Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 113 (Chair, Finance Committee)(By Request - Departmental - Maryland Insurance Administration)

Finance

Health Insurance - Provider Panels - Definitions of Provider and Health Care Services

This departmental bill expands the definition of "provider" to make current credentialing requirements and procedures for carriers that use a provider panel applicable to health care facilities and pharmacies. The bill also defines "health care services."

Fiscal Summary

State Effect: None.

Local Effect: None.

Small Business Effect: The Maryland Insurance Administration (MIA) has determined that this bill has minimal or no impact on small business (attached). The Department of Legislative Services concurs with this assessment.

Analysis

Bill Summary/Current Law: Section 15-112 of the Insurance Article defines "provider" as a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services. Section 15-121 of the Insurance Article defines "provider" as a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health-General Article to provide health care services, *including a health care facility*, *pharmacy*, professional services corporation, partnership, limited liability company, professional office, and any other entity licensed or authorized by law to provide or deliver professional

health care services through or on behalf of a provider. The bill replaces the former definition with the latter.

"Health care services" is currently used throughout § 15-112 of the Insurance Article but is not defined. Under the bill, "health care services" means a health or medical care procedure or service rendered by a provider that provides testing, diagnosis, or treatment of a human disease or dysfunction or dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Under current law as well as under the bill with the expanded definition of "provider," a carrier that uses a provider panel must (1) maintain standards in accordance with regulations adopted by the Insurance Commissioner for availability of health care providers to meet the health care needs of enrollees and (2) establish specified procedures relating to participation on the carrier's provider panel. A carrier must also ensure that all enrollees have access to providers and covered services without unreasonable travel or delay and include standards that ensure access to providers.

A provider seeking to participate on a carrier's provider panel must submit an application to the carrier. Within 30 days after receipt of a completed application, a carrier must send the provider a written notice of the carrier's intent to continue to process the provider's application or the carrier's rejection of the provider for participation on the carrier's provider panel. A carrier that fails to provide this required notice is subject to suspension or revocation of a certificate of authority and/or a penalty of at least $100 and as much as $125,000 per violation.

If a carrier provides notice to the provider of its intent to continue to process the provider's application, the carrier must, within 120 days after the date the notice is provided, accept or reject the provider for participation and send written notice of the acceptance or rejection to the provider. A carrier that fails to send this notice is subject to suspension or revocation of a certificate of authority and/or a penalty of at least $100 and as much as $125,000 per violation as well as being issued a cease and desist order.

A carrier must notify the provider when an application is complete either through the online credentialing system or by mail within 10 days after a complete application is received. A carrier must return an incomplete application to the provider by mail within 10 days of receipt and notify the provider what information is needed to complete the application.

A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, religion, or national origin, as well as the type or number of complaints, appeals, or grievances the provider files. A carrier may reject an application for participation or terminate participation based on the participation of a sufficient number of similarly qualified providers.

Background: MIA advises that it has received complaints from health care facilities and pharmacies that the credentialing process for these facilities can take an extremely long time to complete and is overly burdensome due to the lack of an applicable statutory framework such as that currently provided to health care practitioners and group practices. The bill expands the definition of provider, thereby making existing carrier provider panel credentialing requirements and processes applicable to health care facilities and pharmacies.

Additional Information

Prior Introductions: None.

Designated Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - January 13, 2020
mr/ljm

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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Insurance – Provider and Health Care Services - Definitions

BILL NUMBER: SB 113

PREPARED BY:
(Dept./Agency) Maryland Insurance Administration

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

_X_ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

____ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

There is no fiscal impact on small business associated with this proposal.