

SENATE BILL 707

J2, J5
SB 484/20 – FIN

2lr1839
CF HB 912

By: **Senator Klausmeier**

Introduced and read first time: February 4, 2022

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Provider Panels – Coverage for Nonparticipation**

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

13 BY repealing and reenacting, with amendments,
14 Article – Health – General
15 Section 19–710(p)
16 Annotated Code of Maryland
17 (2019 Replacement Volume and 2021 Supplement)

18 BY repealing and reenacting, with amendments,
19 Article – Insurance
20 Section 15–830
21 Annotated Code of Maryland
22 (2017 Replacement Volume and 2021 Supplement)

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

25 **Article – Health – General**

26 19–710.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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

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

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

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

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

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

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

27 **Article – Insurance**

28 15–830.

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

30 (2) “Carrier” means:

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

33 (ii) a nonprofit health service plan;

1 (iii) a health maintenance organization;

2 (iv) a dental plan organization; or

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

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

8 (ii) “Member” includes a subscriber.

9 (4) “Nonphysician specialist” means a health care provider [who]:

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

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

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

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

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

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

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

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

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

31 (i) the primary care physician of the member determines, in

1 consultation with the specialist, that the member needs continuing care from the specialist;

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

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

4 2. requires specialized medical care; and

5 (iii) the specialist:

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

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

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

12 (i) the primary care physician;

13 (ii) the specialist; and

14 (iii) the member.

15 (4) A treatment plan may:

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

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

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

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

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

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

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

3 (d) (1) Each carrier shall establish and implement a procedure by which a
4 member may request a referral to a specialist or nonphysician specialist who is not part of
5 the carrier's provider panel in accordance with this subsection.

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

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

10 (ii) 1. the carrier does not have in its provider panel a specialist
11 or nonphysician specialist with the professional training and expertise to treat or provide
12 health care services for the condition or disease; or

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

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

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

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

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

25 (5) Each carrier shall:

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

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

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

3 (e) **(1)** For purposes of calculating any deductible, copayment amount, or
4 coinsurance payable by the member, a carrier shall treat services received in accordance
5 with subsection (d) of this section as if the service was provided by a provider on the
6 carrier's provider panel.

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

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

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

20 **(II)** **PAY PROVIDERS.**

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

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

31 (f) A decision by a carrier not to provide access to or coverage of treatment or
32 health care services by a specialist or nonphysician specialist in accordance with this
33 section constitutes an adverse decision as defined under Subtitle 10A of this title if the
34 decision is based on a finding that the proposed service is not medically necessary,
35 appropriate, or efficient.

1 (g) (1) Each carrier shall file with the Commissioner a copy of each of the
2 procedures required under this section, including:

3 (i) steps the carrier requires of a member to request a referral;

4 (ii) the carrier's timeline for decisions; and

5 (iii) the carrier's grievance procedures for denials.

6 (2) Each carrier shall make a copy of each of the procedures filed under
7 paragraph (1) of this subsection available to its members:

8 (i) in the carrier's online network directory required under §
9 15-112(n)(1) of this title; and

10 (ii) on request.

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

17 **(I) THIS SECTION MAY NOT BE CONSTRUED TO LIMIT THE PROVISIONS IN §**
18 **19-710(P) OF THE HEALTH – GENERAL ARTICLE.**

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

22 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
23 October 1, 2022.