HB0579/116586/1

BY: Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 579
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in the sponsor line, strike "and Walker" and substitute, "Walker, Hammen, Benson, Costa, Donoghue, Elliott, Hubbard, Kach, Kipke, Kullen, McDonough, Morhaim, Nathan–Pulliam, Oaks, Pendergrass, V. Turner, and Weldon"; in line 3, after "Discounts" insert "and Study"; strike beginning with "making" in line 4 down through "specialists;" in line 8 and substitute "providing that the Maryland Insurance Commissioner may authorize certain health insurance carriers to offer a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers if the health insurance carrier meets certain requirements;"; in lines 9 and 10, in each instance, after "insurers" insert "and nonprofit health service plans"; strike beginning with "providing" in line 13 down through "circumstances;" in line 16 and substitute "requiring certain carriers that use a provider panel and offer a certain preferred provider insurance policy to adhere to certain standards;"; strike beginning with "providing" in line 18 down through "exclude" in line 20 and substitute "providing that a limited benefit group health insurance contract may be issued only by an insurer or nonprofit health service plan to an employer to provide health coverage only for certain employees; authorizing certain health insurance carriers to condition the sale of certain contracts on an employer taking certain actions"; in line 20, strike "a carrier" and substitute "certain health insurance carriers"; and in line 21, after "circumstances;" insert "requiring the Maryland Health Care Commission to conduct a certain study and report to certain committees of the General Assembly on or before a certain date;".

On pages 1 and 2, strike in their entirety the lines beginning with line 24 on page 1 through line 4 on page 2, inclusive.

(Over)

On page 2, in line 12, strike "14–205, 15–1202, 15–1204," and substitute "15–112(b)(1)"; and strike beginning with "14–205.1" in line 17 down through "Employees"" in line 19 and substitute "14–205.1 and 15–1104".

AMENDMENT NO. 2

On page 2, strike in their entirety lines 24 through 27, inclusive.

On pages 4 and 5, strike beginning with line 17 on page 4 through line 23 on page 5, inclusive.

On page 5, after line 24, insert:

"**(A) THE COMMISSIONER MAY AUTHORIZE AN INSURER OR NONPROFIT HEALTH SERVICE PLAN TO OFFER A PREFERRED PROVIDER INSURANCE POLICY THAT CONDITIONS THE PAYMENT OF BENEFITS ON THE USE OF PREFERRED PROVIDERS IF THE INSURER OR NONPROFIT HEALTH SERVICE PLAN:**

(1) HAS DEMONSTRATED TO THE SECRETARY OF HEALTH AND MENTAL HYGIENE THAT THE PROVIDER PANEL OF THE INSURER OR NONPROFIT HEALTH SERVICE PLAN COMPLIES WITH THE REGULATIONS ADOPTED UNDER § 19–705.1(B)(1)(II) OF THE HEALTH – GENERAL ARTICLE; AND

(2) DOES NOT RESTRICT PAYMENT FOR COVERED SERVICES PROVIDED BY NONPREFERRED PROVIDERS:

(I) FOR EMERGENCY SERVICES, AS DEFINED IN § 19–701 OF THE HEALTH – GENERAL ARTICLE;

(II) FOR AN UNFORESEEN ILLNESS, INJURY, OR CONDITION REQUIRING IMMEDIATE CARE; OR

(III) AS REQUIRED UNDER § 15–830 OF THIS ARTICLE.";

in line 25, strike "**(A)**" and substitute "**(B)**"; and in line 27, after "**INSURER**" insert "**OR NONPROFIT HEALTH SERVICE PLAN**".

On page 6, in line 1, after "**INSURER**" insert "**OR NONPROFIT HEALTH SERVICE PLAN**"; in line 6, strike "**(B)**" and substitute "**(C)**"; and after line 10, insert:

"15–112.

(b) (1) A carrier that uses a provider panel shall:

(i) 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

3. IF THE CARRIER IS AN INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT OFFERS A PREFERRED PROVIDER INSURANCE POLICY THAT CONDITIONS THE PAYMENT OF BENEFITS ON THE USE OF PREFERRED PROVIDERS, 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 AS ENFORCED BY THE SECRETARY OF HEALTH AND MENTAL HYGIENE; AND

(ii) establish procedures to:

1. review applications for participation on the carrier's provider panel in accordance with this section;

2. notify an enrollee of:

A. the termination from the carrier's provider panel of the primary care provider that was furnishing health care services to the enrollee; and

B. the right of the enrollee, on request, to continue to receive health care services from the enrollee's primary care provider for up to 90 days after the date of the notice of termination of the enrollee's primary care provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

3. notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider;

4. verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide under subsection (j) of this section; and

5. notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

15–1104.

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

(2) "EMPLOYER SPONSORED HEALTH BENEFIT PLAN" MEANS ANY PLAN, FUND, OR PROGRAM THAT:

(I) IS ESTABLISHED OR MAINTAINED BY AN EMPLOYER UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974;

(II) OFFERS COVERAGE FOR HEALTH BENEFITS; AND

(III) IS TREATED BY THE EMPLOYER OR ANY ELIGIBLE EMPLOYEE OR DEPENDENT AS PART OF A PLAN, FUND, OR PROGRAM UNDER THE UNITED STATES INTERNAL REVENUE CODE, 26 U.S.C. § 106, § 125, OR § 162.

(3) "GROUP HEALTH INSURANCE" HAS THE MEANING STATED IN § 15–302 OF THIS TITLE.

(4) "LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT" MEANS A GROUP HEALTH INSURANCE CONTRACT THAT PROVIDES HEALTH INSURANCE BENEFITS, BUT IS NOT REQUIRED TO PROVIDE ALL THE BENEFITS REQUIRED UNDER SUBTITLES 7 AND 8 OF THIS TITLE.

(5) "SPECIAL ELIGIBLE EMPLOYEE" MEANS AN EMPLOYEE WHO:

(I) IS ELIGIBLE FOR HEALTH COVERAGE UNDER THE TERMS OF AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN;

(II) WORKS:

1. ON A TEMPORARY OR SUBSTITUTE BASIS; OR

2. LESS THAN 30 HOURS IN A NORMAL WORKWEEK; AND

(III) IS NOT ELIGIBLE FOR COVERAGE UNDER ANY GROUP HEALTH INSURANCE CONTRACT, NONPROFIT HEALTH SERVICE PLAN CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION CONTRACT ISSUED TO THE EMPLOYEE'S EMPLOYER BECAUSE THE EMPLOYEE MEETS THE CRITERIA OF ITEM (II) OF THIS PARAGRAPH.

(B) A LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT MAY BE ISSUED ONLY BY AN INSURER OR NONPROFIT HEALTH SERVICE PLAN TO AN EMPLOYER IF THE LIMITED GROUP HEALTH INSURANCE CONTRACT IS ISSUED TO PROVIDE HEALTH COVERAGE ONLY FOR:

(1) SPECIAL ELIGIBLE EMPLOYEES; OR

(2) SPECIAL ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS.

(C) AN INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT SELLS A LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT, AS A CONDITION OF SALE, MAY REQUIRE THE EMPLOYER TO:

(1) COLLECT PAYMENT FOR PREMIUMS DUE UNDER THE LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT THROUGH PAYROLL DEDUCTION;

(2) CONTRIBUTE TO THE PREMIUM PAYMENTS APPLICABLE TO THE COVERAGE OF A SPECIAL ELIGIBLE EMPLOYEE; AND

(3) OFFER COVERAGE TO ANY DEPENDENT OF A SPECIAL ELIGIBLE EMPLOYEE.

(D) A LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT SHALL COMPLY WITH:

(1) TITLE 15 OF THIS ARTICLE, EXCEPT SUBTITLES 7 AND 8; AND

(2) NOTWITHSTANDING ITEM (1) OF THIS SUBSECTION, §§ 15–802, 15–812, 15–815, 15–830, 15–831, 15–832, AND 15–833 OF THIS ARTICLE.

(E) AN INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL DISCLOSE IN THE GROUP CERTIFICATE AND IN ENROLLMENT MATERIAL PROVIDED TO EACH SPECIAL ELIGIBLE EMPLOYEE THAT THE LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT DOES NOT PROVIDE COMPREHENSIVE HEALTH COVERAGE.".

AMENDMENT NO. 3

On pages 6 through 8, strike in their entirety the lines beginning with line 11 on page 6 through line 23 on page 8, inclusive.

AMENDMENT NO. 4

On page 9, strike beginning with "**ADDITIONAL**" in line 26 down through "**THROUGH**" in line 27 and substitute "**, FOR ITS EMPLOYEES, AN ANNUITY, DENTAL INSURANCE, DISABILITY INSURANCE, LIFE INSURANCE, LONG TERM CARE INSURANCE, VISION INSURANCE, OR, WITH THE APPROVAL OF THE COMMISSIONER, ANY OTHER INSURANCE SOLD BY**".

On pages 10 and 11, strike in their entirety the lines beginning with line 3 on page 10 through line 19 on page 11, inclusive.

(Over)

AMENDMENT NO. 5

On page 11, after line 19, insert:

"SECTION 2. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall:

(1) conduct a study of the comprehensive standard health benefit plan for the small group health insurance market; and

(2) on or before December 1, 2007, report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1246 of the State Government Article, on options available, including modifying the comprehensive standard health benefit plan to specify a separate in–network deductible, out–of–network deductible, in–network out–of–pocket maximum, and out–of–network out–of–pocket maximum, to reform the comprehensive standard health benefit plan in a manner that will encourage more employers to enter the small group market.";

and in line 20, strike "2." and substitute "3.".