Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 946 (Senator Young)
Finance

Health Insurance - Freedom of Choice of Laboratory Act

This bill establishes a series of prohibitions against a "carrier" that provides coverage for laboratory services. A carrier must provide notice to specified laboratories and offer each laboratory the opportunity to participate in the health benefit plan during the next plan year under specified circumstances. A carrier must provide specified notice to enrollees of the laboratories that participate in a health benefit plan, and a laboratory may inform customers of its participation in a health benefit plan network. **The bill takes effect on January 1, 2019, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Special fund revenues increase minimally for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2019 only. MIA can handle the filings with existing resources. The State Employee and Retiree Health and Welfare Benefits Program is not likely materially affected.

Local Effect: Local governments with fully insured health benefit plans are not likely materially affected.

Small Business Effect: Meaningful.

Analysis

Bill Summary: "Carrier" means an insurer, a nonprofit health service plan, a health maintenance organization, or any other person that provides health benefit plans subject to State regulation.

A carrier may not:

- prohibit an enrollee from selecting, or limit the ability of an enrollee to select, a laboratory of the enrollee's choice if the laboratory participates as a contract provider in the health benefit plan offered by the carrier;
- deny a laboratory the right to participate as a contract provider under a health benefit plan if the laboratory agrees to (1) provide laboratory services in a manner that meets the carrier's terms and conditions and (2) the carrier's terms of reimbursement;
- impose on an enrollee a copayment, fee, or condition for a laboratory service from a contract provider that is different than the copayment, fee, or condition imposed on all other enrollees for the same laboratory service under the health benefit plan;
- impose a monetary advantage or penalty, including a higher copayment, a reduction in reimbursement for services, or promotion of one participating laboratory over another, that may affect an enrollee's choice of laboratory; or
- because of an enrollee's selection of a laboratory of the enrollee's choice, reduce allowable reimbursement for an enrollee's laboratory services under a health benefit plan if the laboratory has agreed to participate in the health benefit plan under terms and conditions offered to all laboratories under the health benefit plan.

If a laboratory provides a laboratory service to an enrollee that meets the terms and conditions of the health benefit plan, the laboratory must offer the same laboratory service to all enrollees of the health benefit plan under the same terms and conditions established by the carrier.

If a carrier limits coverage and reimbursement of laboratory services under a health benefit plan to laboratories that contract with the carrier, by March 1, 2019, the carrier must (1) provide written notice to each laboratory within the geographical service area of the health benefit plan of the network established by the carrier and (2) offer to each laboratory the opportunity to participate in the health benefit plan during the next plan year.

Each laboratory to which a carrier extends an offer to participate in a health benefit plan must be eligible to participate in the health benefit plan under identical reimbursement terms and conditions.

On an annual basis, a carrier must inform the enrollees of a health benefit plan offered by the carrier of the names and locations of laboratories that are participating in the health benefit plan. A laboratory may inform its customers of the laboratory's participation in a health benefit plan network through a means that is acceptable to the laboratory and the carrier.

Current Law: The federal Patient Protection and Affordable Care Act requires nongrandfathered health plans to cover 10 essential health benefits, which include items and services in the following categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including dental and vision care.

For each health care facility (including a laboratory) in a carrier's network, the network directory must include the health care facility's name and address, and the type of services provided by the health care facility, as well as a statement that advises enrollees and prospective enrollees to contact a health care facility before seeking treatment or services to confirm the facility's participation in the carrier's network.

Small Business Effect: Any small business laboratories that contract with health insurance carriers to provide diagnostic testing likely benefit.

Additional Information

Prior Introductions: None.

Cross File: HB 1201 (Delegate K. Young, *et al.*) - Health and Government Operations.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Health Benefit Exchange; Department of Legislative Services

Fiscal Note History: First Reader - February 28, 2018
md/ljm

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510