Unofficial Copy 2003 Regular Session
C3 3lr1526

By: **Delegate Rosenberg**
Introduced and read first time: February 3, 2003
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance - Noncontracting Providers - Reimbursement Rate Disclosure

FOR the purpose of requiring certain health insurance carriers that issue or deliver certain health care benefit plans in the State to submit to the Insurance Commissioner, on or before a certain date and on the form the Commissioner requires, a schedule of certain reimbursement rates paid to certain health care providers for certain out-of-network services; requiring certain health insurance carriers to update certain information within a certain time; requiring that certain health insurance carriers provide a certain notification to certain enrollees and certain providers; requiring the Commissioner to compile a certain report by a certain date; prohibiting certain health insurance carriers from filing an application for a rate increase within a certain amount of time; prohibiting certain health insurance carriers from altering certain payments or certain procedures under certain circumstances; prohibiting the Commissioner from approving a certain rate increase based on certain circumstances; defining certain terms; and generally relating to the disclosure and reporting of reimbursement rates for out-of-network services to noncontracting providers.

BY adding to
Article - Insurance
Section 15-131
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

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

Article - Insurance

15-131.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "CPT" MEANS THE CURRENT PROCEDURAL TERMINOLOGY CODE AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION.

(3) "ENROLLEE" MEANS A PERSON OR SUBSCRIBER OR AN AGENT OR BROKER OF A PERSON OR SUBSCRIBER PURCHASING OR CONSIDERING AN OFFER TO PURCHASE A HEALTH CARE BENEFIT PLAN FROM ANY ENTITY SUBJECT TO THIS SECTION.

(4) "OUT-OF-NETWORK SERVICES" MEANS ANY SERVICES PERFORMED BY A HEALTH CARE PROVIDER NOT UNDER CONTRACT TO OR OTHERWISE SUBJECT TO NEGOTIATED PAYMENT AMOUNTS FROM AN ENTITY SUBJECT TO THIS SECTION.

(B) THIS SECTION APPLIES TO AN ENTITY THAT IS A HEALTH MAINTENANCE ORGANIZATION, NONPROFIT HEALTH SERVICE PLAN, OR FRATERNAL BENEFIT SOCIETY THAT ISSUES OR DELIVERS IN THE STATE AN INDIVIDUAL, GROUP, OR BLANKET HEALTH INSURANCE POLICY OR OTHER PLAN OF HEALTH CARE BENEFITS.

(C) ON OR BEFORE DECEMBER 31 OF EACH YEAR, AN ENTITY SUBJECT TO THIS SECTION SHALL:

(1) SUBMIT TO THE COMMISSIONER, ON A FORM THE COMMISSIONER REQUIRES, A SCHEDULE OF THE ACTUAL DOLLAR AMOUNT OF EACH CPT CODE RATE PAYMENT FOR ANY OUT-OF-NETWORK SERVICES FOR EACH HEALTH CARE BENEFIT PLAN OFFERED BY AN ENTITY SUBJECT TO THIS SECTION THAT PROVIDES OUT-OF-NETWORK SERVICES; AND

(2) UPDATE THE INFORMATION REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION WITHIN 30 DAYS AFTER ANY CPT CODE RATE PAYMENT CHANGE AND SUBMIT THE UPDATED INFORMATION TO THE COMMISSIONER.

(D) WHEN A HEALTH CARE BENEFIT PLAN OFFERED BY AN ENTITY SUBJECT TO THIS SECTION PROVIDES COVERAGE FOR ANY PORTION OF THE CHARGES FOR OUT-OF-NETWORK SERVICES, THE ENTITY SHALL DELIVER FREE OF CHARGE AT THE TIME OF INITIAL CONTRACT, CONTRACT RENEWAL, OR WITHIN 30 DAYS AFTER ANY CPT CODE RATE PAYMENT CHANGE THE CURRENT CPT CODE RATE PAYMENT INFORMATION REQUIRED UNDER SUBSECTION (C) OF THIS SECTION TO THE FOLLOWING:

(1) EACH PROSPECTIVE ENROLLEE WHO HAS CONTACTED THE ENTITY FOR THE PURPOSE OF OBTAINING A HEALTH INSURANCE POLICY OR PLAN;

(2) EACH CURRENT ENROLLEE; AND

(3) EACH PROVIDER WHO IS NOT UNDER CONTRACT WITH THE ENTITY.

(E) ON OR BEFORE FEBRUARY 1 OF EACH YEAR, THE COMMISSIONER SHALL COMPILE THE SCHEDULES REQUIRED UNDER SUBSECTION (C) OF THIS SECTION AND ISSUE AN ANNUAL REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY.

(F) (1) ANY ENTITY SUBJECT TO THIS SECTION THAT IS PROVIDING OR HAS OFFERED OR PROVIDED ENROLLEE COVERAGE FOR ANY OUT-OF-NETWORK SERVICES AT ANY TIME UP TO 1 YEAR BEFORE THE ENACTMENT OF THIS SECTION MAY NOT:

(I) FILE AN APPLICATION FOR A PROPOSED RATE INCREASE BASED ON ANY COST RESULTING FROM, OR OTHERWISE REASONABLY ATTRIBUTABLE TO, COMPLIANCE WITH THIS SECTION; OR

(II) ALTER THE DOLLAR AMOUNT OF THE CPT CODE RATE PAYMENT FOR, OR THE CPT CODE PROCEDURES INCLUDED IN, ANY OFFERED OUT-OF-NETWORK SERVICE COVERAGE WITHOUT PRIOR APPROVAL OF THE COMMISSIONER.

(2) THE COMMISSIONER MAY NOT APPROVE AN ALTERATION IN THE DOLLAR AMOUNT OF A CPT CODE OR A CPT CODE PROCEDURE IF THE ALTERATION IS BASED ON ANY COST TO AN ENTITY RESULTING FROM, OR REASONABLY ATTRIBUTABLE TO, COMPLIANCE WITH THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2003.