SENATE BILL 719

C3 8lr2504
CF 8lr2844

By: **Senator Klausmeier**
Introduced and read first time: February 1, 2008
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Carrier Provider Panels – Standards for Availability of Health Care Providers

FOR the purpose of requiring certain standards, maintained by certain health insurance carriers for certain availability of certain health care providers, to be submitted to, and approved by, the Maryland Insurance Commissioner each year; requiring the Commissioner to require certain health insurance carriers to submit certain data to the Commissioner for review in making a certain determination and a certain assessment about certain standards; and generally relating to carrier provider panels under health insurance.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–112(a)(1), (3), (5), (6), (7), and (8)
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–112(b)
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

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

Article – Insurance

15–112.

(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.

(3) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

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

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

(5) "Enrollee" means a person entitled to health care benefits from a carrier.

(6) "Hospital" has the meaning stated in § 19–301 of the Health – General Article.

(7) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(8) (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

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

(b) (1) A carrier that uses a provider panel shall:

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

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

3. if the carrier is an insurer or nonprofit health service plan that offers a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers, adhere to the standards for accessibility of

covered services in accordance with regulations adopted under § 19–705.1(b)(1)(ii) of the Health – General Article and as enforced by the Secretary of Health and Mental Hygiene; and

(ii) establish procedures to:

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

2. notify an enrollee of:

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

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

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

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

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

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

(3) (I) THE STANDARDS MAINTAINED BY A CARRIER THAT IS AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR DENTAL PLAN ORGANIZATION FOR AVAILABILITY OF PROVIDERS TO MEET THE HEALTH CARE NEEDS OF ENROLLEES SHALL BE SUBMITTED TO, AND APPROVED BY, THE COMMISSIONER ANNUALLY.

(II) TO DETERMINE WHETHER THE STANDARDS OF THE CARRIER ARE ADEQUATE AND TO ASSESS THE CARRIER'S PERFORMANCE IN MEETING THE STANDARDS, THE COMMISSIONER SHALL REQUIRE THE CARRIER TO SUBMIT QUANTIFIABLE AND MEASURABLE DATA TO THE COMMISSIONER FOR REVIEW, INCLUDING:

1. INFORMATION ON:

A. APPOINTMENT WAIT TIMES;

B. PROVIDER–ENROLLEE RATIOS BY SPECIALTY;

C. PRIMARY CARE PROVIDER–ENROLLEE RATIOS;

D. GEOGRAPHIC ACCESSIBILITY;

E. HOURS OF OPERATION;

F. THE PERCENTAGE OF ENROLLEES WHO WERE PROVIDED SERVICES IN A HOSPITAL BY OUT–OF–NETWORK PROVIDERS; AND

G. THE PERCENTAGE OF ENROLLEES WHO WERE PROVIDED SERVICES OUTSIDE OF A HOSPITAL BY OUT–OF–NETWORK PROVIDERS; AND

2. ANY OTHER INFORMATION THAT THE COMMISSIONER REQUIRES.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2008.