SENATE BILL 135

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By: **The President (Administration) and Senators Bromwell, Dorman, Hollinger, Astle, Blount, Collins, Conway, Della, Dyson, Exum, Green, Lawlah, Middleton, Ruben, and Teitelbaum**
Introduced and read first time: January 22, 1999
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Patients' Bill of Rights Act of 1999

FOR the purpose of requiring certain health insurance carriers to establish and implement a procedure that provides for a standing referral to a specialist under specified circumstances; requiring certain health insurance carriers to establish and implement a procedure that allows a specialist to act as a primary care coordinator under specified circumstances; requiring certain health insurance carriers to establish and implement a procedure that provides for a referral to a specialist who is not part of a carrier's provider panel under specified circumstances; providing that a decision by a carrier not to provide access to or coverage of certain treatments or certain prescription drugs or devices constitutes an adverse decision; requiring certain health insurance carriers to establish and implement a procedure that provides for coverage of certain prescription drugs and devices under specified circumstances; requiring the Maryland Insurance Administration to serve as the single point of entry for consumers to access certain information regarding health insurance; requiring the Maryland Insurance Administration to adopt certain regulations; requiring certain health insurance carriers to provide a certain minimum length of inpatient hospitalization coverage after a mastectomy, removal of a testicle, lymph node dissection, or lumpectomy that is performed for the treatment of breast or testicular cancer; defining certain terms; providing for the termination of certain provisions of this Act; providing for the application of this Act; and generally relating to health insurance, coverage, and access to services.

BY adding to
Article - Health - General
Section 19-706(ff)
Annotated Code of Maryland
(1996 Replacement Volume and 1998 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance

Section 2-301 through 2-305
Annotated Code of Maryland
(1997 Volume and 1998 Supplement)

BY adding to
Article - Insurance
Section 2-303.1, 15-829, 15-830, and 15-831
Annotated Code of Maryland
(1997 Volume and 1998 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-10A-09(b)
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 - Health - General

19-706.

(FF) THE PROVISIONS OF §§ 15-829, 15-830, AND 15-831 OF THE INSURANCE ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article - Insurance

2-301.

In this subtitle, "Program" means the Consumer Education and Advocacy Program.

2-302.

(a) There is a Consumer Education and Advocacy Program.

(b) The Commissioner may use the Consumer Affairs Unit of the Administration to carry out the Program.

2-303.

The purposes of the Program include:

(1) providing information and helping consumers with the procedures for filing a complaint with the Commissioner against any person regulated by this article;

(2) on request, giving information about an insurer to the extent that the information lawfully is disclosable; and

(3) developing an information and assistance system to provide information about and to help consumers with:

(i) personal insurance coverages, including health insurance and life insurance coverages;

(ii) underwriting practices;

(iii) general rating concepts;

(iv) claim procedures of insurers; and

(v) any other relevant services.

2-303.1.

(A) THE ADMINISTRATION SHALL SERVE AS THE SINGLE POINT OF ENTRY FOR CONSUMERS TO ACCESS ANY AND ALL INFORMATION REGARDING HEALTH INSURANCE AND THE DELIVERY OF HEALTH CARE AS IT RELATES TO HEALTH INSURANCE, INCLUDING INFORMATION PREPARED OR COLLECTED BY:

(1) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE;

(2) THE HEALTH CARE ACCESS AND COST COMMISSION;

(3) THE HEALTH SERVICES COST REVIEW COMMISSION;

(4) THE HEALTH RESOURCES PLANNING COMMISSION; AND

(5) THE HEALTH EDUCATION AND ADVOCACY UNIT OF THE ATTORNEY GENERAL'S OFFICE.

(B) (1) THE ADMINISTRATION, IN COOPERATION WITH THE ENTITIES LISTED IN SUBSECTION (A) OF THIS SECTION AND ANY OTHER PERSON IT DEEMS APPROPRIATE, SHALL PROMOTE THE AVAILABILITY OF THE INFORMATION.

(2) THE HEALTH CARE ACCESS AND COST COMMISSION SHALL ASSIST THE ADMINISTRATION IN PRESENTING THE INFORMATION IN A FORMAT THAT IS EASILY UNDERSTANDABLE FOR CONSUMERS.

2-304.

(a) To carry out the Program, the Commissioner may employ a staff in accordance with the State budget.

(b) The Commissioner may designate a member of the staff of the Program to represent the interests of consumers in any Administration proceeding that is open to the public, including:

(1) an informational hearing; and

(2) a hearing or review of insurance rates or forms.

2-305.

(a) The Commissioner may adopt regulations to carry out the Program.

(b) Each year, the Commissioner shall evaluate the Program.

15-829.

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

(2) "CARRIER" MEANS:

(I) AN INSURER THAT OFFERS HEALTH INSURANCE OTHER THAN LONG-TERM CARE INSURANCE OR DISABILITY INSURANCE;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION; OR

(IV) 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 STATE REGULATION.

(3) (I) "MEMBER" MEANS AN INDIVIDUAL ENTITLED TO HEALTH CARE BENEFITS UNDER A POLICY, PLAN, OR CERTIFICATE ISSUED OR DELIVERED IN THE STATE BY A CARRIER.

(II) "MEMBER" INCLUDES A SUBSCRIBER.

(4) "PROVIDER PANEL" MEANS THOSE PROVIDERS WITH WHICH A CARRIER CONTRACTS TO PROVIDE SERVICES TO ITS MEMBERS.

(5) "SPECIALIST" MEANS A PHYSICIAN WHO IS NOT A PRIMARY CARE PROVIDER.

(B) (1) EACH CARRIER THAT DOES NOT ALLOW DIRECT ACCESS TO SPECIALISTS SHALL ESTABLISH AND IMPLEMENT A PROCEDURE BY WHICH A MEMBER MAY RECEIVE A STANDING REFERRAL TO A SPECIALIST IN ACCORDANCE WITH THIS SUBSECTION.

(2) THE PROCEDURE SHALL PROVIDE FOR A STANDING REFERRAL TO A SPECIALIST IF:

(I) THE PRIMARY CARE PROVIDER OF THE MEMBER DETERMINES, IN CONSULTATION WITH THE SPECIALIST, THAT THE MEMBER NEEDS CONTINUING CARE FROM THE SPECIALIST;

(II) THE MEMBER HAS A CONDITION OR DISEASE THAT:

1. IS LIFE THREATENING, DEGENERATIVE, CHRONIC, OR DISABLING; AND

2. REQUIRES SPECIALIZED MEDICAL CARE; AND

(III) THE SPECIALIST:

1. HAS EXPERTISE IN TREATING THE LIFE-THREATENING, DEGENERATIVE, CHRONIC, OR DISABLING DISEASE OR CONDITION; AND

2. IS PART OF THE CARRIER'S PROVIDER PANEL.

(3) A STANDING REFERRAL SHALL BE MADE IN ACCORDANCE WITH A WRITTEN TREATMENT PLAN THAT IS APPROVED BY THE CARRIER IN CONSULTATION WITH:

(I) THE PRIMARY CARE PROVIDER;

(II) THE SPECIALIST; AND

(III) THE MEMBER.

(4) A TREATMENT PLAN MAY:

(I) LIMIT THE NUMBER OF VISITS TO THE SPECIALIST;

(II) LIMIT THE PERIOD OF TIME IN WHICH VISITS TO THE SPECIALIST ARE AUTHORIZED; AND

(III) REQUIRE THE SPECIALIST TO COMMUNICATE REGULARLY WITH THE PRIMARY CARE PROVIDER REGARDING THE TREATMENT AND HEALTH STATUS OF THE MEMBER.

(C) (1) EACH CARRIER THAT DOES NOT ALLOW DIRECT ACCESS TO SPECIALISTS SHALL ESTABLISH AND IMPLEMENT A PROCEDURE BY WHICH A SPECIALIST MAY ACT AS THE PRIMARY CARE COORDINATOR IN ACCORDANCE WITH THIS SUBSECTION.

(2) THE PROCEDURE SHALL AUTHORIZE A SPECIALIST TO ACT AS THE PRIMARY CARE COORDINATOR FOR A MEMBER IF:

(I) THE MEMBER HAS A DISEASE OR CONDITION THAT:

1. IS LIFE THREATENING, DEGENERATIVE, CHRONIC, OR DISABLING; AND

2. REQUIRES SPECIALIZED MEDICAL CARE FOR AT LEAST 1 YEAR;

(II) THE MEMBER REQUESTS THAT A SPECIALIST ACT AS THE MEMBER'S PRIMARY CARE COORDINATOR WITHIN 30 DAYS AFTER:

1. ENROLLMENT; OR

2. THE MEMBER IS DIAGNOSED WITH A LIFE-THREATENING, DEGENERATIVE, CHRONIC, OR DISABLING DISEASE OR CONDITION; AND

(III) THE SPECIALIST:

1. HAS EXPERTISE IN TREATING THE LIFE-THREATENING, DEGENERATIVE, CHRONIC, OR DISABLING DISEASE OR CONDITION; AND

2. IS PART OF THE CARRIER'S PROVIDER PANEL.

(3) IF A SPECIALIST ACTS AS THE PRIMARY CARE COORDINATOR FOR A MEMBER IN ACCORDANCE WITH THIS SUBSECTION, THE SPECIALIST SHALL:

(I) ACT IN ACCORDANCE WITH A WRITTEN TREATMENT PLAN THAT IS APPROVED BY THE CARRIER IN CONSULTATION WITH:

1. THE PRIMARY CARE PROVIDER;

2. THE SPECIALIST; AND

3. THE MEMBER; AND

(II) COMMUNICATE REGULARLY WITH THE PRIMARY CARE PROVIDER REGARDING THE TREATMENT AND HEALTH STATUS OF THE MEMBER.

(D) (1) EACH CARRIER SHALL ESTABLISH AND IMPLEMENT A PROCEDURE BY WHICH A MEMBER MAY REQUEST A REFERRAL TO A SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL IN ACCORDANCE WITH THIS SUBSECTION.

(2) THE PROCEDURE SHALL PROVIDE FOR A REFERRAL TO A SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL IF:

(I) THE MEMBER IS DIAGNOSED WITH A CONDITION OR DISEASE THAT REQUIRES SPECIALIZED MEDICAL CARE;

(II) THE CARRIER DOES NOT HAVE IN ITS PROVIDER PANEL A SPECIALIST WITH THE SAME PROFESSIONAL TRAINING AND EXPERTISE AS THE SPECIALIST FROM WHOM THE MEMBER SEEKS TREATMENT;

(III) THE SPECIALIST HAS EXPERTISE IN TREATING THE DISEASE OR CONDITION; AND

(IV) THE SPECIALIST AGREES TO ACCEPT THE SAME REIMBURSEMENT AS WOULD BE PROVIDED TO A SPECIALIST WHO IS PART OF THE CARRIER'S PROVIDER PANEL.

(E) A DECISION BY A CARRIER NOT TO PROVIDE ACCESS TO OR COVERAGE OF TREATMENT BY A SPECIALIST UNDER A PROCEDURE REQUIRED UNDER THIS SECTION CONSTITUTES AN ADVERSE DECISION AS DEFINED UNDER SUBTITLE 10A OF THIS TITLE.

(F) EACH CARRIER SHALL FILE WITH THE COMMISSIONER A COPY OF EACH OF THE PROCEDURES REQUIRED UNDER THIS SECTION.

15-830.

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

(2) "FORMULARY" MEANS A LIST OF PRESCRIPTION DRUGS OR DEVICES THAT ARE COVERED BY AN ENTITY SUBJECT TO THIS SECTION.

(3) (I) "MEMBER" MEANS AN INDIVIDUAL ENTITLED TO HEALTH CARE BENEFITS UNDER A POLICY ISSUED OR DELIVERED IN THE STATE BY AN ENTITY SUBJECT TO THIS SECTION.

(II) "MEMBER" INCLUDES A SUBSCRIBER.

(B) (1) THIS SECTION APPLIES TO:

(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS AND DEVICES UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE COVERAGE FOR PRESCRIPTION DRUGS AND DEVICES UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(2) THIS SECTION DOES NOT APPLY TO A MANAGED CARE ORGANIZATION AS DEFINED IN § 15-101 OF THE HEALTH - GENERAL ARTICLE.

(C) EACH ENTITY SUBJECT TO THIS SECTION THAT LIMITS ITS COVERAGE OF PRESCRIPTION DRUGS OR DEVICES TO THOSE IN A FORMULARY SHALL ESTABLISH AND IMPLEMENT A PROCEDURE BY WHICH A MEMBER MAY RECEIVE A PRESCRIPTION DRUG OR DEVICE THAT IS NOT IN THE FORMULARY IN ACCORDANCE WITH THIS SECTION.

(D) THE PROCEDURE SHALL PROVIDE FOR COVERAGE FOR A PRESCRIPTION DRUG OR DEVICE THAT IS NOT IN THE FORMULARY IF, IN THE JUDGMENT OF THE PHYSICIAN WHO IS CARING FOR THE MEMBER:

(1) (I) THE PRESCRIPTION DRUG OR DEVICE THAT IS NOT IN THE FORMULARY IS MEDICALLY NECESSARY; AND

(II) THERE IS NO EQUIVALENT PRESCRIPTION DRUG OR DEVICE IN THE FORMULARY;

(2) THE MEMBER IS IN THE MIDST OF A COURSE OF TREATMENT WITH THE PRESCRIPTION DRUG OR DEVICE THAT IS NOT IN THE FORMULARY; OR

(3) AN EQUIVALENT PRESCRIPTION DRUG OR DEVICE IN THE FORMULARY:

(I) HAS BEEN INEFFECTIVE IN TREATING THE DISEASE OR CONDITION OF THE MEMBER; OR

(II) HAS CAUSED OR IS LIKELY TO CAUSE AN ADVERSE REACTION OR OTHER HARM TO THE MEMBER.

(E) A MEMBER WHO OBTAINS A PRESCRIPTION DRUG OR DEVICE UNDER THIS SECTION MAY NOT BE REQUIRED TO PAY ANY FEE OR COPAYMENT OTHER THAN THAT REQUIRED FOR A PRESCRIPTION DRUG OR DEVICE IN THE FORMULARY.

(F) A DECISION BY A CARRIER TO NOT PROVIDE ACCESS TO OR COVERAGE OF A PRESCRIPTION DRUG OR DEVICE UNDER THE PROCEDURE REQUIRED UNDER THIS SECTION CONSTITUTES AN ADVERSE DECISION AS DEFINED UNDER SUBTITLE 10A OF THIS TITLE.

15-10A-09.

(b) In addition to the requirements of subsection (a) of this section, [on or before January 1, 1999,] the Commissioner shall adopt by regulation a requirement that each carrier provide a mechanism in a form and manner that the Commissioner may require to enable a member to:

(1) be informed of the member's right to challenge a decision made by a carrier that resulted in the nonpayment of a health care service; AND

(2) ACCESS THE CONSUMER EDUCATION AND ADVOCACY PROGRAM IN THE ADMINISTRATION.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Insurance

15-831.

(A) IN THIS SECTION, "MASTECTOMY" MEANS THE SURGICAL REMOVAL OF ALL OR PART OF A BREAST AS A RESULT OF BREAST CANCER.

(B) THIS SECTION APPLIES TO:

(1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE INPATIENT HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS ON AN EXPENSE-INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE INPATIENT HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(C) EACH ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR THE COST OF INPATIENT HOSPITALIZATION SERVICES FOR A MINIMUM OF:

(1) 48 HOURS OF INPATIENT HOSPITALIZATION CARE AFTER A MASTECTOMY OR AFTER THE REMOVAL OF A TESTICLE DUE TO TESTICULAR CANCER; AND

(2) 24 HOURS OF INPATIENT HOSPITALIZATION CARE AFTER A LYMPH NODE DISSECTION OR LUMPECTOMY FOR THE TREATMENT OF BREAST CANCER.

(D) THIS SECTION MAY NOT BE CONSTRUED TO REQUIRE THE PROVISION OF INPATIENT HOSPITALIZATION SERVICES IN ACCORDANCE WITH SUBSECTION (C) OF THIS SECTION IF A PATIENT DETERMINES, IN CONSULTATION WITH THE PATIENT'S ATTENDING PHYSICIAN, THAT:

(1) A SHORTER PERIOD OF INPATIENT HOSPITALIZATION IS APPROPRIATE FOR RECOVERY; OR

(2) THE MASTECTOMY, REMOVAL OF A TESTICLE, LYMPH NODE DISSECTION, OR LUMPECTOMY CAN BE PERFORMED ON AN OUTPATIENT BASIS.

(E) FOR A PATIENT WHO HAS A SHORTER LENGTH OF STAY THAN THAT PROVIDED UNDER SUBSECTION (C) OF THIS SECTION OR DECIDES THAT THE MASTECTOMY, REMOVAL OF A TESTICLE, LYMPH NODE DISSECTION, OR LUMPECTOMY CAN BE PERFORMED ON AN OUTPATIENT BASIS, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR:

(1) ONE HOME VISIT SCHEDULED TO OCCUR WITHIN 24 HOURS AFTER DISCHARGE FROM THE HOSPITAL OR OUTPATIENT HEALTH CARE FACILITY; AND

(2) AN ADDITIONAL HOME VISIT IF PRESCRIBED BY THE PATIENT'S ATTENDING PHYSICIAN.

(F) EACH ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE NOTICE ANNUALLY TO ITS ENROLLEES AND INSUREDS ABOUT THE COVERAGE REQUIRED UNDER THIS SECTION.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall apply to all new policies or health benefit plans issued or delivered in the State on or after July 1, 1999, and to the renewal of all policies in effect before July 1, 1999, except that any

policy or health benefit plan in effect before July 1, 1999, shall comply with the provisions of this Act no later than July 1, 2000.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 1999. Section 2 of this Act shall remain effective for a period of 4 years and, at the end of June 30, 2003, with no further action required by the General Assembly, Section 2 of this Act shall be abrogated and of no further force and effect.