

# HOUSE BILL 1318

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CF SB 929

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By: ~~Delegates Kelly, Angel, Cullison, Hill, Pena-Melnyk, Sample-Hughes, and West West, Hammen, Barron, Bromwell, Hayes, Kipke, Krebs, McDonough, McMillan, Miele, Morgan, Morhaim, Oaks, Pendergrass, Rose, Saab, and K. Young~~

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Assigned to: Health and Government Operations

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Committee Report: Favorable with amendments

House action: Adopted

Read second time: March 15, 2016

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## CHAPTER \_\_\_\_\_

1 AN ACT concerning

2 **Health Benefit Plans – Network Access Standards and**  
3 **Provider Network Directories**

4 FOR the purpose of requiring certain carriers to maintain or adhere to certain standards  
5 that ensure that certain enrollees have certain access to certain health care providers  
6 and covered services; requiring certain carriers to file with the Maryland Insurance  
7 Commissioner, on or before a certain date and then annually, a certain plan for a  
8 certain review ~~and approval~~; requiring certain carriers to notify the Commissioner  
9 of a certain change within a certain time period under certain circumstances;  
10 requiring a certain notice to include certain information; ~~authorizing certain carriers~~  
11 ~~to request that the Commissioner deem certain information as confidential~~  
12 ~~information; requiring certain carriers to make a certain plan available to the public~~  
13 ~~in a certain manner~~ authorizing the Commissioner to order corrective action under  
14 certain circumstances; requiring the Commissioner to deny inspection of the parts of  
15 a certain plan that contain certain confidential information; requiring certain  
16 regulations to identify the parts of a certain plan that may be considered confidential  
17 by the carrier; requiring a certain plan to include certain information; requiring  
18 certain carriers to monitor a certain clinical capacity of certain providers in a certain  
19 manner; requiring the Commissioner, in consultation with certain persons, to adopt  
20 certain regulations on or before a certain date; ~~establishing that certain carriers~~  
21 ~~meet certain requirements by developing and making available to certain individuals~~  
22 ~~a certain network directory; requiring certain carriers to develop and make available~~

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EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.



1 ~~to certain individuals a certain network directory on the Internet and in printed form~~  
2 ~~under certain circumstances; requiring a certain network directory to meet certain~~  
3 ~~requirements and include certain information; requiring certain carriers to update a~~  
4 ~~certain network directory within a certain time period under certain circumstances;~~  
5 authorizing the Commissioner to take into consideration certain factors in adopting  
6 the regulations; requiring the Commissioner, in consultation with certain persons,  
7 to adopt regulations, on or before a certain date, that specify certain standards for  
8 dental services; requiring a carrier to have certain means by which enrollees and  
9 prospective enrollees may notify the carrier of certain information; requiring certain  
10 carriers, at certain occurrences, to notify enrollees how to access or obtain certain  
11 information; requiring certain information to be updated at certain intervals;  
12 requiring certain carriers periodically to review a certain sample of their network  
13 directory for a certain purpose and retain documentation of the review or to contact  
14 certain providers to make a certain determination under certain circumstances;  
15 ~~requiring certain carriers to treat certain services in a certain manner for a certain~~  
16 ~~purpose under certain circumstances;~~ altering a certain requirement on certain  
17 carriers to update certain information; requiring certain certification standards  
18 established by the Maryland Health Benefit Exchange to be consistent with certain  
19 provisions of law and prohibiting the standards from being implemented before a  
20 certain date; requiring a certain carrier to make the carrier's network directory  
21 available to certain enrollees in a certain manner; requiring a certain carrier's  
22 network directory to include certain information; requiring a certain carrier to notify  
23 each enrollee at certain times about how to obtain certain information; requiring  
24 certain information to be accurate on a certain date; requiring a certain carrier to  
25 update certain information at certain intervals; requiring the Commissioner to take  
26 into account certain factors before imposing a penalty on a certain carrier for  
27 inaccurate network directory information; requiring certain procedures established  
28 by certain carriers to ensure that certain requests are addressed in a certain manner;  
29 prohibiting a certain procedure established by certain carriers from being used for a  
30 certain purpose; requiring certain carriers to have a certain system in place for a  
31 certain purpose and to provide certain information to the Commissioner under  
32 certain circumstances; requiring certain carriers to file with the Commissioner a  
33 copy of certain procedures that includes certain information; requiring certain  
34 carriers to make a copy of certain procedures available to certain individuals in a  
35 certain manner and under certain circumstances; specifying the provisions of State  
36 insurance law relating to provider panels that apply to managed care organizations;  
37 repealing a requirement that certain carriers that use provider panels adhere to  
38 certain standards for accessibility of covered services in accordance with certain  
39 regulations; repealing a requirement that certain standards for health maintenance  
40 organizations set out in regulations adopted by the Secretary of Health and Mental  
41 Hygiene include provisions for assuring that certain services are accessible;  
42 repealing a certain condition for an insurer or nonprofit health service plan to receive  
43 authorization from the Commissioner to offer a certain insurance policy; authorizing  
44 the Commissioner to designate a certain system under certain circumstances;  
45 requiring a carrier to accept certain information for a provider submitted in a certain  
46 manner, from certain persons; defining certain terms; making conforming changes;  
47 providing for the application of certain provisions of this Act; providing for a delayed

1 effective date for certain provisions of this Act; and generally relating to health  
2 benefit plans, network access standards, and provider network directories.

3 BY repealing and reenacting, with amendments,

4 Article – Health – General

5 Section 15–102.3(a) and 19–705.1(b)(1)(i)

6 Annotated Code of Maryland

7 (2015 Replacement Volume)

8 BY repealing and reenacting, without amendments,

9 Article – Health – General

10 Section 19–705.1(a)

11 Annotated Code of Maryland

12 (2015 Replacement Volume)

13 BY repealing and reenacting, with amendments,

14 Article – Insurance

15 Section ~~15–112~~ 14–205.1(a), 15–112, and 15–830

16 Annotated Code of Maryland

17 (2011 Replacement Volume and 2015 Supplement)

18 BY repealing and reenacting, with amendments,

19 Article – Insurance

20 Section 15–112(n) and (p)

21 Annotated Code of Maryland

22 (2011 Replacement Volume and 2015 Supplement)

23 (As enacted by Section 1 of this Act)

24 BY adding to

25 Article – Insurance

26 Section 15–112.3 and 31–115(m)

27 Annotated Code of Maryland

28 (2011 Replacement Volume and 2015 Supplement)

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

31 **Article – Health – General**

32 15–102.3.

33 (a) The provisions of [§ 15–112] § 15–112(B)(1)(II) AND (2), (E) THROUGH (L),  
34 (Q), (R), AND (T) of the Insurance Article (Provider panels) shall apply to managed care  
35 organizations in the same manner they apply to carriers.

36 19–705.1.



1 (4) (i) "Carrier" means:

2 1. an insurer;

3 2. a nonprofit health service plan;

4 3. a health maintenance organization;

5 4. a dental plan organization; or

6 5. any other person that provides health benefit plans  
7 subject to regulation by the State.

8 (ii) "Carrier" includes an entity that arranges a provider panel for a  
9 carrier.

10 (5) "Credentialing intermediary" means a person to whom a carrier has  
11 delegated credentialing or recredentialing authority and responsibility.

12 (6) "Enrollee" means a person entitled to health care benefits from a  
13 carrier.

14 (7) "HEALTH BENEFIT PLAN":

15 (I) FOR A GROUP OR BLANKET PLAN IN THE LARGE GROUP  
16 MARKET, HAS THE MEANING STATED IN § 15-1401 OF THIS TITLE;

17 (II) FOR A GROUP IN THE SMALL GROUP MARKET, HAS THE  
18 MEANING STATED IN § 31-101 OF THIS ARTICLE; AND

19 (III) FOR AN INDIVIDUAL PLAN, HAS THE MEANING STATED IN §  
20 15-1301 OF THIS TITLE.

21 (8) (I) "HEALTH CARE FACILITY" MEANS ~~A FIXED OR MOBILE~~  
22 ~~FACILITY AT WHICH DIAGNOSTIC OR TREATMENT SERVICES OR INPATIENT OR~~  
23 ~~AMBULATORY CARE ARE OFFERED TO TWO OR MORE UNRELATED INDIVIDUALS A~~  
24 HEALTH CARE SETTING OR INSTITUTION PROVIDING PHYSICAL, MENTAL, OR  
25 SUBSTANCE USE DISORDER HEALTH CARE SERVICES.

26 (II) "HEALTH CARE FACILITY" INCLUDES:

27 1. A HOSPITAL;

28 2. AN AMBULATORY SURGICAL OR TREATMENT CENTER;

- 1                   **3. A SKILLED NURSING FACILITY;**
- 2                   **4. A RESIDENTIAL TREATMENT CENTER;**
- 3                   **5. AN URGENT CARE CENTER;**
- 4                   **6. A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER;**
- 5                   **7. A REHABILITATION FACILITY; AND**
- 6                   **8. ANY OTHER THERAPEUTIC HEALTH CARE SETTING.**

7                   **[(7)] (9)** “Hospital” has the meaning stated in § 19–301 of the  
8 Health – General Article.

9                   **(10) “NETWORK” MEANS A CARRIER’S PARTICIPATING PROVIDERS**  
10 **AND THE HEALTH CARE FACILITIES WITH WHICH A CARRIER CONTRACTS TO**  
11 **PROVIDE HEALTH CARE SERVICES TO THE CARRIER’S ENROLLEES UNDER THE**  
12 **CARRIER’S HEALTH BENEFIT PLAN.**

13                   **(11) “NETWORK DIRECTORY” MEANS A LIST OF A CARRIER’S**  
14 **PARTICIPATING PROVIDERS AND PARTICIPATING HEALTH CARE FACILITIES.**

15                   **[(8)] ~~(10)~~ (12)** “Participating provider” means a provider on a carrier’s  
16 provider panel.

17                   **[(9)] ~~(11)~~ (13)** “Online credentialing system” means the system through  
18 which a provider may access an online provider credentialing application that the  
19 Commissioner has designated as the uniform credentialing form under § 15–112.1(e) of this  
20 subtitle.

21                   **[(10)] ~~(12)~~ (14)** “Provider” means a health care practitioner or group of  
22 health care practitioners licensed, certified, or otherwise authorized by law to provide  
23 health care services.

24                   **[(11)] ~~(13)~~ (15)** (i) “Provider panel” means the providers that contract  
25 either directly or through a subcontracting entity with a carrier to provide health care  
26 services to the carrier’s enrollees under the carrier’s health benefit plan.

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

30                   (b) (1) **[A] SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, A carrier**  
31 that uses a provider panel shall:

1 (i) ~~1.~~ if the carrier is an insurer, nonprofit health service plan,  
2 HEALTH MAINTENANCE ORGANIZATION, or dental plan organization, maintain  
3 standards in accordance with regulations adopted by the Commissioner for availability of  
4 health care providers to meet the health care needs of enrollees; AND

5 ~~2. if the carrier is a health maintenance organization, adhere~~  
6 ~~to the standards for accessibility of covered services in accordance with regulations adopted~~  
7 ~~under § 19-705.1(b)(1)(i)2 of the Health General Article; and~~

8 ~~3. if the carrier is an insurer or nonprofit health service plan~~  
9 ~~that offers a preferred provider insurance policy that conditions the payment of benefits on~~  
10 ~~the use of preferred providers, adhere to the standards for accessibility of covered services~~  
11 ~~in accordance with regulations adopted under § 19-705.1(b)(1)(i)2 of the Health General~~  
12 ~~Article and as enforced by the Secretary of Health and Mental Hygiene; and~~

13 (ii) establish procedures to:

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

16 2. notify an enrollee of:

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

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

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

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

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

33 (2) The provisions of paragraph (1)(ii)4 of this subsection may not be  
34 construed to require a carrier to allow a provider to refuse to accept new patients covered  
35 by the carrier.

1           **(3) FOR A CARRIER THAT IS AN INSURER, A NONPROFIT HEALTH**  
2 **SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, THE STANDARDS**  
3 **REQUIRED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION SHALL:**

4           **(I) ENSURE THAT ALL ENROLLEES, INCLUDING ADULTS AND**  
5 **CHILDREN, HAVE ACCESS TO PROVIDERS AND COVERED SERVICES WITHOUT**  
6 **UNREASONABLE TRAVEL OR DELAY; AND**

7           **(II) 1. INCLUDE STANDARDS THAT ENSURE ACCESS TO**  
8 **PROVIDERS, INCLUDING ESSENTIAL COMMUNITY PROVIDERS, THAT SERVE**  
9 **PREDOMINANTLY LOW-INCOME AND MEDICALLY UNDERSERVED INDIVIDUALS; OR**

10                           **2. FOR A CARRIER THAT PROVIDES A MAJORITY OF**  
11 **COVERED PROFESSIONAL SERVICES THROUGH PHYSICIANS EMPLOYED BY A SINGLE**  
12 **CONTRACTED MEDICAL GROUP AND THROUGH HEALTH CARE PROVIDERS**  
13 **EMPLOYED BY THE CARRIER, INCLUDE ALTERNATIVE STANDARDS FOR ADDRESSING**  
14 **THE NEEDS OF LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS.**

15           **(C) (1) THIS SUBSECTION APPLIES TO A CARRIER THAT:**

16           **(I) IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A**  
17 **HEALTH MAINTENANCE ORGANIZATION; AND**

18           **(II) USES A PROVIDER PANEL FOR A HEALTH BENEFIT PLAN**  
19 **OFFERED BY THE CARRIER.**

20           **(2) (I) ON OR BEFORE JULY 1, 2018, AND ANNUALLY THEREAFTER,**  
21 **A CARRIER SHALL FILE WITH THE COMMISSIONER FOR REVIEW ~~AND APPROVAL~~ BY**  
22 **THE COMMISSIONER AN ACCESS PLAN THAT MEETS THE REQUIREMENTS OF**  
23 **SUBSECTION (B) OF THIS SECTION AND ANY REGULATIONS ADOPTED BY THE**  
24 **COMMISSIONER UNDER SUBSECTIONS (B) AND (D) OF THIS SECTION.**

25           **(II) IF THE CARRIER MAKES A MATERIAL CHANGE TO THE**  
26 **~~PROVIDER NETWORK~~ ACCESS PLAN, THE CARRIER SHALL:**

27                           **1. NOTIFY THE COMMISSIONER OF THE CHANGE WITHIN**  
28 **15 BUSINESS DAYS AFTER THE CHANGE OCCURS; AND**

29                           **2. INCLUDE IN THE NOTICE REQUIRED UNDER ITEM 1 OF**  
30 **THIS SUBPARAGRAPH A REASONABLE TIMEFRAME WITHIN WHICH THE CARRIER**  
31 **WILL FILE WITH THE COMMISSIONER AN UPDATE TO THE EXISTING ACCESS PLAN**  
32 **FOR REVIEW ~~AND APPROVAL~~ BY THE COMMISSIONER.**



1 (III) THE COMMISSIONER MAY ORDER CORRECTIVE ACTION IF,  
2 AFTER REVIEW, THE ACCESS PLAN IS DETERMINED NOT TO MEET THE  
3 REQUIREMENTS OF THIS SUBSECTION.

4 ~~(3) (i) A CARRIER MAY REQUEST THAT THE COMMISSIONER DEEM~~  
5 ~~INFORMATION IN THE ACCESS PLAN FILED UNDER THIS SUBSECTION AS~~  
6 ~~CONFIDENTIAL INFORMATION UNDER § 4-335 OF THE GENERAL PROVISIONS~~  
7 ~~ARTICLE.~~

8 ~~(ii) A CARRIER SHALL MAKE THE ACCESS PLAN FILED UNDER~~  
9 ~~THIS SUBSECTION AVAILABLE TO THE PUBLIC ON THE CARRIER'S WEB SITE AFTER~~  
10 ~~REDACTION OF ANY INFORMATION DEEMED CONFIDENTIAL INFORMATION BY THE~~  
11 ~~COMMISSIONER.~~

12 (3) (i) IN ACCORDANCE WITH § 4-335 OF THE GENERAL  
13 PROVISIONS ARTICLE, THE COMMISSIONER SHALL DENY INSPECTION OF THE  
14 PARTS OF THE ACCESS PLAN FILED UNDER THIS SUBSECTION THAT CONTAIN  
15 CONFIDENTIAL COMMERCIAL INFORMATION OR CONFIDENTIAL FINANCIAL  
16 INFORMATION.

17 (ii) THE REGULATIONS ADOPTED BY THE COMMISSIONER  
18 UNDER SUBSECTION (D) OF THIS SECTION SHALL IDENTIFY THE PARTS OF THE  
19 ACCESS PLAN THAT MAY BE CONSIDERED CONFIDENTIAL BY THE CARRIER.

20 (4) AN ACCESS PLAN FILED UNDER THIS SUBSECTION SHALL  
21 INCLUDE A DESCRIPTION OF:

22 (i) THE CARRIER'S NETWORK, INCLUDING HOW  
23 TELEMEDICINE, TELEHEALTH, OR OTHER TECHNOLOGY MAY BE USED TO MEET  
24 NETWORK ACCESS STANDARDS REQUIRED UNDER SUBSECTION (B) OF THIS  
25 SECTION;

26 (ii) THE CARRIER'S PROCESS FOR MONITORING AND ENSURING,  
27 ON AN ONGOING BASIS, THE SUFFICIENCY OF THE NETWORK TO MEET THE HEALTH  
28 CARE NEEDS OF ENROLLEES;

29 (iii) THE FACTORS USED BY THE CARRIER TO BUILD ITS  
30 PROVIDER NETWORK, INCLUDING:

31 ~~1. IN PLAIN LANGUAGE,~~ THE CRITERIA USED TO SELECT  
32 PROVIDERS FOR PARTICIPATION IN THE NETWORK AND, IF APPLICABLE, PLACE  
33 PROVIDERS IN NETWORK TIERS; ~~AND~~

1 ~~2. DEMONSTRATION BY THE CARRIER THAT THE~~  
2 ~~CRITERIA COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY~~  
3 ~~ACT;~~

4 (IV) THE CARRIER'S EFFORTS TO ADDRESS THE NEEDS OF BOTH  
5 ADULT AND CHILD ENROLLEES, INCLUDING ADULTS AND CHILDREN WITH:

6 1. LIMITED ENGLISH PROFICIENCY OR ILLITERACY;

7 2. DIVERSE CULTURAL OR ETHNIC BACKGROUNDS;

8 3. PHYSICAL OR MENTAL DISABILITIES; AND

9 4. SERIOUS, CHRONIC, OR COMPLEX HEALTH  
10 CONDITIONS;

11 (V) 1. THE CARRIER'S EFFORTS TO INCLUDE PROVIDERS,  
12 INCLUDING ESSENTIAL COMMUNITY PROVIDERS, IN ITS NETWORK WHO SERVE  
13 PREDOMINATELY LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS; OR

14 2. FOR A CARRIER THAT PROVIDES A MAJORITY OF  
15 COVERED PROFESSIONAL SERVICES THROUGH PHYSICIANS EMPLOYED BY A SINGLE  
16 CONTRACTED MEDICAL GROUP AND THROUGH HEALTH CARE PROVIDERS  
17 EMPLOYED BY THE CARRIER, THE CARRIER'S EFFORTS TO ADDRESS THE NEEDS OF  
18 LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS; AND

19 (VI) THE CARRIER'S METHODS FOR ASSESSING THE HEALTH  
20 CARE NEEDS OF ENROLLEES AND ENROLLEE SATISFACTION WITH HEALTH CARE  
21 SERVICES PROVIDED TO THEM.

22 (5) EACH CARRIER SHALL MONITOR, ON AN ONGOING BASIS ~~AND AT~~  
23 ~~LEAST QUARTERLY,~~ THE CLINICAL CAPACITY OF ITS PARTICIPATING PROVIDERS TO  
24 PROVIDE COVERED SERVICES TO ITS ENROLLEES.

25 (D) (1) ON OR BEFORE DECEMBER 31, 2017, THE COMMISSIONER SHALL,  
26 IN CONSULTATION WITH INTERESTED STAKEHOLDERS, ADOPT REGULATIONS TO  
27 ESTABLISH QUANTITATIVE AND, IF APPROPRIATE, NONQUANTITATIVE CRITERIA TO  
28 EVALUATE THE NETWORK SUFFICIENCY OF HEALTH BENEFIT PLANS SUBJECT TO  
29 THE REQUIREMENTS OF SUBSECTION (C) OF THIS SECTION, ~~INCLUDING CRITERIA~~  
30 ~~RELATING TO.~~

31 (2) IN ADOPTING THE REGULATIONS, THE COMMISSIONER MAY TAKE  
32 INTO CONSIDERATION:

1           ~~(1)~~ (I) GEOGRAPHIC ACCESSIBILITY OF PRIMARY CARE AND  
 2 SPECIALTY PROVIDERS, INCLUDING MENTAL HEALTH AND SUBSTANCE USE  
 3 DISORDER PROVIDERS;

4           ~~(2)~~ (II) WAITING TIMES FOR AN APPOINTMENT WITH  
 5 PARTICIPATING PRIMARY CARE AND SPECIALTY PROVIDERS, INCLUDING MENTAL  
 6 HEALTH AND SUBSTANCE USE DISORDER PROVIDERS;

7           ~~(3)~~ (III) PRIMARY CARE PROVIDER-TO-ENROLLEE RATIOS;

8           ~~(4)~~ (IV) PROVIDER-TO-ENROLLEE RATIOS, BY SPECIALTY;

9           ~~(5)~~ (V) GEOGRAPHIC VARIATION AND POPULATION DISPERSION;

10          ~~(6)~~ (VI) HOURS OF OPERATION;

11          ~~(7)~~ (VII) THE ABILITY OF THE NETWORK TO MEET THE NEEDS OF  
 12 ENROLLEES, WHICH MAY INCLUDE:

13           ~~(I)~~ 1. LOW-INCOME INDIVIDUALS;

14           ~~(II)~~ 2. ADULTS AND CHILDREN WITH:

15                   ~~1.~~ A. SERIOUS, CHRONIC, OR COMPLEX HEALTH  
 16 CONDITIONS; OR

17                   ~~2.~~ B. PHYSICAL OR MENTAL DISABILITIES; AND

18           ~~(III)~~ 3. INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY  
 19 OR ILLITERACY;

20          ~~(8)~~ (VIII) OTHER HEALTH CARE SERVICE DELIVERY SYSTEM OPTIONS,  
 21 INCLUDING TELEMEDICINE, TELEHEALTH, MOBILE CLINICS, AND CENTERS OF  
 22 EXCELLENCE; ~~AND~~

23          ~~(9)~~ (IX) THE VOLUME OF TECHNOLOGICAL AND SPECIALTY CARE  
 24 SERVICES AVAILABLE TO SERVE THE NEEDS OF ENROLLEES REQUIRING  
 25 TECHNOLOGICALLY ADVANCED OR SPECIALTY CARE SERVICES;

26           (X) ANY STANDARDS ADOPTED BY THE FEDERAL CENTERS FOR  
 27 MEDICARE AND MEDICAID SERVICES OR USED BY THE FEDERALLY FACILITATED  
 28 MARKETPLACE; AND

29           (XI) ANY STANDARDS ADOPTED BY ANOTHER STATE.

1           **(E) (1) ON OR BEFORE DECEMBER 31, 2017, FOR A CARRIER THAT IS A**  
2 **DENTAL PLAN ORGANIZATION OR AN INSURER OR NONPROFIT HEALTH SERVICE**  
3 **PLAN THAT PROVIDES COVERAGE FOR DENTAL SERVICES, THE COMMISSIONER, IN**  
4 **CONSULTATION WITH APPROPRIATE STAKEHOLDERS, SHALL ADOPT REGULATIONS**  
5 **TO SPECIFY THE STANDARDS UNDER SUBSECTION (B)(1)(I) OF THIS SECTION FOR**  
6 **DENTAL SERVICES.**

7           **(2) THE REGULATIONS SHALL:**

8                   **(I) ENSURE THAT ALL ENROLLEES, INCLUDING ADULTS AND**  
9 **CHILDREN, HAVE ACCESS TO PROVIDERS AND COVERED SERVICES WITHOUT**  
10 **UNREASONABLE DELAY AND TRAVEL;**

11                   **(II) ENSURE ACCESS TO PROVIDERS, INCLUDING ESSENTIAL**  
12 **COMMUNITY PROVIDERS, THAT SERVE PREDOMINANTLY LOW-INCOME, MEDICALLY**  
13 **UNDERSERVED INDIVIDUALS; AND**

14                   **(III) REQUIRE THE CARRIER TO SPECIFY HOW THE CARRIER**  
15 **WILL MONITOR, ON AN ONGOING BASIS, THE ABILITY OF ITS PARTICIPATING**  
16 **PROVIDERS TO PROVIDE COVERED SERVICES TO ITS ENROLLEES.**

17           **(3) IN ESTABLISHING THE STANDARDS FOR DENTAL SERVICES, THE**  
18 **COMMISSIONER MAY CONSIDER THE APPROPRIATENESS OF QUANTITATIVE AND**  
19 **NONQUANTITATIVE CRITERIA.**

20           **[(c)] ~~(E)~~ (F)** A carrier that uses a provider panel:

21                   (1) on request, shall provide an application and information that relates to  
22 consideration for participation on the carrier's provider panel to any provider seeking to  
23 apply for participation;

24                   (2) shall make publicly available its application; and

25                   (3) shall make efforts to increase the opportunity for a broad range of  
26 minority providers to participate on the carrier's provider panel.

27           **[(d)] ~~(F)~~ (G)** (1) A provider that seeks to participate on a provider panel of a  
28 carrier shall submit an application to the carrier.

29                   (2) (i) Subject to paragraph (3) of this subsection, the carrier, after  
30 reviewing the application, shall accept or reject the provider for participation on the  
31 carrier's provider panel.

1                   (ii) If the carrier rejects the provider for participation on the carrier's  
2 provider panel, the carrier shall send to the provider at the address listed in the application  
3 written notice of the rejection.

4                   (3) (i) Subject to paragraph (4) of this subsection, within 30 days after  
5 the date a carrier receives a completed application, the carrier shall send to the provider at  
6 the address listed in the application written notice of:

7                   1. the carrier's intent to continue to process the provider's  
8 application to obtain necessary credentialing information; or

9                   2. the carrier's rejection of the provider for participation on  
10 the carrier's provider panel.

11                   (ii) The failure of a carrier to provide the notice required under  
12 subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to  
13 the penalties provided by § 4-113(d) of this article.

14                   (iii) Except as provided in subsection [(o)] ~~(u)~~ (v) of this section, if,  
15 under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its  
16 intent to continue to process the provider's application to obtain necessary credentialing  
17 information, the carrier, within 120 days after the date the notice is provided, shall:

18                   1. accept or reject the provider for participation on the  
19 carrier's provider panel; and

20                   2. send written notice of the acceptance or rejection to the  
21 provider at the address listed in the application.

22                   (iv) The failure of a carrier to provide the notice required under  
23 subparagraph (iii)2 of this paragraph is a violation of this article and the carrier is subject  
24 to the provisions of and penalties provided by §§ 4-113 and 4-114 of this article.

25                   (4) (i) 1. Except as provided in subsubparagraph 4 of this  
26 subparagraph, a carrier that receives a complete application shall notify the provider that  
27 the application is complete.

28                   2. If a carrier does not accept applications through the online  
29 credentialing system, notice shall be given to the provider at the address listed in the  
30 application within 10 days after the date the application is received.

31                   3. If a carrier accepts applications through the online  
32 credentialing system, the notice from the online credentialing system to the provider that  
33 the carrier has received the provider's application shall be considered notice that the  
34 application is complete.

1                   4.     This subparagraph does not apply to a carrier that  
2 arranges a dental provider panel until the Commissioner certifies that the online  
3 credentialing system is capable of accepting the uniform credentialing form designated by  
4 the Commissioner for dental provider panels.

5                   (ii) 1.     A carrier that receives an incomplete application shall  
6 return the application to the provider at the address listed in the application within 10 days  
7 after the date the application is received.

8                   2.     The carrier shall indicate to the provider what information  
9 is needed to make the application complete.

10                  3.     The provider may return the completed application to the  
11 carrier.

12                  4.     After the carrier receives the completed application, the  
13 carrier is subject to the time periods established in paragraph (3) of this subsection.

14                  (5)    A carrier may charge a reasonable fee for an application submitted to  
15 the carrier under this section.

16                  [(e)] ~~(G)~~ **(H)**     A carrier may not deny an application for participation or  
17 terminate participation on its provider panel on the basis of:

18                  (1)    gender, race, age, religion, national origin, or a protected category  
19 under the federal Americans with Disabilities Act;

20                  (2)    the type or number of appeals that the provider files under Subtitle 10B  
21 of this title;

22                  (3)    the number of grievances or complaints that the provider files on behalf  
23 of a patient under Subtitle 10A of this title; or

24                  (4)    the type or number of complaints or grievances that the provider files  
25 or requests for review under the carrier's internal review system established under  
26 subsection [(h)] ~~(K)~~ **(L)** of this section.

27                  [(f)] ~~(H)~~ **(I)** (1)    A carrier may not deny an application for participation or  
28 terminate participation on its provider panel solely on the basis of the license, certification,  
29 or other authorization of the provider to provide health care services if the carrier provides  
30 health care services within the provider's lawful scope of practice.

31                  (2)    Notwithstanding paragraph (1) of this subsection, a carrier may reject  
32 an application for participation or terminate participation on its provider panel based on  
33 the participation on the provider panel of a sufficient number of similarly qualified  
34 providers.

1 (3) A violation of this subsection does not create a new cause of action.

2 ~~[(f-1)]~~ **(J)** (1) Subject to the provisions of this subsection, a carrier may  
3 not require a provider participating on its provider panel to be recredentialed based on:

4 (i) a change in the federal tax identification number of the provider;

5 (ii) a change in the federal tax identification number of a provider's  
6 employer; or

7 (iii) a change in the employer of a provider, if the new employer is:

8 1. a participating provider on the carrier's provider panel; or

9 2. the employer of providers that participate on the carrier's  
10 provider panel.

11 (2) A provider that participates on a carrier's provider panel or the  
12 provider's employer shall give written notice to the carrier of a change in the federal tax  
13 identification number of the provider or the provider's employer not less than 45 days before  
14 the effective date of the change.

15 (3) The notice required under paragraph (2) of this subsection shall  
16 include:

17 (i) a statement of the intention of the provider or the provider's  
18 employer to continue to provide health care services in the same field of specialization, if  
19 applicable;

20 (ii) the effective date of the change in the federal tax identification  
21 number of the provider or the provider's employer;

22 (iii) the new federal tax identification number of the provider or the  
23 provider's employer and a copy of U.S. Treasury Form W-9, or any successor or replacement  
24 form; and

25 (iv) the following information about a new employer of the provider:

26 1. the employer's name;

27 2. the name of the employer's contact person for carrier  
28 questions about the provider; and

29 3. the address, telephone number, facsimile transmission  
30 number, and electronic mail address of the contact person for the employer.

1 (4) If the new federal tax identification number or the form required to be  
2 included in the notice under paragraph (3)(iii) of this subsection is not available at the time  
3 the notice is given to a carrier, it shall be provided to the carrier promptly after it is received  
4 by the provider or the provider's employer.

5 (5) Within 30 business days after receipt of the notice required under  
6 paragraph (2) of this subsection, a carrier:

7 (i) shall acknowledge receipt of the notice to the provider or the  
8 provider's employer; and

9 (ii) if the carrier considers it necessary to issue a new provider  
10 number as a result of a change in the federal tax identification number of a provider or a  
11 provider's employer or a change in the employer of a provider, shall issue a new provider  
12 number, by mail, electronic mail, or facsimile transmission, to:

13 1. the provider or the provider's employer; or

14 2. the representative of the provider or the provider's  
15 employer designated in writing to the carrier.

16 (6) A carrier may not terminate its existing contract with a provider or a  
17 provider's employer based solely on a notice given to the carrier in accordance with this  
18 subsection.

19 ~~[(g)]~~ ~~(J)~~ (K) A carrier may not terminate participation on its provider panel or  
20 otherwise penalize a provider for:

21 (1) advocating the interests of a patient through the carrier's internal  
22 review system established under subsection ~~[(h)]~~ ~~(K)~~ (L) of this section;

23 (2) filing an appeal under Subtitle 10B of this title; or

24 (3) filing a grievance or complaint on behalf of a patient under Subtitle 10A  
25 of this title.

26 ~~[(h)]~~ ~~(K)~~ (L) Each carrier shall establish an internal review system to resolve  
27 grievances initiated by providers that participate on the carrier's provider panel, including  
28 grievances involving the termination of a provider from participation on the carrier's  
29 provider panel.

30 ~~[(i)]~~ ~~(L)~~ (M) (1) For at least 90 days after the date of the notice of termination of  
31 a primary care provider from a carrier's provider panel for reasons unrelated to fraud,  
32 patient abuse, incompetency, or loss of licensure status, the primary care provider shall  
33 furnish health care services to each enrollee:



1 (i) who was receiving health care services from the primary care  
2 provider before the notice of termination; and

3 (ii) who, after receiving notice under subsection (b) of this section of  
4 the termination of the primary care provider, requests to continue receiving health care  
5 services from the primary care provider.

6 (2) A carrier shall reimburse a primary care provider that furnishes health  
7 care services under this subsection in accordance with the primary care provider's  
8 agreement with the carrier.

9 ~~[(j)] (M) (N) (1) [A] SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A~~  
10 carrier shall make available to prospective enrollees on the Internet and, on request of a  
11 prospective enrollee, in printed form:

12 ~~(i) (1)~~ a list of providers on the carrier's provider panel; and

13 ~~(ii) (2)~~ information on providers that are no longer accepting new  
14 patients.

15 ~~(2) A CARRIER THAT DEVELOPS AND MAKES AVAILABLE TO~~  
16 ~~ENROLLEES AND PROSPECTIVE ENROLLEES A NETWORK DIRECTORY IN~~  
17 ~~ACCORDANCE WITH SUBSECTION (N) THIS SECTION MEETS THE REQUIREMENTS OF~~  
18 ~~PARAGRAPH (1) OF THIS SUBSECTION.~~

19 ~~(N) (1) THIS SUBSECTION APPLIES TO A CARRIER THAT:~~

20 ~~(I) IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A~~  
21 ~~HEALTH MAINTENANCE ORGANIZATION; AND~~

22 ~~(II) USES A PROVIDER PANEL FOR A HEALTH BENEFIT PLAN~~  
23 ~~OFFERED BY THE CARRIER.~~

24 ~~(2) A CARRIER SHALL DEVELOP AND MAKE AVAILABLE TO~~  
25 ~~ENROLLEES AND PROSPECTIVE ENROLLEES ON THE INTERNET AND, ON REQUEST~~  
26 ~~OF AN ENROLLEE OR A PROSPECTIVE ENROLLEE, IN PRINTED FORM, AN~~  
27 ~~UP TO DATE AND ACCURATE PROVIDER NETWORK DIRECTORY FOR A HEALTH~~  
28 ~~BENEFIT PLAN OFFERED BY THE CARRIER TO ENROLLEES AND PROSPECTIVE~~  
29 ~~ENROLLEES.~~

30 ~~(3) THE NETWORK DIRECTORY MADE AVAILABLE TO ENROLLEES AND~~  
31 ~~PROSPECTIVE ENROLLEES ON THE INTERNET UNDER PARAGRAPH (2) OF THIS~~  
32 ~~SUBSECTION;~~

1 ~~(I) SHALL BE ACCESSIBLE THROUGH A CLEARLY IDENTIFIABLE~~  
2 ~~LINK OR TAB ON THE CARRIER'S WEB SITE;~~

3 ~~(II) MAY NOT REQUIRE AN ENROLLEE OR A PROSPECTIVE~~  
4 ~~ENROLLEE TO CREATE OR ACCESS AN ACCOUNT ON THE CARRIER'S WEB SITE; AND~~

5 ~~(III) SHALL INCLUDE, IN A SEARCHABLE FORMAT, THE~~  
6 ~~INFORMATION REQUIRED UNDER PARAGRAPH (4) OF THIS SUBSECTION.~~

7 ~~(4) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF~~  
8 ~~THIS SUBSECTION SHALL:~~

9 ~~(I) FOR EACH PARTICIPATING HEALTH CARE PRACTITIONER,~~  
10 ~~INCLUDE:~~

11 ~~1. THE HEALTH CARE PRACTITIONER'S NAME AND~~  
12 ~~GENDER;~~

13 ~~2. FOR EACH OFFICE OR HEALTH CARE FACILITY AT~~  
14 ~~WHICH THE HEALTH PRACTITIONER PROVIDES SERVICES TO PATIENTS:~~

15 ~~A. THE LOCATION OF THE OFFICE OR HEALTH CARE~~  
16 ~~FACILITY, INCLUDING THE ADDRESS OF THE OFFICE OR HEALTH CARE FACILITY;~~

17 ~~B. CONTACT INFORMATION FOR THE HEALTH CARE~~  
18 ~~PRACTITIONER; AND~~

19 ~~C. WHETHER THE HEALTH CARE PRACTITIONER IS ON~~  
20 ~~THE PROVIDER PANEL AT THE OFFICE OR HEALTH CARE FACILITY;~~

21 ~~3. THE SPECIALTY AREA OR AREAS OF THE HEALTH~~  
22 ~~CARE PRACTITIONER, IF APPLICABLE;~~

23 ~~4. THE MEDICAL GROUP AFFILIATIONS OF THE HEALTH~~  
24 ~~CARE PRACTITIONER, IF APPLICABLE;~~

25 ~~5. THE LANGUAGES SPOKEN BY THE HEALTH CARE~~  
26 ~~PRACTITIONER OTHER THAN ENGLISH, IF APPLICABLE; AND~~

27 ~~6. WHETHER THE HEALTH CARE PRACTITIONER IS~~  
28 ~~ACCEPTING NEW PATIENTS;~~

29 ~~(II) FOR EACH PARTICIPATING HOSPITAL, INCLUDE:~~

1 ~~1. THE HOSPITAL NAME AND TYPE;~~

2 ~~2. THE LOCATION OF THE HOSPITAL, INCLUDING THE~~  
3 ~~ADDRESS OF THE HOSPITAL;~~

4 ~~3. CONTACT INFORMATION FOR THE HOSPITAL,~~  
5 ~~INCLUDING A TELEPHONE NUMBER FOR THE HOSPITAL; AND~~

6 ~~4. THE ACCREDITATION STATUS OF THE HOSPITAL; AND~~

7 ~~(III) FOR HEALTH CARE FACILITIES AND PROGRAMS LICENSED~~  
8 ~~UNDER TITLE 7.5 OF THE HEALTH GENERAL ARTICLE AT WHICH HEALTH CARE~~  
9 ~~SERVICES ARE PROVIDED, OTHER THAN HOSPITALS, INCLUDE:~~

10 ~~1. THE NAME AND TYPE OF THE HEALTH CARE FACILITY~~  
11 ~~OR PROGRAM;~~

12 ~~2. THE TYPES OF HEALTH CARE SERVICES PROVIDED AT~~  
13 ~~THE HEALTH CARE FACILITY OR PROGRAM;~~

14 ~~3. THE LOCATION OF THE HEALTH CARE FACILITY OR~~  
15 ~~PROGRAM, INCLUDING THE ADDRESS OF THE HEALTH CARE FACILITY OR PROGRAM;~~  
16 ~~AND~~

17 ~~4. CONTACT INFORMATION FOR THE HEALTH CARE~~  
18 ~~FACILITY OR PROGRAM, INCLUDING A TELEPHONE NUMBER FOR THE HEALTH CARE~~  
19 ~~FACILITY OR PROGRAM.~~

20 ~~(5) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF~~  
21 ~~THIS SUBSECTION SHALL, IN PLAIN LANGUAGE:~~

22 ~~(I) INCLUDE A DESCRIPTION OF:~~

23 ~~1. THE CRITERIA USED BY THE CARRIER TO:~~

24 ~~A. SELECT PROVIDERS FOR PARTICIPATION IN THE~~  
25 ~~NETWORK; AND~~

26 ~~B. PLACE PROVIDERS IN NETWORK TIERS, IF~~  
27 ~~APPLICABLE; AND~~

28 ~~2. HOW THE CARRIER DESIGNATES DIFFERENT~~  
29 ~~PROVIDER TIERS OR LEVELS IN THE NETWORK, IF APPLICABLE;~~

~~(H) FOR EACH HEALTH CARE PRACTITIONER, HOSPITAL, HEALTH CARE FACILITY, AND LICENSED PROGRAM IN THE NETWORK, IDENTIFY THE PROVIDER TIER OR LEVEL IN THE NETWORK IN WHICH THE HEALTH CARE PRACTITIONER, HOSPITAL, HEALTH CARE FACILITY, OR LICENSED PROGRAM IS PLACED;~~

~~(HH) INDICATE THAT AUTHORIZATION OR REFERRAL MAY BE REQUIRED TO ACCESS PROVIDERS IN THE NETWORK, IF APPLICABLE; AND~~

~~(IV) IF APPLICABLE, IDENTIFY THE HEALTH BENEFIT PLAN TO WHICH THE NETWORK DIRECTORY APPLIES.~~

~~(6) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION SHALL:~~

~~(I) ACCOMMODATE THE COMMUNICATION NEEDS OF INDIVIDUALS WITH DISABILITIES;~~

~~(II) INCLUDE INFORMATION, OR A LINK TO INFORMATION, REGARDING AVAILABLE ASSISTANCE FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY;~~

~~(III) INCLUDE A CUSTOMER SERVICE PHONE NUMBER AND, IN THE NETWORK DIRECTORY MADE AVAILABLE ON THE INTERNET, AN E-MAIL LINK THAT ENROLLEES, PROSPECTIVE ENROLLEES, AND MEMBERS OF THE PUBLIC MAY USE TO NOTIFY THE CARRIER OF INACCURATE INFORMATION IN THE NETWORK DIRECTORY; AND~~

~~(IV) INCLUDE A NOTICE STATING THAT AN ENROLLEE:~~

~~1. HAS A RIGHT TO AN ACCURATE NETWORK DIRECTORY;~~  
AND

~~2. MAY DIRECT A COMPLAINT TO THE COMMISSIONER IF THERE IS AN INACCURATE LISTING IN THE NETWORK DIRECTORY.~~

(O) (1) A CARRIER SHALL HAVE A CUSTOMER SERVICE TELEPHONE NUMBER, E-MAIL ADDRESS LINK, OR OTHER ELECTRONIC MEANS BY WHICH ENROLLEES AND PROSPECTIVE ENROLLEES MAY NOTIFY THE CARRIER OF INACCURATE INFORMATION IN THE CARRIER'S NETWORK DIRECTORY.

~~(7) (2)~~ IF NOTIFIED OF A POTENTIAL INACCURACY IN A NETWORK DIRECTORY BY A PERSON OTHER THAN THE PROVIDER, A CARRIER SHALL INVESTIGATE THE REPORTED INACCURACY AND TAKE CORRECTIVE ACTION, IF

1 NECESSARY, TO UPDATE THE NETWORK DIRECTORY WITHIN ~~15~~ 45 WORKING DAYS  
2 AFTER RECEIVING THE NOTIFICATION OF THE POTENTIAL INACCURACY.

3 ~~[(2)]~~ ~~(O)~~ (P) (1) A carrier shall notify each enrollee at the time of initial  
4 enrollment and renewal about how to ACCESS OR obtain the [following information on the  
5 Internet and in printed form:

6 (i) a list of providers on the carrier's provider panel; and

7 (ii) information on providers that are no longer accepting new  
8 patients] INFORMATION REQUIRED UNDER SUBSECTIONS (M) AND (N) SUBSECTION  
9 (N) OF THIS SECTION.

10 ~~[(3)]~~ (2) (i) Information provided in printed form under [paragraphs  
11 (1) and (2)] ~~SUBSECTIONS (M) AND (N) SUBSECTION (N)~~ of this [subsection] SECTION  
12 shall be updated at least once a year.

13 (ii) Subject to subsection [(m)] ~~(S)~~ (T) of this section, information  
14 provided on the Internet under [paragraphs (1) and (2)] ~~SUBSECTIONS (M) AND (N)~~  
15 SUBSECTION (N) of this [subsection] SECTION shall be updated at least once every 15  
16 days.

17 ~~(H) IF A PROVIDER LISTED IN A NETWORK DIRECTORY AS A~~  
18 ~~PARTICIPATING PROVIDER HAS NOT SUBMITTED A CLAIM IN THE LAST 6 MONTHS, A~~  
19 ~~CARRIER SHALL CONTACT THE PROVIDER TO DETERMINE IF THE PROVIDER~~  
20 ~~INTENDS TO REMAIN IN THE NETWORK AND UPDATE THE NETWORK DIRECTORY~~  
21 ~~ACCORDINGLY.~~

22 ~~(3) IF AN ENROLLEE RELIES ON MATERIALLY INACCURATE~~  
23 ~~INFORMATION IN A NETWORK DIRECTORY INDICATING THAT A PROVIDER IS~~  
24 ~~IN NETWORK AND THEN RECEIVES HEALTH CARE SERVICES FROM THAT PROVIDER,~~  
25 ~~A CARRIER SHALL TREAT THE HEALTH CARE SERVICES AS IF THEY WERE RENDERED~~  
26 ~~BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL FOR THE PURPOSE OF~~  
27 ~~CALCULATING ANY OUT OF POCKET MAXIMUM, DEDUCTIBLE, COPAYMENT~~  
28 ~~AMOUNT, OR COINSURANCE AMOUNT PAYABLE BY THE ENROLLEE FOR THE HEALTH~~  
29 ~~CARE SERVICES.~~

30 (3) A CARRIER SHALL:

31 (1) 1. PERIODICALLY REVIEW AT LEAST A REASONABLE  
32 SAMPLE SIZE OF ITS NETWORK DIRECTORY FOR ACCURACY; AND

33 2. RETAIN DOCUMENTATION OF THE REVIEW AND MAKE  
34 THE REVIEW AVAILABLE TO THE COMMISSIONER ON REQUEST; OR

1 (II) CONTACT PROVIDERS LISTED IN THE CARRIER'S NETWORK  
 2 DIRECTORY WHO HAVE NOT SUBMITTED A CLAIM IN THE LAST 6 MONTHS TO  
 3 DETERMINE IF THE PROVIDERS INTEND TO REMAIN IN THE CARRIER'S PROVIDER  
 4 NETWORK.

5 [(4)] ~~(P)~~ (Q) A policy, certificate, or other evidence of coverage shall:

6 [(i)] (1) indicate clearly the office in the Administration that is  
 7 responsible for receiving and responding to complaints from enrollees about carriers; and

8 [(ii)] (2) include the telephone number of the office and the  
 9 procedure for filing a complaint.

10 [(k)] ~~(Q)~~ (R) The Commissioner:

11 (1) shall adopt regulations that relate to the procedures that carriers must  
 12 use to process applications for participation on a provider panel; and

13 (2) in consultation with the Secretary of Health and Mental Hygiene, shall  
 14 adopt strategies to assist carriers in maximizing the opportunity for a broad range of  
 15 minority providers to participate in the delivery of health care services.

16 [(l)] ~~(R)~~ (S) A carrier may not include in a contract with a provider, ambulatory  
 17 surgical facility, or hospital a term or condition that:

18 (1) prohibits the provider, ambulatory surgical facility, or hospital from  
 19 offering to provide services to the enrollees of another carrier at a lower rate of  
 20 reimbursement;

21 (2) requires the provider, ambulatory surgical facility, or hospital to  
 22 provide the carrier with the same reimbursement arrangement that the provider,  
 23 ambulatory surgical facility, or hospital has with another carrier if the reimbursement  
 24 arrangement with the other carrier is for a lower rate of reimbursement; or

25 (3) requires the provider, ambulatory surgical facility, or hospital to certify  
 26 to the carrier that the reimbursement rate being paid by the carrier to the provider,  
 27 ambulatory surgical facility, or hospital is not higher than the reimbursement rate being  
 28 received by the provider, ambulatory surgical facility, or hospital from another carrier.

29 [(m)] ~~(S)~~ (T) ~~[(1)]~~ A carrier shall update [its provider information] **THE**  
 30 **INFORMATION THAT MUST BE MADE AVAILABLE ON THE INTERNET** under [subsection  
 31 (j)(3)(ii)] ~~SUBSECTIONS (M) AND (N)~~ **SUBSECTION (N)** of this section within 15 working  
 32 days after receipt of [written] ~~notification~~ **ELECTRONIC NOTIFICATION OR**  
 33 **NOTIFICATION BY FIRST-CLASS MAIL TRACKING METHOD** from the participating  
 34 provider of a change in the applicable information.

1           ~~¶~~(2) Notification is presumed to have been received by a carrier:

2                           (i) 3 working days after the date the participating provider placed  
3 the notification in the U.S. mail, if the participating provider maintains the stamped  
4 certificate of mailing for the notice; or

5                           (ii) on the date recorded by the courier, if the notification was  
6 delivered by courier.†

7           [(n)] ~~(P)~~ (U) (1) A carrier may not require a provider that provides health  
8 care services through a group practice or health care facility that participates on the  
9 carrier's provider panel under a contract with the carrier to be considered a participating  
10 provider or accept the reimbursement fee schedule applicable under the contract when:

11                           (i) providing health care services to enrollees of the carrier through  
12 an individual or group practice or health care facility that does not have a contract with the  
13 carrier; and

14                           (ii) billing for health care services provided to enrollees of the carrier  
15 using a different federal tax identification number than that used by the group practice or  
16 health care facility under a contract with the carrier.

17           (2) A nonparticipating provider shall notify an enrollee:

18                           (i) that the provider does not participate on the provider panel of  
19 the enrollee's carrier; and

20                           (ii) of the anticipated total charges for the health care services.

21           [(o)] ~~(U)~~ (V) The provisions of subsection [(d)(3)(iii)] ~~(F)(3)(III)~~ (G)(3)(III) of this  
22 section do not apply to a carrier that uses a credentialing intermediary that:

23                           (1) is a hospital or academic medical center;

24                           (2) is a participating provider on the carrier's provider panel; and

25                           (3) acts as a credentialing intermediary for that carrier for health care  
26 practitioners that:

27                           (i) participate on the carrier's provider panel; and

28                           (ii) have privileges at the hospital or academic medical center.

29           [(p)] ~~(V)~~ (W) (1) Notwithstanding subsection [(n)(1)] ~~(P)(1)~~ (U)(1) of this  
30 section, a carrier shall reimburse a group practice on the carrier's provider panel at the  
31 participating provider rate for covered services provided by a provider who is not a  
32 participating provider if:

- 1 (i) the provider is employed by or a member of the group practice;
- 2 (ii) the provider has applied for acceptance on the carrier's provider  
3 panel and the carrier has notified the provider of the carrier's intent to continue to process  
4 the provider's application to obtain necessary credentialing information;
- 5 (iii) the provider has a valid license issued by a health occupations  
6 board to practice in the State; and
- 7 (iv) the provider:
- 8 1. is currently credentialed by an accredited hospital in the  
9 State; or
- 10 2. has professional liability insurance.

11 (2) A carrier shall reimburse a group practice on the carrier's provider  
12 panel in accordance with paragraph (1) of this subsection from the date the notice required  
13 under subsection [(d)(3)(i)1] ~~(F)(3)(I)1~~ (G)(3)(I)1 of this section is sent to the provider  
14 until the date the notice required under subsection [(d)(3)(iii)2] ~~(F)(3)(III)2~~ (G)(3)(III)2  
15 of this section is sent to the provider.

16 (3) A carrier that sends written notice of rejection of a provider for  
17 credentialing under subsection [(d)(3)(iii)2] ~~(F)(3)(III)2~~ (G)(3)(III)2 of this section shall  
18 reimburse the provider as a nonparticipating provider for covered services provided on or  
19 after the date the notice is sent.

20 (4) A health maintenance organization may not deny payment to a provider  
21 under this subsection solely because the provider was not a participating provider at the  
22 time the services were provided to an enrollee.

23 (5) A provider who is not a participating provider of a carrier and whose  
24 group practice is eligible for reimbursement under paragraph (1) of this subsection may not  
25 hold an enrollee of the carrier liable for the cost of any covered services provided to the  
26 enrollee during the time period described in paragraph (2) of this subsection, except for any  
27 deductible, copayment, or coinsurance amount owed by the enrollee to the group practice  
28 or provider under the terms of the enrollee's contract or certificate.

29 (6) A group practice shall disclose in writing to an enrollee at the time  
30 services are provided that:

- 31 (i) the treating provider is not a participating provider;
- 32 (ii) the treating provider has applied to become a participating  
33 provider;



1 (iii) the carrier has not completed its assessment of the qualifications  
2 of the treating provider to provide services as a participating provider; and

3 (iv) any covered services received must be reimbursed by the carrier  
4 at the participating provider rate.

5 31-115.

6 **(M) ANY CERTIFICATION STANDARDS ESTABLISHED UNDER SUBSECTION**  
7 **(K) OF THIS SECTION RELATED TO NETWORK ADEQUACY OR NETWORK DIRECTORY**  
8 **ACCURACY:**

9 **(1) SHALL BE CONSISTENT WITH THE PROVISIONS OF § 15-112 OF**  
10 **THIS ARTICLE; AND**

11 **(2) MAY NOT BE IMPLEMENTED UNTIL JANUARY 1, 2019.**

12 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read  
13 as follows:

14 **Article – Insurance**

15 15-112.

16 **(n) (1) A carrier shall make THE CARRIER’S NETWORK DIRECTORY**  
17 **available to prospective enrollees on the Internet and, on request of a prospective enrollee,**  
18 **in printed form[:**

19 **(1) a list of providers on the carrier’s provider panel; and**

20 **(2) information on providers that are no longer accepting new patients].**

21 **(2) THE CARRIER’S NETWORK DIRECTORY ON THE INTERNET SHALL**  
22 **BE AVAILABLE:**

23 **(I) THROUGH A CLEAR LINK OR TAB; AND**

24 **(II) IN A SEARCHABLE FORMAT.**

25 **(3) THE NETWORK DIRECTORY SHALL INCLUDE:**

26 **(I) FOR EACH PROVIDER ON THE CARRIER’S PROVIDER PANEL:**

27 **1. THE NAME OF THE PROVIDER;**

28 **2. THE SPECIALTY AREAS OF THE PROVIDER;**

1                                   **3.    WHETHER THE PROVIDER CURRENTLY IS ACCEPTING**  
 2 **NEW PATIENTS;**

3                                   **4.    FOR EACH OFFICE OF THE PROVIDER WHERE THE**  
 4 **PROVIDER PARTICIPATES ON THE PROVIDER PANEL;**

5                                   **A.    ITS LOCATION, INCLUDING ITS ADDRESS; AND**

6                                   **B.    CONTACT INFORMATION FOR THE PROVIDER;**

7                                   **5.    THE GENDER OF THE PROVIDER, IF THE PROVIDER**  
 8 **NOTIFIES THE CARRIER OR THE MULTI-CARRIER COMMON ONLINE PROVIDER**  
 9 **DIRECTORY INFORMATION SYSTEM DESIGNATED UNDER § 15-112.3 OF THIS**  
 10 **SUBTITLE OF THE INFORMATION; AND**

11                                  **6.    ANY LANGUAGES SPOKEN BY THE PROVIDER OTHER**  
 12 **THAN ENGLISH, IF THE PROVIDER NOTIFIES THE CARRIER OR THE MULTI-CARRIER**  
 13 **COMMON ONLINE PROVIDER DIRECTORY INFORMATION SYSTEM DESIGNATED**  
 14 **UNDER § 15-112.3 OF THIS SUBTITLE OF THE INFORMATION;**

15                                  **(II)   FOR EACH HEALTH CARE FACILITY IN THE CARRIER'S**  
 16 **NETWORK;**

17                                  **1.    THE HEALTH CARE FACILITY'S NAME;**

18                                  **2.    THE HEALTH CARE FACILITY'S ADDRESS;**

19                                  **3.    THE TYPES OF SERVICES PROVIDED BY THE HEALTH**  
 20 **CARE FACILITY; AND**

21                                  **4.    CONTACT INFORMATION FOR THE HEALTH CARE**  
 22 **FACILITY; AND**

23                                  **(III) A STATEMENT THAT ADVISES ENROLLEES AND**  
 24 **PROSPECTIVE ENROLLEES TO CONTACT A PROVIDER OR A HEALTH CARE FACILITY**  
 25 **BEFORE SEEKING TREATMENT OR SERVICES, TO CONFIRM THE PROVIDER'S OR**  
 26 **HEALTH CARE FACILITY'S PARTICIPATION IN THE CARRIER'S NETWORK.**

27                                  

(p)   (1)   A carrier shall notify each enrollee at the time of initial enrollment and  
 28 renewal about how to access or obtain the information required under subsection (n) of this  
 29 section.

30                                  

(2)   (i)   1.   Information provided in printed form under subsection (n)  
 31 of this section shall be [updated] **ACCURATE ON THE DATE OF PUBLICATION.**

1                   **2. A CARRIER SHALL UPDATE THE INFORMATION**  
2 **PROVIDED IN PRINTED FORM at least once a year.**

3                   (ii) **1. [Subject to subsection (t) of this section, information]**  
4 **INFORMATION provided on the Internet under subsection (n) of this section shall be**  
5 **[updated] ACCURATE ON THE DATE OF INITIAL POSTING AND ANY UPDATE.**

6                   **2. IN ADDITION TO THE REQUIREMENT TO UPDATE ITS**  
7 **PROVIDER INFORMATION UNDER SUBSECTION (T)(1) OF THIS SECTION, A CARRIER**  
8 **SHALL UPDATE THE INFORMATION PROVIDED ON THE INTERNET at least once every**  
9 **15 days.**

10                   (3) **A carrier shall:**

11                   (i) **1. periodically review at least a reasonable sample size of its**  
12 **network directory for accuracy; and**

13                   **2. retain documentation of the review and make the review**  
14 **available to the Commissioner on request; or**

15                   (ii) **contact providers listed in the carrier's network directory who**  
16 **have not submitted a claim in the last 6 months to determine if the providers intend to**  
17 **remain in the carrier's provider network.**

18                   **(4) A CARRIER SHALL DEMONSTRATE THE ACCURACY OF THE**  
19 **INFORMATION PROVIDED UNDER PARAGRAPH (3) OF THIS SUBSECTION ON**  
20 **REQUEST OF THE COMMISSIONER.**

21                   **(5) BEFORE IMPOSING A PENALTY AGAINST A CARRIER FOR**  
22 **INACCURATE NETWORK DIRECTORY INFORMATION, THE COMMISSIONER SHALL**  
23 **TAKE INTO ACCOUNT, IN ADDITION TO ANY OTHER FACTORS REQUIRED BY LAW,**  
24 **WHETHER:**

25                   **(I) THE CARRIER AFFORDED A PROVIDER OR OTHER PERSON**  
26 **IDENTIFIED IN § 15-112.3(C) OF THIS SUBTITLE AN OPPORTUNITY TO REVIEW AND**  
27 **UPDATE THE PROVIDER'S NETWORK DIRECTORY INFORMATION:**

28                   **1. THROUGH THE MULTI-CARRIER COMMON ONLINE**  
29 **PROVIDER DIRECTORY INFORMATION SYSTEM DESIGNATED UNDER § 15-112.3 OF**  
30 **THIS SUBTITLE; OR**

31                   **2. DIRECTLY WITH THE CARRIER;**

1                   (II) THE CARRIER CAN DEMONSTRATE THE EFFORTS MADE, IN  
2 WRITING, ELECTRONICALLY, OR BY TELEPHONE, TO OBTAIN UPDATED NETWORK  
3 DIRECTORY INFORMATION FROM A PROVIDER OR OTHER PERSON IDENTIFIED IN §  
4 15-112.3(C) OF THIS SUBTITLE;

5                   (III) THE CARRIER HAS CONTACTED A PROVIDER LISTED IN THE  
6 CARRIER'S NETWORK DIRECTORY WHO HAS NOT SUBMITTED A CLAIM IN THE LAST 6  
7 MONTHS TO DETERMINE IF THE PROVIDER INTENDS TO REMAIN THE CARRIER'S  
8 PROVIDER PANEL;

9                   (IV) THE CARRIER INCLUDES IN ITS NETWORK DIRECTORY THE  
10 LAST DATE THAT A PROVIDER UPDATED THE PROVIDER'S INFORMATION;

11                   (V) THE CARRIER HAS IMPLEMENTED ANY OTHER PROCESS OR  
12 PROCEDURE TO:

13                           1. ENCOURAGE PROVIDERS TO UPDATE THEIR  
14 NETWORK DIRECTORY INFORMATION; OR

15                           2. INCREASE THE ACCURACY OF ITS NETWORK  
16 DIRECTORY; AND

17                   (VI) A PROVIDER OR OTHER PERSON IDENTIFIED IN §  
18 15-112.3(C) OF THIS SUBTITLE HAS NOT UPDATED THE PROVIDER'S NETWORK  
19 DIRECTORY INFORMATION, DESPITE OPPORTUNITIES TO DO SO.

20 15-112.3.

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

23                           (2) (I) "CARRIER" HAS THE MEANING STATED IN § 15-112 OF THIS  
24 SUBTITLE.

25                           (II) "CARRIER" DOES NOT INCLUDE A MANAGED CARE  
26 ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL  
27 ARTICLE.

28                           (3) "MULTI-CARRIER COMMON ONLINE PROVIDER DIRECTORY  
29 INFORMATION SYSTEM" MEANS THE SYSTEM DESIGNATED BY THE COMMISSIONER  
30 FOR USE BY PROVIDERS TO PROVIDE AND UPDATE THEIR NETWORK DIRECTORY  
31 INFORMATION WITH CARRIERS.

1       **(B) THE COMMISSIONER MAY DESIGNATE A MULTI-CARRIER COMMON**  
2 **ONLINE PROVIDER DIRECTORY INFORMATION SYSTEM DEVELOPED BY A**  
3 **NONPROFIT ALLIANCE OF HEALTH PLANS AND TRADE ASSOCIATIONS IF:**

4           **(1) THE SYSTEM IS AVAILABLE TO PROVIDERS NATIONALLY;**

5           **(2) THE SYSTEM IS AVAILABLE TO PROVIDERS AT NO CHARGE;**

6           **(3) THE SYSTEM ALLOWS PROVIDERS TO:**

7                   **(I) ATTEST ONLINE TO THE ACCURACY OF THEIR**  
8 **INFORMATION; AND**

9                           **(II) 1. CORRECT ANY INACCURATE INFORMATION; AND**

10                                   **2. ATTEST TO THE CORRECTION; AND**

11           **(4) THE NONPROFIT ALLIANCE HAS A WELL-ESTABLISHED**  
12 **MECHANISM FOR OUTREACH TO PROVIDERS.**

13       **(C) A CARRIER SHALL ACCEPT NEW AND UPDATED NETWORK DIRECTORY**  
14 **INFORMATION FOR A PROVIDER SUBMITTED:**

15           **(1) (I) THROUGH THE MULTI-CARRIER COMMON ONLINE**  
16 **PROVIDER DIRECTORY INFORMATION SYSTEM; OR**

17                           **(II) DIRECTLY TO THE CARRIER; AND**

18           **(2) FROM:**

19                           **(I) THE PROVIDER;**

20                           **(II) A HOSPITAL OR ACADEMIC MEDICAL CENTER THAT:**

21                                   **1. IS A PARTICIPATING PROVIDER ON THE CARRIER'S**  
22 **PROVIDER PANEL; AND**

23                                   **2. ACTS AS A CREDENTIALING INTERMEDIARY FOR THE**  
24 **CARRIER FOR PROVIDERS THAT:**

25   **A. PARTICIPATE ON THE CARRIER'S PROVIDER PANEL;**  
26 **AND**

27   **B. HAVE PRIVILEGES AT THE HOSPITAL OR ACADEMIC**  
28 **MEDICAL CENTER; OR**

1 (III) ANY OTHER PERSON THAT PERFORMS CREDENTIALING  
2 FUNCTIONS ON BEHALF OF A PROVIDER.

3 15–830.

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

5 (2) “Carrier” means:

6 (i) an insurer that offers health insurance other than long-term  
7 care insurance or disability insurance;

8 (ii) a nonprofit health service plan;

9 (iii) a health maintenance organization;

10 (iv) a dental plan organization; or

11 (v) except for a managed care organization as defined in Title 15,  
12 Subtitle 1 of the Health – General Article, any other person that provides health benefit  
13 plans subject to State regulation.

14 (3) (i) “Member” means an individual entitled to health care benefits  
15 under a policy or plan issued or delivered in the State by a carrier.

16 (ii) “Member” includes a subscriber.

17 (4) “Nonphysician specialist” means a health care provider who:

18 (i) is not a physician;

19 (ii) is licensed or certified under the Health Occupations Article; and

20 (iii) is certified or trained to treat or provide health care services for  
21 a specified condition or disease in a manner that is within the scope of the license or  
22 certification of the health care provider.

23 (5) “Provider panel” has the meaning stated in § 15–112(a) of this title.

24 (6) “Specialist” means a physician who is certified or trained to practice in  
25 a specified field of medicine and who is not designated as a primary care provider by the  
26 carrier.

27 (b) (1) Each carrier that does not allow direct access to specialists shall  
28 establish and implement a procedure by which a member may receive a standing referral  
29 to a specialist in accordance with this subsection.

1           (2)    The procedure shall provide for a standing referral to a specialist if:

2                   (i)    the primary care physician of the member determines, in  
3 consultation with the specialist, that the member needs continuing care from the specialist;

4                   (ii)   the member has a condition or disease that:

5                           1.    is life threatening, degenerative, chronic, or disabling; and

6                           2.    requires specialized medical care; and

7                   (iii)  the specialist:

8                           1.    has expertise in treating the life-threatening,  
9 degenerative, chronic, or disabling disease or condition; and

10                           2.    is part of the carrier's provider panel.

11           (3)    Except as provided in subsection (c) of this section, a standing referral  
12 shall be made in accordance with a written treatment plan for a covered service developed  
13 by:

14                   (i)    the primary care physician;

15                   (ii)  the specialist; and

16                   (iii)  the member.

17           (4)    A treatment plan may:

18                   (i)    limit the number of visits to the specialist;

19                   (ii)  limit the period of time in which visits to the specialist are  
20 authorized; and

21                   (iii)  require the specialist to communicate regularly with the primary  
22 care physician regarding the treatment and health status of the member.

23           (5)    The procedure by which a member may receive a standing referral to a  
24 specialist may not include a requirement that a member see a provider in addition to the  
25 primary care physician before the standing referral is granted.

26           (c)    (1)   Notwithstanding any other provision of this section, a member who is  
27 pregnant shall receive a standing referral to an obstetrician in accordance with this  
28 subsection.

1 (2) After the member who is pregnant receives a standing referral to an  
2 obstetrician, the obstetrician is responsible for the primary management of the member's  
3 pregnancy, including the issuance of referrals in accordance with the carrier's policies and  
4 procedures, through the postpartum period.

5 (3) A written treatment plan may not be required when a standing referral  
6 is to an obstetrician under this subsection.

7 (d) (1) Each carrier shall establish and implement a procedure by which a  
8 member may request a referral to a specialist or nonphysician specialist who is not part of  
9 the carrier's provider panel in accordance with this subsection.

10 (2) The procedure shall provide for a referral to a specialist or nonphysician  
11 specialist who is not part of the carrier's provider panel if:

12 (i) the member is diagnosed with a condition or disease that  
13 requires specialized health care services or medical care; and

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

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

20 **(3) THE PROCEDURE SHALL ENSURE THAT A REQUEST TO OBTAIN A**  
21 **REFERRAL TO A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF**  
22 **THE CARRIER'S PROVIDER PANEL IS ADDRESSED IN A TIMELY MANNER THAT IS:**

23 **(I) APPROPRIATE FOR THE MEMBER'S CONDITION; AND**

24 **(II) ~~CONSISTENT~~ IN ACCORDANCE WITH THE TIMELINESS**  
25 **REQUIREMENTS FOR DETERMINATIONS MADE BY PRIVATE REVIEW AGENTS UNDER**  
26 **§ 15-10B-06 OF THIS TITLE.**

27 **(4) THE PROCEDURE MAY NOT BE USED BY A CARRIER AS A**  
28 **SUBSTITUTE FOR ESTABLISHING AND MAINTAINING A SUFFICIENT PROVIDER**  
29 **NETWORK IN ACCORDANCE WITH § 15-112 OF THIS TITLE; ~~OR.~~**

30 **(5) EACH CARRIER SHALL:**

31 **(I) HAVE A SYSTEM IN PLACE THAT DOCUMENTS ALL REQUESTS**  
32 **TO OBTAIN A REFERRAL TO RECEIVE A COVERED SERVICE FROM A SPECIALIST OR**  
33 **NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL;**  
34 **AND**



1                   **(II) PROVIDE THE INFORMATION DOCUMENTED UNDER ITEM (I)**  
 2 **OF THIS PARAGRAPH TO THE COMMISSIONER ON REQUEST.**

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

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

11           (g) **(1)** Each carrier shall file with the Commissioner a copy of each of the  
 12 procedures required under this section, **INCLUDING:**

13                   **(I) STEPS THE CARRIER REQUIRES OF A MEMBER TO REQUEST**  
 14 **A REFERRAL;**

15                   **(II) THE CARRIER'S TIMELINE FOR DECISIONS; AND**

16                   **(III) THE CARRIER'S GRIEVANCE PROCEDURES FOR DENIALS.**

17           **(2) EACH CARRIER SHALL MAKE A COPY OF EACH OF THE**  
 18 **PROCEDURES FILED UNDER PARAGRAPH (1) OF THIS SUBSECTION AVAILABLE TO**  
 19 **ITS MEMBERS:**

20                   **(I) IN THE CARRIER'S ONLINE NETWORK DIRECTORY**  
 21 **REQUIRED UNDER ~~§ 15-112(M)(1)~~ 15-112(N)(1) OF THIS TITLE; AND**

22                   **(II) ON REQUEST.**

23           ~~SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to health~~  
 24 ~~benefit plans issued, delivered, or renewed in the State on and after January 1, 2019.~~

25           SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take  
 26 effect January 1, 2017.

27           ~~SECTION 3.~~ SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in  
 28 Section 3 of this Act, this Act shall take effect June 1, 2016.