HOUSE BILL 1071

C3 9lr2489
CF SB 854

By: **Delegate Kach**
Introduced and read first time: February 13, 2009
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Definition of Coverage Decisions – Pharmacy Inquiries

FOR the purpose of altering the definition of "coverage decision" so that it does not include a pharmacy inquiry for purposes of a certain complaint process; defining certain terms; and generally relating to health insurance coverage decisions.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–10D–01
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

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

Article – Insurance

15–10D–01.

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

(b) "Appeal" means a protest filed by a member or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

(c) "Appeal decision" means a final determination by a carrier that arises from an appeal filed with the carrier under its appeal process regarding a coverage decision concerning a member.

(d) "Carrier" means a person that offers a health benefit plan and is:

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) except for a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that offers a health benefit plan subject to regulation by the State.

(e) "Complaint" means a protest filed with the Commissioner involving a coverage decision other than that which is covered by Subtitle 10A of this title.

(f) (1) "Coverage decision" means an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service.

(2) "Coverage decision" includes nonpayment of all or any part of a claim.

(3) "Coverage decision" does not include**:**

(I) an adverse decision as defined in § 15–10A–01(b) of this title**; OR**

(II) A PHARMACY INQUIRY.

(g) "Designee of the Commissioner" means any person to whom the Commissioner has delegated the authority to review and decide complaints filed under this subtitle, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

(h) (1) "Health benefit plan" means:

(i) a hospital or medical policy or contract, including a policy or contract issued under a multiple employer trust or association;

(ii) a hospital or medical policy or contract issued by a nonprofit health service plan;

(iii) a health maintenance organization contract; or

(iv) a dental plan organization contract.

(2) "Health benefit plan" does not include one or more, or any combination of the following:

(i) long–term care insurance;

(ii) disability insurance;

(iii) accidental travel and accidental death and dismemberment insurance;

(iv) credit health insurance;

(v) a health benefit plan issued by a managed care organization, as defined in Title 15, Subtitle 1 of the Health – General Article;

(vi) disease–specific insurance; or

(vii) fixed indemnity insurance.

(i) "Health care provider" means:

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

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

(j) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

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

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

(k) (1) "Member" means a person entitled to health care services under a policy, plan, or contract issued or delivered in the State by a carrier.

(2) "Member" includes:

(i) a subscriber; and

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

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

(L) "PHARMACY BENEFITS MANAGER" HAS THE MEANING STATED IN § 15–1601 OF THIS TITLE.

(M) "PHARMACY INQUIRY" MEANS AN INQUIRY SUBMITTED BY A PHARMACIST OR PHARMACY ON BEHALF OF A MEMBER TO A CARRIER OR A PHARMACY BENEFITS MANAGER AT THE POINT OF SALE ABOUT THE SCOPE OF PHARMACY COVERAGE, PHARMACY BENEFIT DESIGN, OR FORMULARY UNDER A HEALTH BENEFIT PLAN.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2009.