Unofficial Copy **2006 Regular Session**
SB0686/167579/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL NO. 686
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 3, after "to" insert "maintain standards in accordance with certain regulations if the carrier is an insurer, nonprofit health service plan, or dental plan organization; requiring a health insurance carrier that uses a provider panel to adhere to certain standards for accessibility of covered services if the carrier is a health maintenance organization; requiring a health insurance carrier that uses a provider panel to"; in line 5, strike "a certain time" and substitute "certain times"; in line 6, strike "promptly"; strike beginning with "requiring" in line 6 down through "panel;" in line 12 and substitute "providing that certain provisions of this Act may not be construed to require a carrier to allow a provider to take a certain action; requiring a carrier to update certain provider information within a certain time period; altering the procedure for referral to a specialist who is not part of a carrier's provider panel; requiring a carrier to treat a certain service in a certain manner, for certain purposes; altering a certain definition; requiring the Maryland Insurance Administration, in consultation with certain parties, to adopt certain regulations on or before a certain date, and to take into consideration certain standards and procedures in adopting the regulations; requiring certain insurers, nonprofit health service plans, and dental plan organizations to comply with the regulations on or before a certain date; requiring the Administration, on or before a certain date, to conduct a certain study and report on the findings and recommendations of its study to certain legislative committees;"; in line 16, after "(j)" insert "and 15-830"; and after line 18, insert:

"BY adding to
Article - Insurance
Section 15-112(m)
Annotated Code of Maryland
(2002 Replacement Volume and 2005 Supplement)".

AMENDMENT NO. 2

(Over)

On page 1, in line 23, after "(b)" insert "(1)(I)"; in the same line, after "shall" insert ":

1. IF THE CARRIER IS AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR DENTAL PLAN ORGANIZATION, MAINTAIN STANDARDS IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE COMMISSIONER FOR AVAILABILITY OF HEALTH CARE PROVIDERS TO MEET THE HEALTH CARE NEEDS OF ENROLLEES; AND

2. IF THE CARRIER IS A HEALTH MAINTENANCE ORGANIZATION, ADHERE TO THE STANDARDS FOR ACCESSIBILITY OF COVERED SERVICES IN ACCORDANCE WITH REGULATIONS ADOPTED UNDER § 19-705.1(B)(1)(II) OF THE HEALTH - GENERAL ARTICLE; AND

(II)";

and in lines 24, 26, and 27, strike "(1)", "(2)", and "(i)", respectively, and substitute "1.", "2.", and "A.", respectively.

On page 2, in lines 1, 6, 8, and 19, strike "(ii)", "(3)", "(4)", and "(6)", respectively, and substitute "B.", "3.", "4.", and "5.", respectively; in line 9, strike "LEAST ANNUALLY" and substitute "THE TIME OF CREDENTIALING AND RECREDENTIALING"; in line 10, strike "PROMPTLY"; in line 11, after "SECTION;" insert "AND"; strike in their entirety lines 12 through 18, inclusive; and after line 21, insert "(2) THE PROVISIONS OF PARAGRAPH (1)(II)4 OF THIS SUBSECTION MAY NOT BE CONSTRUED TO REQUIRE A CARRIER TO ALLOW A PROVIDER TO REFUSE TO ACCEPT NEW PATIENTS COVERED BY THE CARRIER.".

AMENDMENT NO. 3

On page 2, in line 35, strike "Information" and substitute "SUBJECT TO SUBSECTION (M) OF THIS SECTION, INFORMATION".

On page 3, after line 6, insert:

"(M) (1) A CARRIER SHALL UPDATE ITS PROVIDER INFORMATION UNDER SUBSECTION (J)(3)(II) OF THIS SECTION WITHIN 15 WORKING DAYS AFTER RECEIPT OF WRITTEN NOTIFICATION FROM THE PARTICIPATING PROVIDER OF A CHANGE IN THE APPLICABLE INFORMATION.

(2) NOTIFICATION IS PRESUMED TO HAVE BEEN RECEIVED BY A CARRIER:

(I) 3 WORKING DAYS AFTER THE DATE THE PARTICIPATING PROVIDER PLACED THE NOTIFICATION IN THE U.S. MAIL, IF THE PARTICIPATING PROVIDER MAINTAINS THE STAMPED CERTIFICATE OF MAILING FOR THE NOTICE; OR

(II) ON THE DATE RECORDED BY THE COURIER, IF THE NOTIFICATION WAS DELIVERED BY COURIER.".

AMENDMENT NO. 4

On page 3, strike in their entirety lines 7 through 13, inclusive, and substitute:

"15-830.

(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;

(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 State regulation.

(3) (I) "Member" means an individual entitled to health care benefits under a policy or plan 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] HAS THE MEANING STATED IN § 15-112(A) OF THIS TITLE.

(5) "Specialist" means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a primary care provider by the carrier.

(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 physician 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) Except as provided in subsection (c) of this section, a standing referral shall be made in accordance with a written treatment plan for a covered service developed by:

(I) the primary care physician;

(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 physician regarding the treatment and health status of the member.

(5) The procedure by which a member may receive a standing referral to a specialist may not include a requirement that a member see a provider in addition to the primary care physician before the standing referral is granted.

(c) (1) Notwithstanding any other provision of this section, a member who is pregnant shall receive a standing referral to an obstetrician in accordance with this subsection.

(2) After the member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals in accordance with the carrier's policies and procedures, through the postpartum period.

(3) A written treatment plan may not be required when a standing referral is to an obstetrician under this subsection.

(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; AND

(ii) 1. the carrier does not have in its provider panel a specialist with the professional training and expertise to treat the condition or disease; OR

2. THE CARRIER CANNOT PROVIDE REASONABLE ACCESS TO A SPECIALIST WITH THE PROFESSIONAL TRAINING AND EXPERTISE TO TREAT THE CONDITION OR DISEASE WITHOUT UNREASONABLE DELAY OR TRAVEL [and

(iii) 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) FOR PURPOSES OF CALCULATING ANY DEDUCTIBLE, COPAYMENT AMOUNT, OR COINSURANCE PAYABLE BY THE MEMBER, A CARRIER SHALL TREAT SERVICES RECEIVED IN ACCORDANCE WITH SUBSECTION (D) OF THIS SECTION AS IF THE SERVICE WAS PROVIDED BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL.

[(e)] (F) A decision by a carrier not to provide access to or coverage of treatment by a specialist in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed service is not medically necessary, appropriate, or efficient.

[(f)] (G) Each carrier shall file with the Commissioner a copy of each of the procedures required under this section.".

AMENDMENT NO. 5

On page 3, after line 13, insert:

"SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) On or before January 1, 2007, the Maryland Insurance Administration, in consultation with the Department of Health and Mental Hygiene's Office of Health Care Quality and other interested and affected parties, shall adopt regulations to implement the provisions of § 15-112(b)(1)(i)1 of the Insurance Article, as enacted by Section 1 of this Act, with respect to insurers, nonprofit health service plans, and dental plan organizations.

(b) In developing the regulations required under subsection (a) of this section, the Administration shall take into consideration the standards and procedures adopted by national accrediting organizations for preferred provider organizations and the laws of other states.

(c) Each insurer, nonprofit health service plan, and dental plan organization offering preferred provider organization benefit plans in the State shall comply with the regulations on or before July 1, 2007.

SECTION 3. AND BE IT FURTHER ENACTED, That, on or before January 1, 2008, the Maryland Insurance Administration shall:

(1) study the feasibility and desirability of imposing on carriers a network standard for in-network hospital-based physician services; and

(2) report on the findings and recommendations of its study, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee.";

in line 14, strike "2." and substitute "4."; and in line 15, strike "October" and substitute "June".