**Unofficial Copy** **2000 Regular Session**
**SB0497/543696/1**

BY: Economic Matters Committee

AMENDMENTS TO SENATE BILL NO. 497
(Third Reading File Bill)

AMENDMENT NO. 1

On page 1, strike lines 2 and 3 in their entirety and substitute "Health Maintenance Organizations - Responsibility for and Regulation of Downstream Risk"; strike beginning with "clarifying" in line 4 down through "law." in line 20 and substitute "requiring health maintenance organizations and certain other entities that enter into administrative service provider contracts to meet certain requirements; clarifying the responsibility of certain health maintenance organizations for certain claims and payments for health care services under an administrative service provider contract; specifying that certain requirements concerning administrative service provider contracts apply to managed care organizations under the Maryland Medical Assistance Program; requiring the Commissioner, in consultation with the Secretary of Health and Mental Hygiene, to adopt certain regulations for a certain methodology; specifying the type of financial statement that a certain contracting provider must provide to a certain health maintenance organization; requiring a certain health maintenance organization to establish a certain fund; requiring a certain contracting provider to submit monthly reports to a certain health maintenance organization on the status of certain payments and compliance with certain laws; specifying the frequency of certain audits; specifying that a health maintenance organization shall meet certain requirements regardless of the existence of a certain fund or certain contract provisions; specifying the contents of a certain plan to be filed and approved by the Commissioner; requiring certain health maintenance organizations to file certain information with the Commissioner; specifying the responsibilities of certain entities upon a contracting provider's failure to comply with a certain plan; specifying that the failure of a certain health maintenance organization to comply with the terms of a certain contract is a violation of certain provisions of law; providing that a certain segregated fund is not the asset of a certain contracting provider; establishing a certain registration system for certain contracting providers; prohibiting a health maintenance organization from contracting with a certain unregistered contracting provider; providing for certain application requirements; authorizing the Commissioner to adopt certain regulations; establishing certain penalties; altering certain definitions; defining certain terms; requiring the Commissioner to submit a certain report to the Governor and the General

(Over)

Assembly on or before a certain date; and generally relating to health maintenance organizations, contracting providers, and regulation of administrative service provider contracts.

BY renumbering
Article - Health - General
Section 19-713.3 and 19-713.4, respectively
to be Section 19-713.4 and 19-713.5, respectively
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)".

On page 2, in line 2, strike "and 19-713.2" and substitute ", 19-713.2, and 19-730"; and after line 4, insert:

"BY adding to
Article - Health - General
Section 19-712(c) and 19-713.3
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, without amendments,
Article - Health - General
Section 19-729
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-605(a)
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)".

AMENDMENT NO. 2

On pages 2 through 5, strike in their entirety the lines beginning with line 5 on page 2 through line 33 on page 5, inclusive and substitute:

"SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 19-713.3 and 19-713.4, respectively, of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 19-713.4 and 19-713.5, respectively.

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

Article - Health - General

15-102.3.

(a) The provisions of § 15-112 of the Insurance Article (Provider panels) shall apply to managed care organizations in the same manner they apply to carriers.

(b) The provisions of § 15-1005 of the Insurance Article shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

(c) THE PROVISIONS OF §§ 19-712, 19-713.2, AND 19-713.3 OF THIS ARTICLE APPLY TO MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

(D) (1) Except as otherwise provided in this subsection, the provisions of § 19-718 of this article (Financial affairs examination) shall apply to managed care organizations in the same manner they apply to health maintenance organizations.

(2) The Insurance Commissioner or an agent of the Commissioner shall examine the financial affairs and status of each managed care organization at least once every 5 years.

19-712.

(b) (1) A person who holds a certificate of authority to operate a health maintenance organization under this subtitle and who enters into any administrative service provider contract, as

defined in [§ 19-713.1] § 19-713.2 of this subtitle, with a person or entity for the provision of health care services to subscribers shall be responsible for all claims or payments for health care services:

(i) Covered under the subscriber's contract; and

(ii) Rendered by a provider, who is not the person or entity which entered into the administrative service provider contract with the health maintenance organization, pursuant to a referral by a person or entity which entered into the administrative service provider contract with the health maintenance organization.

(2) Responsibility for claims and payments under this subsection is subject to the provisions of [§ 19-712.1 of this subtitle] § 15-1005 OF THE INSURANCE ARTICLE.

(C) THE RESPONSIBILITY OF A HEALTH MAINTENANCE ORGANIZATION FOR CLAIMS OR PAYMENTS FOR HEALTH CARE SERVICES IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION UNDER AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT:

(1) IS NOT LIMITED BY THE AMOUNT IN A SEGREGATED FUND ESTABLISHED UNDER § 19-713.2 OF THIS TITLE;

(2) EXISTS IRRESPECTIVE OF THE INSOLVENCY OR OTHER INABILITY OR FAILURE OF A CONTRACTING PROVIDER, AS DEFINED IN § 19-713.2 OF THIS SUBTITLE, TO PAY;

(3) EXISTS IRRESPECTIVE OF THE DELEGATION OR FURTHER SUBCONTRACTING OF HEALTH CARE SERVICES BY A CONTRACTING PROVIDER TO AN EXTERNAL PROVIDER, AS DEFINED IN § 19-713.2 OF THIS SUBTITLE;

(4) MAY NOT BE ALTERED BY CONTRACT; AND

(5) APPLIES TO ALL HEALTH CARE SERVICES, INCLUDING THOSE PROVIDED UNDER STATE AND FEDERAL PROGRAMS, UNLESS PREEMPTED BY FEDERAL LAW.

19-713.2.

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

(2) "Administrative service provider contract" means a contract or capitation agreement between a health maintenance organization and a contracting provider which includes requirements that:

(i) The contracting provider accept payments from a health maintenance organization for health care services to be provided to members of the health maintenance organization that the contracting provider arranges to be provided by external providers; and

(ii) The contracting provider administer payments pursuant to the contract [within] WITH the health maintenance organization for the health care services to the external providers.

(3) "Contracting provider" means a [physician or other health care provider] PERSON who enters into an administrative service provider contract with a health maintenance organization.

(4) "External provider" means a [health care provider] PERSON, including a physician or hospital, who is not:

(i) A contracting provider; or

(ii) An employee, shareholder, or partner of a contracting provider.

(b) A health maintenance organization may not enter into an administrative service provider contract unless:

(1) The health maintenance organization files with the Insurance Commissioner a plan that satisfies the requirements of subsection (c) of this section; and

(2) The Insurance Commissioner does not disapprove the filing within 30 days after the plan is filed.

(c) The plan required under subsection (b) of this section shall:

(1) Require the contracting provider to provide the health maintenance organization with regular reports, at least quarterly, that identify payments made or owed to external providers in sufficient detail to determine if the payments are being made in compliance with law;

(2) Require the contracting provider to provide to the health maintenance organization a current, AUDITED annual financial statement of the contracting provider each year;

(3) Require the [creation by the contracting provider, or on the contracting provider's behalf, of] HEALTH MAINTENANCE ORGANIZATION TO ESTABLISH a segregated fund, IN A FORM APPROVED BY THE COMMISSIONER, THAT IS:

(I) [(which may include withheld funds, escrow accounts, letters of credit, or similar arrangements), or require the availability of other resources that are] sufficient to satisfy the contracting provider's obligations to external providers for services rendered to members of the health maintenance organization; AND

(II) EQUAL TO AT LEAST 3 MONTHS OF CAPITATION AND OTHER PAYMENTS FOR HEALTH CARE SERVICES BY THE HEALTH MAINTENANCE ORGANIZATION TO THE CONTRACTING PROVIDER;

(4) Require an explanation of how the fund [or resources required] ESTABLISHED under [paragraph] ITEM (3) of this subsection [create funds or other resources] IS sufficient to satisfy the contracting provider's obligations to external providers for services rendered to members of the health maintenance organization; [and]

(5) [Permit] REQUIRE the health maintenance organization, [at mutually agreed upon times and upon reasonable prior notice] AT LEAST QUARTERLY, to audit and inspect the contracting provider's books, records, and operations relevant to the provider's contract for the

purpose of determining the contracting provider's compliance with the plan;

(6) REQUIRE THE HEALTH MAINTENANCE ORGANIZATION TO INCLUDE A COPY OF THE FINANCIAL STATEMENT REQUIRED UNDER ITEM (2) OF THIS SUBSECTION IN ITS ANNUAL REPORT UNDER § 19-717 OF THIS SUBTITLE; AND

(7) REQUIRE THE CONTRACTING PROVIDER TO SUBMIT MONTHLY REPORTS TO THE HEALTH MAINTENANCE ORGANIZATION ON THE STATUS OF THE PAYMENTS MADE AND OWED TO EXTERNAL PROVIDERS AND THE COMPLIANCE BY THE CONTRACTING PROVIDER WITH § 15-1005 OF THE INSURANCE ARTICLE.

(d) The health maintenance organization and the contracting provider shall comply with the plan.

(E) (1) THE HEALTH MAINTENANCE ORGANIZATION SHALL FILE WITH THE COMMISSIONER THE RESULTS OF EACH QUARTERLY AUDIT REQUIRED UNDER SUBSECTION (C)(5) OF THIS SECTION.

(2) AT LEAST ANNUALLY, THE HEALTH MAINTENANCE ORGANIZATION SHALL FILE THE FOLLOWING INFORMATION WITH THE COMMISSIONER IN A FORM APPROVED BY THE COMMISSIONER:

(I) A COPY OR SUMMARY OF EACH ADMINISTRATIVE SERVICE PROVIDER CONTRACT;

(II) DOCUMENTATION OF CAPITATION AND OTHER PAYMENTS MADE UNDER EACH ADMINISTRATIVE SERVICE PROVIDER CONTRACT;

(III) THE NUMBER OF LIVES COVERED UNDER EACH ADMINISTRATIVE SERVICE PROVIDER CONTRACT;

(IV) THE FUNDING AND STATUS OF EACH SEGREGATED FUND; AND

(V) ANY OTHER INFORMATION THE COMMISSIONER DETERMINES TO BE APPROPRIATE.

[(e)] (F) (1) The health maintenance organization shall monitor the contracting provider to assure compliance with the plan, and the health maintenance organization shall notify the contracting provider whenever a failure to comply with the plan occurs.

(2) Upon the failure of the contracting provider to comply with the plan following notice of noncompliance, or upon termination of the administrative service provider contract for any reason, the health maintenance organization shall NOTIFY THE COMMISSIONER AND SHALL assume the administration of any payments due from the contracting provider to external providers on behalf of the contracting provider, AS REQUIRED UNDER § 19-712 OF THIS SUBTITLE.

[(f)] (G) The plan and all supporting documentation submitted in connection with the plan shall be treated as confidential and proprietary, and may not be disclosed except as otherwise required by law.

[(g)] (H) On July 1, 1991, any health maintenance organization which has existing contracts or arrangements subject to this section shall file a plan under this section within 120 days.

(I) THE SEGREGATED FUND ESTABLISHED UNDER SUBSECTION (C) OF THIS SECTION MAY NOT BE CONSIDERED AN ASSET OF A CONTRACTING PROVIDER FOR THE PURPOSE OF DETERMINING THE ASSETS OF A CONTRACTING PROVIDER.

(J) IT IS A VIOLATION OF THIS SECTION FOR A HEALTH MAINTENANCE ORGANIZATION TO FAIL TO COMPLY WITH THE TERMS OF AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT.

19-713.3.

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

(2) "ADMINISTRATIVE SERVICE PROVIDER CONTRACT" HAS THE

MEANING STATED IN § 19-713.2 OF THIS SUBTITLE.

(3) "CONTRACTING PROVIDER" HAS THE MEANING STATED IN § 19-713.2 OF THIS SUBTITLE.

(B) (1) A PERSON MUST REGISTER WITH THE COMMISSIONER BEFORE THE PERSON ACTS AS A CONTRACTING PROVIDER IN THIS STATE.

(2) A HEALTH MAINTENANCE ORGANIZATION MAY NOT ENTER INTO AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT WITH A CONTRACTING PROVIDER THAT HAS NOT REGISTERED WITH THE COMMISSIONER.

(C) (1) AN APPLICANT FOR REGISTRATION SHALL:

(I) SUBMIT AN APPLICATION TO THE COMMISSIONER IN A FORM APPROVED BY THE COMMISSIONER AND INCLUDE ANY INFORMATION REQUIRED UNDER SUBSECTION (D) OF THIS SECTION; AND

(II) PAY TO THE COMMISSIONER AN APPLICATION FEE ESTABLISHED BY THE COMMISSIONER BY REGULATION SUFFICIENT TO COVER THE COSTS ASSOCIATED WITH CARRYING OUT THE PROVISIONS OF THIS SECTION AND § 19-713.2 OF THIS SUBTITLE.

(2) (I) A REGISTRATION UNDER THIS SECTION EXPIRES 2 YEARS FROM THE DATE THE APPLICATION IS APPROVED.

(D) THE REGISTRATION APPLICATION MAY REQUIRE THE FOLLOWING INFORMATION:

(1) THE AMOUNT OF CAPITATION AND OTHER PAYMENTS RECEIVED BY THE CONTRACTING PROVIDER UNDER ALL ADMINISTRATIVE SERVICE PROVIDER CONTRACTS ON AN ANNUAL BASIS, INCLUDING AMOUNTS RECEIVED UNDER STATE AND FEDERAL PROGRAMS;

(2) THE NUMBER OF LIVES COVERED BY THE CONTRACTING PROVIDER UNDER ALL ADMINISTRATIVE SERVICE PROVIDER CONTRACTS;

(3) INFORMATION RELATING TO THE CONTROL OF THE APPLICANT, INCLUDING THE IDENTITY OF:

(I) MANAGEMENT;

(II) THE BOARD OF DIRECTORS; AND

(III) CONTROLLING OWNERS;

(4) A DESCRIPTION OF THE MEDICAL CARE DELIVERY SYSTEM OF THE CONTRACTING PROVIDER, INCLUDING A COPY OF ANY CONTRACT RELATED TO THE PROVISION OF ANY SERVICE REQUIRED UNDER THE ADMINISTRATIVE SERVICE PROVIDER CONTRACT; AND

(5) A COPY OF THE MOST RECENT AUDITED ANNUAL FINANCIAL STATEMENT REQUIRED UNDER § 19-713.2(C)(2) OF THIS SUBTITLE.

(E) THE COMMISSIONER MAY ADOPT REGULATIONS TO CARRY OUT THE REQUIREMENTS OF THIS SECTION.

19-729.

(a) A health maintenance organization may not:

(1) Violate any provision of this subtitle or any rule or regulation adopted under it;

(2) Fail to fulfill its obligations to provide the health care services specified in its contracts with subscribers;

(3) Make any false statement with respect to any report or statement required by

this subtitle or by the Commissioner under this subtitle;

(4) Advertise, merchandise, or attempt to merchandise its services in a way that misrepresents its services or capacity for service;

(5) Engage in a deceptive, misleading, unfair, or unauthorized practice as to advertising or merchandising;

(6) Prevent or attempt to prevent the Commissioner or the Department from performing any duty imposed by this subtitle;

(7) Fraudulently obtain or fraudulently attempt to obtain any benefit under this subtitle;

(8) Fail to fulfill the basic requirements to operate as a health maintenance organization as provided in § 19-710 of this subtitle;

(9) Violate any applicable provision of Title 15, Subtitle 12 of the Insurance Article;

(10) Fail to provide services to a member in a timely manner as provided in § 19-705.1(b)(1) of this subtitle;

(11) Fail to comply with the provisions of Title 15, Subtitle 10A, 10B, or 10C, or § 2-112.2 of the Insurance Article; or

(12) Violate any provision of § 19-712.5 of this subtitle.

(b) If any health maintenance organization violates this section, the Commissioner may pursue any one or more of the courses of action described in § 19-730 of this subtitle.

19-730.

(a) 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 $5,000 for each unlawful act committed;

(3) Impose any penalty that could be imposed on an insurer under § 4-113(d) of the Insurance Article;

(4) Suspend, revoke, or refuse to renew the certificate of authority to do business as a health maintenance organization;

(5) Suspend, revoke, or refuse to renew the certificate of a medical director of a health maintenance organization; OR

[(6) Impose any penalty that could be imposed on an insurer under § 4-113(d) of the Insurance Article; or

(7)] (6) Apply to any court for legal or equitable relief considered appropriate

by the Commissioner or the Department, in accordance with the joint internal procedures.

(b) IN ADDITION TO THE ACTIONS AVAILABLE TO THE COMMISSIONER IN SUBSECTION (A) OF THIS SECTION, IF A PERSON VIOLATES ANY PROVISION OF § 19-712, § 19-713.2, OR § 19-713.3 OF THIS SUBTITLE, THE COMMISSIONER MAY IMPOSE A PENALTY OF NOT MORE THAN $125,000 FOR EACH VIOLATION.

(C) If the Commissioner issues an order or imposes any penalty under this section, the Commissioner immediately shall provide written notice of the order or penalty to the Secretary.

Article - Insurance

15-605.

(a) (1) On or before March 1 of each year, an annual report that meets the specifications of paragraph (2) of this subsection shall be submitted to the Commissioner by:

(i) each authorized insurer that provides health insurance in the State;

(ii) each nonprofit health service plan that is authorized by the Commissioner to operate in the State;

(iii) each health maintenance organization that is authorized by the Commissioner to operate in the State; and

(iv) as applicable in accordance with regulations adopted by the Commissioner, each managed care organization that is authorized to receive Medicaid prepaid capitation payments under Title 15, Subtitle 1 of the Health - General Article.

(2) The annual report required under this subsection shall:

(i) be submitted in a form required by the Commissioner; and

(ii) include for the preceding calendar year the following data for all health

benefit plans specific to the State:

1. premiums written;

2. premiums earned;

3. total amount of incurred claims including reserves for claims incurred but not reported at the end of the previous year;

4. total amount of incurred expenses, including commissions, acquisition costs, general expenses, taxes, licenses, and fees, estimated if necessary;

5. loss ratio; and

6. expense ratio.

(3) The data required under paragraph (2) of this subsection shall be reported:

(i) by product delivery system for health benefit plans that are issued under Subtitle 12 of this title;

(ii) in the aggregate for health benefit plans that are issued to individuals;

(iii) in the aggregate for a managed care organization that operates under Title 15, Subtitle 1 of the Health - General Article; and

(iv) in a manner determined by the Commissioner in accordance with this subsection for all other health benefit plans.

(4) THE COMMISSIONER, IN CONSULTATION WITH THE SECRETARY OF HEALTH AND MENTAL HYGIENE, SHALL ESTABLISH AND ADOPT BY REGULATION A METHODOLOGY TO BE USED IN THE ANNUAL REPORT THAT ENSURES A CLEAR SEPARATION OF ALL MEDICAL AND ADMINISTRATIVE EXPENSES WHETHER INCURRED DIRECTLY OR THROUGH A SUBCONTRACTOR.

[(4)] (5) The Commissioner may conduct an examination to ensure that an annual report submitted under this subsection is accurate.

[(5)] (6) Failure of an insurer, nonprofit health service plan, or health maintenance organization to submit the information required under this subsection in a timely manner shall result in a penalty of $500 for each day after March 1 that the information is not submitted.

SECTION 3. AND BE IT FURTHER ENACTED, That, on or before January 1, 2002, the Insurance Commissioner, after reviewing the information obtained from registrants under § 19-713.3 of the Health - General Article, as enacted by Section 2 of this Act, shall submit a report to the Governor and the General Assembly, in accordance with § 2-1246 of the State Government Article, on the Commissioner's recommendations as to whether, and to what extent, contracting providers should be subject to additional regulation for the protection of health care providers and consumers. The report shall include recommendations relating to licensing standards, solvency requirements, and the application of State receivership laws.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2000.".