

Article - Insurance

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§15–121.

- (a) (1) In this section the following words have the meanings indicated.
- (2) “Carrier” means:
- (i) an insurer;
 - (ii) a nonprofit health service plan;
 - (iii) a health maintenance organization;
 - (iv) a dental plan organization;
 - (v) any person or entity acting as a third party administrator; or
 - (vi) 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 regulation by the State.
- (3) “Contract” means any written agreement between a provider and a carrier for the provider to render health care services to enrollees of the carrier.
- (4) “Enrollee” means any person or subscriber entitled to health care benefits from a carrier.
- (5) “Health care services” means a health or medical care procedure or service rendered by a provider that:
- (i) provides testing, diagnosis, or treatment of a human disease or dysfunction; or
 - (ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.
- (6) (i) “Provider” means a person or entity licensed, certified, or otherwise authorized under the Health Occupations Article or the Health - General Article to provide health care services.
- (ii) “Provider” includes:
- 1. a health care facility;
 - 2. a pharmacy;
 - 3. a professional services corporation;

4. a partnership;
5. a limited liability company;
6. a professional office; or
7. any other entity licensed or authorized by law to provide or deliver professional health care services through or on behalf of a provider.

(b) This section applies to a carrier that provides health care services to enrollees, or otherwise makes health care services available to enrollees, through contracts with providers.

(c) (1) Each carrier shall identify and disclose in layman's terms in its enrollment sales materials the reimbursement methodology or methodologies the carrier uses to reimburse physicians for health care services rendered to enrollees, including capitation, case rates, discounted fee-for-service, and fee-for-service reimbursement methodologies.

(2) The Maryland Health Care Commission shall develop a uniform definition in layman's terms of each reimbursement methodology required to be disclosed and identified by carriers under paragraph (1) of this subsection, including a representative example of a typical capitation arrangement between a carrier and a physician.

(d) (1) In addition to the requirements of subsection (c)(1) of this section, each carrier shall disclose in its enrollment sales materials the distribution of each \$100 it receives in premium dollars from enrollees for the preceding calendar year, for which data are available.

(2) The disclosure required under paragraph (1) of this subsection shall be in the form of a pie chart or bar graph with descriptive terms and in layman's terms that identifies consistent with the National Association of Insurance Commissioners' health maintenance organization annual statement ("orange form"):

(i) the proportion of every \$100 in premium dollars that the carrier uses to pay providers for the direct provision of health care services to enrollees, including what proportion is for direct medical care expenses; and

(ii) the proportion of every \$100 in premium dollars that the carrier uses to pay for plan administration.

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