Chapter 661

(Senate Bill 902)

AN ACT concerning

Health Insurance – Access to Nonparticipating Providers – Referrals, Additional Assistance, and Coverage

FOR the purpose of repealing the termination date for certain provisions of law related to referrals to and reimbursement of specialists and nonphysician specialists who are not part of a carrier's provider panel; requiring that a certain referral procedure required to be established and implemented by certain insurers, nonprofit health service plans, and health maintenance organizations require the carrier to provide certain assistance to a member in identifying and arranging coverage for a specialist or nonphysician specialist for treatment of a mental health or substance use disorder ~~services~~; prohibiting certain carriers from imposing ~~prior authorization requirements for scheduling, reimbursing, or continuing an established treatment plan by certain nonparticipating providers~~ utilization review requirements other than what would be required if the covered benefit was provided by a provider on the carrier's provider panel under certain circumstances; ~~requiring the Maryland Health Care Commission to establish certain reimbursement rates for nonparticipating providers;~~ and generally relating to access to nonparticipating providers.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–830(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–830(d) and (e)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

BY repealing and reenacting, with amendments,
Chapter 271 of the Acts of the General Assembly of 2022
Section 4

BY repealing and reenacting, with amendments,
Chapter 272 of the Acts of the General Assembly of 2022
Section 4

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

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:

(i) 1. who is not a physician;

2. who is licensed or certified under the Health Occupations Article; and

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.

(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) **1.** the member is diagnosed with ~~**OR SEEKING CARE FOR**~~ a condition or disease that requires specialized health care services or medical care; and

~~(ii)~~ ~~1.~~ **2. A.** 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.~~ **B.** 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~~]~~**, INCLUDING WITHIN THE REASONABLE APPOINTMENT WAITING TIME AND TRAVEL DISTANCE STANDARDS ESTABLISHED IN REGULATION FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES; OR**

(II) 1. THE MEMBER IS SEEKING MENTAL HEALTH OR SUBSTANCE USE DISORDER CARE; AND

2. THE CARRIER CANNOT PROVIDE REASONABLE ACCESS TO A SPECIALIST OR NONPHYSICIAN SPECIALIST WITHIN THE REASONABLE APPOINTMENT WAITING TIME AND TRAVEL DISTANCE STANDARDS ESTABLISHED IN REGULATION FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

(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) IF A MEMBER CANNOT ACCESS MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES THROUGH THE REFERRAL REQUIREMENTS UNDER PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, THE PROCEDURE SHALL REQUIRE THE CARRIER TO PROVIDE ADDITIONAL ASSISTANCE TO THE MEMBER IN IDENTIFYING AND ARRANGING COVERAGE OF MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES BY A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL.

(5) ~~**THE PROCEDURE MAY NOT REQUIRE PRIOR AUTHORIZATION FOR PURPOSES OF:**~~

~~**(I) SCHEDULING AN APPOINTMENT WITH A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL;**~~

~~**(II) REIMBURSING A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL; OR**~~

~~**(III) CONTINUING AN ESTABLISHED TREATMENT PLAN WITH A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL**~~ **IF A CARRIER APPROVES A MEMBER'S REQUEST FOR A REFERRAL MADE IN ACCORDANCE WITH THIS SUBSECTION, THE CARRIER MAY NOT REQUIRE UTILIZATION REVIEW OTHER THAN WHAT WOULD BE REQUIRED IF THE COVERED BENEFIT WERE PROVIDED BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL.**

[(4)**] (6)** 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)**] (7)** 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;

(ii) inform members of the procedure to request a referral under paragraph (1) of this subsection; and

(iii) provide the information documented under item (i) of this paragraph to the Commissioner on request.

(e) (1) 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 **FOR THE DURATION OF THE TREATMENT PLAN** at no greater cost to the covered individual than if the covered benefit were provided by a provider on the carrier's provider panel.

~~**(3) (I) SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, AND NOT LATER THAN JANUARY 1, 2026, THE MARYLAND HEALTH CARE COMMISSION SHALL ESTABLISH A REIMBURSEMENT FORMULA TO DETERMINE THE REIMBURSEMENT RATE FOR NONPARTICIPATING PROVIDERS WHO DELIVER SERVICES UNDER PARAGRAPH (2) OF THIS SUBSECTION.**~~

~~**(II) THE MARYLAND HEALTH CARE 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.**~~

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Chapter 271 of the Acts of 2022

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect 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.**]**

Chapter 272 of the Acts of 2022

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect 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.**]**

SECTION 3. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2026.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2026.

SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect June 1, 2025.

Approved by the Governor, May 20, 2025.