Chapter 488

(Senate Bill 858)

AN ACT concerning

Health Insurance – Access to Local Health Departments

FOR the purpose of requiring a carrier that is an insurer, a nonprofit health service plan, or a health maintenance organization, except for a group model health maintenance organization, to ensure in certain standards that certain enrollees have access to local health departments and certain services provided through local health departments to the extent that local health departments are willing to participate on a carrier's provider panel; requiring that a certain access plan filed by a carrier, except for an access plan filed by a group model health maintenance organization, include a description of the carrier's efforts to include local health departments in the carrier's network; defining a certain term; providing for the application of this Act; providing for a delayed effective date; and generally relating to access to health care services provided through local health departments.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–112(a), (b), and (c)(4)
Annotated Code of Maryland
(2017 Replacement Volume)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–112(c)(1) and (2)
Annotated Code of Maryland
(2017 Replacement Volume)

~~BY adding to~~
~~Article – Insurance~~
~~Section 31–115(b)(9)~~
~~Annotated Code of Maryland~~
~~(2017 Replacement Volume)~~

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

Article – Insurance

15–112.

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

(2) "Accredited hospital" has the meaning stated in § 19–301 of the Health – General Article.

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

(4) "BEHAVIORAL HEALTH CARE SERVICES" HAS THE MEANING STATED IN § 15–127 OF THIS SUBTITLE.

[(4)**] (5)** (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

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

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

[(5)**] (6)** "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

[(6)**] (7)** "Enrollee" means a person entitled to health care benefits from a carrier.

[(7)**] (8)** **"GROUP MODEL HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 19–713.6(A) OF THE HEALTH – GENERAL ARTICLE.**

(9) "Health benefit plan":

(i) for a group or blanket plan in the large group market, has the meaning stated in § 15–1401 of this title;

(ii) for a group in the small group market, has the meaning stated in § 31–101 of this article; and

(iii) for an individual plan, has the meaning stated in § 15–1301 of this title.

[(8)**]** ~~**(9)**~~ **(10)** (i) "Health care facility" means a health care setting or institution providing physical, mental, or substance use disorder health care services.

(ii) "Health care facility" includes:

1. a hospital;

2. an ambulatory surgical or treatment center;

3. a skilled nursing facility;

4. a residential treatment center;

5. an urgent care center;

6. a diagnostic, laboratory, or imaging center;

7. a rehabilitation facility; and

8. any other therapeutic health care setting.

[(9)**]** ~~**(10)**~~ **(11)** "Hospital" has the meaning stated in § 19–301 of the Health – General Article.

[(10)**]** ~~**(11)**~~ **(12)** "Network" means a carrier's participating providers and the health care facilities with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

[(11)**]** ~~**(12)**~~ **(13)** "Network directory" means a list of a carrier's participating providers and participating health care facilities.

[(12)**]** ~~**(13)**~~ **(14)** "Online credentialing system" means the system through which a provider may access an online provider credentialing application that the Commissioner has designated as the uniform credentialing form under § 15–112.1(e) of this subtitle.

[(13)**]** ~~**(14)**~~ **(15)** "Participating provider" means a provider on a carrier's provider panel.

[(14)**]** ~~**(15)**~~ **(16)** "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

[(15)**]** ~~**(16)**~~ **(17)** (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

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

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

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

(ii) establish procedures to:

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

2. notify an enrollee of:

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

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

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

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

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

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

(3) For a carrier that is an insurer, a nonprofit health service plan, or a health maintenance organization, the standards required under paragraph (1)(i) if this subsection shall:

(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable travel or delay; **[**and**]**

(ii) 1. include standards that ensure access to providers, including essential community providers, that serve predominantly low–income and medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, include alternative standards for addressing the needs of low–income, medically underserved individuals**; AND**

(III) EXCEPT FOR A CARRIER THAT IS A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION, ENSURE THAT ALL ENROLLEES HAVE ACCESS TO LOCAL HEALTH DEPARTMENTS AND COVERED SERVICES PROVIDED THROUGH LOCAL HEALTH DEPARTMENTS, INCLUDING BEHAVIORAL HEALTH CARE SERVICES, TO THE EXTENT THAT LOCAL HEALTH DEPARTMENTS ARE WILLING TO PARTICIPATE ON A CARRIER'S PROVIDER PANEL.

(c) (1) This subsection applies to a carrier that:

(i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and

(ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

(ii) If the carrier makes a material change to the access plan, the carrier shall:

1. notify the Commissioner of the change within 15 business days after the change occurs; and

2. include in the notice required under item 1 of this subparagraph a reasonable timeframe within which the carrier will file with the Commissioner an update to the existing access plan for review by the Commissioner.

(iii) The Commissioner may order corrective action if, after review, the access plan is determined not to meet the requirements of this subsection.

(4) An access plan filed under this subsection shall include a description of:

(i) the carrier's network, including how telemedicine, telehealth, or other technology may be used to meet network access standards required under subsection (b) of this section;

(ii) the carrier's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of enrollees;

(iii) the factors used by the carrier to build its provider network, including the criteria used to select providers for participation in the network and, if applicable, place providers in network tiers;

(iv) the carrier's efforts to address the needs of both adult and child enrollees, including adults and children with:

1. limited English proficiency or illiteracy;

2. diverse cultural or ethnic backgrounds;

3. physical or mental disabilities; and

4. serious, chronic, or complex health conditions;

(v) 1. the carrier's efforts to include providers, including essential community providers, in its network who serve predominantly low–income, medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, the carrier's efforts to address the needs of low–income, medically underserved individuals; **[**and**]**

(vi) **EXCEPT FOR AN ACCESS PLAN FILED BY A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION, THE CARRIER'S EFFORTS TO INCLUDE LOCAL HEALTH DEPARTMENTS IN ITS NETWORK; AND**

(VII) the carrier's methods for assessing the health care needs of enrollees and enrollee satisfaction with health care services provided to them.

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

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2019.

Approved by the Governor, May 8, 2018.