render an adverse decision as to the admission of

a patient during the first 24 hours the patient is in an inpatient facility or until the next business day of the private review agent, whichever is later. The hospital shall immediately notify the private review agent that a patient has been admitted and shall state the reasons for the admission.

(F) A PRIVATE REVIEW AGENT MAY NOT DENY HEALTH CARE SERVICES TO A PATIENT TO WHICH THE PATIENT IS OTHERWISE ENTITLED TO RECEIVE AND WHICH HAVE BEEN RECOMMENDED BY THE PATIENT'S ATTENDING PHYSICIAN OR OTHER APPROPRIATELY LICENSED HEALTH CARE PRACTITIONER ACTING WITHIN THEIR SCOPE OF PRACTICE, UNLESS ALL OF THE FOLLOWING CONDITIONS ARE MET:

(1) THE PRIVATE REVIEW AGENT, OR AN INDIVIDUAL AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF THE PRIVATE REVIEW AGENT, WHO AUTHORIZED THE DENIAL OF THE HEALTH CARE SERVICES PHYSICALLY EXAMINED THE PATIENT IN A TIMELY MANNER;

(2) THE PRIVATE REVIEW AGENT, OR AN INDIVIDUAL AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF THE PRIVATE REVIEW AGENT, IS AN APPROPRIATELY LICENSED HEALTH CARE PRACTITIONER WITH THE EDUCATION, TRAINING, AND RELEVANT EXPERTISE THAT IS APPROPRIATE FOR EVALUATING THE SPECIFIC CLINICAL ISSUES INVOLVED IN THE DENIAL; AND

(3) THE DENIAL AND THE REASONS FOR THE DENIAL HAVE BEEN COMMUNICATED BY THE PRIVATE REVIEW AGENT OR AN INDIVIDUAL AFFILIATED WITH, UNDER CONTRACT WITH, OR ACTING ON BEHALF OF THE PRIVATE REVIEW AGENT TO THE PATIENT'S ATTENDING PHYSICIAN OR OTHER APPROPRIATELY LICENSED HEALTH CARE PRACTITIONER.

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.

(g) (1) A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

[(1)] (I) advocating the interests of a patient IN PUBLIC OR INTERNALLY through the carrier's internal review system established under subsection (h) of this section OR REPORTING ANY VIOLATION OF STATE OR FEDERAL LAW BY THE CARRIER TO APPROPRIATE AUTHORITIES; or

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

(2) A CARRIER MAY ONLY TERMINATE A HEALTH CARE PROVIDER FROM PARTICIPATION ON ITS PROVIDER PANEL FOR JUST CAUSE, WHICH INCLUDES PROVEN MALPRACTICE, PATIENT ENDANGERMENT, SUBSTANCE ABUSE, SEXUAL ABUSE OF PATIENTS, OR ECONOMIC NECESSITY.

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 FOR THE DENIAL, WITHHOLDING, OR DELAY OF MEDICALLY APPROPRIATE CARE TO WHICH ENROLLEES OR INSUREDS ARE 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.

15-121.

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

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

(B) (1) EACH CARRIER SHALL ESTABLISH CRITERIA FOR:

(I) AUTHORIZING OR DENYING PAYMENT FOR HEALTH CARE SERVICES; AND

(II) ASSURING THE QUALITY OF HEALTH CARE SERVICES PROVIDED TO ENROLLEES BY HEALTH CARE PRACTITIONERS EMPLOYED BY OR UNDER CONTRACT WITH THE CARRIER.

(2) THE CRITERIA SHALL:

(I) BE DEVELOPED BY HEALTH CARE PRACTITIONERS EMPLOYED BY OR UNDER CONTRACT WITH THE CARRIER THAT PROVIDE DIRECT CARE TO PATIENTS;

(II) USE SOLID CLINICAL PRINCIPLES AND PROCESSES;

(III) BE UPDATED AT LEAST ANNUALLY; AND

(IV) BE PUBLICLY AVAILABLE AT THE REQUEST OF A CURRENT ENROLLEE OR PROSPECTIVE ENROLLEE OF THE CARRIER.

(C) A CARRIER MAY NOT DENY HEALTH CARE SERVICES TO AN ENROLLEE TO WHICH THE ENROLLEE IS OTHERWISE ENTITLED TO RECEIVE UNDER THE ENROLLEE'S POLICY OR CONTRACT WITH THE CARRIER AND WHICH THE ENROLLEE'S HEALTH CARE PRACTITIONER RECOMMENDED UNLESS ALL OF THE FOLLOWING CONDITIONS ARE MET:

(1) THE INDIVIDUAL WHO AUTHORIZED THE DENIAL OF THE HEALTH CARE SERVICES PHYSICALLY EXAMINED THE ENROLLEE IN A TIMELY MANNER;

(2) THE INDIVIDUAL IS AN APPROPRIATELY LICENSED HEALTH CARE PRACTITIONER WITH THE EDUCATION, TRAINING, AND RELEVANT EXPERTISE THAT IS APPROPRIATE FOR EVALUATING THE SPECIFIC CLINICAL ISSUES INVOLVED IN THE DENIAL; AND

(3) THE DENIAL AND THE REASONS FOR THE DENIAL HAVE BEEN COMMUNICATED BY THE INDIVIDUAL TO THE ENROLLEE'S HEALTH CARE PRACTITIONER.

15-605.

(a) (1) On or before March 1 of each year, an annual report that meets the specifications of paragraph (2) of this subsection shall be submitted to the Commissioner by:

(i) each authorized insurer that provides health insurance in the State;

(ii) each nonprofit health service plan that is authorized by the Commissioner to operate in the State;

(iii) each health maintenance organization that is authorized by the Commissioner to operate in the State; and

(iv) as applicable in accordance with regulations adopted by the Commissioner, each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health - General Article.

(2) The annual report required under this subsection shall:

(i) be submitted in a form required by the Commissioner; and

(ii) include for the preceding calendar year the following data for all health benefit plans specific to the State:

1. premiums written;

2. premiums earned;

3. total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

4. total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, estimated if necessary;

5. loss ratio; and

6. expense ratio.

(3) The data required under paragraph (2) of this subsection shall be reported:

(i) by product delivery system for health benefit plans that are issued under Subtitle 12 of this title;

(ii) in the aggregate for health benefit plans that are issued to individuals;

(iii) in the aggregate for a managed care organization that operates under Title 15, Subtitle 1 of the Health - General Article; and

(iv) in a manner determined by the Commissioner in accordance with this subsection for all other health benefit plans.

(4) The Commissioner may conduct an examination to ensure that an annual report submitted under this subsection is accurate.

(5) Failure of an insurer, nonprofit health service plan, or health maintenance organization to submit the information required under this subsection in a timely manner shall result in a penalty of $500 for each day after March 1 that the information is not submitted.

(B) (1) AS PART OF THE DATA REQUIRED FOR THE ANNUAL REPORT UNDER SUBSECTION (A)(2) OF THIS SECTION, AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL INCLUDE, IN ADDITION TO THE TOTAL PREMIUMS WRITTEN, FEES AND OTHER PERIODIC PAYMENTS RECEIVED AND THE AMOUNT SPENT ON ADMINISTRATIVE COSTS.

(2) FOR PURPOSES OF THIS SUBSECTION, ADMINISTRATIVE COSTS SHALL INCLUDE THE FOLLOWING:

(I) MARKETING AND ADVERTISING, INCLUDING SALES COSTS AND COMMISSIONS;

(II) TOTAL COMPENSATION, INCLUDING BONUSES, INCENTIVES, AND STOCK OPTIONS FOR OFFICERS AND DIRECTORS OF THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION;

(III) DIVIDENDS, SHARES OF PROFIT, AND ANY OTHER COMPENSATION RECEIVED BY SHAREHOLDERS, IF ANY, OR ANY OTHER REVENUE IN EXCESS OF EXPENDITURES FOR THE DIRECT PROVISION OF HEALTH CARE SERVICES; AND

(IV) ALL OTHER EXPENSES NOT RELATED TO THE PROVISION OF DIRECT HEALTH CARE SERVICES.

(3) IF THE AMOUNT OF ADMINISTRATIVE COSTS EXCEEDS 10% OF THE TOTAL PREMIUMS, FEES, AND OTHER PERIODIC PAYMENTS RECEIVED BY THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL FURTHER PROVIDE TO THE COMMISSIONER THE SPECIFIC AMOUNTS SPENT ON MARKETING AND ADVERTISING, ON TOTAL COMPENSATION, DIVIDENDS, PROFITS OR EXCESS REVENUES, AND ON OTHER EXPENSES NOT RELATED TO THE PROVISION OF DIRECT HEALTH CARE SERVICES.

[(b)] (C) (1) Before a managed care organization may enroll a medical assistance program recipient, the managed care organization shall provide a business plan to the Commissioner.

(2) As part of the annual report required under subsection (a) of this section, a managed care organization shall:

(i) file a consolidated financial statement in accordance with paragraph (3) of this subsection;

(ii) provide a list of the total compensation from the managed care organization, including all cash and deferred compensation, stock, and stock options in addition to salary, of each member of the Board of Directors of the managed care organization, and each senior officer of the managed care organization or any subsidiary of the managed care organization as designated by the Commissioner; and

(iii) provide any other information or documents necessary for the Commissioner to ensure compliance with this subsection and subsections (a)(3)(iii) and [(c)] (D)(5), (6), and (7) of this section and for the Secretary of Health and Mental Hygiene to carry out Title 15, Subtitle 1 of the Health - General Article.

(3) The consolidated financial statement shall:

(i) cover the managed care organization and each of its affiliates and subsidiaries; and

(ii) consist of the financial statements of the managed care organization and each of its affiliates and subsidiaries prepared in accordance with statutory accounting principles and on a form approved by the Commissioner, and certified to by an independent certified public accountant as to the financial condition, transactions, and affairs of the managed care organization and its affiliates and subsidiaries for the immediately preceding calendar year.

[(c)] (D) (1) For a health benefit plan that is issued under Subtitle 12 of this title, the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 75%.

(2) (i) subject to subparagraph (ii) of this paragraph, for a health benefit plan that is issued to individuals the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 60%.

(ii) Subparagraph (i) of this paragraph does not apply to an insurance product that:

1. is listed under § 15-1201(f)(3) of this title; or

2. is nonrenewable and has a policy term of no more than 6 months.

(iii) The Commissioner may establish a loss ratio for each insurance product described in subparagraph (ii)1 and 2 of this paragraph.

(3) The authority of the Commissioner under paragraphs (1) and (2) of this subsection to require an insurer, nonprofit health service plan, or health maintenance organization to file new rates based on loss ratio:

(i) is in addition to any other authority of the Commissioner under this article to require that rates not be excessive, inadequate, or unfairly discriminatory; and

(ii) does not limit any existing authority of the Commissioner to determine whether a rate is excessive.

(4) (i) In determining whether to require an insurer to file new rates under this subsection, the Commissioner may consider the amount of health insurance premiums earned in the State on individual policies in proportion to the total health insurance premiums earned in the State for the insurer.

(ii) The insurer shall provide to the Commissioner the information necessary to determine the proportion of individual health insurance premiums to total health insurance premiums as provided under this paragraph.

(5) The Secretary of Health and Mental Hygiene, in consultation with the Commissioner and in accordance with their memorandum of understanding, may adjust capitation payments for a managed care organization or for the Maryland Medical Assistance Program of a managed care organization that is a certified health maintenance organization:

(i) if the loss ratio is less than 80% during calendar year 1997; and

(ii) during each subsequent calendar year if the loss ratio is less than 85%.

(6) A loss ratio reported under paragraph (5) of this subsection shall be calculated separately and may not be part of another loss ratio reported under this section.

(7) Any rebate received by a managed care organization may not be considered part of the loss ratio of the managed care organization.

[(d)] (E) Each insurer, nonprofit health service plan, and health maintenance organization shall provide annually to each contract holder:

(1) THE INFORMATION REQUIRED TO BE SUBMITTED TO THE COMMISSIONER UNDER SUBSECTION (B) OF THIS SECTION; AND

(2) a written statement of the loss ratio for a health benefit plan as submitted to the Commissioner under this section.

[(e)] (F) (1) On or before May 1 of each year, the Commissioner shall transmit to the Health Care Access and Cost Commission any information it needs to evaluate the Comprehensive Standard Health Benefit Plan as required under § 15-1207 of this title.

(2) The information provided by the Commissioner shall be specified in regulations adopted by the Commissioner in consultation with the Health Care Access and Cost Commission.

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