HB 1318

Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
Enrolled - Revised

House Bill 1318 (Delegate Kelly, *et al.*)
Health and Government Operations Finance

Health Benefit Plans - Network Access Standards and Provider Network Directories

This bill requires the Insurance Commissioner, by December 31, 2017, to adopt regulations to establish quantitative and, if appropriate, nonquantitative criteria to evaluate the network sufficiency of health benefit plans. By July 1, 2018, and annually thereafter, an insurer, nonprofit health service plan, or health maintenance organization (collectively known as carriers) that uses a provider panel for a health benefit plan must file a specified network access plan with the Commissioner for review. The bill establishes specified requirements for network directories relating to content and submission of new and updated information, and it requires carriers to demonstrate accuracy of network directory information on request of the Commissioner.

The bill generally takes effect June 1, 2016; however, most network directory requirements and provisions regarding referrals to specialists take effect January 1, 2017, and other provisions take effect January 1, 2018.

Fiscal Summary

State Effect: No impact in FY 2016. Special fund expenditures for the Maryland Insurance Administration (MIA) increase in FY 2017 to hire personnel to monitor and enforce network directory requirements beginning January 1, 2017, and by an additional amount in FY 2019 to hire personnel to review carrier network access plans beginning July 1, 2018. Future years reflect annualization and inflation. Revenues are not affected.

(in dollars)	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Revenues	$0	$0	$0	$0	$0
SF Expenditure	79,800	143,300	385,200	386,700	401,900
Net Effect	($79,800)	($143,300)	($385,200)	($386,700)	($401,900)

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

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary:

Managed Care Organizations: The bill specifies which provisions of law regarding provider panels (*i.e.*, existing provisions under current law and no new provisions established under the bill) apply to Medicaid managed care organizations.

Standards Regarding Availability of Providers: Specified standards that carriers with provider panels must use regarding the availability of providers to meet the health care needs of enrollees or the accessibility of covered services must (1) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay and (2) include standards that ensure access to providers that serve predominantly low-income and medically underserved individuals (or, for specified carriers, include alternative standards for addressing the needs of low-income, medically underserved individuals).

Access Plan: An access plan must include a description of the carrier's network, process for monitoring and ensuring network sufficiency, factors used to build the provider network, efforts to address the needs of adult and child enrollees, efforts to include providers who serve predominantly low-income or medically underserved individuals (or, for specified carriers, efforts to address the needs of such individuals), and methods for assessing the health care needs of enrollees and enrollee satisfaction.

If a carrier makes a material change to the access plan, the carrier must notify the Commissioner within 15 business days and provide a reasonable timeframe within which the carrier will file an update to the existing access plan for the Commissioner's review. The Commissioner may order corrective action if, after review, the access plan does not meet the bill's requirements. The Commissioner must deny inspection of the parts of an access plan that contain confidential commercial or financial information. Each carrier must monitor, on an ongoing basis, the clinical capacity of participating providers to provide covered services.

The regulations adopted by the Commissioner governing access plans must identify the parts of the access plan that may be considered confidential by the carrier. In adopting the regulations, the Commissioner may take into consideration specified factors and standards.

Standards for Dental Services: By December 31, 2017, the Commissioner, in consultation with appropriate stakeholders, must adopt regulations that specify network adequacy standards for dental services for a dental plan organization or an insurer or nonprofit health service plan that provides coverage for dental services.

Correcting Inaccuracies in Network Directories: Each carrier that uses a provider panel must have a customer service telephone number, email address link, or other electronic means by which enrollees and prospective enrollees may notify the carrier of inaccurate information in the carrier's network directory. If notified of a potential inaccuracy by a person other than the provider, a carrier must investigate and, if necessary, take corrective action within 45 working days. A carrier must (1) periodically review at least a reasonable sample size of its network directory for accuracy, retain documentation of the review, and make such documentation available to the Commissioner on request or (2) contact providers listed in the network directory who have not submitted a claim in the last six months to determine if the providers intend to remain in the network. Although most provisions related to network directories take effect January 1, 2017, these provisions take effect June 1, 2016.

Network Directory: A carrier must make the carrier's network directory available on the Internet and in printed form on request. The carrier's network directory on the Internet must be available through a clear link or tab and in a searchable format. The network directory must include specified information about each provider on the carrier's provider panel and each health care facility in the carrier's network, as well as a statement that advises enrollees and prospective enrollees to contact a provider or health care facility before seeking treatment or services to confirm the provider's or health care facility's participation in the carrier's network.

A carrier must update the network directory information provided in printed form at least once annually and the information provided on the Internet at least once every 15 days. Information must be accurate on the date of initial publication or posting and any update. A carrier must demonstrate the accuracy of network directory information on request of the Commissioner. Before imposing a penalty against a carrier for inaccurate network directory information, the Commissioner must take into account specified factors.

The Commissioner may designate a multi-carrier common online provider directory information system developed by a nonprofit alliance of health plans and trade associations under specified circumstances. A carrier must accept new and updated network directory information for a provider submitted (1) through the multi-carrier common online provider directory information system or (2) directly to the carrier. A carrier must accept information from (1) the provider; (2) specified hospitals or academic medical centers; or (3) any other person that performs credentialing functions on behalf of a provider.

These network directory provisions take effect January 1, 2017.

Referrals to Specialists and Nonphysician Specialists: A carrier's procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel due to network inadequacy must ensure that a request for such a referral is addressed in a timely manner that is appropriate for the member's condition and in accordance with the timeliness requirements for determinations made by private review agents. The procedure may not be used by a carrier as a substitute for establishing and maintaining a sufficient provider network. Each carrier must have a system in place that documents all requests to obtain such a referral and must provide the documentation to the Commissioner on request.

Each carrier must file with the Commissioner the steps required of a member to request a referral, the carrier's timeline for decisions, and the carrier's grievance procedures for denials. Each carrier must make a copy of each of these procedures available to its members in the carrier's online network directory and on request.

As noted earlier, these provisions take effect January 1, 2017.

Oversight of Network Adequacy for Health Maintenance Organizations and Exclusive Provider Organizations: The requirement that the Secretary of Health and Mental Hygiene adopt regulations regarding standards for accessibility of covered services for health maintenance organizations (HMOs) is repealed. Correspondingly, the requirement that HMOs and certain insurers and nonprofit health service plans adhere to those regulations is also repealed, as is the requirement that an insurer or nonprofit health service plan demonstrate compliance with such regulations as a condition of being authorized to offer a preferred provider insurance policy (also known as exclusive provider organizations or EPOs). Oversight of network adequacy for HMOs and EPOs is transferred to MIA. These provisions take effect January 1, 2018, as MIA must adopt regulations relating to network adequacy by December 31, 2017.

Certification Standards Adopted by the Maryland Health Benefit Exchange: Any certification standards established by the Maryland Health Benefit Exchange related to network adequacy or network directory accuracy must be consistent with the bill and may not be implemented until January 1, 2019.

Current Law: A carrier that uses a provider panel must maintain certain standards regarding the availability of providers to meet the health care needs of enrollees or adhere to certain standards for accessibility of covered services. A carrier must establish specified procedures regarding provider participation, notification of enrollees and providers, and verification of certain provider information and must follow specified application procedures for providers seeking to participate on the panel.

A carrier must make available to prospective enrollees on the Internet and, on request, in printed form, a list of providers on the carrier's provider panel and information on providers that are no longer accepting new patients. A carrier must notify each enrollee at the time of initial enrollment and renewal about how to obtain a list of providers on the carrier's provider panel and information on providers that are no longer accepting new patients. Printed information must be updated at least once a year. Information provided on the Internet must be updated at least once every 15 days. A carrier must update its provider information within 15 working days after receipt of written notification from the participating provider of a change in the applicable information.

Each carrier must establish and implement a procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel. The procedure must provide for such a referral if (1) the member is diagnosed with a condition or disease that requires specialized health care services or medical care and (2) the carrier either does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease or the carrier cannot provide reasonable access to such a specialist or nonphysician specialist without unreasonable delay or travel.

Background: The National Association of Insurance Commissioners (NAIC) recently updated its Health Benefit Plan Network Access and Adequacy Model Act. The model act is intended to establish standards for the creation and maintenance of networks by health carriers and assure the adequacy, accessibility, transparency, and quality of health care services under a network plan, in part by requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. Many of the bill's provisions mirror the NAIC model act, including quantitative standards as criteria to evaluate network adequacy, the requirement that the Commissioner review access plans (the model act specifies review and *approval*), the timeframe for reporting changes in an access plan, ongoing monitoring by carriers of the clinical capacity of providers, required information in the access plan, and much of the information that must be included in network directories.

State Expenditures: The bill requires the Commissioner to adopt regulations to establish specified quantitative and, if appropriate, nonquantitative criteria to evaluate the network sufficiency of health benefit plans subject to the bill's requirements. Additionally, the Commissioner must adopt regulations that specify network adequacy standards for dental services. Both sets of regulations must be adopted by December 31, 2017. Beginning January 1, 2017, carriers must meet specified network directory requirements and demonstrate the accuracy of network directory information on request of the Commissioner. Based on the regulations adopted, the Commissioner must then review each carrier's network access plan, which must be submitted to MIA by July 1, 2018, and

annually thereafter. As the sole regulator of network access standards for *all* health benefit plans, MIA must also absorb the workload previously handled by the Department of Health and Mental Hygiene (DHMH) to review and enforce the network adequacy of HMOs and EPOs. This workload is currently shared across three existing positions, requiring the total equivalent of one part-time (30%) position.

MIA advises that, while the regulations can be adopted using existing budgeted resources, additional personnel are required to monitor and enforce compliance with the bill's network directory requirements, review network access plans, and review and enforce the network adequacy of HMOs and EPOs previously done by DHMH. Thus, special fund expenditures increase by $79,776 in fiscal 2017, which reflects the cost of hiring two full-time grade 15 analysts, beginning January 1, 2017, to monitor and enforce compliance with the bill's network directory requirements (the majority of which take effect on that date) and later also enforce the network adequacy of HMOs and EPOs. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

In fiscal 2019, three additional full-time grade 15 analysts are required to review carrier network access plans, beginning July 1, 2018, and annually thereafter.

	FY 2017	**FY 2018**	**FY 2019**
New Positions	2	-	3
Salaries and Fringe Benefits	$68,248	$137,592	$357,823
One-time Start-up Expenses	8,726	-	13,089
Ongoing Operating Expenses	2,802	5,660	14,291
Total State Expenditures	**$79,776**	**$143,252**	**$385,203**

Future year expenditures reflect full salaries for a total of five positions with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

DHMH expenditures are not affected as staff whose duties encompassed HMO and EPO network adequacy can spend more time on their other duties.

Additional Information

Prior Introductions: None.

Cross File: SB 929 (Senator Klausmeier, *et al.*) - Finance.

Information Source(s): National Association of Insurance Commissioners, Maryland Health Benefit Exchange, Maryland Insurance Administration, Department of Legislative Services

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