Unofficial Copy **1998 Regular Session**
SB0401/377757/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL NO. 401
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in the sponsor line, strike "Senator Astle" and substitute "Senators Dorman, Bromwell, Green, Kelley, Madden, and Teitelbaum"; in line 21, after the semicolon, insert "establishing a certain health care regulatory assessment; transferring responsibility for investigating complaints concerning health maintenance organizations to the Insurance Commissioner; requiring the Secretary of Health and Mental Hygiene to adopt certain regulations and make a certain report to the Commissioner; altering certain penalties;"; after line 26, insert "altering certain provisions of law related to utilization review concerning the types of health care providers that may make an adverse determination or make a determination in the appeal of an adverse determination;"; strike beginning with "authorizing" in line 27 down through "authority;" in line 30 and substitute "requiring certain individuals to obtain a certification from the Commissioner in order to perform their responsibilities as a medical director for a health maintenance organization; requiring the Commissioner to adopt certain regulations related to the certification of medical directors;"; and in line 34, after "date;" insert "requiring the Maryland Insurance Administration to conduct a certain study by a certain date; providing for the delayed effective date of certain provisions of this Act;".

On page 2, in line 22, after "19-706(y)" insert "and (z)"; and in line 27, strike "19-729" and substitute "19-705.2, 19-729, and 19-730".

On pages 2 and 3, strike in their entirety the lines beginning with line 35 on page 2 through line 7 on page 3, inclusive.

On page 3, in line 10, after "15-1001" insert ", 27-303,"; in line 15, after "Section" insert "2-112.2;"; and in line 16, after "Grievances"" insert "; and 15-10C-01 through 15-10C-04, inclusive, to be under the new subtitle "Subtitle 10C. Medical Directors""".

AMENDMENT NO. 2

(Over)

On page 4, after line 5 insert:

"19-705.2.

(a) With the advice of the [Commissioner] SECRETARY, the [Secretary] COMMISSIONER shall adopt regulations to establish a system for the receipt and timely investigation of complaints of members and subscribers of health maintenance organizations concerning the operation of any health maintenance organization in this State.

(b) The complaint system shall include:

(1) A procedure for the timely acknowledgement of receipt of a complaint;

(2) Criteria THAT THE SECRETARY SHALL ADOPT BY REGULATION for determining the appropriate level of investigation for a complaint concerning quality of care, including:

(i) A determination as to whether the member or subscriber with the complaint previously attempted to have the complaint resolved; and

(ii) A determination as to whether a complaint should be sent to the member's or subscriber's health maintenance organization for resolution prior to investigation under the provisions of this section; and

(3) A procedure for the referral OF QUALITY OF CARE COMPLAINTS to the [Commissioner] SECRETARY [of all complaints, other than quality of care complaints,] for an appropriate investigation.

(c) If a determination is made to investigate a complaint under the provisions of this section prior to the member or subscriber attempting to otherwise resolve the complaint, the reasons for that determination shall be documented.

(d) Notice of the complaint system established under the provisions of this section shall be included in all contracts between a health maintenance organization and a member or subscriber of a health maintenance organization.

(E) FOR QUALITY OF CARE COMPLAINTS REFERRED TO THE SECRETARY FOR INVESTIGATION UNDER SUBSECTION (B)(3) OF THIS SECTION, THE SECRETARY

SHALL REPORT TO THE COMMISSIONER IN A TIMELY MANNER ON THE RESULTS AND FINDINGS OF EACH INVESTIGATION.".

AMENDMENT NO. 3

On page 4, after line 8, insert:

"(Z) THE PROVISIONS OF § 2-112.2 OF THE INSURANCE ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.";

and in line 31, after "SUBTITLE 10A" insert "AND § 2-112.2".

AMENDMENT NO. 4

On page 5, after line 3, insert:

"19-730.

If any person violates any provision of § 19-729 of this subtitle, the Commissioner may:

(1) Issue an administrative order that requires the health maintenance organization to:

(i) Cease inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(ii) Fulfill its contractual obligations;

(iii) Provide a service that has been denied improperly;

(iv) Take appropriate steps to restore its ability to provide a service that is provided under a contract;

(v) Cease the enrollment of any additional enrollees except newborn children or other newly acquired dependents or existing enrollees; or

(vi) Cease any advertising or solicitation;

(2) Impose a penalty of not more than [$1,000] $5,000 for each unlawful act committed;

(3) Suspend or revoke the certificate of authority to do business as a health maintenance organization; or

(4) Apply to any court for legal or equitable relief considered appropriate by the Commissioner or the Department, in accordance with the joint internal procedures.".

AMENDMENT NO. 5

On page 5, strike in their entirety lines 4 through 36, inclusive.

AMENDMENT NO. 6

On page 6, after line 1, insert:

"2-112.2.

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

(2) "CARRIER" MEANS:

(I) AN INSURER THAT OFFERS HEALTH INSURANCE;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

(V) EXCEPT FOR A MANAGED CARE ORGANIZATION AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH-GENERAL ARTICLE, ANY OTHER PERSON

THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(3) (I) "PREMIUM" HAS THE MEANING STATED IN § 1-101 OF THIS ARTICLE TO THE EXTENT IT IS ALLOCABLE TO HEALTH INSURANCE POLICIES OR CONTRACTS ISSUED OR DELIVERED IN THIS STATE.

(II) "PREMIUM" INCLUDES ANY AMOUNTS PAID TO A HEALTH MAINTENANCE ORGANIZATION AS COMPENSATION FOR PROVIDING TO MEMBERS AND SUBSCRIBERS THE SERVICES SPECIFIED IN TITLE 19, SUBTITLE 7 OF THE HEALTH-GENERAL ARTICLE TO THE EXTENT THE AMOUNTS ARE ALLOCABLE TO THIS STATE.

(B) THE COMMISSIONER SHALL COLLECT A HEALTH CARE REGULATORY ASSESSMENT FROM EACH CARRIER FOR THE COSTS ATTRIBUTABLE TO THE IMPLEMENTATION OF TITLE 15, SUBTITLES 10A AND 10B OF THIS ARTICLE.

(C) THE HEALTH CARE REGULATORY ASSESSMENT THAT IS PAYABLE BY EACH CARRIER SHALL BE CALCULATED BY TAKING THE TOTAL COSTS UNDER SUBSECTION (B) OF THIS SECTION MULTIPLIED BY THE PERCENTAGE OF GROSS DIRECT HEALTH INSURANCE PREMIUMS WRITTEN IN THE STATE ATTRIBUTABLE TO THAT CARRIER IN THE PRIOR CALENDAR YEAR.".

AMENDMENT NO. 7

On page 6, strike in their entirety lines 25 through 31, inclusive, and substitute:

"(B) (1) "ADVERSE DECISION" MEANS A UTILIZATION REVIEW DETERMINATION BY A PRIVATE REVIEW AGENT, A CARRIER, OR A HEALTH CARE PROVIDER ACTING ON BEHALF OF A CARRIER THAT:

(I) A PROPOSED OR DELIVERED HEALTH CARE SERVICE COVERED UNDER THE MEMBER'S CONTRACT IS OR WAS NOT MEDICALLY NECESSARY, APPROPRIATE, OR EFFICIENT; AND

(II) MAY RESULT IN NONCOVERAGE OF THE HEALTH CARE SERVICE.".

AMENDMENT NO. 8

On page 7, after line 9, insert:

"(E) "GRIEVANCE" MEANS A PROTEST FILED BY A MEMBER OR A HEALTH CARE PROVIDER ON BEHALF OF A MEMBER WITH A CARRIER THROUGH THE CARRIER'S INTERNAL GRIEVANCE PROCESS REGARDING AN ADVERSE DECISION CONCERNING THE MEMBER.";

in lines 10, 13, 17, and 32, strike "(E)", "(F)", "(G)", and "(I)", respectively, and substitute "(F)", "(G)", "(H)", and "(J)", respectively; in line 20, after "PROFESSION" insert "AND IS A TREATING PROVIDER OF THE MEMBER"; strike beginning with "A" in line 21 down through "(I)" in line 22; in line 22, after "HOSPITAL" insert "AS DEFINED"; in the same line, strike the semicolon and substitute a period; and strike in their entirety lines 23 through 31, inclusive, and substitute:

"(I) "HEALTH CARE SERVICE" MEANS A SERVICE, AN ITEM OF MEDICAL EQUIPMENT, OR SUPPLIES, AS DESCRIBED IN §19-701(E)(2) OF THE HEALTH-GENERAL ARTICLE.".

AMENDMENT NO. 9

On page 8, in line 1, after "INCLUDES" insert ":

(I)";

in the same line, after "SUBSCRIBER" insert "; AND

(II) UNLESS PREEMPTED BY FEDERAL LAW, A MEDICARE RECIPIENT.

(3) "MEMBER" DOES NOT INCLUDE A MEDICAID RECIPIENT";

in line 2, strike "(J)" and substitute "(K)"; in line 15, after "DECISION" insert "IN PRINT"; in line 19, strike "OR"; in line 22, strike "AND" and substitute "OR"; after line 22 insert:

"3. THE GRIEVANCE INVOLVES A RETROSPECTIVE DENIAL UNDER ITEM (IV) OF THIS PARAGRAPH;";

in line 24, strike the period and substitute a semicolon; after line 24 insert:

"(IV) PROVIDE THAT A CARRIER RENDER A FINAL DECISION IN PRINT ON A GRIEVANCE WITHIN 45 DAYS AFTER THE DATE ON WHICH THE GRIEVANCE IS FILED WHEN THE GRIEVANCE INVOLVES A RETROSPECTIVE DENIAL; AND

(V) PROVIDE FOR COVERAGE OF HOSPITAL SERVICES WHENEVER THE INTERNAL GRIEVANCE PROCESS REVERSES AN ADVERSE DECISION PERTAINING TO THE SERVICES OF A HEALTH CARE PROVIDER TO A MEMBER DURING A PERIOD OF HOSPITALIZATION.";

strike in their entirety lines 25 through 28, inclusive, and substitute:

"(C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, THE CARRIER'S INTERNAL GRIEVANCE PROCESS SHALL BE EXHAUSTED PRIOR TO FILING A COMPLAINT WITH THE COMMISSIONER UNDER THIS SUBTITLE.

(D) (1) (I) A MEMBER OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON BEHALF OF A MEMBER MAY FILE A COMPLAINT WITH THE COMMISSIONER WITHOUT FIRST FILING A GRIEVANCE WITH A CARRIER AND RECEIVING A FINAL DECISION ON THE GRIEVANCE IF THE MEMBER OR THE HEALTH CARE PROVIDER PROVIDES SUFFICIENT INFORMATION AND SUPPORTING DOCUMENTATION IN THE COMPLAINT THAT DEMONSTRATES A COMPELLING REASON TO DO SO.

(II) THE COMMISSIONER SHALL DEFINE BY REGULATION THE STANDARDS THAT THE COMMISSIONER SHALL USE TO DECIDE WHAT

DEMONSTRATES A COMPELLING REASON UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.

(2) SUBJECT TO SUBSECTIONS (B)(2)(II) AND (H) OF THIS SECTION, A MEMBER OR A HEALTH CARE PROVIDER MAY FILE A COMPLAINT WITH THE COMMISSIONER IF THE MEMBER OR THE HEALTH CARE PROVIDER DOES NOT RECEIVE A GRIEVANCE DECISION FROM THE CARRIER ON OR BEFORE THE 30TH DAY ON WHICH THE GRIEVANCE IS FILED.

(3) WHENEVER THE COMMISSIONER RECEIVES A COMPLAINT UNDER PARAGRAPH (1) OR (2) OF THIS SUBSECTION, THE COMMISSIONER SHALL NOTIFY THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT WITHIN 7 DAYS AFTER THE DATE THE COMPLAINT IS FILED WITH THE COMMISSIONER.";

and in lines 29 and 34, strike "(D)" and "(E)", respectively, and substitute "(E)" and "(F)", respectively.

On page 9, in lines 22 and 31, strike "(F)" and "(G)", respectively, and substitute "(G)" and "(H)", respectively; and in line 31, after "DAY" insert "OR 45-DAY".

On page 10, in lines 1 and 32, strike "(H)" and "(I)", respectively, and substitute "(I)" and "(J)", respectively; and in line 27, after "NOT" insert "SOLELY".

AMENDMENT NO. 10

On page 11, in line 5, strike "(J)" and substitute "(K)"; in line 6, strike "(H)(2)(III)" and substitute "(I)(2)(III)"; and after line 9 insert:

"(L) (1) NOTHING IN THIS SUBTITLE PROHIBITS A CARRIER FROM DELEGATING ITS INTERNAL GRIEVANCE PROCESS TO A PRIVATE REVIEW AGENT THAT HAS A CERTIFICATE ISSUED UNDER SUBTITLE 10B OF THIS TITLE AND IS ACTING ON BEHALF OF THAT CARRIER.

(2) IF A CARRIER DELEGATES ITS INTERNAL GRIEVANCE PROCESS TO A PRIVATE REVIEW AGENT, THE CARRIER SHALL BE BOUND BY THE DETERMINATION

MADE BY THE PRIVATE REVIEW AGENT ACTING ON THE CARRIER'S BEHALF.".

AMENDMENT NO. 11

On page 11, in line 4, strike "(H)" and substitute "(I)"; in line 11, after "(A)" insert "(1)"; after line 15, insert:

"(2) EXCEPT FOR AN EMERGENCY CASE UNDER SUBSECTION (B)(2) OF THIS SECTION, THE CARRIER THAT IS THE SUBJECT OF A COMPLAINT FILED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL PROVIDE TO THE COMMISSIONER ANY INFORMATION REQUESTED BY THE COMMISSIONER NO LATER THAN 7 DAYS FROM THE DATE THE CARRIER RECEIVES THE REQUEST FOR INFORMATION.";

in line 16, after "(B)" insert "(1)"; in lines 18 and 20, strike "(1)" and "(2)", respectively and substitute "(I)" and "(II)", respectively; after line 22, insert:

"(2) FOR PURPOSES OF USING THE EXPEDITED PROCEDURE FOR AN EMERGENCY CASE UNDER PARAGRAPH (1)(II) OF THIS SUBSECTION, THE COMMISSIONER SHALL DEFINE BY REGULATION THE STANDARDS REQUIRED FOR A GRIEVANCE TO BE CONSIDERED AN EMERGENCY CASE.";

in line 23, after "(C)" insert:

"(1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION AND";

in the same line, strike "(B)(2)" and substitute "(B)(1)(II)"; in line 24, after "COMPLAINT" insert a colon; and strike line 25 in its entirety and substitute:

"(I) WITHIN 30 DAYS AFTER A COMPLAINT REGARDING A PENDING HEALTH CARE SERVICE IS FILED; AND

(II) WITHIN 45 DAYS AFTER A COMPLAINT IS FILED REGARDING A RETROSPECTIVE DENIAL OF SERVICES ALREADY PROVIDED.

(Over)

(2) THE COMMISSIONER MAY EXTEND THE PERIOD IN WHICH A FINAL DECISION SHALL BE MADE UNDER PARAGRAPH (1) OF THIS SUBSECTION FOR UP TO 30 ADDITIONAL DAYS ONLY IF THE COMMISSIONER HAS NOT YET RECEIVED INFORMATION:

(I) REQUESTED BY THE COMMISSIONER; AND

(II) NECESSARY TO RENDER A FINAL DECISION ON A COMPLAINT.".

AMENDMENT NO. 12

On page 12, in line 1, strike "§ 15-10A-02(H)" and substitute "§ 15-10A-02(I)"; in line 6, after "(4)" insert "(I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH,"; after line 7, insert:

"(II) THE COMMISSIONER MAY ALLOW A CARRIER, A MEMBER, OR A HEALTH CARE PROVIDER FILING A COMPLAINT ON BEHALF OF A MEMBER TO PROVIDE ADDITIONAL INFORMATION AS MAY BE RELEVANT FOR THE COMMISSIONER TO MAKE A FINAL DECISION ON THE COMPLAINT.

(III) THE COMMISSIONER'S USE OF ADDITIONAL INFORMATION MAY NOT DELAY THE COMMISSIONER'S DECISION ON THE COMPLAINT BY MORE THAN 7 DAYS.";

after line 14, insert:

"(1) PRIORITIZE FOR A DECISION COMPLAINTS REGARDING PENDING HEALTH CARE SERVICES OVER COMPLAINTS REGARDING SERVICES ALREADY DELIVERED;

(2) ORDER PAYMENT FOR ANY MEDICALLY NECESSARY HOSPITAL SERVICES WHENEVER THE COMMISSIONER REVERSES AN ADVERSE DECISION OR GRIEVANCE DECISION PERTAINING TO THE SERVICES OF A HEALTH CARE PROVIDER TO A MEMBER DURING A PERIOD OF HOSPITALIZATION;";

in lines 15 and 18, strike "(1)" and "(2)", respectively, and substitute "(3)" and "(4)", respectively; strike beginning with "TITLE" in line 20 down through "SUBTITLE" in line 22 and substitute "§ 2-210 OF THIS ARTICLE"; and in line 30, strike "(2)" and substitute "(4)".

AMENDMENT NO. 13

On page 12, strike in their entirety, lines 31 through 34, inclusive, and substitute:

"(C) (1) IT IS A VIOLATION OF THIS SUBTITLE FOR A CARRIER TO FAIL TO FULFILL THE CARRIER'S OBLIGATIONS TO PROVIDE OR REIMBURSE FOR HEALTH CARE SERVICES SPECIFIED IN THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS.

(2) IF, IN RENDERING AN ADVERSE DECISION OR GRIEVANCE DECISION, A CARRIER FAILS TO FULFILL THE CARRIER'S OBLIGATIONS TO PROVIDE OR REIMBURSE FOR HEALTH CARE SERVICES SPECIFIED IN THE CARRIER'S POLICIES OR CONTRACTS WITH MEMBERS, THE COMMISSIONER MAY:

(I) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES THE CARRIER TO:

1. CEASE INAPPROPRIATE CONDUCT OR PRACTICES BY THE CARRIER OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH THE CARRIER;

2. FULFILL THE CARRIER'S CONTRACTUAL OBLIGATIONS;

3. PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT HAS BEEN DENIED IMPROPERLY; OR

4. TAKE APPROPRIATE STEPS TO RESTORE THE CARRIER'S ABILITY TO PROVIDE A HEALTH CARE SERVICE OR PAYMENT THAT IS PROVIDED UNDER A CONTRACT; OR

(II) IMPOSE ANY PENALTY OR FINE OR TAKE ANY ACTION AS AUTHORIZED:

1. FOR AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR DENTAL PLAN ORGANIZATION UNDER THIS ARTICLE; OR

2. FOR A HEALTH MAINTENANCE ORGANIZATION, UNDER THE HEALTH-GENERAL ARTICLE.".

AMENDMENT NO. 14

On page 13, in line 8, strike "(1)"; strike lines 12 and 13 in their entirety and substitute:

"(C) ANY EXPERT REVIEWER ASSIGNED BY AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT SHALL BE A PHYSICIAN OR OTHER APPROPRIATE HEALTH CARE PROVIDER WHO MEETS THE FOLLOWING MINIMUM REQUIREMENTS:

(1) BE AN EXPERT IN THE TREATMENT OF THE MEMBER'S MEDICAL CONDITION, AND KNOWLEDGEABLE ABOUT THE RECOMMENDED HEALTH CARE SERVICE OR TREATMENT THROUGH ACTUAL CLINICAL EXPERIENCE;

(2) HOLD:

(I) A NONRESTRICTED LICENSE IN A STATE OF THE UNITED STATES; AND

(II) IN THE CASE OF A PHYSICIAN, A CURRENT CERTIFICATION BY A RECOGNIZED AMERICAN MEDICAL SPECIALTY BOARD IN THE AREA OR AREAS APPROPRIATE TO THE SUBJECT OF REVIEW; AND

(3) HAVE NO HISTORY OF DISCIPLINARY ACTIONS OR SANCTIONS, INCLUDING LOSS OF STAFF PRIVILEGES OR PARTICIPATION RESTRICTIONS THAT HAVE BEEN TAKEN BY ANY HOSPITAL, GOVERNMENTAL AGENCY OR UNIT, OR

REGULATORY BODY THAT THE COMMISSIONER, IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE COMMISSIONER, CONSIDERS RELEVANT IN MEETING THE REQUIREMENTS OF THIS SUBSECTION.

(D) AN INDEPENDENT REVIEW ORGANIZATION MAY NOT BE A SUBSIDIARY OF, OR IN ANY WAY OWNED OR CONTROLLED BY, A HEALTH BENEFIT PLAN, A TRADE ASSOCIATION OF HEALTH BENEFIT PLANS, OR A TRADE ASSOCIATION OF HEALTH CARE PROVIDERS.

(E) IN ADDITION TO SUBSECTION (D) OF THIS SECTION, TO BE INCLUDED ON THE LIST COMPILED UNDER SUBSECTION (B) OF THIS SECTION, AN INDEPENDENT REVIEW ORGANIZATION SHALL SUBMIT TO THE COMMISSIONER THE FOLLOWING INFORMATION:

(1) IF THE INDEPENDENT REVIEW ORGANIZATION IS A PUBLICLY HELD ORGANIZATION, THE NAMES OF ALL STOCKHOLDERS AND OWNERS OF MORE THAN 5% OF ANY STOCK OR OPTIONS OF THE INDEPENDENT REVIEW ORGANIZATION;

(2) THE NAMES OF ALL HOLDERS OF BONDS OR NOTES IN EXCESS OF $100,000, IF ANY;

(3) THE NAMES OF ALL CORPORATIONS AND ORGANIZATIONS THAT THE INDEPENDENT REVIEW ORGANIZATION CONTROLS OR IS AFFILIATED WITH, AND THE NATURE AND EXTENT OF ANY OWNERSHIP OR CONTROL, INCLUDING THE AFFILIATED ORGANIZATION'S TYPE OF BUSINESS; AND

(4) THE NAMES OF ALL DIRECTORS, OFFICERS, AND EXECUTIVES OF THE INDEPENDENT REVIEW ORGANIZATION, AS WELL AS A STATEMENT REGARDING ANY RELATIONSHIPS THE DIRECTORS, OFFICERS, AND EXECUTIVES MAY HAVE WITH ANY CARRIER OR HEALTH CARE PROVIDER GROUP.

(F) AN EXPERT REVIEWER ASSIGNED BY THE INDEPENDENT REVIEW ORGANIZATION OR THE INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT SELECTED BY THE COMMISSIONER UNDER THIS SECTION MAY NOT HAVE A

MATERIAL PROFESSIONAL, FAMILIAL, OR FINANCIAL CONFLICT OF INTEREST WITH ANY OF THE FOLLOWING:

(1) THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT;

(2) ANY OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE OF THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT;

(3) THE HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER'S MEDICAL GROUP, OR THE INDEPENDENT PRACTICE ASSOCIATION THAT RENDERED OR IS PROPOSING TO RENDER THE HEALTH CARE SERVICE THAT IS UNDER REVIEW;

(4) THE HEALTH CARE FACILITY AT WHICH THE HEALTH CARE SERVICE WAS PROVIDED OR WILL BE PROVIDED; OR

(5) THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, OR OTHER THERAPY THAT IS BEING PROPOSED FOR THE MEMBER.

(G) FOR ANY INDEPENDENT REVIEW ORGANIZATION SELECTED BY THE COMMISSIONER UNDER SUBSECTION (A) OF THIS SECTION, THE INDEPENDENT REVIEW ORGANIZATION SHALL HAVE A QUALITY ASSURANCE MECHANISM IN PLACE THAT ENSURES:

(1) THE TIMELINESS AND QUALITY OF THE REVIEWS;

(2) THE QUALIFICATIONS AND INDEPENDENCE OF THE EXPERT REVIEWERS; AND

(3) THE CONFIDENTIALITY OF MEDICAL RECORDS AND REVIEW MATERIALS.";

in line 14, strike "(C)" and substitute "(H)"; strike in their entirety lines 18 through 24, inclusive, and substitute:

"(2) THE INDEPENDENT REVIEW ORGANIZATION OR INDEPENDENT MEDICAL EXPERT SHALL:

(I) PRESENT TO THE CARRIER FOR PAYMENT A DETAILED ACCOUNT OF THE EXPENSES INCURRED BY THE INDEPENDENT REVIEW ORGANIZATION OR INDEPENDENT MEDICAL EXPERT; AND

(II) PROVIDE A COPY OF THE DETAILED ACCOUNT OF EXPENSES TO THE COMMISSIONER.";

and strike in their entirety lines 33 through 37, inclusive.

AMENDMENT NO. 15

On page 14, in line 26, after "PROVIDED" insert ":

(I)";

and after line 26, insert:

"(II) BY THE SECRETARY UNDER § 19-705.2(E) OF THE HEALTH-GENERAL ARTICLE; AND".

AMENDMENT NO. 16

On page 14, strike in their entirety lines 27 through 29, inclusive, and substitute:

"(2) PROVIDE COPIES OF THE SUMMARY REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY.".

On page 15, strike beginning with "LEGISLATIVE" in line 15 down through "COMMITTEE" in line 17 and substitute "GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY".

AMENDMENT NO. 17

On page 17, strike in their entirety lines 11 through 16, inclusive, and substitute:

"(F) "HEALTH CARE SERVICE" MEANS A SERVICE, AN ITEM OF MEDICAL EQUIPMENT, OR SUPPLIES, AS DESCRIBED IN § 19-701(E)(2) OF THE HEALTH-GENERAL ARTICLE.".

AMENDMENT NO. 18

On page 20, after line 31, insert:

"(C) IT SHALL CONSTITUTE A VIOLATION OF THIS SUBTITLE IF THE COMMISSIONER, IN CONSULTATION WITH AN INDEPENDENT REVIEW ORGANIZATION, MEDICAL EXPERT, THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OR OTHER APPROPRIATE ENTITY, DETERMINES THAT THE CRITERIA AND STANDARDS USED IN CONDUCTING UTILIZATION REVIEW ARE NOT:

(1) OBJECTIVE;

(2) CLINICALLY VALID;

(3) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH CARE; OR

(4) FLEXIBLE ENOUGH TO ALLOW DEVIATIONS FROM NORMS WHEN JUSTIFIED ON A CASE BY CASE BASIS.".

AMENDMENT NO. 19

On page 22, in line 4, strike "All" and substitute "EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, ALL"; after line 5, insert:

"(2) WHEN THE HEALTH CARE SERVICE UNDER REVIEW IS A DENTAL SERVICE, THE ADVERSE DECISION SHALL BE MADE BY A LICENSED DENTIST OR A PANEL OF OTHER APPROPRIATE HEALTH CARE PROVIDERS WITH AT LEAST 1 LICENSED DENTIST ON THE PANEL.";

in line 6, strike "(2)" and substitute "(3)"; in line 10, strike the first "a" and substitute ":

(I) A";

in line 11, after "panel" insert "WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS THE TREATMENT UNDER REVIEW; OR

(II) WHEN THE ADVERSE DECISION INVOLVES A DENTAL SERVICE, A LICENSED DENTIST OR A PANEL OF APPROPRIATE HEALTH CARE PROVIDERS WITH AT LEAST 1 DENTIST ON THE PANEL WHO IS A LICENSED DENTIST AND WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME SPECIALTY AS THE DENTIST PROVIDING THE SERVICE UNDER REVIEW";

and in line 12, strike "(3)" and substitute "(4)".

AMENDMENT NO. 20

On page 24, strike beginning with "to:" in line 13 down through "list" in line 18 and substitute "TO ANY PERSON ON REQUEST"; and in line 26, strike "$1,000" and substitute "$5,000".

AMENDMENT NO. 21

On page 25, before line 5, insert:

"27-303.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(3) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(4) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which payment is being made;

(5) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim; [or]

(7) fail to meet the requirements of [Title 19, Subtitle 13 of the Health - General Article] TITLE 15, SUBTITLE 10B OF THIS ARTICLE for preauthorization for a health care service; OR

(8) FAIL TO COMPLY WITH THE PROVISIONS OF TITLE 15, SUBTITLE 10A OF THIS ARTICLE.".

AMENDMENT NO. 22

On page 25, after line 4, insert:

"SUBTITLE 10C. MEDICAL DIRECTORS.

15-10C-01.

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

(B) "BOARD" MEANS THE STATE BOARD OF PHYSICIAN QUALITY ASSURANCE ESTABLISHED UNDER TITLE 14 OF THE HEALTH OCCUPATIONS ARTICLE.

(C) "CERTIFICATE" MEANS A CERTIFICATE ISSUED BY THE COMMISSIONER UNDER THIS SUBTITLE TO ACT AS A MEDICAL DIRECTOR.

(D) "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(E) "HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 19-701 OF THE HEALTH - GENERAL ARTICLE.

(F) (1) "MEDICAL DIRECTOR" MEANS A PHYSICIAN EMPLOYED BY OR UNDER CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION WHO IS RESPONSIBLE FOR:

(I) THE ESTABLISHMENT OR MAINTENANCE OF THE POLICIES AND PROCEDURES AT THE HEALTH MAINTENANCE ORGANIZATION FOR:

1. QUALITY ASSURANCE; AND

2. UTILIZATION MANAGEMENT;

(II) COMPLIANCE WITH THE QUALITY ASSURANCE AND UTILIZATION MANAGEMENT POLICIES AND PROCEDURES OF THE HEALTH MAINTENANCE ORGANIZATION; AND

(III) OVERSIGHT OF UTILIZATION REVIEW DECISIONS OF PRIVATE REVIEW AGENTS EMPLOYED BY OR UNDER CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION.

(2) "MEDICAL DIRECTOR" INCLUDES AN ASSOCIATE MEDICAL DIRECTOR OR AN ASSISTANT MEDICAL DIRECTOR, AS DEFINED BY THE COMMISSIONER IN REGULATION.

15-10C-02.

THE COMMISSIONER, IN CONSULTATION WITH THE DEPARTMENT AND THE BOARD, SHALL ESTABLISH AND ADOPT BY REGULATION STANDARDS FOR:

(1) THE CERTIFICATION OF MEDICAL DIRECTORS;

(2) THE RENEWAL, SUSPENSION, AND REVOCATION OF A CERTIFICATE; AND

(3) THE ISSUANCE OF A TEMPORARY CERTIFICATE.

15-10C-03.

(A) TO BE CERTIFIED AS A MEDICAL DIRECTOR UNDER THIS SUBTITLE, AN APPLICANT SHALL:

(1) SUBMIT AN APPLICATION TO THE COMMISSIONER ON THE FORM REQUIRED BY THE COMMISSIONER; AND

(2) PAY TO THE COMMISSIONER AN APPLICATION FEE OF NO MORE THAN $100 ESTABLISHED BY THE COMMISSIONER BY REGULATION.

(B) THE APPLICATION SHALL INCLUDE:

(1) A DESCRIPTION OF THE APPLICANT'S PROFESSIONAL QUALIFICATIONS, INCLUDING MEDICAL EDUCATION INFORMATION AND, IF APPROPRIATE, BOARD CERTIFICATIONS AND LICENSURE STATUS;

(2) THE UTILIZATION MANAGEMENT PROCEDURES AND POLICIES TO BE USED BY THE HEALTH MAINTENANCE ORGANIZATION; AND

(3) CERTIFICATION BY THE MEDICAL DIRECTOR THAT THE UTILIZATION MANAGEMENT PROCEDURES AND POLICIES ARE:

(I) OBJECTIVE;
(II) CLINICALLY VALID;

(III) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH

CARE; AND

(IV) FLEXIBLE ENOUGH TO ALLOW DEVIATIONS FROM THE NORMS WHEN JUSTIFIED ON A CASE BY CASE BASIS.

15-10C-04.

(A) SUBJECT TO THE HEARING PROCEDURES IN §§ 2-210 THROUGH 2-214 OF THIS ARTICLE, THE COMMISSIONER MAY SUSPEND, REVOKE, OR REFUSE TO RENEW A CERTIFICATE OF A MEDICAL DIRECTOR IF THE COMMISSIONER FINDS A PATTERN THAT THE UTILIZATION MANAGEMENT PROCEDURES AND POLICIES USED BY THE MEDICAL DIRECTOR IN MAKING UTILIZATION REVIEW DECISIONS, OR USED BY A PRIVATE REVIEW AGENT EMPLOYED BY OR UNDER CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION OVER WHOSE UTILIZATION REVIEW DECISIONS THE MEDICAL DIRECTOR HAS RESPONSIBILITY, ARE NOT:

(1) OBJECTIVE;

(2) CLINICALLY VALID;

(3) COMPATIBLE WITH ESTABLISHED PRINCIPLES OF HEALTH CARE; OR

(4) FLEXIBLE ENOUGH TO ALLOW DEVIATIONS FROM THE NORMS WHEN JUSTIFIED ON A CASE BY CASE BASIS.

(B) THE COMMISSIONER MAY CONSULT WITH AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT THAT MEETS THE REQUIREMENTS OF § 15-10A-05 OF THIS TITLE, THE DEPARTMENT, THE BOARD, OR ANY OTHER APPROPRIATE ENTITY FOR PURPOSES OF TAKING AN ACTION DESCRIBED UNDER SUBSECTION (A) OF THIS SECTION.".

AMENDMENT NO. 23

On page 26, after line 35, insert:

"SECTION 6. AND BE IT FURTHER ENACTED, That the Maryland Insurance Administration shall conduct a 2-year study of the relationship between the number of complaints involving each carrier and the health care regulatory assessment paid by each carrier for the costs attributable to the implementation of Title 15, Subtitle 10A of the Insurance Article, as enacted by Section 2 of this Act, and shall report the results of its study to the Senate Finance Committee, the House Economic Matters Committee, and the House Environmental Matters Committee by October 1, 2001.";

in lines 36 and 38, strike "6." and "7.", respectively, and substitute "7." and "8.", respectively; and after line 41, insert:

"SECTION 9. AND BE IT FURTHER ENACTED, That the provisions of this Act shall apply to all health insurance policies and contracts existing on and issued on or after January 1, 1999.".

On page 27, in line 1, strike "8." and substitute "10."; and in line 2, strike "6" and substitute "7"; and in the same line, strike "July 1, 1998" and substitute "January 1, 1999".