CHAPTER 516

(Senate Bill 173)

AN ACT concerning

Health Insurance – Mandated Benefits – Hospitalization and Home Visits Following a Mastectomy

FOR the purpose of requiring certain insurers, nonprofit health service plans, and health maintenance organizations to provide inpatient hospitalization coverage for a certain minimum length of time following a mastectomy that is performed for the treatment of breast cancer; providing that the inpatient hospitalization services required under this Act need not be provided if a patient, in consultation with the patient's attending physician, decides that a shorter period of inpatient hospitalization is needed for recovery; requiring certain insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for certain home visits under certain circumstances; prohibiting an entity subject to this Act from denying, limiting, or otherwise impairing the participation of an attending physician under contract with the entity under certain circumstances; prohibiting certain insurers, nonprofit health service plans, and health maintenance organizations from ~~imposing certain cost–sharing requirements or~~ refusing reimbursement for certain services ~~except under certain circumstances~~; requiring certain insurers, nonprofit health service plans, and health maintenance organizations to provide a certain notice to enrollees and insureds; defining ~~certain terms~~ a certain term; providing for the application of this Act; and generally relating to health insurance coverage for hospitalization and home visits following a mastectomy.

BY adding to
Article – Health – General
Section 19–706(ttt)
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–832
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY adding to
Article – Insurance
Section 15–832.1
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 – Health – General

19–706.

(TTT) THE PROVISIONS OF § 15–832.1 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

15–832.

(a) **[**In this section, "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

(b)**]** This section applies to:

(1) insurers and nonprofit health service plans that provide inpatient hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide inpatient hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

[(c)**]** **(B)** For a patient who receives less than 48 hours of inpatient hospitalization following **[**a mastectomy or**]** the surgical removal of a testicle, or who undergoes **[**a mastectomy or**]** the surgical removal of a testicle on an outpatient basis, an entity subject to this section shall provide coverage for:

(1) one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and

(2) an additional home visit if prescribed by the patient's attending physician.

[(d)**]** **(C)** Each entity subject to this section shall provide notice annually to its enrollees and insureds about the coverage required under this section.

15–832.1.

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

~~(2) "HIGH–DEDUCTIBLE HEALTH PLAN" MEANS A HEALTH PLAN THAT MEETS THE FEDERAL REQUIREMENTS ESTABLISHED BY § 1201 OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003.~~

~~(3)~~ ~~"MASTECTOMY" MEANS~~, "MASTECTOMY" MEANS THE SURGICAL REMOVAL OF ALL OR PART OF A BREAST AS A RESULT OF BREAST CANCER.

(B) THIS SECTION APPLIES TO:

(1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE INPATIENT HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS ON AN EXPENSE–INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE INPATIENT HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(C) AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR THE COST OF INPATIENT HOSPITALIZATION SERVICES FOR A PATIENT FOR A MINIMUM OF 48 HOURS FOLLOWING A MASTECTOMY.

(D) A PATIENT MAY REQUEST A SHORTER LENGTH OF STAY THAN THAT PROVIDED IN SUBSECTION (C) OF THIS SECTION IF THE PATIENT DECIDES, IN CONSULTATION WITH THE PATIENT'S ATTENDING PHYSICIAN, THAT LESS TIME IS NEEDED FOR RECOVERY.

(E) (1) FOR A PATIENT WHO RECEIVES LESS THAN 48 HOURS OF INPATIENT HOSPITALIZATION FOLLOWING A MASTECTOMY OR WHO UNDERGOES A MASTECTOMY ON AN OUTPATIENT BASIS, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR:

(I) ONE HOME VISIT SCHEDULED TO OCCUR WITHIN 24 HOURS AFTER DISCHARGE FROM THE HOSPITAL OR OUTPATIENT HEALTH CARE FACILITY; AND

(II) AN ADDITIONAL HOME VISIT IF PRESCRIBED BY THE PATIENT'S ATTENDING PHYSICIAN.

(2) FOR A PATIENT WHO REMAINS IN THE HOSPITAL FOR AT LEAST THE LENGTH OF TIME PROVIDED UNDER SUBSECTION (C) OF THIS SECTION, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR A HOME VISIT IF PRESCRIBED BY THE ATTENDING PHYSICIAN.

(F) AN ENTITY SUBJECT TO THIS SECTION MAY NOT DENY, LIMIT, OR OTHERWISE IMPAIR THE PARTICIPATION OF AN ATTENDING PHYSICIAN UNDER CONTRACT WITH THE ENTITY IN PROVIDING HEALTH CARE SERVICES TO ENROLLEES OR INSUREDS FOR:

(1) ADVOCATING THE INTEREST OF A MASTECTOMY PATIENT THROUGH THE ENTITY'S UTILIZATION REVIEW OR APPEALS SYSTEM;

(2) ADVOCATING MORE THAN 48 HOURS OF INPATIENT HOSPITAL CARE FOR A PATIENT WITH COMPLICATIONS RELATED TO A MASTECTOMY; OR

(3) PRESCRIBING A HOME VISIT UNDER SUBSECTION (E)(1)(II) OR (2) OF THIS SECTION.

(G) ~~(1)~~ ~~EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, AN ENTITY SUBJECT TO THIS SECTION MAY NOT:~~

~~(I) IMPOSE A COPAYMENT OR COINSURANCE REQUIREMENT OR DEDUCTIBLE FOR COVERAGE REQUIRED UNDER SUBSECTION (E)(1) OR (2) OF THIS SECTION; OR~~

~~(II)~~ AN ENTITY SUBJECT TO THIS SECTION MAY NOT REFUSE REIMBURSEMENT UNDER SUBSECTION (E)(1) OF THIS SECTION IF THE SERVICES DO NOT OCCUR WITHIN THE TIME SPECIFIED.

~~(2) IF AN INSURED OR ENROLLEE IS COVERED UNDER A HIGH–DEDUCTIBLE HEALTH PLAN, AN ENTITY SUBJECT TO THIS SECTION MAY REQUIRE THAT THE COVERAGE REQUIRED UNDER SUBSECTION (E)(1) AND (2) OF THIS SECTION BE SUBJECT TO THE DEDUCTIBLE OF THE HIGH–DEDUCTIBLE HEALTH PLAN.~~

(H) AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE NOTICE ANNUALLY TO INSUREDS AND ENROLLEES ABOUT THE COVERAGE PROVIDED BY THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2009.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2009.

Approved by the Governor, May 19, 2009.