

Article - Insurance

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§15–140.

- (a) (1) In this section the following words have the meanings indicated.
- (2) “Acute condition” means a medical or dental condition that:
- (i) involves a sudden onset of symptoms due to an illness, an injury, or any other medical or dental problem that requires prompt medical attention; and
 - (ii) has a limited duration.
- (3) “Carrier” means:
- (i) an insurer authorized to sell health insurance;
 - (ii) a nonprofit health service plan;
 - (iii) a health maintenance organization;
 - (iv) a dental plan organization; or
 - (v) any other entity providing a plan of health insurance, health benefits, or health services authorized under this article or the Affordable Care Act.
- (4) “Enrollee” means:
- (i) a person entitled to health care benefits from a carrier; or
 - (ii) a Program recipient who is enrolled in a managed care organization.
- (5) (i) “Health benefit plan” means a policy, a contract, a certificate, or an agreement offered, issued, or delivered by a carrier to an individual or a group in the State to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.
- (ii) “Health benefit plan” does not include:
- 1. coverage only for accident or disability insurance or any combination of accident and disability insurance;
 - 2. coverage issued as a supplement to liability insurance;
 - 3. liability insurance, including general liability insurance and automobile liability insurance;

4. workers' compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;
7. coverage for on-site medical clinics; or
8. other similar insurance coverage, specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act, under which benefits for health care services are secondary or incidental to other insurance benefits.

(iii) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:

1. limited scope vision benefits;
2. benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; or
3. such other similar limited benefits as are specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act.

(iv) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether the benefits are provided under any group health plan maintained by the same plan sponsor:

1. coverage only for a specified disease or illness; or
2. hospital indemnity or other fixed indemnity insurance.

(v) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

1. Medicare Supplemental Insurance (as defined under § 1882(g)(1) of the Social Security Act);
2. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
3. similar supplemental coverage provided to coverage under

a group health plan.

(6) (i) “Health care provider” means:

1. a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized to provide, in the ordinary course of business or practice of a profession, health care services covered in a health benefit plan, the Maryland Medical Assistance Program, or the Maryland Children’s Health Program; or

2. a facility where health care is provided to patients or recipients including:

A. a hospital, as defined in § 19–301 of the Health – General Article;

B. a related institution as defined in § 19–301 of the Health – General Article;

C. a freestanding ambulatory care facility as defined in § 19–3B–01 of the Health – General Article;

D. a facility that is organized primarily to help in the rehabilitation of persons with disabilities;

E. a home health agency as defined in § 19–901 of the Health – General Article;

F. a hospice as defined in § 19–901 of the Health – General Article;

G. a facility that provides radiological or other diagnostic imagery services;

H. a medical laboratory as defined in § 17–201 of the Health – General Article;

I. an alcohol abuse and drug abuse treatment program as defined in § 8–403 of the Health – General Article; and

J. a Federally Qualified Health Center.

(ii) “Health care provider” includes the agents, employees, officers, and directors of a health care provider described in subparagraph (i) of this paragraph.

(7) “Managed care organization” means:

(i) a certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments;

(ii) a corporation that:

1. is a managed care system that is authorized to receive medical assistance prepaid capitation payments;

2. enrolls only Program recipients or individuals or families served under the Maryland Children’s Health Program; and

3. is subject to the requirements of § 15–102.4 of the Health – General Article; or

(iii) a prepaid dental plan that receives fees to manage dental services.

(8) “Nonparticipating provider” means a health care provider who is not on the provider panel of a carrier or managed care organization.

(9) “Participating provider” means a health care provider who is on the provider panel of a carrier or managed care organization.

(10) “Prior authorization” means a utilization management technique that:

(i) is used by carriers and managed care organizations;

(ii) requires prior approval for a procedure, treatment, medication, or service before an enrollee is eligible for full payment of the benefit; and

(iii) is used to determine whether the procedure, treatment, medication, or service is medically necessary.

(11) “Program recipient” means an individual who receives benefits under the Maryland Medical Assistance Program.

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

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

(13) “Receiving carrier or managed care organization” means:

(i) the carrier that issues the new health benefit plan when an enrollee transitions from another carrier or a managed care organization; or

(ii) the managed care organization that accepts the enrollee when the enrollee transitions from another managed care organization or a carrier.

(14) “Relinquishing carrier or managed care organization” means:

(i) the carrier that issued the prior health benefit plan when an enrollee transitions to a new carrier or a managed care organization; or

(ii) the managed care organization in which an enrollee had been enrolled prior to the enrollee’s transition to a new managed care organization or a carrier.

(15) “Serious chronic condition” means a medical or dental condition due to a disease, an illness, or any other medical or dental problem that:

(i) is serious in nature;

(ii) persists without full cure or worsens over an extended period of time; and

(iii) is actively managed or supervised by a health care provider to maintain remission or prevent deterioration.

(16) “Third-party administrator” means an organization under contract with the Maryland Medical Assistance Program to administer certain benefits and services provided by the Maryland Medical Assistance Program.

(b) (1) The purpose of this section is to advance the State’s progress in:

(i) protecting Marylanders from harmful disruptions in health care services; and

(ii) promoting reasonable continuity of health care for Marylanders when transitioning:

1. from one carrier to another carrier; and

2. between a carrier and the Maryland Medical Assistance Program or the Maryland Children’s Health Program.

(2) This section:

(i) with respect to any benefit or service that is provided through the Maryland Medical Assistance fee-for-service program:

1. shall not apply when the enrollee is transitioning from a carrier to the Maryland Medical Assistance Program; and

2. except as provided in subsection (c) of this section, shall apply when the enrollee is transitioning from the Maryland Medical Assistance Program to a carrier;

(ii) shall apply to contracts issued or renewed on or after January 1, 2015; and

(iii) subject to subparagraph (i) of this paragraph, with respect to dental benefits, shall apply to covered services for which a coordinated treatment plan is in progress.

(c) (1) With respect to any benefit or service provided through the Maryland Medical Assistance fee-for-service program, this subsection shall apply:

(i) only to enrollees transitioning from the Maryland Medical Assistance Program to a carrier; and

(ii) only to behavioral health and dental benefits, to the extent they are authorized by a third-party administrator.

(2) Subject to paragraph (3) of this subsection, at the request of an enrollee or an enrollee's parent, guardian, designee, or health care provider, a receiving carrier or managed care organization shall accept a preauthorization from a relinquishing carrier, managed care organization, or third-party administrator for:

(i) the procedures, treatments, medications, or services covered by the benefits offered by the receiving carrier or managed care organization; and

(ii) the following time periods:

1. the lesser of the course of treatment or 90 days; and

2. the duration of the three trimesters of a pregnancy and the initial postpartum visit.

(3) Subject to applicable laws relating to the confidentiality of medical records, including 42 C.F.R. Part 2, at the request and with the consent of an enrollee or an enrollee's parent, guardian, or designee, a relinquishing carrier, managed care organization, or third-party administrator, shall provide a copy of a preauthorization to the enrollee's receiving carrier or managed care organization within 10 days after receipt of the request.

(4) After the time periods under paragraph (2)(ii) have lapsed, the receiving carrier or managed care organization may elect to perform its own utilization review in order to:

(i) reassess and make its own determination regarding the need for continued treatment; and

(ii) authorize any continued procedure, treatment, medication, or service determined to be medically necessary.

(d) (1) Subject to paragraphs (2) through (5) of this subsection, at the request of an enrollee or an enrollee's parent, guardian, designee, or health care provider, a receiving carrier or managed care organization shall allow a new enrollee to continue to receive health care services being rendered by a nonparticipating provider at the time of the enrollee's transition to the receiving health benefit plan or managed care organization.

(2) (i) The services an enrollee shall be allowed to continue to receive are services for:

1. the following conditions:

A. acute conditions;

B. serious chronic conditions;

C. pregnancy; and

D. mental health conditions and substance use disorders; and

2. any other condition on which the nonparticipating provider and the receiving carrier or managed care organization reach agreement.

(ii) Examples of conditions set forth in subparagraph (i)1A and B of this paragraph may include:

1. bone fractures;

2. joint replacements;

3. heart attacks;

4. cancer;

5. HIV/AIDS; and

6. organ transplants.

(iii) An enrollee shall be allowed to continue to receive services for the conditions under this paragraph for the time periods under subsection (c)(2)(ii) of this section.

(3) (i) This paragraph does not apply to compensation rates or methods of payment established under § 14–205.2 of this article or § 19–710.1 of the Health – General Article.

(ii) Subject to paragraphs (4) and (5) of this subsection, the receiving carrier or managed care organization, with respect to the provision of the covered services, shall pay the nonparticipating provider the rate and method of payment

the receiving carrier or managed care organization normally would pay and use for participating providers who provide similar services in the same or similar geographic area.

(iii) The nonparticipating provider may decline to accept the rate or method of payment under subparagraph (ii) of this paragraph by giving 10 days' prior notice to the enrollee and receiving carrier.

(iv) Subject to paragraphs (4) and (5) of this subsection, if the nonparticipating provider does not accept the rate or method of payment under subparagraph (ii) of this paragraph, the nonparticipating provider and the receiving carrier or managed care organization may reach agreement on an alternative rate or method of payment for the provision of covered services.

(4) The rates and methods of payment under paragraph (3)(ii) and (iv) of this subsection shall:

(i) be subject to any State or federal requirements applicable to reimbursement for health care provider services, including:

1. § 1302(g) of the Affordable Care Act, which applies to reimbursement rates for Federally Qualified Health Centers; and

2. Title 19, Subtitle 2 of the Health – General Article, under which the Health Services Cost Review Commission establishes provider rates; and

(ii) ensure that:

1. an enrollee is not subject to balance billing; and

2. the copayments, deductibles, and any coinsurance required of an enrollee for the services rendered in accordance with this section are the same as those that would be required if the enrollee were receiving the services from a participating provider of the receiving carrier or managed care organization.

(5) If the nonparticipating provider does not accept the rate and method of compensation under paragraph (3)(ii) of this subsection, and the carrier or managed care organization does not reach an agreement with the nonparticipating provider for an alternative rate and method of payment under paragraph (3)(iv) of this subsection:

(i) the nonparticipating provider is not required to continue to provide the services;

(ii) § 14–205.3 of this article, under which an enrollee may assign benefits to a nonpreferred provider and the provider may balance bill the enrollee, shall apply to the extent it would apply absent this section; and

(iii) unless the enrollee has assigned benefits to a nonpreferred

provider under § 14–205.3 of this article, the carrier or managed care organization shall facilitate transition of the enrollee to a provider on the provider panel of the carrier or managed care organization.

(e) (1) This section does not:

(i) require a carrier or managed care organization to cover services or provide benefits that are not otherwise covered under the terms and conditions of a health benefit plan, the Maryland Medical Assistance Program, or the Maryland Children’s Health Program; or

(ii) preclude a carrier or managed care organization from providing continuity of care beyond the requirements of this section within the parameters of the approved rates of the carrier or managed care organization.

(2) (i) To ensure continuity of treatment in progress for dental services provided to an enrollee, a relinquishing carrier may elect to allow an enrollee to continue to receive dental services being provided by a participating provider of the relinquishing carrier through an arrangement in which the relinquishing carrier pays the participating provider according to the rate and method of payment the relinquishing carrier normally would pay and use for the participating provider.

(ii) The rate and method of payment under subparagraph (i) of this paragraph shall comply with:

1. the prohibition on balance billing under subsection (d)(4)(ii) of this section; and

2. any copayments, deductibles, and coinsurance requirements in the enrollee’s health benefit plan under the relinquishing carrier.

(f) (1) A receiving carrier or managed care organization shall provide notice to a new enrollee of the enrollee’s options and responsibilities under this section in a manner prescribed by the Commissioner.

(2) The requirements of this section are:

(i) in addition to any other legal, professional, or ethical obligations of a carrier or managed care organization to provide continuity of care; and

(ii) not intended to limit or make more restrictive any other continuity of care requirements in State or federal law, regulations, or professional codes of conduct.

(g) The Commissioner and the Secretary of Health and Mental Hygiene each may adopt regulations to enforce the requirements of this section.

(h) (1) The Commissioner, the Maryland Health Benefit Exchange, and the

Secretary of Health and Mental Hygiene shall collaborate to determine the data, to the extent its collection is feasible and permitted by law, that is necessary to:

(i) assess the implementation and efficacy of the requirements of this section; and

(ii) develop a process to evaluate and monitor continuity of care, with particular focus on newly eligible populations, any disparate or discriminatory impact on specific populations, and trends in health disparities.

(2) On request of the Commissioner, the Maryland Health Benefit Exchange, or the Secretary of Health and Mental Hygiene carriers, managed care organizations, and health care providers shall provide the requisite data.

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