Unofficial Copy **1998 Regular Session**
HB0003/623971/1

BY: Economic Matters Committee and Environmental Matters Committee

AMENDMENTS TO HOUSE BILL NO. 3
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in the sponsor line, strike "and Workman" and substitute "Workman, DeCarlo, McHale, Miller, Valderrama, Gordon, Kach, McClenahan, Eckardt, Boston, Exum, Kirk, Pendergrass, Mohorovic, D. Davis, Ciliberti, Stup, Elliott, Stull, and Klausmeier".

AMENDMENT NO. 2

On page 1, in line 18, after "organization" insert "or certain other individuals"; in line 21, after "circumstances;" insert "requiring certain carriers to provide certain requested information to the Unit and the Commissioner within a certain time under certain circumstances; establishing a certain health care complaint fee; transferring the responsibility for receiving complaints on health maintenance organizations from the Department of Health and Mental Hygiene to the Commissioner; requiring the Secretary of Health and Mental Hygiene to submit certain reports to the Commissioner concerning the investigation of certain complaints;"; in line 22, after "regulations;" insert "altering certain penalties;"; and in line 26, after "Commissioner;" 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;".

On page 2, in line 2, strike "certain persons" and substitute "a health maintenance organization"; in line 4, after "directors;" insert "requiring a medical director of a health maintenance organization to be a physician licensed in this State and be certified in accordance with this Act;"; in line 8, after "date;" insert "providing for the accurate codification of provisions of this Act;"; after line 24, insert:

"BY repealing and reenacting, with amendments,
Article - Commercial Law
Section 13-4A-02(b)
Annotated Code of Maryland

(Over)

(1990 Replacement Volume and 1997 Supplement)";

in line 32, strike "19-706(y)" and substitute "19-706(y) and (z)"; after line 34, insert:

"BY repealing and reenacting, without amendments,
Article - Health- General
Section 19-728
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)";

and in line 37, strike "19-729" and substitute "19-705.2, 19-708, 19-729, and 19-730".

On page 3, strike line 2 in its entirety and substitute "Section 4-113(d) and (e), 15-112(e) and (g), 15-1001, 27-303, 27-304, and 27-305(a),"; in line 7, after "Section" insert "2-112.2;"; and in line 9, strike "15-10C-03" and substitute "15-10C-04".

AMENDMENT NO. 3

On page 4, after line 1, 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.".

On page 13, in line 26, after "SECTION" insert "AND THE INFORMATION PROVIDED BY THE SECRETARY UNDER § 19-705.2(E) OF THE HEALTH - GENERAL ARTICLE".

AMENDMENT NO. 4

On page 4, after line 31, 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, 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;

(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 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 IT IS ALLOCABLE TO THIS STATE.

(B) IN ADDITION TO THE FEES COLLECTED UNDER § 2-112 OF THIS SUBTITLE, THE COMMISSIONER SHALL COLLECT A HEALTH CARE COMPLAINT FEE FROM EACH CARRIER FOR THE COSTS ATTRIBUTABLE TO THE IMPLEMENTATION OF TITLE 15, SUBTITLES 10A, 10B, AND 10C OF THIS ARTICLE.

(C) THE HEALTH CARE COMPLAINT FEE SHALL BE CALCULATED BY DIVIDING THE GROSS DIRECT PREMIUMS WRITTEN BY THE CARRIER IN THE PRIOR CALENDAR YEAR BY THE TOTAL AMOUNT OF GROSS DIRECT PREMIUMS WRITTEN BY THE CARRIERS IN THE PRIOR CALENDAR YEAR.".

On page 4, after line 4, insert:

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

AMENDMENT NO. 6

On page 5, before line 2, insert:

"4-113.

(d) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:

(1) impose on the holder a penalty of not less than $100 but not exceeding [$50,000] $250,000 for each violation of this article; and

(2) require the holder to make restitution to any person who has suffered financial injury because of the violation of this article.

(e) The Commissioner shall adopt regulations TO ESTABLISH STANDARDS FOR THE IMPOSITION OF A PENALTY UNDER SUBSECTION (D) OF THIS SECTION AND to carry out the provisions of subsection (b) (11) of this section.

15-112.

(e) 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] SUBTITLE 10B OF THIS TITLE; [or]

(3) THE NUMBER OF GRIEVANCES OR COMPLAINTS THAT THE PROVIDER FILES ON BEHALF OF A PATIENT UNDER SUBTITLE 10A OF THIS TITLE; OR

[(3)] (4) 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) of this section.

(g) 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) of this section; [or]

(2) filing an appeal under [Title 19, Subtitle 13 of the Health - General Article] SUBTITLE 10B OF THIS TITLE; OR

(3) FILING A GRIEVANCE OR COMPLAINT ON BEHALF OF A PATIENT UNDER SUBTITLE 10A OF THIS TITLE.".

AMENDMENT NO. 7

On page 5 in line 28, and on page 10 in line 31, in each instance, after "NECESSARY" insert ", APPROPRIATE, OR EFFICIENT".

On page 12, in line 10, after "NECESSARY," insert "APPROPRIATE, OR EFFICIENT,".

On page 15, in line 3, strike the brackets.

AMENDMENT NO. 8

On page 6, in line 26, after "INCLUDES" insert ":

(I)";

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

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

and after line 26, insert:

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

AMENDMENT NO. 9

On page 3, after line 31, insert:

"13-4A-02.

(b) (1) (I) The Unit may assist health care consumers in understanding their health care bills and third party coverage, in identifying improper billing or coverage determinations, and in reporting any billing or coverage problems to appropriate entities, including the Division, the Attorney General or other governmental agencies, insurers, or providers.

(II) WHENEVER THE UNIT REQUESTS INFORMATION FROM AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION IN ORDER TO ASSIST A HEALTH CARE CONSUMER FOR THE PURPOSES PROVIDED IN THIS PARAGRAPH, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE THE INFORMATION TO THE UNIT NO LATER THAN 7 WORKING DAYS FROM THE DATE THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION RECEIVED THE REQUEST.

(2) Whenever any billing or coverage question concerns the adequacy or propriety of any services or treatment, the Unit shall refer the matter to an appropriate professional, licensing, or disciplinary body, as applicable. The Unit may monitor the progress of the concerns raised by health consumers through such referrals.

(3) Whenever any billing or coverage question concerns a matter within the jurisdiction of the Insurance Commissioner, the Unit shall refer the matter to the Commissioner. The Unit may monitor the progress of the concerns raised by health consumers through such referrals.

(4) The Unit shall work with the Department of Health and Mental Hygiene to assist with resolving any billing or coverage questions as necessary.".

On page 6, in line 16, after "PROFESSION" insert "AND IS A TREATING PROVIDER OF THE MEMBER".

On page 7, in line 4, after "DECISION" insert "IN WRITING"; in line 17, after "(1)" insert "(I)"; after line 22, insert:

"(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.";

after line 27, insert:

"(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 5 WORKING DAYS AFTER THE DATE THE COMPLAINT IS FILED WITH THE COMMISSIONER.";

in line 29, after "FILE" insert "FOR REVIEW"; in line 30, after "PROCESS" insert "ESTABLISHED UNDER THIS SUBTITLE"; in line 35, strike "1" and substitute "2"; and in line 36, strike "DAY" and substitute "DAYS".

On page 9, in line 8, strike "2" and substitute "5".

On page 10, in line 11, after "(A)" insert "(1)"; after line 15, insert:

"(2) WHENEVER THE COMMISSIONER RECEIVES A COMPLAINT UNDER THIS SUBSECTION, THE COMMISSIONER SHALL NOTIFY THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT WITHIN 5 WORKING DAYS AFTER THE DATE THE COMPLAINT IS FILED WITH THE COMMISSIONER.

(3) 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 WORKING DAYS FROM THE DATE THE CARRIER RECEIVES THE REQUEST FOR INFORMATION.".

On page 11, strike in their entirety lines 9 through 15, inclusive, and substitute:

"(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.";

and strike beginning with "TITLE" in line 28 down through "SUBTITLE" in line 30 and substitute "§ 2-210 OF THIS ARTICLE".

On page 17, in line 30, after "America" insert ", THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND,".

On page 23, strike beginning with the colon in line 13 down through "list" in line 18 and substitute "ANY PERSON ON REQUEST".

On page 27, strike beginning with "Title" in line 25 down through "Article" in line 26 and substitute "TITLE 15, SUBTITLE 10B OF THIS ARTICLE".

AMENDMENT NO. 10

On page 9, in line 20, strike "AND"; after line 20, insert:

"(III) STATE THE NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF THE PHYSICIAN THAT MADE THE ADVERSE DECISION OR GRIEVANCE DECISION;

(IV) BE SIGNED BY THE MEDICAL DIRECTOR IF THE CARRIER IS A HEALTH MAINTENANCE ORGANIZATION OR A DESIGNATED OFFICER OF THE CARRIER IF THE CARRIER IS NOT A HEALTH MAINTENANCE ORGANIZATION; AND";

in line 21, strike "(III)" and substitute "(V)"; and after line 30, insert:

"(3) A CARRIER MAY NOT USE IN A NOTICE SENT UNDER PARAGRAPH (1) OF THIS SUBSECTION GENERALIZED TERMS SUCH AS "EXPERIMENTAL PROCEDURE NOT COVERED", "COSMETIC PROCEDURE NOT COVERED", "SERVICE INCLUDED UNDER ANOTHER PROCEDURE", OR "NOT MEDICALLY NECESSARY" TO SATISFY THE REQUIREMENTS OF PARAGRAPH (2)(I) OR (II) OF THIS SUBSECTION.".

AMENDMENT NO. 11

On pages 11 and 12, strike in their entirety the lines beginning with line 39 on page 11 through line 2 on page 12, 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. 12

On page 10 in line 28, and on page 12 in line 13, in each instance, after "ORGANIZATION" insert "OR MEDICAL EXPERT".

On page 12, in line 16, after "ORGANIZATIONS" insert "OR MEDICAL EXPERTS"; after line 16, insert:

"(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 ADDITION, FOR PHYSICIANS, 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 OR ARE PENDING BY ANY HOSPITAL, GOVERNMENTAL AGENCY OR UNIT, OR REGULATORY BODY.

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

(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) NEITHER AN EXPERT REVIEWER ASSIGNED BY THE INDEPENDENT REVIEW ORGANIZATION NOR THE INDEPENDENT REVIEW ORGANIZATION NOR MEDICAL EXPERT SELECTED BY THE COMMISSIONER UNDER THIS SECTION MAY 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 17, strike "(C)" and substitute"(H)"; in line 19, after "ORGANIZATION" insert "OR MEDICAL EXPERT"; and strike in their entirety lines 21 through 37, inclusive, and substitute:

"(2) THE CARRIER THAT IS THE SUBJECT OF THE COMPLAINT MAY NOT PAY AND AN INDEPENDENT REVIEW ORGANIZATION OR MEDICAL EXPERT MAY NOT ACCEPT ANY COMPENSATION IN ADDITION TO THE PAYMENT FOR REASONABLE EXPENSES UNDER PARAGRAPH (1) OF THIS SUBSECTION.".

AMENDMENT NO. 13

On page 13, 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 14, 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. 14

On page 19, 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, 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.".

On page 23, in line 26, strike "$1,000" and substitute "$5,000".

AMENDMENT NO. 15

On page 21, 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 DENTIST OR A PANEL OF OTHER APPROPRIATE HEALTH CARE PROVIDERS WITH AT LEAST 1 DENTIST ON THE PANEL.";

in lines 6 and 12, strike "(2)" and "(3)", respectively, and substitute "(3)" and "(4)", respectively; in line 10, strike the first "a" and substitute ":

(I) A";

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

(II) WHEN THE ADVERSE DECISION INVOLVES A DENTAL SERVICE, A DENTIST OR A PANEL OF APPROPRIATE HEALTH CARE PROVIDERS WITH AT LEAST 1 DENTIST ON THE PANEL".

AMENDMENT NO. 16

On page 4, before line 5, insert:

"19-708.

(b) The application shall include or be accompanied by:

(1) A copy of the basic health maintenance organizational document and any amendments to it that, where applicable, are certified by the Department of Assessments and Taxation;

(2) A copy of the bylaws of the health maintenance organization, if any, that are certified by the appropriate officer;

(3) A list of the individuals who are to be responsible for the conduct of the affairs of the health maintenance organization, including all members of the governing body, the officers and directors if it is a corporation, and the partners or associates if it is a partnership or association;

(4) The addresses of those individuals and their official capacity with the health maintenance organization;

(5) A statement by each individual referred to in item (3) of this subsection that fully discloses the extent and nature of any contract or arrangement between the individual and the health maintenance organization and any possible conflict of interest;

(6) A resume of the qualifications of:

(i) The administrator;

(ii) The medical director, WHO SHALL BE A PHYSICIAN LICENSED IN THIS STATE AND CERTIFIED UNDER TITLE 15, SUBTITLE 10C OF THE INSURANCE ARTICLE;

(iii) The enrollment director; and

(iv) Any other individual who is associated with the health maintenance organization that the Commissioner and the Secretary request under their joint internal procedures;

(7) A statement that describes generally:

(i) The health maintenance organization, including:

1. Its operations;

2. Its enrollment process;

3. Its quality assurance mechanism; and

4. Its internal grievance procedures;

(ii) The methods the health maintenance organization proposes to use to offer its members and public representatives an opportunity to participate in matters of policy and operation;

(iii) The location of the facilities where health care services will be available regularly to members;

(iv) The type and specialty of physicians and health care personnel who are engaged to provide health care services;

(v) The number of physicians and personnel in each category; and

(vi) The health and medical records system to provide documentation of use by members;

(8) The form of each contract that the health maintenance organization proposes to offer to subscribers showing the benefits to which they are entitled and a table of the rates charged or proposed to be charged for each form of contract;

(9) A statement that describes with reasonable certainty each geographic area to be served by the health maintenance organization;

(10) A statement of the financial condition of the health maintenance organization, including:

(i) Sources of financial support;

(ii) A balance sheet showing assets, liabilities, and minimum tangible net worth; and

(iii) Any other financial information the Commissioner requires for adequate financial evaluation;

(11) Copies of any proposed advertising and proposed techniques and methods of selling the services of the health maintenance organization;

(12) A power of attorney that is executed by the health maintenance organization appointing the Commissioner as agent of the organization in this State to accept service of process in any action, proceeding, or cause of action arising in this State against the health maintenance organization; and

(13) Copies of the agreements proposed to be made between the health maintenance organizations and providers of health care services.

19-728.

(a) If, as to a matter that is within the jurisdiction of the Department under this subtitle, the Secretary finds that a health maintenance organization does not meet the requirements of this subtitle or the rules and regulations adopted under it and cannot or will not make corrective changes or new arrangements to meet these requirements, the Secretary may send to the Commissioner a written directive that sets out the findings of the Secretary and reasons for them and directs the Commissioner to suspend or revoke the certificate of authority of the health maintenance organization or to take any other appropriate action that the Secretary specifies. The Commissioner shall comply with the directive.

(b) The Commissioner is responsible for:

(1) Determining whether each health maintenance organization is or will be able to provide a fiscally sound operation and adequate provision against risk of insolvency and may adopt reasonable rules and regulations designed to achieve this goal; and

(2) Actuarial and financial evaluations and determinations of each health maintenance organization.

(c) (1) If the Commissioner determines that a health maintenance organization is not operating in a fiscally sound manner, the Commissioner shall notify the Department of the determination.

(2) After notifying the Department in accordance with the provisions of paragraph (1) of this subsection, the Commissioner shall monitor the health maintenance organization on a continuous basis until the Commissioner determines that the health maintenance organization is operating in a fiscally sound manner.".

On pages 24 through 26, strike in their entirety the lines beginning with line 5 on page 24 through line 22 on page 26, inclusive, and substitute:

"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) "MEDICAL DIRECTOR" MEANS A PHYSICIAN WHO IS RESPONSIBLE FOR THE OVERALL COORDINATION OF PATIENT CARE AND THE DELIVERY OF HEALTH CARE SERVICES THROUGH:

(1) THE ESTABLISHMENT OR MAINTENANCE OF QUALITY ASSURANCE AND UTILIZATION MANAGEMENT STANDARDS AND PRACTICES AT A HEALTH MAINTENANCE ORGANIZATION;

(2) THE SUPERVISION OF HEALTH CARE PROVIDERS EMPLOYED BY OR UNDER CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION IN ORDER TO ENSURE COMPLIANCE WITH AND GUIDANCE ON COMPLYING WITH THE QUALITY ASSURANCE AND UTILIZATION MANAGEMENT STANDARDS AND PRACTICES; AND

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

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; AND

(2) THE RENEWAL, SUSPENSION, AND REVOCATION OF A 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; 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 PATIENT CARE AND HEALTH CARE SERVICE DELIVERY; AND

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

15-10C-04.

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, IN CONSULTATION 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, 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 PATIENT CARE AND HEALTH CARE SERVICE DELIVERY; AND

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

AMENDMENT NO. 17

On page 26, before line 23, 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.".

On page 27, after line 28, insert:

"27-305.

(a) The Commissioner may impose a penalty not exceeding [$500] $5,000 for each violation of § 27-303 of this subtitle or a regulation adopted under § 27-303 of this subtitle.".

AMENDMENT NO. 18

On page 28, after line 14, insert:

"SECTION 6. AND BE IT FURTHER ENACTED, That, subject to the approval of the Executive Director of the Department of Legislative Services, the publishers of the Annotated Code of Maryland shall correct any cross-references that are rendered incorrect by this Act.";

in lines 15, 17, and 21, strike "6.", "7.", and "8.", respectively, and substitute "7.", "8.", and "9.",

respectively; and in line 22, strike “6” and substitute “7”.