

SENATE BILL 484

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0lr2939
CF 0lr1760

By: **Senator Klausmeier**

Introduced and read first time: January 29, 2020

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Provider Panels – Coverage for Nonparticipating Providers**

3 FOR the purpose of requiring each carrier to inform members and beneficiaries in a certain
4 manner of a certain right to request a certain referral; requiring, under certain
5 circumstances, certain insurers, nonprofit health service plans, and health
6 maintenance organizations to cover certain mental health and substance use
7 disorder services provided to a member by a nonparticipating provider at a certain
8 cost; requiring the Consumer Education and Advocacy Program, in collaboration
9 with the Health Education and Advocacy Unit of the Office of the Attorney General,
10 to provide public education to inform consumers of certain rights; defining a certain
11 term; making a stylistic change; providing for the construction of certain provisions
12 of law; providing for the application of this Act; providing for a delayed effective date;
13 and generally relating to provider panels and coverage for nonparticipating
14 providers.

15 BY repealing and reenacting, with amendments,
16 Article – Health – General
17 Section 19–710(p)
18 Annotated Code of Maryland
19 (2019 Replacement Volume)

20 BY repealing and reenacting, with amendments,
21 Article – Insurance
22 Section 15–830
23 Annotated Code of Maryland
24 (2017 Replacement Volume and 2019 Supplement)

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

27 **Article – Health – General**

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 19–710.

2 (p) (1) Except as provided in paragraph (3) of this subsection, individual
3 enrollees and subscribers of health maintenance organizations issued certificates of
4 authority to operate in this State [shall] **MAY** not be liable to any health care provider for
5 any covered services provided to the enrollee or subscriber.

6 (2) (i) A health care provider or any representative of a health care
7 provider may not collect or attempt to collect from any subscriber or enrollee any money
8 owed to the health care provider by a health maintenance organization issued a certificate
9 of authority to operate in this State.

10 (ii) A health care provider or any representative of a health care
11 provider may not maintain any action against any subscriber or enrollee to collect or
12 attempt to collect any money owed to the health care provider by a health maintenance
13 organization issued a certificate of authority to operate in this State.

14 (3) Notwithstanding any other provision of this subsection, a health care
15 provider or representative of a health care provider may collect or attempt to collect from a
16 subscriber or enrollee:

17 (i) Any copayment or coinsurance sums owed by the subscriber or
18 enrollee to a health maintenance organization issued a certificate of authority to operate in
19 this State for covered services provided by the health care provider;

20 (ii) If Medicare is the primary insurer and a health maintenance
21 organization is the secondary insurer, any amount up to the Medicare approved or limiting
22 amount, as specified under the Social Security Act, that is not owed to the health care
23 provider by Medicare or the health maintenance organization after coordination of benefits
24 has been completed, for Medicare covered services provided to the subscriber or enrollee by
25 the health care provider; or

26 (iii) Any payment or charges for services that are not covered
27 services.

28 **Article – Insurance**

29 15–830.

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

31 (2) “Carrier” means:

32 (i) an insurer that offers health insurance other than long-term
33 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) “Nonphysician specialist” means a health care provider [who]:

(i) 1. WHO is not a physician;

[(ii)] 2. WHO is licensed or certified under the Health Occupations Article; and

[(iii)] 3. WHO is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider; OR

(II) THAT IS LICENSED AS A BEHAVIORAL HEALTH PROGRAM UNDER § 7.5–401 OF THE HEALTH – GENERAL ARTICLE.

(5) (i) “Provider panel” means the providers that contract with a carrier either directly or through a subcontracting entity to provide health care services to enrollees of the carrier.

(ii) “Provider panel” does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee-for-service rate.

(6) “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 or nonphysician 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 or nonphysician 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 health care services or medical care; and

(ii) 1. the carrier does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

2. the carrier cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

(3) The procedure shall ensure that a request to obtain a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel is addressed in a timely manner that is:

(i) appropriate for the member's condition; and

(ii) in accordance with the timeliness requirements for determinations made by private review agents under § 15–10B–06 of this title.

(4) The procedure may not be used by a carrier as a substitute for establishing and maintaining a sufficient provider network in accordance with § 15–112 of this title.

(5) Each carrier shall:

(i) have a system in place that documents all requests to obtain a referral to receive a covered service from a specialist or nonphysician specialist who is not part of the carrier's provider panel; [and]

(II) INFORM MEMBERS AND BENEFICIARIES, IN PLAIN LANGUAGE, OF THE RIGHT TO REQUEST A REFERRAL UNDER PARAGRAPH (1) OF THIS SUBSECTION IN PRINT AND ELECTRONIC PLAN DOCUMENTS AND ANY

1 PROVIDER DIRECTORY; AND

2 **[(ii)] (III)** provide the information documented under item (i) of this
3 paragraph to the Commissioner on request.

4 (e) **(1)** For purposes of calculating any deductible, copayment amount, or
5 coinsurance payable by the member, a carrier shall treat services received in accordance
6 with subsection (d) of this section as if the service was provided by a provider on the
7 carrier's provider panel.

8 **(2) IF THE CARRIER'S PROVIDER PANEL HAS AN INSUFFICIENT**
9 **NUMBER OR TYPE OF PARTICIPATING SPECIALISTS OR NONPHYSICIAN SPECIALISTS**
10 **WITH THE EXPERTISE TO PROVIDE THE COVERED MENTAL HEALTH OR SUBSTANCE**
11 **USE DISORDER SERVICES REQUIRED UNDER § 15-802 OR § 15-840 UNDER THIS**
12 **SUBTITLE TO A MEMBER WITHIN THE APPOINTMENT WAITING TIME OR TRAVEL**
13 **DISTANCE STANDARDS ESTABLISHED IN REGULATIONS, THE CARRIER SHALL COVER**
14 **THE SERVICES PROVIDED BY A NONPARTICIPATING PROVIDER AT NO GREATER COST**
15 **TO THE MEMBER THAN IF THE SERVICES WERE PROVIDED BY A PROVIDER ON THE**
16 **CARRIER'S PROVIDER PANEL.**

17 (f) A decision by a carrier not to provide access to or coverage of treatment or
18 health care services by a specialist or nonphysician specialist in accordance with this
19 section constitutes an adverse decision as defined under Subtitle 10A of this title if the
20 decision is based on a finding that the proposed service is not medically necessary,
21 appropriate, or efficient.

22 (g) **(1)** Each carrier shall file with the Commissioner a copy of each of the
23 procedures required under this section, including:

24 (i) steps the carrier requires of a member to request a referral;

25 (ii) the carrier's timeline for decisions; and

26 (iii) the carrier's grievance procedures for denials.

27 **(2)** Each carrier shall make a copy of each of the procedures filed under
28 paragraph (1) of this subsection available to its members:

29 (i) in the carrier's online network directory required under §
30 15-112(n)(1) of this title; and

31 (ii) on request.

32 **(H) THE CONSUMER EDUCATION AND ADVOCACY PROGRAM, ESTABLISHED**
33 **UNDER TITLE 2, SUBTITLE 3 OF THIS ARTICLE, IN COLLABORATION WITH THE**
34 **HEALTH EDUCATION AND ADVOCACY UNIT OF THE OFFICE OF THE ATTORNEY**

1 GENERAL, SHALL PROVIDE PUBLIC EDUCATION TO INFORM CONSUMERS OF THEIR
2 RIGHT TO REQUEST A REFERRAL TO A SPECIALIST OR NONPHYSICIAN SPECIALIST
3 AS PROVIDED FOR IN THIS SECTION.

4 (I) THIS SECTION MAY NOT BE CONSTRUED TO LIMIT THE PROVISIONS IN §
5 19-710(P) OF THE HEALTH – GENERAL ARTICLE.

6 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all
7 policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or
8 after January 1, 2021.

9 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
10 January 1, 2021.