Unofficial Copy 1999 Regular Session
C3 9lr2150

By: **Delegate Donoghue**
Introduced and read first time: February 15, 1999
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

AN ACT concerning

Health Insurance - Health Care Regulatory Fund and Complaint Process for Adverse Decisions or Grievances

FOR the purpose of exempting certain carriers from the health care regulatory assessment for the Health Care Regulatory Fund and from the requirements relating to the adverse decision and grievance process; altering a certain definition; defining a certain term; and generally relating to the Health Care Regulatory Fund and the establishment of an internal grievance process by carriers.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 2-112.2 and 15-10A-01
Annotated Code of Maryland
(1997 Volume and 1998 Supplement)

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

Article - Insurance

2-112.2.

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

(2) "Carrier" means A PERSON THAT OFFERS A HEALTH BENEFIT PLAN AND IS:

[(i) an insurer that offers health insurance other than long term care insurance or disability insurance]

(I) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN THE STATE;

(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) "HEALTH BENEFIT PLAN" MEANS:

1. A HOSPITAL OR MEDICAL POLICY OR CERTIFICATE, INCLUDING THOSE ISSUED UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS LOCATED IN MARYLAND OR ANY OTHER STATE COVERING MARYLAND RESIDENTS;

2. A POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A NONPROFIT HEALTH SERVICE PLAN THAT COVERS MARYLAND RESIDENTS;

3. A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR

4. A DENTAL PLAN.

(II) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

1. LONG-TERM CARE INSURANCE;

2. DISABILITY INSURANCE;

3. ACCIDENTAL TRAVEL AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE;

4. CREDIT HEALTH INSURANCE;

5. ANY INSURANCE, MEDICAL POLICY, OR CERTIFICATE FOR WHICH PAYMENT OF BENEFITS ARE CONDITIONED ON A DETERMINATION OF MEDICAL NECESSITY MADE SOLELY BY THE TREATING HEALTH CARE PROVIDER;

6. ANY INSURANCE, MEDICAL POLICY, OR CERTIFICATE FOR WHICH PAYMENT OF BENEFITS IS NOT CONDITIONED ON A DETERMINATION OF MEDICAL NECESSITY; OR

7. A HEALTH BENEFIT PLAN ISSUED BY A MANAGED CARE ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

[(3)] (4) (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:

(1) collect a health care regulatory assessment from each carrier for the costs attributable to the implementation of Title 15, Subtitles 10A, 10B, and 10C of this article; and

(2) deposit the amounts collected under paragraph (1) of this subsection into the health care regulatory fund established in § 2-112.3 of this subtitle.

(c) The health care regulatory assessment that is payable by each carrier shall be calculated by taking the total costs under subsection (b)(1) 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.

15-10A-01.

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

(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.

(2) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

(c) "Carrier" means A PERSON THAT OFFERS A HEALTH BENEFIT PLAN AND IS:

[(1) an insurer that offers health insurance other than long term care insurance or disability insurance;]

(1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN THE STATE;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) 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.

(d) "Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

(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.

(f) "Grievance decision" means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

(g) "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article.

(H) (1) "HEALTH BENEFIT PLAN" MEANS:

(I) A HOSPITAL OR MEDICAL POLICY OR CERTIFICATE, INCLUDING THOSE ISSUED UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS LOCATED IN MARYLAND OR ANY OTHER STATE COVERING MARYLAND RESIDENTS;

(II) A POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A NONPROFIT HEALTH SERVICE PLAN THAT COVERS MARYLAND RESIDENTS;

(III) A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR

(IV) A DENTAL PLAN.

(2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

(I) LONG-TERM CARE INSURANCE;

(II) DISABILITY INSURANCE;

(III) ACCIDENTAL TRAVEL AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE;

(IV) CREDIT HEALTH INSURANCE;

(V) ANY INSURANCE, MEDICAL POLICY, OR CERTIFICATE FOR WHICH PAYMENT OF BENEFITS ARE CONDITIONED ON A DETERMINATION OF MEDICAL NECESSITY MADE SOLELY BY THE TREATING HEALTH CARE PROVIDER;

(VI) ANY INSURANCE, MEDICAL POLICY, OR CERTIFICATE FOR WHICH PAYMENT OF BENEFITS IS NOT CONDITIONED ON A DETERMINATION OF MEDICAL NECESSITY; OR

(VII) A HEALTH BENEFIT PLAN ISSUED BY A MANAGED CARE ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

[(h)] (I) "Health care provider" means:

(1) an individual who is licensed under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the member; or

(2) a hospital, as defined in § 19-301 of the Health - General Article.

[(i)] (J) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

[(j)] (K) (1) "Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

(ii) unless preempted by federal law, a Medicare recipient.

(3) "Member" does not include a Medicaid recipient.

[(k)] (L) "Private review agent" has the meaning stated in § 15-10B-01 of this title.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1999.