Unofficial Copy 1996 Regular Session
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HB 1210/95 - ECM

By: Delegate Benson
Introduced and read first time: January 10, 1996
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Health Care Provider Panels - Criteria and Procedures

FOR the purpose of requiring certain carriers that use certain panels of providers to provide certain services to enrollees to establish certain criteria and procedures for membership on those panels and maintain the criteria and procedures at a certain location for a certain purpose and under certain circumstances; requiring a carrier to provide the criteria and procedures to any provider requesting anapplication for membership on a carrier's provider panel; requiring the Insurance Commissioner and the Secretary of Health and Mental Hygiene to adopt certain regulations relating to the criteria and procedures; providing certain review and appeal procedures to certain persons under certain circumstances; prohibiting a carrier from denying membership on a panel on the basis of gender, race, age, religion, national origin, or disability; prohibiting a carrier from restricting or terminating membership on a provider panel under certain circumstances; prohibiting a carrier from terminating a provider without just cause; prohibiting a carrier from limiting a provider panel exclusively to physicians; requiring a carrier to give certain priorities in formulating a provider panel; requiring a carrier to include certain information in the carrier's marketing materials; requiring a carrier that terminates a participating provider for certain reasons to continue to reimburse the provider acertain amount for a certain period of time; requiring certain insurers, including health maintenance organizations, to provide benefits to enrollees in a certain manner under certain circumstances; defining certain terms; requiring the Commissioner and the Secretary of Health and Mental Hygiene jointly to adopt regulations to maximize the opportunity of certain minority providers to participate in the delivery of health care services; and generally relating to access to health care in this State.

BY adding to
Article 48A - Insurance Code
Section 490FF
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, without amendments,
Article 48A - Insurance Code
Section 657
Annotated Code of Maryland

(1994 Replacement Volume and 1995 Supplement)

BY repealing and reenacting, with amendments,
Article 48A - Insurance Code
Section 354
Annotated Code of Maryland
(1994 Replacement Volume and 1995 Supplement)

BY adding to
Article - Health - General
Section 19-710(r)
Annotated Code of Maryland
(1990 Replacement Volume and 1995 Supplement)

Preamble

WHEREAS, Statistical data clearly show that African American citizens in the State suffer disproportionately from a myriad of health-related conditions that, in the extreme, account for significantly higher incidence of disease, disability, and premature death than that experienced by the population at large; and

WHEREAS, Studies have indicated that among the reasons for this disparity in the maintenance of good health within the African American community is thelack of access to appropriate, culturally sensitive providers in numbers sufficiently adequate to provide necessary services; and

WHEREAS, Historical practices of discrimination in the training of these community-rooted practitioners is the most significant contributing cause of the lack of African American providers and thereby, indirectly a major factor in the disproportionately high incidence of disease and death within this community; and

WHEREAS, Within the African American community there is not only a demonstrated need of, but a demand for access to the community-based African American provider; and

WHEREAS, Health care reform manifested as "managed care" limits consumer choice of the range and source of health care services to a few selected managed care panels; and

WHEREAS, While African American communities with a high representation of Medical Assistance Program recipients have previously been seen as an educational necessity but neither socially nor financially desirable, recently these communities have become prime targets for managed care organizations; and

WHEREAS, Managed care organizations, by using arbitrary and capricious "credentialling criteria" have, unfairly and with little or no understanding of or sensitivity for community needs and desires, systematically excluded essential African American providers from managed care provider panels despite many of these providers having served their communities' critical needs under adverse circumstances for years; and

WHEREAS, These exclusions from provider panels serve to exacerbate the already recognized shortage of African American providers with the intent and result of replacing these providers and thereby limiting the rights of individuals to a reasonable choice of competent and culturally sensitive providers; and

WHEREAS, These practices of arbitrary exclusion from managed care provider panels result in de facto reversal of hard-fought affirmative action gains in the area of health care within the African American community; and

WHEREAS, Too often health care dollars that are generated within theAfrican American community enter the profit pools of the large insurance and health maintenance corporations rather than being recycled into the community in the form of services to enhance the health of the community; and

WHEREAS, African American communities have a responsibility to participate actively in health care reform and have a right to full participation in the financial opportunities afforded by health care reform; now, therefore,

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

Article 48A - Insurance Code

354.

Any corporation without capital stock heretofore or hereafter organized for the purpose of establishing, maintaining and operating a nonprofit health service plan whereby hospital, medical, chiropodial, chiropractic, pharmaceutical, dental, psychological or optometric care is provided by a hospital or hospitals, a physician or physicians, a chiropodist or chiropodists, a chiropractor or chiropractors, a pharmacist or pharmacists, a dentist or dentists, a duly licensed psychologist or psychologists, or an optometrist or optometrists, to persons who become subscribers to such plan under contracts which entitle each subscriber to certain hospital, medical, chiropodial, chiropractic, pharmaceutical, dental, psychological, or optometric careor any of them, shall be governed and regulated by:

(1) The provisions of this subtitle;

(2) Subtitle 2 of this article;

(3) Subtitle 5 of this article;

(4) Subtitle 6 of this article;

(5) Subtitles 9A and 10 of this article;

(6) Subtitle 11 of this article;

(7) Subtitle 15 of this article;

(8) Except for §§ 493 and 497, Subtitle 32 of this article;

(9) Subtitle 34 of this article;

(10) Sections [55 and 55A] 55, 55A, AND 490FF of this article; and

(11) Any other provisions of this article that:

(i) Are expressly referred to in this subtitle; or

(ii) Expressly refer to this subtitle.

490FF.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A PREFERRED PROVIDER ORGANIZATION;

(V) A DENTAL PLAN ORGANIZATION; OR

(VI) ANY PERSON ACTING AS A THIRD PARTY ADMINISTRATOR.

(3) "CRITERIA" MEANS A SYSTEM, PLAN, METHODOLOGY, PROVIDER PROFILE, OR STANDARD USED BY A CARRIER TO SELECT OR DENY PROVIDERS THAT HAVE APPLIED TO BECOME MEMBERS OF THE CARRIER'S PROVIDER PANEL.

(4) "ENROLLEE" MEANS ANY PERSON ENTITLED TO HEALTH CARE BENEFITS FROM A CARRIER.

(5) "PARTICIPATING PROVIDER" MEANS A PROVIDER THAT HAS ENTERED INTO A WRITTEN PROVIDER SERVICE CONTRACT WITH A CARRIER TO PROVIDE SERVICES UNDER THE CARRIER'S HEALTH BENEFIT PLAN.

(6) (I) "PROVIDER" MEANS A PERSON LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES.

(II) "PROVIDER" INCLUDES A HEALTH CARE FACILITY, PHARMACY, PROFESSIONAL SERVICE CORPORATION, PARTNERSHIP, LIMITED LIABILITY COMPANY, PROFESSIONAL OFFICE, OR ANY OTHER ENTITY LICENSED OR AUTHORIZED BY LAW TO PROVIDE OR DELIVER PROFESSIONAL SERVICES THROUGH OR ON BEHALF OF A PROVIDER.

(7) "PROVIDER PANEL" MEANS A GROUP OF PROVIDERS THAT HAVE ENTERED INTO A WRITTEN PROVIDER SERVICE CONTRACT WITH A CARRIER TO PROVIDE SERVICES UNDER THE CARRIER'S HEALTH BENEFIT PLAN.

(B) A CARRIER SHALL PROVIDE HEALTH CARE SERVICES TO ENROLLEES IN ACCORDANCE WITH THE PROVISIONS OF § 657 OF THIS ARTICLE.

(C) (1) A CARRIER THAT USES A PROVIDER PANEL SHALL:

(I) ESTABLISH REASONABLE CRITERIA FOR MEMBERSHIP ON THE CARRIER'S PROVIDER PANEL;

(II) ESTABLISH REASONABLE PROCEDURES FOR THE REVIEW OF APPLICATIONS FOR MEMBERSHIP ON THE CARRIER'S PROVIDER PANEL;

(III) REVIEW APPLICATIONS SUBMITTED BY PROVIDERS APPLYING FOR MEMBERSHIP OR CONTINUED MEMBERSHIP ON THE CARRIER'S PROVIDER PANEL IN ACCORDANCE WITH THIS SECTION; AND

(IV) MAINTAIN THE CRITERIA AND PROCEDURES ESTABLISHED UNDER THIS SUBSECTION AT A LOCATION IN THE STATE AND MAKE THE CRITERIA AVAILABLE TO THE PUBLIC UPON REQUEST.

(2) (I) THE COMMISSIONER AND THE SECRETARY OF HEALTH AND MENTAL HYGIENE JOINTLY SHALL ADOPT REGULATIONS FOR:

1. THE FILING OF CRITERIA AND PROCEDURES WITH THE STATE; AND

2. INSPECTION AND REVIEW BY THE PUBLIC OF THE CRITERIA AND PROCEDURES.

(II) THE REGULATIONS ADOPTED UNDER THIS SUBSECTION SHALL INCLUDE PROVISIONS FOR THE UPDATING AND FILING OF ALL AMENDMENTS TO EACH CARRIER'S CRITERIA AND PROCEDURES.

(D) (1) A CARRIER THAT USES A PROVIDER PANEL SHALL PROVIDE THE CRITERIA AND PROCEDURES ESTABLISHED UNDER SUBSECTION (C) OF THIS SECTION TO ANY PROVIDER REQUESTING AN APPLICATION FOR MEMBERSHIP ON THE CARRIER'S PROVIDER PANEL.

(2) AFTER REVIEW BY A CARRIER OF AN APPLICATION:

(I) THE CARRIER MAY, SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION:

1. ACCEPT THE PROVIDER AS A MEMBER OF ITS PROVIDER PANEL; OR

2. REJECT THE PROVIDER AS A MEMBER OF THE PROVIDER PANEL; AND

(II) IF THE APPLICATION IS REJECTED, THE CARRIER SHALL INFORM THE PROVIDER IN WRITING OF THE CRITERIA ON WHICH THE REJECTION WAS BASED.

(3) (I) A CARRIER SHALL GIVE NOTICE OF THE ACCEPTANCE OR DENIAL OF A COMPLETED APPLICATION WITHIN 60 DAYS OF RECEIPT OF THE APPLICATION.

(II) SUBJECT TO PARAGRAPH (2)(II) OF THIS SUBSECTION, A CARRIER SHALL HOLD CONFIDENTIAL ALL APPLICATIONS, NOTICES OF DENIAL, AND THE CRITERIA APPLIED IN REJECTING AN APPLICATION.

(4) A CARRIER MAY NOT DENY AN APPLICATION FOR MEMBERSHIP ON ITS PROVIDER PANEL ON THE BASIS OF GENDER, RACE, AGE, RELIGION, NATIONAL ORIGIN, OR DISABILITY.

(5) A CARRIER MAY NOT RESTRICT, TERMINATE, OR DENY A PROVIDER'S MEMBERSHIP ON ITS PROVIDER PANEL SOLELY ON THE BASIS OF:

(I) THE TYPE OR NUMBER OF APPEALS FILED BY THE PROVIDER UNDER THE PROVISIONS OF TITLE 19, SUBTITLE 13 OF THE HEALTH - GENERAL ARTICLE;

(II) ANY OTHER COMPLAINT OR GRIEVANCE, OR THE NUMBER OF COMPLAINTS OR GRIEVANCES, THE PROVIDER HAS FILED WITH THE CARRIER; OR

(III) THE DEGREE HELD BY THE PROVIDER.

(6) A CARRIER MAY NOT TERMINATE A PROVIDER WITHOUT JUST CAUSE.

(7) A CARRIER MAY NOT LIMIT A PROVIDER PANEL EXCLUSIVELY TO PHYSICIANS.

(8) IN FORMULATING A PROVIDER PANEL, A CARRIER SHALL GIVE PRIORITY TO:

(I) ACCEPTING FOR MEMBERSHIP PROVIDERS WHO HAVE PROVIDED SERVICES WITHIN A CITY OR COUNTY ON A CONTINUOUS BASIS FOR AT LEAST 5 YEARS; AND

(II) MAKING THE PANEL AS ETHNICALLY REPRESENTATIVE AS POSSIBLE OF THE COMMUNITY FOR WHICH THE SERVICES ARE PROVIDED.

(9) (I) A CARRIER MAY CHARGE A REASONABLE FEE FOR ANY APPLICATION THAT A PROVIDER SUBMITS UNDER THIS SECTION.

(II) THE FEES AUTHORIZED UNDER THIS PARAGRAPH MAY VARY ACCORDING TO THE TYPE OF APPLICATION.

(E) (1) (I) EACH CARRIER SUBJECT TO THIS SECTION SHALL PROVIDE AN INTERNAL MECHANISM THROUGH WHICH A PROVIDER WHO IS REFUSED PARTICIPATION IN A PROVIDER PANEL OR TERMINATED FROM PARTICIPATION IN A PROVIDER PANEL MAY, ON THE PROVIDER'S WRITTEN REQUEST, OBTAIN A REVIEW OF THE MANNER IN WHICH THE CARRIER'S CRITERIA HAVE BEEN APPLIED TO THE PROVIDER.

(II) A REVIEW UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL BE PROVIDED BY A MULTISPECIALTY COMMITTEE THAT INCLUDES INDIVIDUALS ACTIVELY ENGAGED IN:

1. THE PRACTICE OF THE SPECIALTY OF THE PROVIDER BEING REVIEWED; OR

2. THE PRACTICE OF SPECIALTIES CLOSELY RELATED TO THAT OF THE PROVIDER BEING REVIEWED.

(2) (I) FOR A TERMINATION OF A PROVIDER FROM A PROVIDER PANEL, THE CARRIER SHALL PROVIDE A REVIEW REQUESTED BY THE PROVIDER WITHIN 60 DAYS OF THE REQUEST.

(II) THE FAILURE OF A CARRIER TO PROVIDE THE REVIEW WITHIN 60 DAYS AFTER A REQUEST UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL BE DEEMED AN ACCEPTANCE BY THE CARRIER OF THE PROVIDER'S CONTINUING MEMBERSHIP ON THE CARRIER'S PROVIDER PANEL.

(3) (I) A PROVIDER WHOSE APPLICATION HAS BEEN REJECTED UNDER PARAGRAPH (D)(2) OF THIS SECTION MAY, WITHIN 30 DAYS AFTER WRITTEN NOTICE OF THE REJECTION, APPLY IN WRITING FOR AN APPEAL TO THE MEDICAL DIRECTOR OF THE CARRIER.

(II) AN APPEAL UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL STATE THE BASIS FOR THE APPEAL.

(4) (I) ON RECEIPT OF AN APPEAL MEETING THE REQUIREMENTS OF PARAGRAPH (3) OF THIS SUBSECTION, THE MEDICAL DIRECTOR OF THE CARRIER SHALL REVIEW THE APPLICATION AND MAY MEET WITH THE PROVIDER WITH RESPECT TO THE APPLICATION AND THE REJECTION.

(II) IF THE MEDICAL DIRECTOR FINDS THAT THE REJECTION OF THE APPLICATION WAS MADE IN ACCORDANCE WITH THE CRITERIA AND THE PROCEDURES ESTABLISHED BY THE CARRIER UNDER SUBSECTION (C) OF THIS SECTION, THE MEDICAL DIRECTOR MAY AFFIRM THE DECISION OF THE REVIEW COMMITTEE.

(F) THIS SECTION DOES NOT PROHIBIT A CARRIER FROM:

(1) REQUIRING PREAUTHORIZATION OR UTILIZATION REVIEW; OR

(2) ESTABLISHING REASONABLE PROFESSIONAL QUALIFICATIONS APPLICABLE TO ALL PROVIDERS OF THE SAME TYPE, PROFESSION, AND SPECIALTY.

(G) (1) THE MARKETING MATERIALS OF A CARRIER SHALL LIST MEMBERS OF ITS PROVIDER PANEL AND SHALL BE UPDATED IMMEDIATELY PRIOR TO THE DISTRIBUTION OF MARKETING MATERIALS FOR AN OPEN ENROLLMENT PERIOD, BUT AT LEAST ONCE A YEAR.

(2) ALL MEMBERSHIP ENROLLMENT MATERIALS SHALL CLEARLY INDICATE:

(I) THE OFFICE WITHIN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR THE ADMINISTRATION THAT IS RESPONSIBLE FOR RECEIVING AND RESPONDING TO ENROLLEES' COMPLAINTS CONCERNING CARRIERS;

(II) THE TELEPHONE NUMBER OF THE OFFICE IN SUBPARAGRAPH (I) OF THIS PARAGRAPH; AND

(III) THE PROCESS FOR AN ENROLLEE TO FILE A COMPLAINT CONCERNING A CARRIER.

(H) (1) A CARRIER THAT TERMINATES A PARTICIPATING PROVIDER FOR REASONS OTHER THAN PROFESSIONAL COMPETENCE SHALL CONTINUE TO REIMBURSE THE PROVIDER FOR A PERIOD OF AT LEAST 60 DAYS FOR THE PROVIDER'S SERVICES TO THE CARRIER'S ENROLLEES WHO ELECT TO CONTINUE WITH THE PROVIDER.

(2) REIMBURSEMENT UNDER THIS SUBSECTION SHALL BE THE LESSER OF:

(I) THE RATE USED BY THE CARRIER TO REIMBURSE NONPARTICIPATING PROVIDERS; OR

(II) THE USUAL AND CUSTOMARY RATE OF THE PROVIDER.

(I) THE COMMISSIONER AND THE SECRETARY OF HEALTH AND MENTAL HYGIENE JOINTLY SHALL ADOPT REGULATIONS TO MAXIMIZE THE OPPORTUNITY OF A BROAD RANGE OF MINORITY PROVIDERS TO PARTICIPATE IN THE DELIVERY OF HEALTH CARE SERVICES.

657.

(a) If a preferred provider insurance policy offered by an insurer provides benefits for any service that is within the lawful scope of practice of a healthcare provider licensed under the Health Occupations Article, any insured covered by the preferred provider insurance policy shall be entitled to receive the benefits for that service either through direct payments to the provider or to reimbursement to the insured.

(b) (1) A preferred provider insurance policy offered by an insurer under this subtitle shall provide for payment of services rendered by nonpreferredproviders as provided under this section.

(2) Unless the insurer demonstrates to the satisfaction of the Insurance Commissioner that an alternative level of payment is more appropriate under the circumstances, aggregate payments in any full calendar year made under this paragraph to nonpreferred providers after all deductible and copayment provisions have been applied may not on the average be less than 80 percent of the aggregate payments in that full calendar year to preferred providers for similar services in the same geographic area pursuant to the providers' agreements to provide the services under their provider service agreements.

(c) If the rates for each institutional provider under a preferred provider insurance policy offered by an insurer vary based upon individual negotiations, geographic differences, or market conditions and are approved by the Health Services Cost Review Commission, the rates may not be deemed to constitute unfair discrimination under this article.

Article - Health - General

19-710.

(R) A HEALTH MAINTENANCE ORGANIZATION IS SUBJECT TO THE PROVISIONS OF ARTICLE 48A, § 657 OF THE CODE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1996.