SB 334

Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 334 (Senator Kelley, *et al.*)
Finance

Health Insurance - Access to Accurate Provider Directories

This bill prohibits an insurer, nonprofit health service plan, health maintenance organization, or other specified entity (collectively known as carriers) from issuing or delivering a health benefit plan before a provider directory is submitted to and approved by the Insurance Commissioner. The bill specifies the contents of and delivery requirements for each provider directory. A carrier must also establish, for each health benefit plan, an online graphic interactive map. The Commissioner must adopt regulations to implement the bill. A violation of the bill's requirements is an unfair trade practice, subject to specified penalties. An insured, enrollee, or provider may bring an action in a court of competent jurisdiction against a carrier for a violation of the bill and is eligible for applicable remedies.

Fiscal Summary

State Effect: Special fund expenditures for the Maryland Insurance Administration (MIA) increase by $625,200 in FY 2017 to hire additional personnel to review and approve provider directories and enforce provider directory requirements. Future years reflect annualization and inflation. General fund revenues increase to the extent penalties are imposed by the Insurance Commissioner.

(in dollars)	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
GF Revenue	-	-	-	-	-
SF Expenditure	$625,200	$776,000	$806,400	$838,000	$871,100
Net Effect	($625,200)	($776,000)	($806,400)	($838,000)	($871,100)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: The bill is not anticipated to have a material impact on local operations or finances.

Small Business Effect: Potential minimal. Small business providers may benefit from more accurate provider directories and gain a private right of action against carriers for failure to comply with the bill.

Analysis

Bill Summary: "Provider tiering" means a system that compares, rates, ranks, measures, tiers, or classifies a provider's or a provider group's performance, quality, or cost of care against objective standards, subjective standards, or the practice of other providers. Provider tiering includes quality improvement programs, pay-for-performance programs, public reporting on provider performance or ratings, and the use of tiered or narrowed networks.

Each provider directory must (1) include specified information about each participating physician; (2) include a notice regarding the availability of physicians listed; (3) include information about how to select a primary care physician (PCP), change a PCP, and use the PCP for access to other care; (4) if the carrier uses provider tiering, indicate which physicians are placed in which tier and how each tier impacts the financial or other obligations of the insured or enrollee; (5) include a conspicuous disclaimer if the provider directory includes the name of any physician to which the insured or enrollee has no right to access on an in-network basis; (6) provide specified information for each participating nonphysician health care professional who bills independently for health care services; (7) include specified information about each participating health care facility, including which health care facilities are placed in which tier and how each tier impacts the financial or other obligations of the insured or enrollee, if the carrier uses provider tiering; (8) include a conspicuous disclaimer if the provider directory includes the name of any health care facility to which the insured or enrollee has no right to access on an in-network basis; and (9) include relevant contact information and online links to pharmacies, pharmacy benefit managers, durable medical equipment providers, clinical laboratories, and ancillary services providers participating in the provider network, if available.

Each provider directory must be (1) provided to the insured or enrollee at the time of enrollment in a downloadable or hard copy format; (2) posted on the carrier's website; and (3) kept current and accurate, with updates of the online directory at least every 30 days. A carrier must annually submit a provider directory to the Commissioner for review and reapproval.

Each online graphic interactive map must allow current and prospective insureds and enrollees to input a reference address and locate providers by name, type, specialty, subspecialty, and distance. The map must display specified information for each provider identified by each search.

A violation of the bill's provisions is an unfair trade practice in the business of insurance. If the Commissioner finds that a carrier has violated these provisions or any regulation adopted under the bill, the Commissioner must take any authorized enforcement action necessary to obtain compliance, including imposition of any penalty. Additionally, if the violation results in an insured's or enrollee's use of an out-of-network provider despite reasonable efforts to remain in-network, the Commissioner must require the carrier to (1) pay the out-of-network provider's usual, customary, and reasonable charge as stated on the claim form; (2) ensure that the insured's or enrollee's financial obligations are no greater than if the service had been provided by an in-network provider; and (3) apply the insured's or enrollee's out-of-pocket expenses to any out-of-pocket maximum under the insured's or enrollee's health benefit plan.

An insured, an enrollee, or a provider may bring an action in a court of competent jurisdiction against a carrier for a violation of the bill's provisions. An insured, enrollee, or provider who prevails in such an action is entitled to all remedies provided under the bill (or otherwise provided by law) and reasonable attorney's fees and costs.

Current Law: Federal regulations adopted under the Patient Protection and Affordable Care Act require a qualified health plan (QHP) issuer to make its provider directory available to the exchange for publication online and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients. Guidance from the federal Center for Consumer Information and Insurance Oversight further specified that a provider directory must be updated at least monthly, accurate, complete, and include information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations. The general public must be able to view all of the current providers for a plan on the issuer's public website through a clearly identifiable link or tab without having to create or access an account or enter a policy number. The general public should be able to easily discern which providers participate in which plan(s) and provider network(s). Further, if the health plan issuer maintains multiple provider networks, the plan(s) and provider network(s) associated with each provider, including the tier in which the provider is included, should be clearly identified on the website and in the provider directory.

The Department of Health and Mental Hygiene (DHMH) must provide Medicaid and Maryland Children's Health Program enrollees and health care providers with an accurate directory or other listing of all available providers in written form, made available on request, and on an Internet database. DHMH must update the Internet database at least every 30 days. The written directory must include a conspicuous reference to the Internet database.

If the Commissioner finds that a person has engaged in or is engaging in an unfair trade practice, the Commissioner must issue a cease and desist order, subject to hearing and notice requirements. Under § 4-113(d) of the Insurance Article, the Commissioner may also impose a penalty of at least $100 and up to $125,000 for each violation of the Insurance Article and require the carrier to make restitution to any person who has suffered financial injury because of the violation. Under the Code of Maryland Regulations (31.02.04.02), in determining the amount of the penalty, the Commissioner must consider the seriousness of the violation, the good faith of the violator, any history of previous violations, and the deleterious effect of the violation on the public and the insurance industry.

Background: In 2015, California enacted legislation (SB 137) requiring health plans to review and update their entire provider directories. The state's Department of Managed Care and Department of Insurance must develop uniform provider directory standards. Insurers must update their online directories weekly and maintain a process for enrollees and providers to report possible inaccurate, incomplete, or misleading information. Insurers are authorized to delay payment or reimbursement to a provider that fails to verify his or her information in a directory. If regulators find that a consumer reasonably relied upon materially inaccurate, incomplete, or misleading information in a provider directory, the regulator may require the insurer to provide coverage for all covered services provided to the consumer and to reimburse the consumer for any amount beyond what the consumer would have paid had the services been delivered by an in-network provider.

State Revenues: General fund revenues increase to the extent the Commissioner imposes penalties of between $100 and $125,000 on carriers that violate the bill. The amount of such penalties cannot be reliably estimated.

State Expenditures: The bill requires the Commissioner to initially approve each provider directory before a carrier may issue or deliver a health benefit plan in the State and thereafter to annually review and reapprove each provider directory. Although no specific criteria for the review and approval are included in the bill, at a minimum, MIA will need to verify that each provider directory includes all information, notices, and disclaimers required by the bill and likely verify that at least a certain percentage of the provider listings are accurate. MIA advises that at least 11 additional personnel are required to review and approve provider directories and otherwise enforce compliance with the bill.

Thus, special fund expenditures increase by $625,184 in fiscal 2017, which accounts for the bill's October 1, 2016 effective date. This estimate reflects the cost of hiring 11 full-time positions (1 grade 20 supervisor and 10 grade 14 analysts) to review and approve provider directories and enforce compliance with the bill. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	11
Salaries and Fringe Benefits	$554,074
One-time Start-up Expenses	47,993
Ongoing Operating Expenses	23,117
Total FY 2017 State Expenditures	**$625,184**

Future year expenditures reflect full salaries with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

The bill's provisions authorizing an insured, an enrollee, or a provider to bring an action in a court of competent jurisdiction against a carrier for a violation of the bill are not anticipated to have any material impact on the operations or finances of the District Court.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Families USA, Centers for Medicare & Medicaid Services, Department of Health and Mental Hygiene, Health Benefit Exchange, Maryland Insurance Administration, Department of Legislative Services

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