HOUSE BILL 912

J2, J5 2lr1985
HB 1165/20 – HGO CF SB 707

By: ~~Delegate Sample–Hughes~~ **Delegates Sample–Hughes, Bagnall, Belcastro, Bhandari, Carr, Chisholm, Cullison, Hill, Johnson, Kaiser, Kelly, Kerr, Kipke, Landis, R. Lewis, Morgan, Reilly, Rosenberg, Saab, Szeliga, and K. Young**

Introduced and read first time: February 7, 2022
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 10, 2022

CHAPTER _____

AN ACT concerning

Health Insurance – Provider Panels – Coverage for Nonparticipation

FOR the purpose of requiring each carrier to inform members and beneficiaries of the ~~right~~ procedure to request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel; establishing a certain ~~requirements~~ requirement on certain insurers, nonprofit health service plans, and health maintenance organizations related to the ~~coverage~~ provision of certain mental health and substance use disorder services provided to a member by a nonparticipating provider; requiring the Consumer Education and Advocacy Program, in collaboration with the Health Education and Advocacy Unit of the Office of the Attorney General, to provide public education to inform consumers of certain ~~rights~~ procedures; and generally relating to provider panels and coverage for nonparticipating providers.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–710(p)
Annotated Code of Maryland
(2019 Replacement Volume and 2021 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–830

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.

Annotated Code of Maryland
(2017 Replacement Volume and 2021 Supplement)

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

Article – Health – General

19–710.

(p) (1) Except as provided in paragraph (3) of this subsection, individual enrollees and subscribers of health maintenance organizations issued certificates of authority to operate in this State **[**shall**]** **MAY** not be liable to any health care provider for any covered services provided to the enrollee or subscriber.

(2) (i) A health care provider or any representative of a health care provider may not collect or attempt to collect from any subscriber or enrollee any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(ii) A health care provider or any representative of a health care provider may not maintain any action against any subscriber or enrollee to collect or attempt to collect any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(3) Notwithstanding any other provision of this subsection, a health care provider or representative of a health care provider may collect or attempt to collect from a subscriber or enrollee:

(i) Any copayment or coinsurance sums owed by the subscriber or enrollee to a health maintenance organization issued a certificate of authority to operate in this State for covered services provided by the health care provider;

(ii) If Medicare is the primary insurer and a health maintenance organization is the secondary insurer, any amount up to the Medicare approved or limiting amount, as specified under the Social Security Act, that is not owed to the health care provider by Medicare or the health maintenance organization after coordination of benefits has been completed, for Medicare covered services provided to the subscriber or enrollee by the health care provider; or

(iii) Any payment or charges for services that are not covered services.

Article – Insurance

15–830.

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

(2) "Carrier" means:

(i) an insurer that offers health insurance other than long–term care insurance or disability insurance;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to State regulation.

(3) (i) "Member" means an individual entitled to health care benefits under a policy or plan issued or delivered in the State by a carrier.

(ii) "Member" includes a subscriber.

(4) "Nonphysician specialist" means a health care provider **[**who**]**:

(i) **1.** **WHO** is not a physician;

[(ii)**]** **2.** **WHO** is licensed or certified under the Health Occupations Article; and

[(iii)**]** **3.** **WHO** is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider**; OR**

(II) THAT IS LICENSED AS A BEHAVIORAL HEALTH PROGRAM UNDER § 7.5–401 OF THE HEALTH – GENERAL ARTICLE.

(5) (i) "Provider panel" means the providers that contract with a carrier either directly or through a subcontracting entity to provide health care services to enrollees of the carrier.

(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.

(6) "Specialist" means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a primary care provider by the carrier.

(b) (1) Each carrier that does not allow direct access to specialists shall establish and implement a procedure by which a member may receive a standing referral to a specialist in accordance with this subsection.

(2) The procedure shall provide for a standing referral to a specialist if:

(i) the primary care physician of the member determines, in consultation with the specialist, that the member needs continuing care from the specialist;

(ii) the member has a condition or disease that:

1. is life threatening, degenerative, chronic, or disabling; and

2. requires specialized medical care; and

(iii) the specialist:

1. has expertise in treating the life–threatening, degenerative, chronic, or disabling disease or condition; and

2. is part of the carrier's provider panel.

(3) Except as provided in subsection (c) of this section, a standing referral shall be made in accordance with a written treatment plan for a covered service developed by:

(i) the primary care physician;

(ii) the specialist; and

(iii) the member.

(4) A treatment plan may:

(i) limit the number of visits to the specialist;

(ii) limit the period of time in which visits to the specialist are authorized; and

(iii) require the specialist to communicate regularly with the primary care physician regarding the treatment and health status of the member.

(5) The procedure by which a member may receive a standing referral to a specialist may not include a requirement that a member see a provider in addition to the primary care physician before the standing referral is granted.

(c) (1) Notwithstanding any other provision of this section, a member who is pregnant shall receive a standing referral to an obstetrician in accordance with this subsection.

(2) After the member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals in accordance with the carrier's policies and procedures, through the postpartum period.

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

(d) (1) Each carrier shall 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 in accordance with this subsection.

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

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

(ii) 1. the carrier 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

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

(3) The procedure shall ensure that a request to obtain a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel is addressed in a timely manner that is:

(i) appropriate for the member's condition; and

(ii) in accordance with the timeliness requirements for determinations made by private review agents under § 15–10B–06 of this title.

(4) The procedure may not be used by a carrier as a substitute for establishing and maintaining a sufficient provider network in accordance with § 15–112 of this title.

(5) Each carrier shall:

(i) have a system in place that documents all requests to obtain a referral to receive a covered service from a specialist or nonphysician specialist who is not part of the carrier's provider panel; **[**and**]**

(II) INFORM MEMBERS ~~AND BENEFICIARIES, IN PLAIN LANGUAGE,~~ OF THE ~~RIGHT~~ PROCEDURE TO REQUEST A REFERRAL UNDER PARAGRAPH (1) OF THIS SUBSECTION ~~IN PRINT AND ELECTRONIC PLAN DOCUMENTS AND ANY PROVIDER DIRECTORY~~; AND

[(ii)**] (III)** provide the information documented under item (i) of this paragraph to the Commissioner on request.

(e) **(1)** ~~For~~ **EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, 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.

(2) A CARRIER SHALL ENSURE THAT SERVICES RECEIVED IN ACCORDANCE WITH SUBSECTION (D) OF THIS SECTION FOR MENTAL HEALTH OR SUBSTANCE USE DISORDERS ARE PROVIDED AT NO GREATER COST TO THE COVERED INDIVIDUAL THAN IF THE COVERED BENEFIT WERE PROVIDED BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL.

~~**(2) ON REQUEST FOR AN IN–PERSON OR TELEHEALTH VISIT, IF THE CARRIER'S PROVIDER PANEL HAS AN INSUFFICIENT NUMBER OR TYPE OF PARTICIPATING SPECIALISTS OR NONPHYSICIAN SPECIALISTS WITH THE EXPERTISE TO PROVIDE THE COVERED MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES REQUIRED UNDER § 15–802 OR § 15–840 OF THIS SUBTITLE TO A MEMBER WITHIN THE APPOINTMENT WAITING TIME OR TRAVEL DISTANCE STANDARDS ESTABLISHED IN REGULATIONS, THE CARRIER SHALL COVER THE SERVICES PROVIDED BY A NONPARTICIPATING PROVIDER AT NO GREATER COST TO THE MEMBER THAN IF THE SERVICES WERE PROVIDED BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL.**~~

~~**(3) EACH CARRIER SHALL USE THE REIMBURSEMENT RATE ESTABLISHED UNDER PARAGRAPH (4) OF THIS SUBSECTION TO:**~~

~~**(I) ENTER TIMELY SINGLE CASE AGREEMENTS; AND**~~

~~**(II) PAY PROVIDERS.**~~

~~(4) (I) SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, AND NOT LATER THAN JANUARY 1, 2023, THE MARYLAND HEALTH COMMISSION SHALL ESTABLISH A REIMBURSEMENT FORMULA TO DETERMINE THE REIMBURSEMENT RATE FOR NONPARTICIPATING PROVIDERS THAT DELIVER SERVICES UNDER PARAGRAPH (2) OF THIS SUBSECTION.~~

~~(II) THE MARYLAND HEALTH COMMISSION SHALL HOLD PUBLIC MEETINGS WITH CARRIERS, MENTAL HEALTH AND SUBSTANCE USE DISORDER PROVIDERS, CONSUMERS OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, AND OTHER INTERESTED PARTIES TO DETERMINE THE REIMBURSEMENT FORMULA.~~

(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(n)(1) of this title; and

(ii) on request.

(H) THE CONSUMER EDUCATION AND ADVOCACY PROGRAM, ESTABLISHED UNDER TITLE 2, SUBTITLE 3 OF THIS ARTICLE, IN COLLABORATION WITH THE HEALTH EDUCATION AND ADVOCACY UNIT OF THE OFFICE OF THE ATTORNEY GENERAL, SHALL PROVIDE PUBLIC EDUCATION TO INFORM CONSUMERS OF THEIR ~~RIGHT~~ PROCEDURES TO REQUEST A REFERRAL TO A SPECIALIST OR NONPHYSICIAN SPECIALIST AS PROVIDED FOR IN THIS SECTION.

(I) THIS SECTION MAY NOT BE CONSTRUED TO LIMIT THE PROVISIONS IN § 19–710(P) OF THE HEALTH – GENERAL ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That, on or before December 31, 2022, the health occupations boards that license, certify, or otherwise regulate mental health and substance use disorder providers under the Health Occupations Article shall report to the Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article, on the progress the boards have made to develop a process for providing information on mental health and substance use disorder providers to carriers for the purpose of the carriers reaching out to the providers regarding participation in the carriers' provider panels.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2023.

SECTION ~~3.~~ 4. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October 1, 2022.~~ July 1, 2022. It shall remain effective for a period of 3 years and, at the end of June 30, 2025, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.