

HOUSE BILL 1318

C3

(6lr2562)

ENROLLED BILL

— Health and Government Operations/Finance —

Introduced by **Delegates Kelly, Angel, Cullison, Hill, Pena-Melnyk, Sample-Hughes, ~~and West West, Hammen, Barron, Bromwell, Hayes, Kipke, Krebs, McDonough, McMillan, Miele, Morgan, Morhaim, Oaks, Pendergrass, Rose, Saab, and K. Young~~**

Read and Examined by Proofreaders:

Proofreader.

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of _____ at _____ o'clock, _____ M.

Speaker.

CHAPTER _____

1 AN ACT concerning

2 **Health Benefit Plans – Network Access Standards and**
3 **Provider Network Directories**

4 FOR the purpose of requiring certain carriers to maintain or adhere to certain standards
5 that ensure that certain enrollees have certain access to certain health care providers
6 and covered services; requiring certain carriers to file with the Maryland Insurance
7 Commissioner, on or before a certain date and then annually, a certain plan for a
8 certain review ~~and approval~~; requiring certain carriers to notify the Commissioner
9 of a certain change within a certain time period under certain circumstances;
10 requiring a certain notice to include certain information; ~~authorizing certain carriers~~
11 ~~to request that the Commissioner deem certain information as confidential~~
12 ~~information; requiring certain carriers to make a certain plan available to the public~~

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Italics indicate opposite chamber/conference committee amendments.



~~in a certain manner~~ authorizing the Commissioner to order corrective action under certain circumstances; requiring the Commissioner to deny inspection of the parts of a certain plan that contain certain confidential information; requiring certain regulations to identify the parts of a certain plan that may be considered confidential by the carrier; requiring a certain plan to include certain information; requiring certain carriers to monitor a certain clinical capacity of certain providers in a certain manner; requiring the Commissioner, in consultation with certain persons, to adopt certain regulations on or before a certain date; ~~establishing that certain carriers meet certain requirements by developing and making available to certain individuals a certain network directory; requiring certain carriers to develop and make available to certain individuals a certain network directory on the Internet and in printed form under certain circumstances; requiring a certain network directory to meet certain requirements and include certain information; requiring certain carriers to update a certain network directory within a certain time period under certain circumstances;~~ authorizing the Commissioner to take into consideration certain factors in adopting the regulations; requiring the Commissioner, in consultation with certain persons, to adopt regulations, on or before a certain date, that specify certain standards for dental services; requiring a carrier to have certain means by which enrollees and prospective enrollees may notify the carrier of certain information; requiring certain carriers, at certain occurrences, to notify enrollees how to access or obtain certain information; requiring certain information to be updated at certain intervals; requiring certain carriers periodically to review a certain sample of their network directory for a certain purpose and retain documentation of the review or to contact certain providers to make a certain determination under certain circumstances; ~~requiring certain carriers to treat certain services in a certain manner for a certain purpose under certain circumstances;~~ altering a certain requirement on certain carriers to update certain information; requiring certain certification standards established by the Maryland Health Benefit Exchange to be consistent with certain provisions of law and prohibiting the standards from being implemented before a certain date; requiring a certain carrier to make the carrier's network directory available to certain enrollees in a certain manner; requiring a certain carrier's network directory to include certain information; requiring a certain carrier to notify each enrollee at certain times about how to obtain certain information; requiring certain information to be accurate on a certain date; requiring a certain carrier to update certain information at certain intervals; requiring the Commissioner to take into account certain factors before imposing a penalty on a certain carrier for inaccurate network directory information; requiring certain procedures established by certain carriers to ensure that certain requests are addressed in a certain manner; prohibiting a certain procedure established by certain carriers from being used for a certain purpose; requiring certain carriers to have a certain system in place for a certain purpose and to provide certain information to the Commissioner under certain circumstances; requiring certain carriers to file with the Commissioner a copy of certain procedures that includes certain information; requiring certain carriers to make a copy of certain procedures available to certain individuals in a certain manner and under certain circumstances; specifying the provisions of State insurance law relating to provider panels that apply to managed care organizations; repealing a requirement that certain carriers that use provider panels adhere to

1 certain standards for accessibility of covered services in accordance with certain
 2 regulations; repealing a requirement that certain standards for health maintenance
 3 organizations set out in regulations adopted by the Secretary of Health and Mental
 4 Hygiene include provisions for assuring that certain services are accessible;
 5 repealing a certain condition for an insurer or nonprofit health service plan to receive
 6 authorization from the Commissioner to offer a certain insurance policy; authorizing
 7 the Commissioner to designate a certain system under certain circumstances;
 8 requiring a carrier to accept certain information for a provider submitted in a certain
 9 manner, from certain persons; defining certain terms; making conforming changes;
 10 providing for the application of certain provisions of this Act; providing for a delayed
 11 effective date for certain provisions of this Act; and generally relating to health
 12 benefit plans, network access standards, and provider network directories.

13 BY repealing and reenacting, with amendments,

14 Article – Health – General
 15 Section 15–102.3(a) and 19–705.1(b)(1)(i)
 16 Annotated Code of Maryland
 17 (2015 Replacement Volume)

18 BY repealing and reenacting, without amendments,

19 Article – Health – General
 20 Section 19–705.1(a)
 21 Annotated Code of Maryland
 22 (2015 Replacement Volume)

23 BY repealing and reenacting, with amendments,

24 Article – Insurance
 25 Section ~~15–112~~ 14–205.1(a), 15–112, and 15–830
 26 Annotated Code of Maryland
 27 (2011 Replacement Volume and 2015 Supplement)

28 BY repealing and reenacting, with amendments,

29 Article – Insurance
 30 Section ~~15–112(n)~~ 15–112(b)(1)(i), (n), and (p)
 31 Annotated Code of Maryland
 32 (2011 Replacement Volume and 2015 Supplement)
 33 (As enacted by Section 1 of this Act)

34 BY adding to

35 Article – Insurance
 36 Section 15–112.3 and 31–115(m)
 37 Annotated Code of Maryland
 38 (2011 Replacement Volume and 2015 Supplement)

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

Article – Health – General15–102.3.

(a) ~~The provisions of [§ 15–112] § 15–112(B)(1)(II) AND (2), (E) THROUGH (L), (Q), (R), AND (T) (F) THROUGH (M), (R), (S), AND (U) THROUGH (W) of the Insurance Article (Provider panels) shall apply to managed care organizations in the same manner they apply to carriers.~~

~~19–705.1.~~

~~(a) The Secretary shall adopt regulations that set out reasonable standards of quality of care that a health maintenance organization shall provide to its members.~~

~~(b) (1) The standards of quality of care shall include:~~

~~(i) 1. A requirement that a health maintenance organization shall provide for regular hours during which a member may receive services, including providing for services to a member in a timely manner that takes into account the immediacy of need for services; and~~

~~2. Provisions for assuring that all covered services, including any services for which the health maintenance organization has contracted, are accessible to the enrollee with reasonable safeguards with respect to geographic locations; and~~

~~Article – Insurance~~~~14–205.1.~~

~~(a) The Commissioner may authorize an insurer or nonprofit health service plan to offer a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers if the insurer or nonprofit health service plan:~~

~~(1) has demonstrated to the Secretary of Health and Mental Hygiene that the provider panel of the insurer or nonprofit health service plan complies with the regulations adopted under § 19–705.1(b)(1)(i)2 of the Health – General Article; and~~

~~(2) does not restrict payment for covered services provided by nonpreferred providers;~~

~~(i) (1) for emergency services, as defined in § 19–701 of the Health – General Article;~~

~~(ii) (2) for an unforeseen illness, injury, or condition requiring immediate care; or~~

1 ~~[(iii)] (3) as required under § 15-830 of this article.~~

2 **Article – Insurance**

3 15–112.

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

5 (2) “Accredited hospital” has the meaning stated in § 19–301 of the Health
6 – General Article.

7 (3) “Ambulatory surgical facility” has the meaning stated in § 19–3B–01 of
8 the Health – General Article.

9 (4) (i) “Carrier” means:

- 10 1. an insurer;
- 11 2. a nonprofit health service plan;
- 12 3. a health maintenance organization;
- 13 4. a dental plan organization; or
- 14 5. any other person that provides health benefit plans
15 subject to regulation by the State.

16 (ii) “Carrier” includes an entity that arranges a provider panel for a
17 carrier.

18 (5) “Credentialing intermediary” means a person to whom a carrier has
19 delegated credentialing or recredentialing authority and responsibility.

20 (6) “Enrollee” means a person entitled to health care benefits from a
21 carrier.

22 **(7) “HEALTH BENEFIT PLAN”:**

23 **(I) FOR A GROUP OR BLANKET PLAN IN THE LARGE GROUP**
24 **MARKET, HAS THE MEANING STATED IN § 15–1401 OF THIS TITLE;**

25 **(II) FOR A GROUP IN THE SMALL GROUP MARKET, HAS THE**
26 **MEANING STATED IN § 31–101 OF THIS ARTICLE; AND**

27 **(III) FOR AN INDIVIDUAL PLAN, HAS THE MEANING STATED IN §**
28 **15–1301 OF THIS TITLE.**

1 **(8) (I) “HEALTH CARE FACILITY” MEANS ~~A FIXED OR MOBILE~~**
 2 **~~FACILITY AT WHICH DIAGNOSTIC OR TREATMENT SERVICES OR INPATIENT OR~~**
 3 **~~AMBULATORY CARE ARE OFFERED TO TWO OR MORE UNRELATED INDIVIDUALS A~~**
 4 **HEALTH CARE SETTING OR INSTITUTION PROVIDING PHYSICAL, MENTAL, OR**
 5 **SUBSTANCE USE DISORDER HEALTH CARE SERVICES.**

6 **(II) “HEALTH CARE FACILITY” INCLUDES:**

- 7 **1. A HOSPITAL;**
- 8 **2. AN AMBULATORY SURGICAL OR TREATMENT CENTER;**
- 9 **3. A SKILLED NURSING FACILITY;**
- 10 **4. A RESIDENTIAL TREATMENT CENTER;**
- 11 **5. AN URGENT CARE CENTER;**
- 12 **6. A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER;**
- 13 **7. A REHABILITATION FACILITY; AND**
- 14 **8. ANY OTHER THERAPEUTIC HEALTH CARE SETTING.**

15 **[(7)] (9)** “Hospital” has the meaning stated in § 19–301 of the
 16 Health – General Article.

17 **(10) “NETWORK” MEANS A CARRIER’S PARTICIPATING PROVIDERS**
 18 **AND THE HEALTH CARE FACILITIES WITH WHICH A CARRIER CONTRACTS TO**
 19 **PROVIDE HEALTH CARE SERVICES TO THE CARRIER’S ENROLLEES UNDER THE**
 20 **CARRIER’S HEALTH BENEFIT PLAN.**

21 **(11) “NETWORK DIRECTORY” MEANS A LIST OF A CARRIER’S**
 22 **PARTICIPATING PROVIDERS AND PARTICIPATING HEALTH CARE FACILITIES.**

23 **[(8)] ~~(10)~~ (12)** “Participating provider” means a provider on a carrier’s
 24 provider panel.

25 **[(9)] ~~(11)~~ (13)** “Online credentialing system” means the system through
 26 which a provider may access an online provider credentialing application that the
 27 Commissioner has designated as the uniform credentialing form under § 15–112.1(e) of this
 28 subtitle.

1 [(10)] ~~(12)~~ (14) “Provider” means a health care practitioner or group of
 2 health care practitioners licensed, certified, or otherwise authorized by law to provide
 3 health care services.

4 [(11)] ~~(13)~~ (15) (i) “Provider panel” means the providers that contract
 5 either directly or through a subcontracting entity with a carrier to provide health care
 6 services to the carrier’s enrollees under the carrier’s health benefit plan.

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

10 (b) (1) [A] SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, A carrier
 11 that uses a provider panel shall:

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

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

19 ~~3. if the carrier is an insurer or nonprofit health service plan~~
 20 ~~that offers a preferred provider insurance policy that conditions the payment of benefits on~~
 21 ~~the use of preferred providers, adhere to the standards for accessibility of covered services~~
 22 ~~in accordance with regulations adopted under § 19-705.1(b)(1)(i)2 of the Health – General~~
 23 ~~Article and as enforced by the Secretary of Health and Mental Hygiene; and~~

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

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

31 3. if the carrier is an insurer or nonprofit health service plan
 32 that offers a preferred provider insurance policy that conditions the payment of benefits on
 33 the use of preferred providers, adhere to the standards for accessibility of covered services in
 34 accordance with regulations adopted under § 19-705.1(b)(1)(i)2 of the Health – General
 35 Article and as enforced by the Secretary of Health and Mental Hygiene; and

36 (ii) establish procedures to:

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

3 2. notify an enrollee of:

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

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

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

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

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

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

23 **(3) FOR A CARRIER THAT IS AN INSURER, A NONPROFIT HEALTH**
24 **SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, THE STANDARDS**
25 **REQUIRED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION SHALL:**

26 **(I) ENSURE THAT ALL ENROLLEES, INCLUDING ADULTS AND**
27 **CHILDREN, HAVE ACCESS TO PROVIDERS AND COVERED SERVICES WITHOUT**
28 **UNREASONABLE TRAVEL OR DELAY; AND**

29 **(II) 1. INCLUDE STANDARDS THAT ENSURE ACCESS TO**
30 **PROVIDERS, INCLUDING ESSENTIAL COMMUNITY PROVIDERS, THAT SERVE**
31 **PREDOMINANTLY LOW-INCOME AND MEDICALLY UNDERSERVED INDIVIDUALS; OR**

32 **2. FOR A CARRIER THAT PROVIDES A MAJORITY OF**
33 **COVERED PROFESSIONAL SERVICES THROUGH PHYSICIANS EMPLOYED BY A SINGLE**
34 **CONTRACTED MEDICAL GROUP AND THROUGH HEALTH CARE PROVIDERS**

1 EMPLOYED BY THE CARRIER, INCLUDE ALTERNATIVE STANDARDS FOR ADDRESSING
2 THE NEEDS OF LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS.

3 (C) (1) THIS SUBSECTION APPLIES TO A CARRIER THAT:

4 (I) IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A
5 HEALTH MAINTENANCE ORGANIZATION; AND

6 (II) USES A PROVIDER PANEL FOR A HEALTH BENEFIT PLAN
7 OFFERED BY THE CARRIER.

8 (2) (I) ON OR BEFORE JULY 1, 2018, AND ANNUALLY THEREAFTER,
9 A CARRIER SHALL FILE WITH THE COMMISSIONER FOR REVIEW ~~AND APPROVAL~~ BY
10 THE COMMISSIONER AN ACCESS PLAN THAT MEETS THE REQUIREMENTS OF
11 SUBSECTION (B) OF THIS SECTION AND ANY REGULATIONS ADOPTED BY THE
12 COMMISSIONER UNDER SUBSECTIONS (B) AND (D) OF THIS SECTION.

13 (II) IF THE CARRIER MAKES A MATERIAL CHANGE TO THE
14 ~~PROVIDER NETWORK~~ ACCESS PLAN, THE CARRIER SHALL:

15 1. NOTIFY THE COMMISSIONER OF THE CHANGE WITHIN
16 15 BUSINESS DAYS AFTER THE CHANGE OCCURS; AND

17 2. INCLUDE IN THE NOTICE REQUIRED UNDER ITEM 1 OF
18 THIS SUBPARAGRAPH A REASONABLE TIMEFRAME WITHIN WHICH THE CARRIER
19 WILL FILE WITH THE COMMISSIONER AN UPDATE TO THE EXISTING ACCESS PLAN
20 FOR REVIEW ~~AND APPROVAL~~ BY THE COMMISSIONER.

21 (III) THE COMMISSIONER MAY ORDER CORRECTIVE ACTION IF,
22 AFTER REVIEW, THE ACCESS PLAN IS DETERMINED NOT TO MEET THE
23 REQUIREMENTS OF THIS SUBSECTION.

24 ~~(3) (I) A CARRIER MAY REQUEST THAT THE COMMISSIONER DEEM~~
25 ~~INFORMATION IN THE ACCESS PLAN FILED UNDER THIS SUBSECTION AS~~
26 ~~CONFIDENTIAL INFORMATION UNDER § 4-335 OF THE GENERAL PROVISIONS~~
27 ~~ARTICLE.~~

28 ~~(II) A CARRIER SHALL MAKE THE ACCESS PLAN FILED UNDER~~
29 ~~THIS SUBSECTION AVAILABLE TO THE PUBLIC ON THE CARRIER'S WEB SITE AFTER~~
30 ~~REDACTION OF ANY INFORMATION DEEMED CONFIDENTIAL INFORMATION BY THE~~
31 ~~COMMISSIONER.~~

32 (3) (I) IN ACCORDANCE WITH § 4-335 OF THE GENERAL
33 PROVISIONS ARTICLE, THE COMMISSIONER SHALL DENY INSPECTION OF THE

1 PARTS OF THE ACCESS PLAN FILED UNDER THIS SUBSECTION THAT CONTAIN
2 CONFIDENTIAL COMMERCIAL INFORMATION OR CONFIDENTIAL FINANCIAL
3 INFORMATION.

4 (II) THE REGULATIONS ADOPTED BY THE COMMISSIONER
5 UNDER SUBSECTION (D) OF THIS SECTION SHALL IDENTIFY THE PARTS OF THE
6 ACCESS PLAN THAT MAY BE CONSIDERED CONFIDENTIAL BY THE CARRIER.

7 (4) AN ACCESS PLAN FILED UNDER THIS SUBSECTION SHALL
8 INCLUDE A DESCRIPTION OF:

9 (I) THE CARRIER'S NETWORK, INCLUDING HOW
10 TELEMEDICINE, TELEHEALTH, OR OTHER TECHNOLOGY MAY BE USED TO MEET
11 NETWORK ACCESS STANDARDS REQUIRED UNDER SUBSECTION (B) OF THIS
12 SECTION;

13 (II) THE CARRIER'S PROCESS FOR MONITORING AND ENSURING,
14 ON AN ONGOING BASIS, THE SUFFICIENCY OF THE NETWORK TO MEET THE HEALTH
15 CARE NEEDS OF ENROLLEES;

16 (III) THE FACTORS USED BY THE CARRIER TO BUILD ITS
17 PROVIDER NETWORK, INCLUDING:

18 ~~1. IN PLAIN LANGUAGE,~~ THE CRITERIA USED TO SELECT
19 PROVIDERS FOR PARTICIPATION IN THE NETWORK AND, IF APPLICABLE, PLACE
20 PROVIDERS IN NETWORK TIERS; ~~AND~~

21 ~~2. DEMONSTRATION BY THE CARRIER THAT THE~~
22 ~~CRITERIA COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY~~
23 ~~ACT;~~

24 (IV) THE CARRIER'S EFFORTS TO ADDRESS THE NEEDS OF BOTH
25 ADULT AND CHILD ENROLLEES, INCLUDING ADULTS AND CHILDREN WITH:

- 26 1. LIMITED ENGLISH PROFICIENCY OR ILLITERACY;
- 27 2. DIVERSE CULTURAL OR ETHNIC BACKGROUNDS;
- 28 3. PHYSICAL OR MENTAL DISABILITIES; AND
- 29 4. SERIOUS, CHRONIC, OR COMPLEX HEALTH
30 CONDITIONS;

1 (V) 1. THE CARRIER'S EFFORTS TO INCLUDE PROVIDERS,
2 INCLUDING ESSENTIAL COMMUNITY PROVIDERS, IN ITS NETWORK WHO SERVE
3 ~~PREDOMINATELY~~ PREDOMINANTLY LOW-INCOME, MEDICALLY UNDERSERVED
4 INDIVIDUALS; OR

5 2. FOR A CARRIER THAT PROVIDES A MAJORITY OF
6 COVERED PROFESSIONAL SERVICES THROUGH PHYSICIANS EMPLOYED BY A SINGLE
7 CONTRACTED MEDICAL GROUP AND THROUGH HEALTH CARE PROVIDERS
8 EMPLOYED BY THE CARRIER, THE CARRIER'S EFFORTS TO ADDRESS THE NEEDS OF
9 LOW-INCOME, MEDICALLY UNDERSERVED INDIVIDUALS; AND

10 (VI) THE CARRIER'S METHODS FOR ASSESSING THE HEALTH
11 CARE NEEDS OF ENROLLEES AND ENROLLEE SATISFACTION WITH HEALTH CARE
12 SERVICES PROVIDED TO THEM.

13 (5) EACH CARRIER SHALL MONITOR, ON AN ONGOING BASIS ~~AND AT~~
14 ~~LEAST QUARTERLY~~, THE CLINICAL CAPACITY OF ITS PARTICIPATING PROVIDERS TO
15 PROVIDE COVERED SERVICES TO ITS ENROLLEES.

16 (D) (1) ON OR BEFORE DECEMBER 31, 2017, THE COMMISSIONER SHALL,
17 IN CONSULTATION WITH INTERESTED STAKEHOLDERS, ADOPT REGULATIONS TO
18 ESTABLISH QUANTITATIVE AND, IF APPROPRIATE, NONQUANTITATIVE CRITERIA TO
19 EVALUATE THE NETWORK SUFFICIENCY OF HEALTH BENEFIT PLANS SUBJECT TO
20 THE REQUIREMENTS OF SUBSECTION (C) OF THIS SECTION, ~~INCLUDING CRITERIA~~
21 ~~RELATING TO.~~

22 (2) IN ADOPTING THE REGULATIONS, THE COMMISSIONER MAY TAKE
23 INTO CONSIDERATION:

24 ~~(1)~~ (I) GEOGRAPHIC ACCESSIBILITY OF PRIMARY CARE AND
25 SPECIALTY PROVIDERS, INCLUDING MENTAL HEALTH AND SUBSTANCE USE
26 DISORDER PROVIDERS;

27 ~~(2)~~ (II) WAITING TIMES FOR AN APPOINTMENT WITH
28 PARTICIPATING PRIMARY CARE AND SPECIALTY PROVIDERS, INCLUDING MENTAL
29 HEALTH AND SUBSTANCE USE DISORDER PROVIDERS;

30 ~~(3)~~ (III) PRIMARY CARE PROVIDER-TO-ENROLLEE RATIOS;

31 ~~(4)~~ (IV) PROVIDER-TO-ENROLLEE RATIOS, BY SPECIALTY;

32 ~~(5)~~ (V) GEOGRAPHIC VARIATION AND POPULATION DISPERSION;

33 ~~(6)~~ (VI) HOURS OF OPERATION;

1 ~~(7)~~ **(VII) THE ABILITY OF THE NETWORK TO MEET THE NEEDS OF**
2 **ENROLLEES, WHICH MAY INCLUDE:**

3 ~~(I)~~ **1. LOW-INCOME INDIVIDUALS;**

4 ~~(II)~~ **2. ADULTS AND CHILDREN WITH:**

5 ~~1.~~ **A. SERIOUS, CHRONIC, OR COMPLEX HEALTH**
6 **CONDITIONS; OR**

7 ~~2.~~ **B. PHYSICAL OR MENTAL DISABILITIES; AND**

8 ~~(III)~~ **3. INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY**
9 **OR ILLITERACY;**

10 ~~(8)~~ **(VIII) OTHER HEALTH CARE SERVICE DELIVERY SYSTEM OPTIONS,**
11 **INCLUDING TELEMEDICINE, TELEHEALTH, MOBILE CLINICS, AND CENTERS OF**
12 **EXCELLENCE; ~~AND~~**

13 ~~(9)~~ **(IX) THE VOLUME OF TECHNOLOGICAL AND SPECIALTY CARE**
14 **SERVICES AVAILABLE TO SERVE THE NEEDS OF ENROLLEES REQUIRING**
15 **TECHNOLOGICALLY ADVANCED OR SPECIALTY CARE SERVICES;**

16 **(X) ANY STANDARDS ADOPTED BY THE FEDERAL CENTERS FOR**
17 **MEDICARE AND MEDICAID SERVICES SERVICES OR USED BY THE FEDERALLY**
18 **FACILITATED MARKETPLACE; AND**

19 **(XI) ANY STANDARDS ADOPTED BY ANOTHER STATE.**

20 **(E) (1) ON OR BEFORE DECEMBER 31, 2017, FOR A CARRIER THAT IS A**
21 **DENTAL PLAN ORGANIZATION OR AN INSURER OR NONPROFIT HEALTH SERVICE**
22 **PLAN THAT PROVIDES COVERAGE FOR DENTAL SERVICES, THE COMMISSIONER, IN**
23 **CONSULTATION WITH APPROPRIATE STAKEHOLDERS, SHALL ADOPT REGULATIONS**
24 **TO SPECIFY THE STANDARDS UNDER SUBSECTION (B)(1)(I) OF THIS SECTION FOR**
25 **DENTAL SERVICES.**

26 **(2) THE REGULATIONS SHALL:**

27 **(1) ENSURE THAT ALL ENROLLEES, INCLUDING ADULTS AND**
28 **CHILDREN, HAVE ACCESS TO PROVIDERS AND COVERED SERVICES WITHOUT**
29 **UNREASONABLE DELAY AND TRAVEL;**

1 **(II) ENSURE ACCESS TO PROVIDERS, INCLUDING ESSENTIAL**
2 **COMMUNITY PROVIDERS, THAT SERVE PREDOMINANTLY LOW-INCOME, MEDICALLY**
3 **UNDERSERVED INDIVIDUALS; AND**

4 **(III) REQUIRE THE CARRIER TO SPECIFY HOW THE CARRIER**
5 **WILL MONITOR, ON AN ONGOING BASIS, THE ABILITY OF ITS PARTICIPATING**
6 **PROVIDERS TO PROVIDE COVERED SERVICES TO ITS ENROLLEES.**

7 **(3) IN ESTABLISHING THE STANDARDS FOR DENTAL SERVICES, THE**
8 **COMMISSIONER MAY CONSIDER THE APPROPRIATENESS OF QUANTITATIVE AND**
9 **NONQUANTITATIVE CRITERIA.**

10 **[(c)] ~~(E)~~ (F)** A carrier that uses a provider panel:

11 (1) on request, shall provide an application and information that relates to
12 consideration for participation on the carrier's provider panel to any provider seeking to
13 apply for participation;

14 (2) shall make publicly available its application; and

15 (3) shall make efforts to increase the opportunity for a broad range of
16 minority providers to participate on the carrier's provider panel.

17 **[(d)] ~~(E)~~ (G)** (1) A provider that seeks to participate on a provider panel of a
18 carrier shall submit an application to the carrier.

19 (2) (i) Subject to paragraph (3) of this subsection, the carrier, after
20 reviewing the application, shall accept or reject the provider for participation on the
21 carrier's provider panel.

22 (ii) If the carrier rejects the provider for participation on the carrier's
23 provider panel, the carrier shall send to the provider at the address listed in the application
24 written notice of the rejection.

25 (3) (i) Subject to paragraph (4) of this subsection, within 30 days after
26 the date a carrier receives a completed application, the carrier shall send to the provider at
27 the address listed in the application written notice of:

28 1. the carrier's intent to continue to process the provider's
29 application to obtain necessary credentialing information; or

30 2. the carrier's rejection of the provider for participation on
31 the carrier's provider panel.

1 (ii) The failure of a carrier to provide the notice required under
2 subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to
3 the penalties provided by § 4–113(d) of this article.

4 (iii) Except as provided in subsection [(o)] ~~(u)~~ (v) of this section, if,
5 under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its
6 intent to continue to process the provider’s application to obtain necessary credentialing
7 information, the carrier, within 120 days after the date the notice is provided, shall:

8 1. accept or reject the provider for participation on the
9 carrier’s provider panel; and

10 2. send written notice of the acceptance or rejection to the
11 provider at the address listed in the application.

12 (iv) The failure of a carrier to provide the notice required under
13 subparagraph (iii)2 of this paragraph is a violation of this article and the carrier is subject
14 to the provisions of and penalties provided by §§ 4–113 and 4–114 of this article.

15 (4) (i) 1. Except as provided in subsubparagraph 4 of this
16 subparagraph, a carrier that receives a complete application shall notify the provider that
17 the application is complete.

18 2. If a carrier does not accept applications through the online
19 credentialing system, notice shall be given to the provider at the address listed in the
20 application within 10 days after the date the application is received.

21 3. If a carrier accepts applications through the online
22 credentialing system, the notice from the online credentialing system to the provider that
23 the carrier has received the provider’s application shall be considered notice that the
24 application is complete.

25 4. This subparagraph does not apply to a carrier that
26 arranges a dental provider panel until the Commissioner certifies that the online
27 credentialing system is capable of accepting the uniform credentialing form designated by
28 the Commissioner for dental provider panels.

29 (ii) 1. A carrier that receives an incomplete application shall
30 return the application to the provider at the address listed in the application within 10 days
31 after the date the application is received.

32 2. The carrier shall indicate to the provider what information
33 is needed to make the application complete.

34 3. The provider may return the completed application to the
35 carrier.

1 4. After the carrier receives the completed application, the
2 carrier is subject to the time periods established in paragraph (3) of this subsection.

3 (5) A carrier may charge a reasonable fee for an application submitted to
4 the carrier under this section.

5 ~~[(e)]~~ ~~(G)~~ (H) A carrier may not deny an application for participation or
6 terminate participation on its provider panel on the basis of:

7 (1) gender, race, age, religion, national origin, or a protected category
8 under the federal Americans with Disabilities Act;

9 (2) the type or number of appeals that the provider files under Subtitle 10B
10 of this title;

11 (3) the number of grievances or complaints that the provider files on behalf
12 of a patient under Subtitle 10A of this title; or

13 (4) the type or number of complaints or grievances that the provider files
14 or requests for review under the carrier's internal review system established under
15 subsection ~~[(h)]~~ ~~(K)~~ (L) of this section.

16 ~~[(f)]~~ ~~(H)~~ (I) (1) A carrier may not deny an application for participation or
17 terminate participation on its provider panel solely on the basis of the license, certification,
18 or other authorization of the provider to provide health care services if the carrier provides
19 health care services within the provider's lawful scope of practice.

20 (2) Notwithstanding paragraph (1) of this subsection, a carrier may reject
21 an application for participation or terminate participation on its provider panel based on
22 the participation on the provider panel of a sufficient number of similarly qualified
23 providers.

24 (3) A violation of this subsection does not create a new cause of action.

25 ~~[(f-1)]~~ ~~(I)~~ (J) (1) Subject to the provisions of this subsection, a carrier may
26 not require a provider participating on its provider panel to be recredentialed based on:

27 (i) a change in the federal tax identification number of the provider;

28 (ii) a change in the federal tax identification number of a provider's
29 employer; or

30 (iii) a change in the employer of a provider, if the new employer is:

31 1. a participating provider on the carrier's provider panel; or

1 1. the provider or the provider's employer; or

2 2. the representative of the provider or the provider's
3 employer designated in writing to the carrier.

4 (6) A carrier may not terminate its existing contract with a provider or a
5 provider's employer based solely on a notice given to the carrier in accordance with this
6 subsection.

7 [(g)] ~~(J)~~ (K) A carrier may not terminate participation on its provider panel or
8 otherwise penalize a provider for:

9 (1) advocating the interests of a patient through the carrier's internal
10 review system established under subsection [(h)] ~~(K)~~ (L) of this section;

11 (2) filing an appeal under Subtitle 10B of this title; or

12 (3) filing a grievance or complaint on behalf of a patient under Subtitle 10A
13 of this title.

14 [(h)] ~~(K)~~ (L) Each carrier shall establish an internal review system to resolve
15 grievances initiated by providers that participate on the carrier's provider panel, including
16 grievances involving the termination of a provider from participation on the carrier's
17 provider panel.

18 [(i)] ~~(H)~~ (M) (1) For at least 90 days after the date of the notice of termination of
19 a primary care provider from a carrier's provider panel for reasons unrelated to fraud,
20 patient abuse, incompetency, or loss of licensure status, the primary care provider shall
21 furnish health care services to each enrollee:

22 (i) who was receiving health care services from the primary care
23 provider before the notice of termination; and

24 (ii) who, after receiving notice under subsection (b) of this section of
25 the termination of the primary care provider, requests to continue receiving health care
26 services from the primary care provider.

27 (2) A carrier shall reimburse a primary care provider that furnishes health
28 care services under this subsection in accordance with the primary care provider's
29 agreement with the carrier.

30 [(j)] ~~(M)~~ (N) ~~(1)~~ [A] ~~SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A~~
31 carrier shall make available to prospective enrollees on the Internet and, on request of a
32 prospective enrollee, in printed form:

1 ~~(i)~~ **(1)** a list of providers on the carrier's provider panel; and

2 ~~(ii)~~ **(2)** information on providers that are no longer accepting new
3 patients.

4 ~~(2) A CARRIER THAT DEVELOPS AND MAKES AVAILABLE TO~~
5 ~~ENROLLEES AND PROSPECTIVE ENROLLEES A NETWORK DIRECTORY IN~~
6 ~~ACCORDANCE WITH SUBSECTION (N) THIS SECTION MEETS THE REQUIREMENTS OF~~
7 ~~PARAGRAPH (1) OF THIS SUBSECTION.~~

8 ~~(N) (1) THIS SUBSECTION APPLIES TO A CARRIER THAT:~~

9 ~~(I) IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A~~
10 ~~HEALTH MAINTENANCE ORGANIZATION; AND~~

11 ~~(II) USES A PROVIDER PANEL FOR A HEALTH BENEFIT PLAN~~
12 ~~OFFERED BY THE CARRIER.~~

13 ~~(2) A CARRIER SHALL DEVELOP AND MAKE AVAILABLE TO~~
14 ~~ENROLLEES AND PROSPECTIVE ENROLLEES ON THE INTERNET AND, ON REQUEST~~
15 ~~OF AN ENROLLEE OR A PROSPECTIVE ENROLLEE, IN PRINTED FORM, AN~~
16 ~~UP-TO-DATE AND ACCURATE PROVIDER NETWORK DIRECTORY FOR A HEALTH~~
17 ~~BENEFIT PLAN OFFERED BY THE CARRIER TO ENROLLEES AND PROSPECTIVE~~
18 ~~ENROLLEES.~~

19 ~~(3) THE NETWORK DIRECTORY MADE AVAILABLE TO ENROLLEES AND~~
20 ~~PROSPECTIVE ENROLLEES ON THE INTERNET UNDER PARAGRAPH (2) OF THIS~~
21 ~~SUBSECTION:~~

22 ~~(I) SHALL BE ACCESSIBLE THROUGH A CLEARLY IDENTIFIABLE~~
23 ~~LINK OR TAB ON THE CARRIER'S WEB SITE;~~

24 ~~(II) MAY NOT REQUIRE AN ENROLLEE OR A PROSPECTIVE~~
25 ~~ENROLLEE TO CREATE OR ACCESS AN ACCOUNT ON THE CARRIER'S WEB SITE; AND~~

26 ~~(III) SHALL INCLUDE, IN A SEARCHABLE FORMAT, THE~~
27 ~~INFORMATION REQUIRED UNDER PARAGRAPH (4) OF THIS SUBSECTION.~~

28 ~~(4) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF~~
29 ~~THIS SUBSECTION SHALL:~~

30 ~~(I) FOR EACH PARTICIPATING HEALTH CARE PRACTITIONER,~~
31 ~~INCLUDE:~~

1 ~~1. THE HEALTH CARE PRACTITIONER'S NAME AND~~
2 ~~GENDER;~~

3 ~~2. FOR EACH OFFICE OR HEALTH CARE FACILITY AT~~
4 ~~WHICH THE HEALTH PRACTITIONER PROVIDES SERVICES TO PATIENTS:~~

5 ~~A. THE LOCATION OF THE OFFICE OR HEALTH CARE~~
6 ~~FACILITY, INCLUDING THE ADDRESS OF THE OFFICE OR HEALTH CARE FACILITY;~~

7 ~~B. CONTACT INFORMATION FOR THE HEALTH CARE~~
8 ~~PRACTITIONER; AND~~

9 ~~C. WHETHER THE HEALTH CARE PRACTITIONER IS ON~~
10 ~~THE PROVIDER PANEL AT THE OFFICE OR HEALTH CARE FACILITY;~~

11 ~~3. THE SPECIALTY AREA OR AREAS OF THE HEALTH~~
12 ~~CARE PRACTITIONER, IF APPLICABLE;~~

13 ~~4. THE MEDICAL GROUP AFFILIATIONS OF THE HEALTH~~
14 ~~CARE PRACTITIONER, IF APPLICABLE;~~

15 ~~5. THE LANGUAGES SPOKEN BY THE HEALTH CARE~~
16 ~~PRACTITIONER OTHER THAN ENGLISH, IF APPLICABLE; AND~~

17 ~~6. WHETHER THE HEALTH CARE PRACTITIONER IS~~
18 ~~ACCEPTING NEW PATIENTS;~~

19 ~~(II) FOR EACH PARTICIPATING HOSPITAL, INCLUDE:~~

20 ~~1. THE HOSPITAL NAME AND TYPE;~~

21 ~~2. THE LOCATION OF THE HOSPITAL, INCLUDING THE~~
22 ~~ADDRESS OF THE HOSPITAL;~~

23 ~~3. CONTACT INFORMATION FOR THE HOSPITAL,~~
24 ~~INCLUDING A TELEPHONE NUMBER FOR THE HOSPITAL; AND~~

25 ~~4. THE ACCREDITATION STATUS OF THE HOSPITAL; AND~~

26 ~~(III) FOR HEALTH CARE FACILITIES AND PROGRAMS LICENSED~~
27 ~~UNDER TITLE 7.5 OF THE HEALTH GENERAL ARTICLE AT WHICH HEALTH CARE~~
28 ~~SERVICES ARE PROVIDED, OTHER THAN HOSPITALS, INCLUDE:~~

1 ~~1. THE NAME AND TYPE OF THE HEALTH CARE FACILITY~~
2 ~~OR PROGRAM;~~

3 ~~2. THE TYPES OF HEALTH CARE SERVICES PROVIDED AT~~
4 ~~THE HEALTH CARE FACILITY OR PROGRAM;~~

5 ~~3. THE LOCATION OF THE HEALTH CARE FACILITY OR~~
6 ~~PROGRAM, INCLUDING THE ADDRESS OF THE HEALTH CARE FACILITY OR PROGRAM;~~
7 ~~AND~~

8 ~~4. CONTACT INFORMATION FOR THE HEALTH CARE~~
9 ~~FACILITY OR PROGRAM, INCLUDING A TELEPHONE NUMBER FOR THE HEALTH CARE~~
10 ~~FACILITY OR PROGRAM.~~

11 ~~(5) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF~~
12 ~~THIS SUBSECTION SHALL, IN PLAIN LANGUAGE:~~

13 ~~(I) INCLUDE A DESCRIPTION OF:~~

14 ~~1. THE CRITERIA USED BY THE CARRIER TO:~~

15 ~~A. SELECT PROVIDERS FOR PARTICIPATION IN THE~~
16 ~~NETWORK; AND~~

17 ~~B. PLACE PROVIDERS IN NETWORK TIERS, IF~~
18 ~~APPLICABLE; AND~~

19 ~~2. HOW THE CARRIER DESIGNATES DIFFERENT~~
20 ~~PROVIDER TIERS OR LEVELS IN THE NETWORK, IF APPLICABLE;~~

21 ~~(II) FOR EACH HEALTH CARE PRACTITIONER, HOSPITAL,~~
22 ~~HEALTH CARE FACILITY, AND LICENSED PROGRAM IN THE NETWORK, IDENTIFY THE~~
23 ~~PROVIDER TIER OR LEVEL IN THE NETWORK IN WHICH THE HEALTH CARE~~
24 ~~PRACTITIONER, HOSPITAL, HEALTH CARE FACILITY, OR LICENSED PROGRAM IS~~
25 ~~PLACED;~~

26 ~~(III) INDICATE THAT AUTHORIZATION OR REFERRAL MAY BE~~
27 ~~REQUIRED TO ACCESS PROVIDERS IN THE NETWORK, IF APPLICABLE; AND~~

28 ~~(IV) IF APPLICABLE, IDENTIFY THE HEALTH BENEFIT PLAN TO~~
29 ~~THE WHICH THE NETWORK DIRECTORY APPLIES.~~

30 ~~(6) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF~~
31 ~~THIS SUBSECTION SHALL:~~

1 ~~(I) ACCOMMODATE THE COMMUNICATION NEEDS OF~~
2 ~~INDIVIDUALS WITH DISABILITIES;~~

3 ~~(H) INCLUDE INFORMATION, OR A LINK TO INFORMATION,~~
4 ~~REGARDING AVAILABLE ASSISTANCE FOR INDIVIDUALS WITH LIMITED ENGLISH~~
5 ~~PROFICIENCY;~~

6 ~~(HH) INCLUDE A CUSTOMER SERVICE PHONE NUMBER AND, IN~~
7 ~~THE NETWORK DIRECTORY MADE AVAILABLE ON THE INTERNET, AN E-MAIL LINK~~
8 ~~THAT ENROLLEES, PROSPECTIVE ENROLLEES, AND MEMBERS OF THE PUBLIC MAY~~
9 ~~USE TO NOTIFY THE CARRIER OF INACCURATE INFORMATION IN THE NETWORK~~
10 ~~DIRECTORY; AND~~

11 ~~(IV) INCLUDE A NOTICE STATING THAT AN ENROLLEE:~~

12 ~~1. HAS A RIGHT TO AN ACCURATE NETWORK DIRECTORY;~~
13 ~~AND~~

14 ~~2. MAY DIRECT A COMPLAINT TO THE COMMISSIONER IF~~
15 ~~THERE IS AN INACCURATE LISTING IN THE NETWORK DIRECTORY.~~

16 (O) (1) A CARRIER SHALL HAVE A CUSTOMER SERVICE TELEPHONE
17 NUMBER, E-MAIL ADDRESS LINK, OR OTHER ELECTRONIC MEANS BY WHICH
18 ENROLLEES AND PROSPECTIVE ENROLLEES MAY NOTIFY THE CARRIER OF
19 INACCURATE INFORMATION IN THE CARRIER'S NETWORK DIRECTORY.

20 ~~(7) (2)~~ (2) IF NOTIFIED OF A POTENTIAL INACCURACY IN A NETWORK
21 DIRECTORY BY A PERSON OTHER THAN THE PROVIDER, A CARRIER SHALL
22 INVESTIGATE THE REPORTED INACCURACY AND TAKE CORRECTIVE ACTION, IF
23 NECESSARY, TO UPDATE THE NETWORK DIRECTORY WITHIN 15 45 WORKING DAYS
24 AFTER RECEIVING THE NOTIFICATION OF THE POTENTIAL INACCURACY.

25 [(2)] ~~(O)~~ (P) (1) A carrier shall notify each enrollee at the time of initial
26 enrollment and renewal about how to ACCESS OR obtain the [following information on the
27 Internet and in printed form:

28 (i) a list of providers on the carrier's provider panel; and

29 (ii) information on providers that are no longer accepting new
30 patients] INFORMATION REQUIRED UNDER SUBSECTIONS (M) AND (N) SUBSECTION
31 (N) OF THIS SECTION.

1 ~~[(3)] (2)~~ (i) Information provided in printed form under [paragraphs
2 (1) and (2)] ~~SUBSECTIONS (M) AND (N)~~ SUBSECTION (N) of this [subsection] SECTION
3 shall be updated at least once a year.

4 (ii) Subject to subsection [(m)] ~~(s)~~ (T) of this section, information
5 provided on the Internet under [paragraphs (1) and (2)] ~~SUBSECTIONS (M) AND (N)~~
6 SUBSECTION (N) of this [subsection] SECTION shall be updated at least once every 15
7 days.

8 ~~(III) IF A PROVIDER LISTED IN A NETWORK DIRECTORY AS A
9 PARTICIPATING PROVIDER HAS NOT SUBMITTED A CLAIM IN THE LAST 6 MONTHS, A
10 CARRIER SHALL CONTACT THE PROVIDER TO DETERMINE IF THE PROVIDER
11 INTENDS TO REMAIN IN THE NETWORK AND UPDATE THE NETWORK DIRECTORY
12 ACCORDINGLY.~~

13 ~~(3) IF AN ENROLLEE RELIES ON MATERIALLY INACCURATE
14 INFORMATION IN A NETWORK DIRECTORY INDICATING THAT A PROVIDER IS
15 IN NETWORK AND THEN RECEIVES HEALTH CARE SERVICES FROM THAT PROVIDER,
16 A CARRIER SHALL TREAT THE HEALTH CARE SERVICES AS IF THEY WERE RENDERED
17 BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL FOR THE PURPOSE OF
18 CALCULATING ANY OUT-OF-POCKET MAXIMUM, DEDUCTIBLE, COPAYMENT
19 AMOUNT, OR COINSURANCE AMOUNT PAYABLE BY THE ENROLLEE FOR THE HEALTH
20 CARE SERVICES.~~

21 (3) A CARRIER SHALL:

22 (I) 1. PERIODICALLY REVIEW AT LEAST A REASONABLE
23 SAMPLE SIZE OF ITS NETWORK DIRECTORY FOR ACCURACY; AND

24 2. RETAIN DOCUMENTATION OF THE REVIEW AND MAKE
25 THE REVIEW AVAILABLE TO THE COMMISSIONER ON REQUEST; OR

26 (II) CONTACT PROVIDERS LISTED IN THE CARRIER'S NETWORK
27 DIRECTORY WHO HAVE NOT SUBMITTED A CLAIM IN THE LAST 6 MONTHS TO
28 DETERMINE IF THE PROVIDERS INTEND TO REMAIN IN THE CARRIER'S PROVIDER
29 NETWORK.

30 ~~[(4)] (P)~~ (Q) A policy, certificate, or other evidence of coverage shall:

31 (i) (1) indicate clearly the office in the Administration that is
32 responsible for receiving and responding to complaints from enrollees about carriers; and

33 (ii) (2) include the telephone number of the office and the
34 procedure for filing a complaint.

1 [(k)] ~~(Q)~~ **(R)** The Commissioner:

2 (1) shall adopt regulations that relate to the procedures that carriers must
3 use to process applications for participation on a provider panel; and

4 (2) in consultation with the Secretary of Health and Mental Hygiene, shall
5 adopt strategies to assist carriers in maximizing the opportunity for a broad range of
6 minority providers to participate in the delivery of health care services.

7 **[(l)] ~~(R)~~ (S)** A carrier may not include in a contract with a provider, ambulatory
8 surgical facility, or hospital a term or condition that:

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

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

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

20 **[(m)] ~~(S)~~ (T) ~~[(1)]~~** A carrier shall update [its provider information] **THE**
21 **INFORMATION THAT MUST BE MADE AVAILABLE ON THE INTERNET** under [subsection
22 (j)(3)(ii)] **~~SUBSECTIONS (M) AND (N)~~ SUBSECTION (N)** of this section within 15 working
23 days after receipt of [written] ~~notification~~ **ELECTRONIC NOTIFICATION OR**
24 **NOTIFICATION BY FIRST-CLASS MAIL TRACKING METHOD** from the participating
25 provider of a change in the applicable information.

26 ~~[(2)]~~ Notification is presumed to have been received by a carrier:

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

30 (ii) on the date recorded by the courier, if the notification was
31 delivered by courier. ~~]~~

32 **[(n)] ~~(T)~~ (U)** (1) A carrier may not require a provider that provides health
33 care services through a group practice or health care facility that participates on the

1 carrier's provider panel under a contract with the carrier to be considered a participating
2 provider or accept the reimbursement fee schedule applicable under the contract when:

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

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

9 (2) A nonparticipating provider shall notify an enrollee:

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

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

13 [(o)] ~~(u)~~ (v) The provisions of subsection [(d)(3)(iii)] ~~(F)(3)(III)~~ (G)(3)(III) of this
14 section do not apply to a carrier that uses a credentialing intermediary that:

15 (1) is a hospital or academic medical center;

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

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

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

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

21 [(p)] ~~(v)~~ (w) (1) Notwithstanding subsection [(n)(1)] ~~(T)(1)~~ (U)(1) of this section,
22 a carrier shall reimburse a group practice on the carrier's provider panel at the
23 participating provider rate for covered services provided by a provider who is not a
24 participating provider if:

25 (i) the provider is employed by or a member of the group practice;

26 (ii) the provider has applied for acceptance on the carrier's provider
27 panel and the carrier has notified the provider of the carrier's intent to continue to process
28 the provider's application to obtain necessary credentialing information;

29 (iii) the provider has a valid license issued by a health occupations
30 board to practice in the State; and

31 (iv) the provider:

1 1. is currently credentialed by an accredited hospital in the
2 State; or

3 2. has professional liability insurance.

4 (2) A carrier shall reimburse a group practice on the carrier's provider
5 panel in accordance with paragraph (1) of this subsection from the date the notice required
6 under subsection [(d)(3)(i)1] ~~(F)(3)(I)1~~ (G)(3)(I)1 of this section is sent to the provider
7 until the date the notice required under subsection [(d)(3)(iii)2] ~~(F)(3)(II)2~~ (G)(3)(III)2
8 of this section is sent to the provider.

9 (3) A carrier that sends written notice of rejection of a provider for
10 credentialing under subsection [(d)(3)(iii)2] ~~(F)(3)(II)2~~ (G)(3)(III)2 of this section shall
11 reimburse the provider as a nonparticipating provider for covered services provided on or
12 after the date the notice is sent.

13 (4) A health maintenance organization may not deny payment to a provider
14 under this subsection solely because the provider was not a participating provider at the
15 time the services were provided to an enrollee.

16 (5) A provider who is not a participating provider of a carrier and whose
17 group practice is eligible for reimbursement under paragraph (1) of this subsection may not
18 hold an enrollee of the carrier liable for the cost of any covered services provided to the
19 enrollee during the time period described in paragraph (2) of this subsection, except for any
20 deductible, copayment, or coinsurance amount owed by the enrollee to the group practice
21 or provider under the terms of the enrollee's contract or certificate.

22 (6) A group practice shall disclose in writing to an enrollee at the time
23 services are provided that:

24 (i) the treating provider is not a participating provider;

25 (ii) the treating provider has applied to become a participating
26 provider;

27 (iii) the carrier has not completed its assessment of the qualifications
28 of the treating provider to provide services as a participating provider; and

29 (iv) any covered services received must be reimbursed by the carrier
30 at the participating provider rate.

31 31-115.

1 (M) ANY CERTIFICATION STANDARDS ESTABLISHED UNDER SUBSECTION
 2 (K) OF THIS SECTION RELATED TO NETWORK ADEQUACY OR NETWORK DIRECTORY
 3 ACCURACY:

4 (1) SHALL BE CONSISTENT WITH THE PROVISIONS OF § 15-112 OF
 5 THIS ARTICLE; AND

6 (2) MAY NOT BE IMPLEMENTED UNTIL JANUARY 1, 2019.

7 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read
 8 as follows:

9 Article – Insurance

10 15-112.

11 (n) (1) A carrier shall make THE CARRIER'S NETWORK DIRECTORY
 12 available to prospective enrollees on the Internet and, on request of a prospective enrollee,
 13 in printed form[:

14 (1) a list of providers on the carrier's provider panel; and

15 (2) information on providers that are no longer accepting new patients].

16 (2) THE CARRIER'S NETWORK DIRECTORY ON THE INTERNET SHALL
 17 BE AVAILABLE:

18 (I) THROUGH A CLEAR LINK OR TAB; AND

19 (II) IN A SEARCHABLE FORMAT.

20 (3) THE NETWORK DIRECTORY SHALL INCLUDE:

21 (I) FOR EACH PROVIDER ON THE CARRIER'S PROVIDER PANEL:

22 1. THE NAME OF THE PROVIDER;

23 2. THE SPECIALTY AREAS OF THE PROVIDER;

24 3. WHETHER THE PROVIDER CURRENTLY IS ACCEPTING
 25 NEW PATIENTS;

26 4. FOR EACH OFFICE OF THE PROVIDER WHERE THE
 27 PROVIDER PARTICIPATES ON THE PROVIDER PANEL;

1 A. ITS LOCATION, INCLUDING ITS ADDRESS; AND

2 B. CONTACT INFORMATION FOR THE PROVIDER;

3 5. THE GENDER OF THE PROVIDER, IF THE PROVIDER
4 NOTIFIES THE CARRIER OR THE MULTI-CARRIER COMMON ONLINE PROVIDER
5 DIRECTORY INFORMATION SYSTEM DESIGNATED UNDER § 15-112.3 OF THIS
6 SUBTITLE OF THE INFORMATION; AND

7 6. ANY LANGUAGES SPOKEN BY THE PROVIDER OTHER
8 THAN ENGLISH, IF THE PROVIDER NOTIFIES THE CARRIER OR THE MULTI-CARRIER
9 COMMON ONLINE PROVIDER DIRECTORY INFORMATION SYSTEM DESIGNATED
10 UNDER § 15-112.3 OF THIS SUBTITLE OF THE INFORMATION;

11 (II) FOR EACH HEALTH CARE FACILITY IN THE CARRIER'S
12 NETWORK:

13 1. THE HEALTH CARE FACILITY'S NAME;

14 2. THE HEALTH CARE FACILITY'S ADDRESS;

15 3. THE TYPES OF SERVICES PROVIDED BY THE HEALTH
16 CARE FACILITY; AND

17 4. CONTACT INFORMATION FOR THE HEALTH CARE
18 FACILITY; AND

19 (III) A STATEMENT THAT ADVISES ENROLLEES AND
20 PROSPECTIVE ENROLLEES TO CONTACT A PROVIDER OR A HEALTH CARE FACILITY
21 BEFORE SEEKING TREATMENT OR SERVICES, TO CONFIRM THE PROVIDER'S OR
22 HEALTH CARE FACILITY'S PARTICIPATION IN THE CARRIER'S NETWORK.

23 (p) (1) A carrier shall notify each enrollee at the time of initial enrollment and
24 renewal about how to access or obtain the information required under subsection (n) of this
25 section.

26 (2) (i) 1. Information provided in printed form under subsection (n)
27 of this section shall be [updated] ACCURATE ON THE DATE OF PUBLICATION.

28 2. A CARRIER SHALL UPDATE THE INFORMATION
29 PROVIDED IN PRINTED FORM at least once a year.

1 (ii) 1. [Subject to subsection (t) of this section, information]
2 INFORMATION provided on the Internet under subsection (n) of this section shall be
3 [updated] ACCURATE ON THE DATE OF INITIAL POSTING AND ANY UPDATE.

4 2. IN ADDITION TO THE REQUIREMENT TO UPDATE ITS
5 PROVIDER INFORMATION UNDER SUBSECTION (T)(1) OF THIS SECTION, A CARRIER
6 SHALL UPDATE THE INFORMATION PROVIDED ON THE INTERNET at least once every
7 15 days.

8 (3) A carrier shall:

9 (i) 1. periodically review at least a reasonable sample size of its
10 network directory for accuracy; and

11 2. retain documentation of the review and make the review
12 available to the Commissioner on request; or

13 (ii) contact providers listed in the carrier's network directory who
14 have not submitted a claim in the last 6 months to determine if the providers intend to
15 remain in the carrier's provider network.

16 (4) A CARRIER SHALL DEMONSTRATE THE ACCURACY OF THE
17 INFORMATION PROVIDED UNDER PARAGRAPH (3) OF THIS SUBSECTION ON
18 REQUEST OF THE COMMISSIONER.

19 (5) BEFORE IMPOSING A PENALTY AGAINST A CARRIER FOR
20 INACCURATE NETWORK DIRECTORY INFORMATION, THE COMMISSIONER SHALL
21 TAKE INTO ACCOUNT, IN ADDITION TO ANY OTHER FACTORS REQUIRED BY LAW,
22 WHETHER:

23 (I) THE CARRIER AFFORDED A PROVIDER OR OTHER PERSON
24 IDENTIFIED IN § 15-112.3(C) OF THIS SUBTITLE AN OPPORTUNITY TO REVIEW AND
25 UPDATE THE PROVIDER'S NETWORK DIRECTORY INFORMATION:

26 1. THROUGH THE MULTI-CARRIER COMMON ONLINE
27 PROVIDER DIRECTORY INFORMATION SYSTEM DESIGNATED UNDER § 15-112.3 OF
28 THIS SUBTITLE; OR

29 2. DIRECTLY WITH THE CARRIER;

30 (II) THE CARRIER CAN DEMONSTRATE THE EFFORTS MADE, IN
31 WRITING, ELECTRONICALLY, OR BY TELEPHONE, TO OBTAIN UPDATED NETWORK
32 DIRECTORY INFORMATION FROM A PROVIDER OR OTHER PERSON IDENTIFIED IN §
33 15-112.3(C) OF THIS SUBTITLE;

1 (III) THE CARRIER HAS CONTACTED A PROVIDER LISTED IN THE
2 CARRIER'S NETWORK DIRECTORY WHO HAS NOT SUBMITTED A CLAIM IN THE LAST 6
3 MONTHS TO DETERMINE IF THE PROVIDER INTENDS TO REMAIN ON THE CARRIER'S
4 PROVIDER PANEL;

5 (IV) THE CARRIER INCLUDES IN ITS NETWORK DIRECTORY THE
6 LAST DATE THAT A PROVIDER UPDATED THE PROVIDER'S INFORMATION;

7 (V) THE CARRIER HAS IMPLEMENTED ANY OTHER PROCESS OR
8 PROCEDURE TO:

9 1. ENCOURAGE PROVIDERS TO UPDATE THEIR
10 NETWORK DIRECTORY INFORMATION; OR

11 2. INCREASE THE ACCURACY OF ITS NETWORK
12 DIRECTORY; AND

13 (VI) A PROVIDER OR OTHER PERSON IDENTIFIED IN §
14 15-112.3(C) OF THIS SUBTITLE HAS NOT UPDATED THE PROVIDER'S NETWORK
15 DIRECTORY INFORMATION, DESPITE OPPORTUNITIES TO DO SO.

16 15-112.3.

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

19 (2) (I) "CARRIER" HAS THE MEANING STATED IN § 15-112 OF THIS
20 SUBTITLE.

21 (II) "CARRIER" DOES NOT INCLUDE A MANAGED CARE
22 ORGANIZATION, AS DEFINED IN TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL
23 ARTICLE.

24 (3) "MULTI-CARRIER COMMON ONLINE PROVIDER DIRECTORY
25 INFORMATION SYSTEM" MEANS THE SYSTEM DESIGNATED BY THE COMMISSIONER
26 FOR USE BY PROVIDERS TO PROVIDE AND UPDATE THEIR NETWORK DIRECTORY
27 INFORMATION WITH CARRIERS.

28 (B) THE COMMISSIONER MAY DESIGNATE A MULTI-CARRIER COMMON
29 ONLINE PROVIDER DIRECTORY INFORMATION SYSTEM DEVELOPED BY A
30 NONPROFIT ALLIANCE OF HEALTH PLANS AND TRADE ASSOCIATIONS IF:

31 (1) THE SYSTEM IS AVAILABLE TO PROVIDERS NATIONALLY;

1 **(2) THE SYSTEM IS AVAILABLE TO PROVIDERS AT NO CHARGE;**

2 **(3) THE SYSTEM ALLOWS PROVIDERS TO:**

3 **(I) ATTEST ONLINE TO THE ACCURACY OF THEIR**
4 **INFORMATION; AND**

5 **(II) 1. CORRECT ANY INACCURATE INFORMATION; AND**

6 **2. ATTEST TO THE CORRECTION; AND**

7 **(4) THE NONPROFIT ALLIANCE HAS A WELL-ESTABLISHED**
8 **MECHANISM FOR OUTREACH TO PROVIDERS.**

9 **(C) A CARRIER SHALL ACCEPT NEW AND UPDATED NETWORK DIRECTORY**
10 **INFORMATION FOR A PROVIDER SUBMITTED:**

11 **(1) (I) THROUGH THE MULTI-CARRIER COMMON ONLINE**
12 **PROVIDER DIRECTORY INFORMATION SYSTEM; OR**

13 **(II) DIRECTLY TO THE CARRIER; AND**

14 **(2) FROM:**

15 **(I) THE PROVIDER;**

16 **(II) A HOSPITAL OR ACADEMIC MEDICAL CENTER THAT:**

17 **1. IS A PARTICIPATING PROVIDER ON THE CARRIER'S**
18 **PROVIDER PANEL; AND**

19 **2. ACTS AS A CREDENTIALING INTERMEDIARY FOR THE**
20 **CARRIER FOR PROVIDERS THAT:**

21 **A. PARTICIPATE ON THE CARRIER'S PROVIDER PANEL;**
22 **AND**

23 **B. HAVE PRIVILEGES AT THE HOSPITAL OR ACADEMIC**
24 **MEDICAL CENTER; OR**

25 **(III) ANY OTHER PERSON THAT PERFORMS CREDENTIALING**
26 **FUNCTIONS ON BEHALF OF A PROVIDER.**

- 1 (a) (1) In this section the following words have the meanings indicated.
- 2 (2) “Carrier” means:
- 3 (i) an insurer that offers health insurance other than long-term
4 care insurance or disability insurance;
- 5 (ii) a nonprofit health service plan;
- 6 (iii) a health maintenance organization;
- 7 (iv) a dental plan organization; or
- 8 (v) except for a managed care organization as defined in Title 15,
9 Subtitle 1 of the Health – General Article, any other person that provides health benefit
10 plans subject to State regulation.
- 11 (3) (i) “Member” means an individual entitled to health care benefits
12 under a policy or plan issued or delivered in the State by a carrier.
- 13 (ii) “Member” includes a subscriber.
- 14 (4) “Nonphysician specialist” means a health care provider who:
- 15 (i) is not a physician;
- 16 (ii) is licensed or certified under the Health Occupations Article; and
- 17 (iii) is certified or trained to treat or provide health care services for
18 a specified condition or disease in a manner that is within the scope of the license or
19 certification of the health care provider.
- 20 (5) “Provider panel” has the meaning stated in § 15–112(a) of this title.
- 21 (6) “Specialist” means a physician who is certified or trained to practice in
22 a specified field of medicine and who is not designated as a primary care provider by the
23 carrier.
- 24 (b) (1) Each carrier that does not allow direct access to specialists shall
25 establish and implement a procedure by which a member may receive a standing referral
26 to a specialist in accordance with this subsection.
- 27 (2) The procedure shall provide for a standing referral to a specialist if:
- 28 (i) the primary care physician of the member determines, in
29 consultation with the specialist, that the member needs continuing care from the specialist;

- 1 (ii) the member has a condition or disease that:
- 2 1. is life threatening, degenerative, chronic, or disabling; and
- 3 2. requires specialized medical care; and
- 4 (iii) the specialist:
- 5 1. has expertise in treating the life-threatening,
- 6 degenerative, chronic, or disabling disease or condition; and
- 7 2. is part of the carrier's provider panel.
- 8 (3) Except as provided in subsection (c) of this section, a standing referral
- 9 shall be made in accordance with a written treatment plan for a covered service developed
- 10 by:
- 11 (i) the primary care physician;
- 12 (ii) the specialist; and
- 13 (iii) the member.
- 14 (4) A treatment plan may:
- 15 (i) limit the number of visits to the specialist;
- 16 (ii) limit the period of time in which visits to the specialist are
- 17 authorized; and
- 18 (iii) require the specialist to communicate regularly with the primary
- 19 care physician regarding the treatment and health status of the member.
- 20 (5) The procedure by which a member may receive a standing referral to a
- 21 specialist may not include a requirement that a member see a provider in addition to the
- 22 primary care physician before the standing referral is granted.
- 23 (c) (1) Notwithstanding any other provision of this section, a member who is
- 24 pregnant shall receive a standing referral to an obstetrician in accordance with this
- 25 subsection.
- 26 (2) After the member who is pregnant receives a standing referral to an
- 27 obstetrician, the obstetrician is responsible for the primary management of the member's
- 28 pregnancy, including the issuance of referrals in accordance with the carrier's policies and
- 29 procedures, through the postpartum period.

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

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

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

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

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

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

16 (3) **THE PROCEDURE SHALL ENSURE THAT A REQUEST TO OBTAIN A**
17 **REFERRAL TO A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF**
18 **THE CARRIER'S PROVIDER PANEL IS ADDRESSED IN A TIMELY MANNER THAT IS:**

19 (I) **APPROPRIATE FOR THE MEMBER'S CONDITION; AND**

20 (II) **CONSISTENT IN ACCORDANCE WITH THE TIMELINESS**
21 **REQUIREMENTS FOR DETERMINATIONS MADE BY PRIVATE REVIEW AGENTS UNDER**
22 **§ 15-10B-06 OF THIS TITLE.**

23 (4) **THE PROCEDURE MAY NOT BE USED BY A CARRIER AS A**
24 **SUBSTITUTE FOR ESTABLISHING AND MAINTAINING A SUFFICIENT PROVIDER**
25 **NETWORK IN ACCORDANCE WITH § 15-112 OF THIS TITLE; ~~OR.~~**

26 (5) **EACH CARRIER SHALL:**

27 (I) **HAVE A SYSTEM IN PLACE THAT DOCUMENTS ALL REQUESTS**
28 **TO OBTAIN A REFERRAL TO RECEIVE A COVERED SERVICE FROM A SPECIALIST OR**
29 **NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL;**
30 **AND**

31 (II) **PROVIDE THE INFORMATION DOCUMENTED UNDER ITEM (I)**
32 **OF THIS PARAGRAPH TO THE COMMISSIONER ON REQUEST.**

(e) 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.

(f) 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) (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(M)(1)~~ 15-112(N)(1) OF THIS TITLE; AND

(II) ON REQUEST.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health – General

19-705.1.

(a) The Secretary shall adopt regulations that set out reasonable standards of quality of care that a health maintenance organization shall provide to its members.

(b) (1) The standards of quality of care shall include:

(i) [1.] A requirement that a health maintenance organization shall provide for regular hours during which a member may receive services, including providing for services to a member in a timely manner that takes into account the immediacy of need for services; [and

1 2. Provisions for assuring that all covered services, including
 2 any services for which the health maintenance organization has contracted, are accessible to
 3 the enrollee with reasonable safeguards with respect to geographic locations;]

4 Article – Insurance

5 14–205.1.

6 (a) The Commissioner may authorize an insurer or nonprofit health service plan
 7 to offer a preferred provider insurance policy that conditions the payment of benefits on the
 8 use of preferred providers if the insurer or nonprofit health service plan[:

9 (1) has demonstrated to the Secretary of Health and Mental Hygiene that
 10 the provider panel of the insurer or nonprofit health service plan complies with the
 11 regulations adopted under § 19–705.1(b)(1)(i)2 of the Health – General Article; and

12 (2)] does not restrict payment for covered services provided by nonpreferred
 13 providers:

14 [(i)] (1) for emergency services, as defined in § 19–701 of the Health
 15 – General Article;

16 [(ii)] (2) for an unforeseen illness, injury, or condition requiring
 17 immediate care; or

18 [(iii)] (3) as required under § 15–830 of this article.

19 15–112.

20 (b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider
 21 panel shall:

22 (i) [1.] if the carrier is an insurer, nonprofit health service plan,
 23 HEALTH MAINTENANCE ORGANIZATION, or dental plan organization, maintain
 24 standards in accordance with regulations adopted by the Commissioner for availability of
 25 health care providers to meet the health care needs of enrollees; AND

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

29 3. if the carrier is an insurer or nonprofit health service plan
 30 that offers a preferred provider insurance policy that conditions the payment of benefits on
 31 the use of preferred providers, adhere to the standards for accessibility of covered services in
 32 accordance with regulations adopted under § 19–705.1(b)(1)(i)2 of the Health – General
 33 Article and as enforced by the Secretary of Health and Mental Hygiene; and]

1 ~~SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to health~~
2 ~~benefit plans issued, delivered, or renewed in the State on and after January 1, 2019.~~

3 SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall
4 take effect January 1, 2017.

5 SECTION 5. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take
6 effect January 1, 2018.

7 SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in
8 Section 3 Sections 4 and 5 of this Act, this Act shall take effect June 1, 2016.

Approved:

Governor.

Speaker of the House of Delegates.

President of the Senate.