

SENATE BILL 699

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1999 Regular Session
9lr2414
CF 9lr2150

By: **Senator Bromwell**
Introduced and read first time: February 19, 1999
Assigned to: Rules
Re-referred to: Finance, February 25, 1999

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 26, 1999

CHAPTER _____

1 AN ACT concerning

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

4 FOR the purpose of exempting certain carriers from the health care regulatory
5 assessment for the Health Care Regulatory Fund and from the requirements
6 relating to the adverse decision and grievance process; altering a certain
7 definition; defining a certain term; making certain provisions of law applicable
8 to certain health benefit plans; and generally relating to the Health Care
9 Regulatory Fund and the establishment of an internal grievance process by
10 carriers.

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

16 BY adding to
17 Article - Insurance
18 Section 15-10A-01.1
19 Annotated Code of Maryland
20 (1997 Volume and 1998 Supplement)

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

1

Article - Insurance

2 2-112.2.

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

4 (2) "Carrier" means A PERSON THAT OFFERS A HEALTH BENEFIT PLAN
5 AND IS:6 [(i) an insurer that offers health insurance other than long term
7 care insurance or disability insurance]8 (I) AN AUTHORIZED INSURER THAT PROVIDES HEALTH
9 INSURANCE IN THE STATE;

10 (ii) a nonprofit health service plan;

11 (iii) a health maintenance organization;

12 (iv) a dental plan organization; or

13 (v) except for a managed care organization as defined in Title 15,
14 Subtitle 1 of the Health - General Article, any other person that provides health
15 benefit plans subject to regulation by the State.

16 (3) (I) "HEALTH BENEFIT PLAN" MEANS:

17 1. A HOSPITAL OR MEDICAL ~~POLICY POLICY, CONTRACT, OR~~
18 CERTIFICATE, INCLUDING THOSE ISSUED UNDER MULTIPLE EMPLOYER TRUSTS OR
19 ASSOCIATIONS LOCATED IN MARYLAND OR ANY OTHER STATE COVERING MARYLAND
20 RESIDENTS;21 2. A HOSPITAL OR MEDICAL POLICY, CONTRACT, OR
22 CERTIFICATE ISSUED BY A NONPROFIT HEALTH SERVICE PLAN ~~THAT COVERS~~
23 ~~MARYLAND RESIDENTS~~;

24 3. A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR

25 4. A DENTAL PLAN.

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

28 1. LONG-TERM CARE INSURANCE;

29 2. DISABILITY INSURANCE;

30 3. ACCIDENTAL TRAVEL AND ACCIDENTAL DEATH AND
31 DISMEMBERMENT INSURANCE;

32 4. CREDIT HEALTH INSURANCE;

1 5. ANY INSURANCE, MEDICAL POLICY, OR CERTIFICATE FOR
2 WHICH PAYMENT OF BENEFITS ~~ARE IS~~ IS CONDITIONED ON A DETERMINATION OF
3 MEDICAL NECESSITY MADE SOLELY BY THE TREATING HEALTH CARE PROVIDER NOT
4 ACTING ON BEHALF OF THE CARRIER;

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

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

11 [(3)] (4) (i) "Premium" has the meaning stated in § 1-101 of this
12 article to the extent it is allocable to health insurance policies or contracts issued or
13 delivered in this State.

14 (ii) "Premium" includes any amounts paid to a health maintenance
15 organization as compensation for providing to members and subscribers the services
16 specified in Title 19, Subtitle 7 of the Health - General Article to the extent the
17 amounts are allocable to this State.

18 (b) The Commissioner shall:

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

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

24 (c) The health care regulatory assessment that is payable by each carrier
25 shall be calculated by taking the total costs under subsection (b)(1) of this section
26 multiplied by the percentage of gross direct health insurance premiums written in the
27 State attributable to that carrier in the prior calendar year.

28 15-10A-01.

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

30 (b) (1) "Adverse decision" means a utilization review determination by a
31 private review agent, a carrier, or a health care provider acting on behalf of a carrier
32 that:

33 (i) a proposed or delivered health care service covered under the
34 member's contract is or was not medically necessary, appropriate, or efficient; and

35 (ii) may result in noncoverage of the health care service.

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

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

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

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

9 (2) a nonprofit health service plan;

10 (3) a health maintenance organization;

11 (4) a dental plan organization; or

12 (5) EXCEPT FOR A MANAGED CARE ORGANIZATION AS DEFINED IN TITLE
13 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, any other person that provides
14 health benefit plans subject to regulation by the State.

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

17 (e) "Grievance" means a protest filed by a member or a health care provider on
18 behalf of a member with a carrier through the carrier's internal grievance process
19 regarding an adverse decision concerning the member.

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

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

26 (H) ~~(+)~~ "HEALTH BENEFIT PLAN" ~~MEANS:~~ HAS THE MEANING STATED IN §
27 2-112.2(A) OF THIS ARTICLE.

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

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

33 ~~(III) A HEALTH MAINTENANCE ORGANIZATION CONTRACT; OR~~

34 ~~(IV) A DENTAL PLAN.~~

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

3 (I) ~~LONG TERM CARE INSURANCE;~~

4 (II) ~~DISABILITY INSURANCE;~~

5 (III) ~~ACCIDENTAL TRAVEL AND ACCIDENTAL DEATH AND~~
6 ~~DISMEMBERMENT INSURANCE;~~

7 (IV) ~~CREDIT HEALTH INSURANCE;~~

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

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

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

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

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

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

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

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

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

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

30 (2) "Member" includes:

31 (i) a subscriber; and

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

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

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

3 15-10A-01.1.

4 THIS SUBTITLE APPLIES TO A HEALTH BENEFIT PLAN THAT:

5 (1) IS DELIVERED OR ISSUED IN THIS STATE; OR

6 (2) COVERS INDIVIDUALS WHO RESIDE OR WORK IN THE STATE IF THE
7 HEALTH BENEFIT PLAN IS DELIVERED OR ISSUED IN A STATE THAT THE
8 COMMISSIONER DETERMINES DOES NOT HAVE AN EXTERNAL COMPLAINT PROCESS
9 FOR ADVERSE DECISIONS OR GRIEVANCES COMPARABLE TO THE COMPLAINT
10 PROCESS ESTABLISHED IN THIS SUBTITLE.

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