CHAPTER 688

(House Bill 1219)

AN ACT concerning

Health Insurance – Health Care Provider Panels – Provider Contracts

FOR the purpose of repealing a prohibition that certain health insurance carriers that offer coverage for health care services in a certain manner may not require certain health care providers to serve on certain provider panels under certain circumstances; repealing a certain exception to the prohibition; repealing certain requirements for providers that elect to terminate participation on certain provider panels; prohibiting certain provider contracts from containing a provision that requires certain health care providers to participate in certain provider panels under certain circumstances; authorizing certain provider contracts to contain a requirement that certain providers participate in a certain managed care organization under certain circumstances; requiring certain provider contracts to disclose certain information; prohibiting certain provider contracts from containing a provision requiring providers to accept certain schedules of fees under certain circumstances; prohibiting a provider contract from requiring providers to treat certain enrollees of certain carriers under certain circumstances; authorizing a provider contract, notwithstanding certain provisions of law, to include a provision that requires a provider, as a condition of participation, to accept a certain schedule of applicable fees; providing for a certain exception; requiring a provider that elects to terminate participation on a certain provider panel to provide certain notification and continue to furnish certain health care services for a certain period of time; providing for the application of this Act; providing for a delayed effective date; making certain provisions of law applicable to health maintenance organizations; defining certain terms; making stylistic changes; and generally relating to health care provider panels and provider contracts under health insurance.

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

BY repealing
Article – Insurance
Section 15–112(l)
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

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

BY adding to
Article – Insurance
Section 15–112.2
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–706(i)
Annotated Code of Maryland
(2005 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.

(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.

(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.

[(l) (1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Health benefit plan" has the meaning stated in § 15–1201 of this title.

2. "Health benefit plan" includes dental plans and other health benefit plans that contract with dentists to offer dental care services.

(iii) "Provider panel" includes 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.

(2) Except as provided in paragraph (3) of this subsection, a carrier that offers coverage for health care services through one or more health benefit plans or contracts with providers to offer health care services through one or more provider panels may not require a provider, as a condition of participation or continuation on a provider panel for one health benefit plan of a carrier, to serve also on a provider panel of another health benefit plan of the carrier.

(3) Subject to § 15–102.5 of the Health – General Article, a carrier that offers health care services as a managed care organization as defined under § 15–101(e) of the Health – General Article, may require a provider, as a condition of participation on a provider panel for one or more health benefit plans of the carrier, to serve on a provider panel of the managed care organization.

(4) If a provider elects to terminate participation on the provider panel of a health benefit plan, the provider shall:

(i) notify the carrier at least 90 days before the date of termination; and

(ii) for at least 90 days after the date of the notice of termination, continue to furnish health care services to an enrollee of the carrier for whom the provider was responsible for the delivery of health care services prior to the notice of termination.**]**

[(m)**] (L)** A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

(1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;

(2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider, ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or

(3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.

[(n)**] (M)** (1) A carrier shall update its provider information under subsection (j)(3)(ii) of this section within 15 working days after receipt of written notification from the participating provider of a change in the applicable information.

(2) Notification is presumed to have been received by a carrier:

(i) 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or

(ii) on the date recorded by the courier, if the notification was delivered by courier.

[(o)**] (N)** (1) A carrier may not require a provider that provides health care services through a group practice or health care facility that participates on the carrier's provider panel under a contract with the carrier to be considered a participating provider or accept the reimbursement fee schedule applicable under the contract when:

(i) providing health care services to enrollees of the carrier through an individual or group practice or health care facility that does not have a contract with the carrier; and

(ii) billing for health care services provided to enrollees of the carrier using a different federal tax identification number than that used by the group practice or health care facility under a contract with the carrier.

(2) A nonparticipating provider shall notify an enrollee:

(i) that the provider does not participate on the provider panel of the enrollee's carrier; and

(ii) of the anticipated total charges for the health care services.

[(p)**] (O)** The provisions of subsection (d)(3)(iii) of this section do not apply to a carrier that uses a credentialing intermediary that:

(1) is a hospital or academic medical center;

(2) is a participating provider on the carrier's provider panel; and

(3) acts as a credentialing intermediary for that carrier for health care practitioners that:

(i) participate on the carrier's provider panel; and

(ii) have privileges at the hospital or academic medical center.

15–112.2.

(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; OR

(IV) A DENTAL PLAN ORGANIZATION.

(3) "DENTAL PROVIDER PANEL" MEANS A PROVIDER PANEL FOR ONE OR MORE DENTAL PLAN ~~ORGANIZATIONS~~ ORGANIZATIONS, INSURERS, OR NONPROFIT HEALTH SERVICE PLANS OFFERING CONTRACTS ONLY FOR DENTAL SERVICES.

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

(5) "HMO PROVIDER PANEL" MEANS A PROVIDER PANEL FOR ONE OR MORE HEALTH MAINTENANCE ORGANIZATIONS.

(6) "MANAGED CARE ORGANIZATION" HAS THE MEANING STATED IN § 15–101 OF THE HEALTH – GENERAL ARTICLE.

(7) "NON–HMO PROVIDER PANEL" MEANS A PROVIDER PANEL FOR ONE OR MORE NONPROFIT HEALTH SERVICE PLANS OR INSURERS.

(8) "PROVIDER" HAS THE MEANING STATED IN § 19–701 OF THE HEALTH – GENERAL ARTICLE.

(9) "PROVIDER CONTRACT" MEANS A CONTRACT:

(I) BETWEEN A PROVIDER AND A CARRIER, AN AFFILIATE OF A CARRIER, OR AN ENTITY THAT CONTRACTS WITH A PROVIDER TO SERVE A CARRIER; AND

(II) UNDER WHICH THE PROVIDER AGREES TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES.

(10) "PROVIDER PANEL" MEANS THE PROVIDERS THAT CONTRACT EITHER DIRECTLY OR THROUGH A SUBCONTRACTING ENTITY WITH A CARRIER TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES.

(B) (1) A PROVIDER CONTRACT MAY NOT CONTAIN A PROVISION THAT REQUIRES A PROVIDER, AS A CONDITION OF PARTICIPATING IN A NON–HMO PROVIDER PANEL, TO PARTICIPATE IN AN HMO PROVIDER PANEL OR DENTAL PROVIDER PANEL.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, A PROVIDER CONTRACT MAY CONTAIN A PROVISION THAT REQUIRES A PROVIDER, AS A CONDITION OF PARTICIPATING IN A NON–HMO PROVIDER PANEL, AN HMO PROVIDER PANEL, OR A DENTAL PROVIDER PANEL, TO PARTICIPATE IN A MANAGED CARE ORGANIZATION.

(C) (1) THIS SUBSECTION DOES NOT APPLY TO A PROVIDER CONTRACT FOR A DENTAL PROVIDER PANEL.

(2) EACH PROVIDER CONTRACT SHALL DISCLOSE:

~~(1)~~ THE CARRIERS COMPRISING EACH PROVIDER PANEL~~; AND~~

~~(2) ALL SCHEDULES OF APPLICABLE FEES FOR UP TO THE 20 MOST COMMON SERVICES BILLED BY A PROVIDER IN THE SAME SPECIALTY AS THE PROVIDER FOR EACH PROVIDER PANEL AND EACH CARRIER IN THE PROVIDER PANEL~~.

(D) (1) THIS SUBSECTION DOES NOT APPLY TO A PROVIDER CONTRACT FOR A DENTAL PROVIDER PANEL.

(2) IF A PROVIDER CONTRACT INCLUDES MORE THAN ONE SCHEDULE OF APPLICABLE FEES, THE PROVIDER CONTRACT MAY NOT CONTAIN A PROVISION THAT REQUIRES A PROVIDER AS A CONDITION OF PARTICIPATION TO ACCEPT EACH SCHEDULE OF APPLICABLE FEES INCLUDED IN THE PROVIDER CONTRACT.

~~(2)~~ (3) IF A PROVIDER REJECTS A SCHEDULE OF APPLICABLE FEES, THE PROVIDER CONTRACT MAY NOT REQUIRE THE PROVIDER TO TREAT THE ENROLLEES OF THE CARRIERS THAT REIMBURSE THE PROVIDER IN ACCORDANCE WITH ANY OF THE REJECTED SCHEDULES OF APPLICABLE FEES.

(4) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (1) OF THIS SUBSECTION, A PROVIDER CONTRACT MAY INCLUDE A PROVISION THAT REQUIRES A PROVIDER, AS A CONDITION OF PARTICIPATION, TO ACCEPT EACH SCHEDULE OF APPLICABLE FEES FOR A CARRIER THAT IS NOT AFFILIATED THROUGH COMMON OWNERSHIP WITH THE ENTITY ARRANGING THE PROVIDER PANEL.

(E) IF A PROVIDER ELECTS TO TERMINATE PARTICIPATION ON A PROVIDER PANEL, THE PROVIDER SHALL:

(1) NOTIFY THE CARRIER AT LEAST 90 DAYS BEFORE THE DATE OF TERMINATION; AND

(2) FOR AT LEAST 90 DAYS AFTER THE DATE OF THE NOTICE OF TERMINATION, CONTINUE TO FURNISH HEALTH CARE SERVICES TO AN ENROLLEE OF THE CARRIER FOR WHOM THE PROVIDER WAS RESPONSIBLE FOR THE DELIVERY OF HEALTH CARE SERVICES BEFORE THE NOTICE OF TERMINATION.

Article – Health – General

19–706.

(i) The provisions of §§ 12–203(g), 15–105, 15–112, **15–112.2,** 15–113, 15–804, 15–812, 15–826, 15–828, and 15–836 of the Insurance Article shall apply to health maintenance organizations.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all provider contracts issued or ~~delivered~~ *renewed* in the State on or after ~~January 1~~ *October 1*, 2009, or, for provider contracts in effect in the State on ~~January 1~~ *October 1*, 2009, but not subject to renewal ~~in 2009~~ *before October 1, 2010*, no later than ~~December 31, 2009~~ *October 1, 2010*.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~June 1, 2008~~ ~~January 1~~ *October 1*, 2009.

Approved by the Governor, May 22, 2008.