

# SENATE BILL 48

C3

9lr0077

(PRE-FILED)

---

By: **Chair, Finance Committee (By Request – Departmental – Maryland Insurance Administration)**

Requested: October 15, 2018

Introduced and read first time: January 9, 2019

Assigned to: Finance

---

## A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Referral to Specialists – Definition of Provider Panel**

3 FOR the purpose of altering the definition of “provider panel” as it relates to certain  
4 provisions of health insurance law pertaining to referrals to specialists; and  
5 generally relating to provider panels and health insurance.

6 BY repealing and reenacting, with amendments,

7 Article – Insurance

8 Section 15–830

9 Annotated Code of Maryland

10 (2017 Replacement Volume and 2018 Supplement)

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

13 **Article – Insurance**

14 15–830.

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

16 (2) “Carrier” means:

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

19 (ii) a nonprofit health service plan;

20 (iii) a health maintenance organization;

---

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 (iv) a dental plan organization; or

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

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

7 (ii) “Member” includes a subscriber.

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

9 (i) is not a physician;

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

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

14 (5) **(I) “Provider panel” [has the meaning stated in § 15–112(a) of this**  
15 **title] MEANS THE PROVIDERS THAT CONTRACT WITH A CARRIER EITHER DIRECTLY**  
16 **OR THROUGH A SUBCONTRACTING ENTITY TO PROVIDE HEALTH CARE SERVICES TO**  
17 **ENROLLEES OF THE CARRIER.**

18 **(II) “PROVIDER PANEL” DOES NOT INCLUDE AN ARRANGEMENT**  
19 **IN WHICH ANY PROVIDER MAY PARTICIPATE SOLELY BY CONTRACTING WITH THE**  
20 **CARRIER TO PROVIDE HEALTH CARE SERVICES AT A DISCOUNTED**  
21 **FEE-FOR-SERVICE RATE.**

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

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

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

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

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

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

2                   2.     requires specialized medical care; and

3                   (iii)  the specialist:

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

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

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

10                  (i)     the primary care physician;

11                  (ii)  the specialist; and

12                  (iii) the member.

13                  (4)    A treatment plan may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (5) Each carrier shall:

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

27 (ii) provide the information documented under item (i) of this  
28 paragraph to the Commissioner on request.

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

32 (f) A decision by a carrier not to provide access to or coverage of treatment or  
33 health care services by a specialist or nonphysician specialist in accordance with this

1 section constitutes an adverse decision as defined under Subtitle 10A of this title if the  
2 decision is based on a finding that the proposed service is not medically necessary,  
3 appropriate, or efficient.

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

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

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

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

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

11 (i) in the carrier's online network directory required under  
12 § 15-112(n)(1) of this title; and

13 (ii) on request.

14 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect  
15 October 1, 2019.