Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 521 (Senator Kramer)
Finance Health

Health Insurance - Material Changes to Provider Networks - Notification and Special Enrollment Period

This bill expands the requirements on carriers regarding notification to enrollees about the termination of providers from provider panels. The bill alters when and how carriers must notify the Insurance Commissioner about a material change to their provider network, including requirements relating to updating a carrier access plan. The Commissioner may impose a specified fine on carriers that fail to timely file the required update. The bill requires carriers and health systems to provide notice of intent to terminate a contract. For specified contracts, carriers and health systems must adhere to the terms of the contract (including reimbursement terms and patient balance billing protections) for at least 90 days, with specified exception. The bill also requires carriers in the individual market to provide a special enrollment period (SEP) for an individual (or dependent) whose provider is terminated from the health plan's provider panel.

Fiscal Summary

State Effect: Any additional workload on the Maryland Insurance Administration (MIA) and the Maryland Health Benefit Exchange is minimal and absorbable within existing budgeted resources. The bill's penalty provision is not anticipated to materially impact State revenues.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary/Current Law:

Carrier Notification to Enrollees Regarding Provider Termination of Participation

Under current law, a carrier that uses a provider panel must establish procedures to notify an enrollee when the enrollee's primary care provider is terminated from the provider panel. Notification must include the right of the enrollee to request and continue to receive health care services from the provider for up to 90 days after the notice of termination. This requirement applies to Medicaid managed care organizations as well as commercial carriers.

The bill specifies that a carrier must also provide notice regarding the termination of any provider of behavioral health services for whom the carrier has received a claim for services performed on the enrollee within the preceding three months. The bill extends the right of the enrollee to request and continue to receive health care services to encompass care from these behavioral health providers for up to 90 days. The bill also requires that notice be given regarding the termination of a primary care or specified behavioral health provider, including if the provider *elects* to terminate participation from the provider panel. The notice provided to the enrollee by the carrier must include (1) contact information the enrollee may use to direct comments or concerns to the carrier regarding the provider's termination; (2) instructions on how to notify the carrier of the need for transitional care by submitting a uniform form developed by the Commissioner; and (3) the telephone number and email address for the MIA office that receives and responds to complaints.

Carrier Reimbursement

Under current law, for at least 90 days from the date of the notice of termination of a primary care provider from a carrier panel, the primary care provider must furnish health care services to an enrollee who (1) was receiving services from the primary care provider before the termination and (2) requests to continue receiving services. A carrier must reimburse a primary care provider that furnishes this care in accordance with the primary care provider's agreement with the carrier.

The bill adds a provider of behavioral health care services to these provisions and substitutes the term "primary care provider" with "provider." A provider that furnishes health care services under these provisions in accordance with a provider's agreement with a carrier must accept as payment in full for the services payment from the carrier and the cost sharing from the patient, as applicable.

Carrier Access Plan

Under current law, a carrier that uses a provider panel for a health benefit plan must annually file a network access plan with the Commissioner. An access plan must include, among other things, a description of the carrier's network, the process for monitoring and ensuring network sufficiency, and factors used to build the provider network. A carrier that makes a material change to their access plan must notify the Commissioner within 15 business days after the change occurs and provide a reasonable timeframe within which the carrier will file an update to their existing access plan.

The bill specifies that, if the termination of a provider or health care facility from a carrier's provider panel will result in a material change to the carrier's access plan, the carrier must (1) notify the Commissioner of the impending termination at least 60 days before the anticipated termination date; (2) have a continuing obligation to update and supplement initial and subsequent notifications until the termination is effective or an agreement is reached with the provider or health care facility; and (3) submit an update to the access plan for review by the Commissioner within five business days after the effective date of the termination.

However, the bill further specifies that notice of a material change due to the impending termination of a provider is only required if (1) the provider or health care facility provides advance notice of its intention to terminate participation; (2) the carrier provides advance notice to the provider or health care facility of the intent to terminate participation; (3) the current contract between the carrier and the provider or health care facility is set to expire within 60 days and no extension or renewal agreement has been reached; or (4) the carrier possesses other information that indicates that termination of the provider or health care facility is likely within 60 days. Also, carrier updates to the access plan are only required to include information related to the provider specialty types affected by the material change and, unless the network experienced a 10% reduction, the geographic areas where enrollees were affected by the material change.

The bill authorizes the Commissioner to impose a $5,000 fine (per day) for each day beyond five business days that a carrier fails to file a required update to the access plan.

Carriers and Health Systems

The bill defines "health system" to mean (1) a hospital and any entity affiliated with the hospital through ownership, governance, membership, or other means or (2) a parent corporation of one or more hospitals and any entity affiliated with the parent corporation through ownership, governance, membership, or other means.

Under the bill, a carrier and a health system must provide each other with written notice of any intent to terminate a contract at least 90 days before the proposed termination date or the end of the contract period.

The bill specifies that, for each contract between a carrier and a health system that is entered into, renewed, amended, or continued on or after October 1, 2026, if the contract is not renewed or is terminated, the carrier and the health system must continue to adhere to the terms of the contract (including reimbursement terms and patient balance billing protections for all health care services) for at least 90 days after the termination or nonrenewal. Except as otherwise agreed to, the reimbursement terms during the 90-day period must be retroactive to the date of termination or the end of the contract period. This requirement does not apply if the carrier and the health system agree in writing to the termination or nonrenewal of the contract and provide notice to each other regarding any intent to terminate or not renew the contract.

Uniform Form for Requests to Continue to Receive Health Care Services

The bill requires the Commissioner to develop a uniform form that carriers, providers, and health systems must use for requests to continue to receive health care services, as specified.

Special Enrollment Period – Individual Market

The bill establishes a new SEP for an individual (or their dependent) who is a patient being treated on a regular basis by or at a "provider" (which includes a health care practitioner or facility) and enrolled in a health benefit plan in which the provider is terminated from the provider panel. An SEP must be open for 90 days and begin on (1) the date of the termination of the provider from the health benefit plan's provider panel or (2) if the consumer did not receive notice of the termination before the termination date, the date of the notice of the termination. An individual who enrolls for coverage (or enrolls a dependent for coverage) under this SEP must select if coverage must become effective on the first day of the month (1) following the date the health benefit plan was selected or (2) in which the termination of the provider became effective.

Additional Comments: MIA advises that disputes between carriers and large provider groups can lead to provider groups leaving carrier provider panels, which may leave current plan participants and future enrollees without access to a provider network that matches their health needs. Negotiation disputes between carriers and large provider groups/medical systems have increasingly threatened enrollee access to enough in-network providers.

Currently, a carrier must notify the Commissioner 15 business days *after* a material change to its network access plan. However, MIA advises that the administration needs to receive *advance* notification of potential material changes to carrier networks to be able to monitor the progress of negotiations and ensure that a carrier is taking all reasonable steps to maintain an adequate network. Likewise, should negotiations fail between carriers and providers and health systems, MIA advises that consumers need to be properly notified.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

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

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