# SENATE BILL 761

C3 9lr2438
CF 9lr2311

By: **Senator Klausmeier**
Introduced and read first time: February 4, 2019
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

**Health Insurance – Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists**

FOR the purpose of requiring each carrier to inform members and beneficiaries in a certain manner of the procedure to request a certain referral; requiring, under certain circumstances, certain insurers, nonprofit health service plans, and health maintenance organizations to pay a certain amount for certain services provided to a member by a noncontracting specialist or noncontracting nonphysician specialist when a referral is granted to the member; requiring a carrier to disclose certain reimbursement rates to certain persons at certain times; prohibiting a noncontracting specialist or a noncontracting nonphysician specialist from billing the member certain costs; defining a certain term; altering a certain definition; providing for the application of this Act; providing for a delayed effective date; and generally relating to payments to noncontracting health care providers.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–830
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

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

**Article – Insurance**

15–830.

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

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
**[**Brackets**]** indicate matter deleted from existing law.

**(2) "ASSIGNMENT OF BENEFITS" MEANS THE TRANSFER OF HEALTH CARE COVERAGE REIMBURSEMENT BENEFITS OR OTHER RIGHTS UNDER A PREFERRED PROVIDER INSURANCE POLICY BY AN INSURED.**

**[**(2)**] (3)** "Carrier" means:

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

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

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

**[**(3)**] (4)** (i) "Member" means an individual entitled to health care benefits under a policy or plan issued or delivered in the State by a carrier.

(ii) "Member" includes a subscriber.

**[**(4)**] (5)** "Nonphysician specialist" means a health care provider **[**who**]:**

(i) **1. WHO** is not a physician;

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

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

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

**[**(5)**] (6)** "Provider panel" has the meaning stated in § 15–112(a) of this title.

**[**(6)**] (7)** "Specialist" means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a primary care provider by the carrier.

(b) (1) Each carrier that does not allow direct access to specialists shall

establish and implement a procedure by which a member may receive a standing referral to a specialist in accordance with this subsection.

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

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

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

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

2. requires specialized medical care; and

(iii) the specialist:

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

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

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

(i) the primary care physician;

(ii) the specialist; and

(iii) the member.

(4) A treatment plan may:

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

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

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

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

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

subsection.

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

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

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

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

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

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

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

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

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

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

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

(5) Each carrier shall:

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

**(II) INFORM MEMBERS AND BENEFICIARIES OF THE PROCEDURE TO REQUEST A REFERRAL UNDER PARAGRAPH (1) OF THIS SUBSECTION IN PRINT AND ELECTRONIC PLAN DOCUMENTS AND ANY PROVIDER DIRECTORY; AND**

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

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

**(2) IF A MEMBER RECEIVES A COVERED MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICE FROM A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL IN ACCORDANCE WITH SUBSECTION (D) OF THIS SECTION:**

**(I) A CARRIER THAT IS AN INSURER OR A NONPROFIT HEALTH SERVICE PLAN SHALL PAY THE BENEFITS FOR THE COVERED SERVICE PROVIDED BY THE SPECIALIST OR NONPHYSICIAN SPECIALIST BASED ON AN ALLOWABLE AMOUNT THAT IS NO LESS THAN THE GREATER OF:**

**1. 140% OF THE AVERAGE RATE THE INSURER OR NONPROFIT HEALTH SERVICE PLAN PAID FOR THE 12–MONTH PERIOD THAT ENDS JANUARY 1 OF THE IMMEDIATELY PRECEDING CALENDAR YEAR IN THE SAME GEOGRAPHIC AREA, AS DEFINED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, FOR THE SAME COVERED SERVICE TO SIMILARLY LICENSED PROVIDERS AND FACILITIES UNDER WRITTEN CONTRACT WITH THE INSURER OR NONPROFIT HEALTH SERVICE PLAN; OR**

**2. 140% OF THE RATE PAID BY THE MEDICARE PROGRAM AS OF JANUARY 1 EACH CALENDAR YEAR, AS PUBLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, FOR THE SAME SERVICE PROVIDED BY A SIMILARLY LICENSED PROVIDER IN THE SAME GEOGRAPHIC AREA; AND**

**(II) A CARRIER THAT IS A HEALTH MAINTENANCE ORGANIZATION SHALL PAY BENEFITS FOR THE COVERED SERVICE TO THE SPECIALIST OR NONPHYSICIAN SPECIALIST BASED ON AN ALLOWED AMOUNT THAT IS NO LESS THAN THE GREATER OF:**

**1. 140% OF THE AVERAGE RATE THE INSURER PAID FOR THE 12–MONTH PERIOD THAT ENDS JANUARY 1 OF THE IMMEDIATELY PRECEDING CALENDAR YEAR IN THE SAME GEOGRAPHIC AREA, AS DEFINED BY THE CENTERS**

**FOR MEDICARE AND MEDICAID SERVICES, FOR THE SAME COVERED SERVICE TO SIMILARLY LICENSED PROVIDERS AND FACILITIES UNDER WRITTEN CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION;**

**2. 140% OF THE RATE PAID BY THE MEDICARE PROGRAM AS OF JANUARY 1 EACH CALENDAR YEAR, AS PUBLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, FOR THE SAME SERVICE PROVIDED BY A SIMILARLY LICENSED PROVIDER IN THE SAME GEOGRAPHIC AREA; OR**

**3. THE AMOUNT REQUIRED TO BE PAID UNDER § 19–710.1(B) OF THE HEALTH – GENERAL ARTICLE.**

**(F) A CARRIER SHALL DISCLOSE THE REIMBURSEMENT RATE REQUIRED UNDER SUBSECTION (E)(2):**

**(1) ON REQUEST OF A HEALTH CARE PROVIDER NOT UNDER WRITTEN CONTRACT WITH THE CARRIER;**

**(2) ON OR BEFORE FEBRUARY 1, 2020, AND EACH JANUARY 1 THEREAFTER, TO THE COMMISSIONER; AND**

**(3) TO THE MEMBER OR BENEFICIARY AT THE TIME OF THE SERVICE APPROVAL THROUGH THE PROCESS ESTABLISHED UNDER SUBSECTION (D) OF THIS SECTION.**

**(G) A SPECIALIST OR A NONPHYSICIAN SPECIALIST THAT INFORMS THE CARRIER THAT THE SPECIALIST OR NONPHYSICIAN SPECIALIST HAS OBTAINED AND ACCEPTS AN ASSIGNMENT OF BENEFITS FROM THE MEMBER TO PROVIDE A COVERED MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICE IN ACCORDANCE WITH THIS SECTION MAY NOT BILL THE MEMBER THE DIFFERENCE BETWEEN THE BILL OF THE SPECIALIST OR NONPHYSICIAN SPECIALIST AND THE ALLOWABLE AMOUNT OF THE CARRIER FOR THE COVERED SERVICE.**

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

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

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

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

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

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

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

(ii) on request.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2020.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2020.