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Bill # / Title: Senate Bill 521 - Health Insurance - Material Changes to Provider Networks - Notification and Special Enrollment Period

Committee: Senate Finance Committee

Position: Support

The Maryland Insurance Administration (MIA) appreciates the opportunity to share its support for Senate Bill 521.

Senate Bill 521 amends §§ 19-310.7, 15-112(b) and (c), and 15-1316(a),(c),(d),(e), and (f) of the Insurance Article in order to ensure that patients continue to have access to care when doctors, hospitals, or health systems are in a network dispute with an insurer. When a health provider leaves a health insurance carrier's network, it can make it difficult for patients who were relying on that provider to continue to get the care they need – affecting access to provider networks for both current and future enrollees. Recent negotiations between carriers and providers have intensified – prompting concerns about access to in-network providers in Maryland. Senate Bill 521 aims to provide greater consumer protections for patients to keep them out of the middle when these disputes arise.

Senate Bill 521 requires carriers with regulated health plans to provide more advanced notice to the Maryland Insurance Commissioner of potential significant network changes prior to their effective date, and greatly expands the details of required notification to consumers when providers are no longer under contract with an insurer. The bill also creates broader continuity of care protections for patients seeing behavioral health providers as well as patients seeing health systems for any type of care.

Specifically, the bill as introduced:

- Requires insurers to provide earlier and clearer notice to enrollees and the State when provider contracts are being terminated.
- Creates a 90-day special enrollment period for those who buy individual insurance, so patients whose provider leaves their network can enroll in a different individual policy sold through or outside the Maryland Health Benefit Exchange.

- Requires health insurers and hospitals involved in a contract dispute to adhere to their contractual terms, including reimbursement conditions, for 90 days following contract expiration or termination, so that patients covered by that insurance company can continue to see their provider and pay the same out-of-pocket costs that they did prior to termination.
- Permits patients to request to see certain providers, including primary care or behavioral care providers, for up to 90 days after a termination and provides for specifications on the notice that insurers must use to inform members on how to request that care.
- Requires insurers and health systems to give advance notice to each other before ending contracts; and
- Requires insurers to give 30 days advance notice to consumers before the termination of a contract with a health system.

Together, the provisions of Senate Bill 521 will simultaneously help to ensure market stability and continuing access to care, even in the face of uncertain provider-carrier negotiations. Patients will have a better opportunity to adapt to changes in provider networks, and the state will have enhanced ability to monitor the health insurance market to ensure network adequacy.

The MIA has been in contact with a number of state agencies and stakeholders, and is open to further discussion regarding amendments designed to ensure the effectiveness of the bill. The Health Education and Advocacy Unit of the Office of the Attorney General has shared amendments designed to further protect consumers and the MIA is supportive of those amendments.

For the reasons set forth above, the MIA urges a favorable committee report on Senate Bill 521 and thanks the committee for the opportunity to share its support.