SB0314/537370/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 314
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 4, after the first "of" insert "providing that the difference between certain coinsurance percentages may not be greater than a certain amount under certain circumstances; prohibiting certain provisions in a preferred provider insurance policy from applying to certain on-call physicians; prohibiting a certain allowed amount in certain insurance policies from being less than a certain amount;"; in the same line, strike "insurance carriers" and substitute "insurers"; in lines 9, 11, 12, 15, 23, 25, and 26, in each instance, strike "carriers" and substitute "insurers"; strike beginning with "requiring" in line 17 down through "Administration;" in line 20; in line 20, after "the" insert "Maryland Insurance"; in line 21, after "Act;" insert "authorizing the Maryland Insurance Commissioner to impose a certain penalty for each violation of certain provisions of this Act;"; in line 24, strike "a provider" and substitute "certain providers"; strike beginning with the first comma in line 24 down through "enrollee" in line 25; in lines 25 and 26, strike "a provider" and substitute "certain providers"; in line 27, strike ", subscriber, or enrollee"; in line 29, strike "a patient" and substitute "an insured"; and in the same line, after "circumstances;" insert "requiring certain physicians to submit a certain disclosure form to an insurer under certain circumstances;".

On page 2, in line 1, after "certain" insert "disclosure"; in the same line, after "forms;" insert "authorizing an insurer to refuse to directly reimburse a certain provider under certain circumstances;"; in line 4, after "reports;" insert "requiring the Administration to conduct a certain study and submit a certain report to the Governor and the General Assembly on or before a certain date; prohibiting the Administration from imposing certain penalties for a violation of certain provisions of this Act until a certain date;"; in the same line, after "terms;" insert "making a certain conforming

(Over)

change;"; in line 5, after "application" insert "of certain provisions"; strike in their entirety lines 8 through 12, inclusive, and substitute:

"BY repealing and reenacting, with amendments,
Article - Insurance
Section 14-201, 14-205, and 15-304
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)";

and in line 15, strike "15-134" and substitute "14-205.3".

AMENDMENT NO. 2

On page 2, strike in their entirety lines 20 through 23, inclusive; and after line 24, insert:

"14–201.

(a) In this subtitle the following words have the meanings indicated.

(B) "ALLOWED AMOUNT" MEANS THE DOLLAR AMOUNT THAT AN INSURER DETERMINES IS THE VALUE OF THE HEALTH CARE SERVICE PROVIDED BY A PROVIDER BEFORE ANY COST SHARING AMOUNTS ARE APPLIED.

(C) "ASSIGNMENT OF BENEFITS" MEANS THE TRANSFER OF HEALTH CARE COVERAGE REIMBURSEMENT BENEFITS OR OTHER RIGHTS UNDER A PREFERRED PROVIDER INSURANCE POLICY BY AN INSURED.

(D) "BALANCE BILL" MEANS THE DIFFERENCE BETWEEN A NONPREFERRED PROVIDER'S BILL FOR A HEALTH CARE SERVICE AND THE INSURER'S ALLOWED AMOUNT.

(E) "COST SHARING AMOUNTS" MEANS THE AMOUNTS THAT AN INSURED IS RESPONSIBLE FOR UNDER A PREFERRED PROVIDER INSURANCE POLICY, INCLUDING ANY DEDUCTIBLES, COINSURANCE, OR COPAYMENTS.

(F) "COVERED SERVICE" MEANS A HEALTH CARE SERVICE THAT IS A COVERED BENEFIT UNDER A PREFERRED PROVIDER INSURANCE POLICY.

(G) "HEALTH CARE SERVICES" HAS THE MEANING STATED IN § 19-701 OF THE HEALTH – GENERAL ARTICLE.

[(b)**] (H)** "Insured" means a person covered for benefits under a preferred provider insurance policy offered or administered by an insurer.

(I) "MEDICARE ECONOMIC INDEX" MEANS THE FIXED-WEIGHT INPUT PRICE INDEX THAT:

(1) MEASURES THE WEIGHTED AVERAGE ANNUAL PRICE CHANGE FOR VARIOUS INPUTS NEEDED TO PRODUCE PHYSICIAN SERVICES; AND

(2) IS USED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES IN THE CALCULATION OF REIMBURSEMENT OF PHYSICIAN SERVICES UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT.

(J) "NONHOSPITAL-BASED PHYSICIAN" MEANS A PHYSICIAN WHO:

(1) IS AUTHORIZED UNDER THE MARYLAND MEDICAL PRACTICE ACT TO PRACTICE MEDICINE IN THE STATE; AND

(2) IS NOT UNDER CONTRACT WITH A HOSPITAL TO PROVIDE HEALTH CARE SERVICES TO PATIENTS IN THE HOSPITAL, EXCEPT AS AN ON-CALL PHYSICIAN.

[(c)**] (K)** "Nonpreferred provider" means a provider that is eligible for payment under a preferred provider insurance policy, but that is not a preferred provider under the applicable provider service contract.

(L) "ON-CALL PHYSICIAN" MEANS A NONHOSPITAL-BASED PHYSICIAN WHO:

(1) HAS PRIVILEGES AT A HOSPITAL; AND

(2) IS REQUIRED TO RESPOND WITHIN AN AGREED UPON TIME PERIOD TO PROVIDE HEALTH CARE SERVICES FOR UNASSIGNED PATIENTS AT THE REQUEST OF A HOSPITAL OR A HOSPITAL EMERGENCY DEPARTMENT.

[(d)**] (M)** "Preferential basis" means an arrangement under which the insured or subscriber under a preferred provider insurance policy is entitled to receive health care services from preferred providers at no cost, at a reduced fee, or under more favorable terms than if the insured or subscriber received similar services from a nonpreferred provider.

[(e)**] (N)** "Preferred provider" means a provider that has entered into a provider service contract.

[(f)**] (O)** "Preferred provider insurance policy" means:

(1) a policy or insurance contract that is issued or delivered in the State by an insurer, under which health care services are to be provided to the insured by a preferred provider on a preferential basis; or

(2) another contract that is offered by an employer, third party administrator, or other entity, under which health care services are to be provided to the subscriber by a preferred provider on a preferential basis.

[(g)**]** **(P)** "Provider" means a physician, hospital, or other person that is licensed or otherwise authorized to provide health care services.

[(h)**]** **(Q)** "Provider service contract" means a contract between a provider and an insurer, employer, third party administrator, or other entity, under which the provider agrees to provide health care services on a preferential basis under specific preferred provider insurance policies.

(R) "SIMILARLY LICENSED PROVIDER" MEANS:

(1) A PHYSICIAN WHO IS BOARD CERTIFIED OR ELIGIBLE IN THE SAME PRACTICE SPECIALTY; OR

(2) A GROUP PHYSICIAN PRACTICE THAT CONTAINS BOARD CERTIFIED OR ELIGIBLE PHYSICIANS IN THE SAME PRACTICE SPECIALTY.

[(i)**]** **(S)** "Subscriber" means a person covered for benefits under a preferred provider insurance policy issued by a person that is not an insurer.

14–205.

(a) If a preferred provider insurance policy offered by an insurer provides benefits for a service that is within the lawful scope of practice of a health care provider licensed under the Health Occupations Article, an insured covered by the preferred provider insurance policy is entitled to receive the benefits for that service

either through direct payments to the health care provider or through reimbursement to the insured.

(b) (1) A preferred provider insurance policy offered by an insurer under this subtitle shall provide for payment of services rendered by nonpreferred providers as provided in this subsection.

(2) Unless the insurer demonstrates to the satisfaction of the Commissioner that an alternative level of payment is more appropriate, **[**aggregate payments made in a full calendar year to nonpreferred providers, after all deductible and copayment provisions have been applied, on average may not be less than 80% of the aggregate payments made in that full calendar year to preferred providers for similar services, in the same geographic area, under their provider service contracts**]** **FOR EACH COVERED SERVICE UNDER A PREFERRED PROVIDER INSURANCE POLICY, THE DIFFERENCE BETWEEN THE COINSURANCE PERCENTAGE APPLICABLE TO NONPREFERRED PROVIDERS AND THE COINSURANCE PERCENTAGE APPLICABLE TO PREFERRED PROVIDERS MAY NOT BE GREATER THAN 20 PERCENTAGE POINTS**.

(3) IF THE PREFERRED PROVIDER INSURANCE POLICY CONTAINS A PROVISION FOR THE INSURED TO PAY THE BALANCE BILL, THE PROVISION MAY NOT APPLY TO AN ON-CALL PHYSICIAN WHO HAS ACCEPTED AN ASSIGNMENT OF BENEFITS IN ACCORDANCE WITH § 14-205.2 OF THIS SUBTITLE.

(4) THE INSURER'S ALLOWED AMOUNT FOR A HEALTH CARE SERVICE COVERED UNDER THE PREFERRED PROVIDER INSURANCE POLICY PROVIDED BY NONPREFERRED PROVIDERS MAY NOT BE LESS THAN THE ALLOWED AMOUNT PAID TO A PREFERRED PROVIDER FOR THE SAME HEALTH CARE SERVICE IN THE SAME GEOGRAPHIC REGION.

(c) (1) In this subsection, "unfair discrimination" means an act, method of competition, or practice engaged in by an insurer:

(i) that is prohibited by Title 27, Subtitle 2 of this article; or

(ii) that, although not specified in Title 27, Subtitle 2 of this article, the Commissioner believes is unfair or deceptive and that results in the institution of an action by the Commissioner under § 27–104 of this article.

(2) If the rates for each institutional provider under a preferred provider insurance policy offered by an insurer vary based on individual negotiations, geographic differences, or market conditions and are approved by the Health Services Cost Review Commission, the rates do not constitute unfair discrimination under this article.".

On pages 2 and 3, strike in their entirety the lines beginning with line 26 on page 2 through line 23 on page 3, inclusive.

On page 3, in lines 24 and 28, strike "**(B)**" and "**(C)**", respectively, and substitute "**(A)**" and "**(B)**", respectively; and in line 26, strike "**A VALID**" and substitute "**AN**".

On page 4, in line 18, strike "**TO THE INSURER**"; and in line 29, strike "**(D)**" and substitute "**(C)**".

On page 5, in line 4, strike "**AS OF**" and substitute "**FOR THE 12-MONTH PERIOD THAT ENDS ON**"; in lines 14, 21, 24, and 33, strike "**(E)**", "**(F)**", "**(G)**", and "**(H)**", respectively, and substitute "**(D)**", "**(E)**", "**(F)**", and "**(G)**", respectively; and in lines 14, 23, 25, and 32, in each instance, strike "**(D)**" and substitute "**(C)**".

On page 6, strike beginning with "**IF**" in line 2 down through "**SUSTAINED**" in line 3 and substitute "**IF THE ADMINISTRATION OR COURT FINDS THAT:**

(I) THE INSURER'S CONDUCT IN MAINTAINING OR DEFENDING THE PROCEEDING WAS IN BAD FAITH; OR

(II) THE INSURER ACTED WILLFULLY IN THE ABSENCE OF A BONA FIDE DISPUTE";

strike in their entirety lines 4 through 8, inclusive; in lines 9, 13, and 18, strike "**(J)**", "**(K)**", and "**(L)**", respectively, and substitute "**(H)**", "**(I)**", and "**(J)**", respectively; and strike beginning with "**THAT**" in line 15 down through "**INSURER**" in line 17 and substitute "**FOR EACH VIOLATION OF THIS SECTION**".

AMENDMENT NO. 3

On page 6, in line 21, strike "**15-134.**" and substitute "**14-205.3.**".

On pages 6 and 7, strike beginning with "**(1)**" in line 22 on page 6 down through "**TITLE**" in line 27 on page 7 and substitute "**THIS SECTION DOES NOT APPLY TO ON-CALL PHYSICIANS**".

On page 7, in line 28, strike "**A CARRIER**" and substitute "**AN INSURER**".

On page 8, in line 1, after "**PROVIDER**" insert "**WHO IS A PHYSICIAN**"; in line 2, strike "**, SUBSCRIBER, OR ENROLLEE**"; in line 3, strike "**REIMBURSE DIRECTLY**" and substitute "**DIRECTLY REIMBURSE**"; in the same line, after the first "**A**" insert "**NONPREFERRED**"; in the same line, after "**PROVIDER**" insert "**WHO IS A PHYSICIAN**"; strike beginning with the second "**A**" in line 3 down through "**VALID**" in line 4 and substitute "**AN**"; strike beginning with the first comma in line 5 down through "**VALID**" in line 6 and substitute "**HAS NOT PROVIDED AN**"; in line 7, strike

"**CARRIER**" and substitute "**INSURER**"; strike beginning with the first comma in line 8 down through "**ENROLLEE**" in line 9; in lines 10, 16, 18, and 19, in each instance, strike "**NONPARTICIPATING**" and substitute "**NONPREFERRED**"; in line 10, after "**PROVIDER**" insert "**WHO IS A PHYSICIAN**"; strike beginning with the first comma in line 13 down through "**ENROLLEE'S**" in line 14; strike beginning with the first comma in line 15 down through "**ENROLLEE**" in line 16; in line 17, strike "**, SUBSCRIBER, OR ENROLLEE**"; strike beginning with "**(1)**" in line 20 down through "**(2)**" in line 22; in line 22, after "**PHYSICIAN**" insert "**WHO IS A NONPREFERRED PROVIDER**"; in line 23, strike "**A PATIENT**" and substitute "**AN INSURED**"; in line 24, strike "**PATIENT**" and substitute "**INSURED, PRIOR TO PERFORMING A HEALTH CARE SERVICE**"; in lines 25 and 27, in each instance, strike "**PATIENT**" and substitute "**INSURED**"; in the same line, strike "**(I)**" and "**(II)**", respectively, and substitute "**(1)**" and "**(2)**", respectively; in line 26, strike "**AND**"; strike beginning with the first comma in line 28 down through "**PLAN**" in line 30 and substitute "**FOR NONCOVERED SERVICES;**

(3) A STATEMENT INFORMING THE INSURED THAT THE NONHOSPITAL-BASED PHYSICIAN MAY CHARGE THE INSURED THE BALANCE BILL FOR COVERED SERVICES;

(4) AN ESTIMATE OF THE COST OF SERVICES THAT THE NONHOSPITAL-BASED PHYSICIAN WILL PROVIDE TO THE INSURED;

(5) ANY TERMS OF PAYMENT THAT MAY APPLY; AND

(6) WHETHER INTEREST WILL APPLY AND, IF SO, THE AMOUNT OF INTEREST CHARGED BY THE NONHOSPITAL-BASED PHYSICIAN.

(E) A NONHOSPITAL-BASED PHYSICIAN WHO IS A NONPREFERRED PROVIDER SHALL SUBMIT THE DISCLOSURE FORM DEVELOPED BY THE

COMMISSIONER UNDER SUBSECTION (F) OF THIS SECTION TO DOCUMENT TO THE INSURER THE ASSIGNMENT OF BENEFITS BY AN INSURED";

in line 31, strike "**(E)**" and substitute "**(F)**"; in the same line, after "**DEVELOP**" insert "**DISCLOSURE**"; and after line 32, insert:

"**(G) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (B) OF THIS SECTION, AN INSURER MAY REFUSE TO DIRECTLY REIMBURSE A NONPREFERRED PROVIDER UNDER AN ASSIGNMENT OF BENEFITS IF:**

(1) THE INSURER RECEIVES NOTICE OF THE ASSIGNMENT OF BENEFITS AFTER THE TIME THE INSURER HAS PAID THE BENEFITS TO THE INSURED;

(2) THE INSURER, DUE TO AN INADVERTENT ADMINISTRATIVE ERROR, HAS PREVIOUSLY PAID THE INSURED;

(3) THE INSURED WITHDRAWS THE ASSIGNMENT OF BENEFITS BEFORE THE INSURER HAS PAID THE BENEFITS TO THE NONPREFERRED PROVIDER; OR

(4) THE INSURED PAID THE NONPREFERRED PROVIDER THE FULL AMOUNT DUE AT THE TIME OF SERVICE.

15–304.

(a) **[**Subject**] EXCEPT AS PROVIDED IN §§ 14-205.2 AND 14-205.3 OF THIS ARTICLE, AND SUBJECT** to subsection (b) of this section, on request of the policyholder, a policy of group health insurance may contain a provision that all or part of the benefits provided by the policy for hospital, nursing, medical, or surgical

services, at the insurer's option, may be paid directly to the hospital or person that provides the services.

(b) A policy of group health insurance may not require that hospital, nursing, medical, or surgical services be provided by a particular hospital or person.

(c) A direct payment made under subsection (a) of this section discharges the insurer's obligation with respect to the amount paid.".

AMENDMENT NO. 4

On page 9, in line 14, after "of" insert "primary and specialty"; in the same line, strike "networks" and substitute "networks, including the impact on billed charges, allowed charges, and patient responsibility for remaining charges, by specialty"; after line 23, insert:

"SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Insurance Administration shall study:

(1) the benefits provided by health insurers under preferred provider insurance policies for covered services rendered by nonpreferred providers at hospitals that are preferred providers during emergencies and elective admissions; and

(2) the impact of these benefits on complaints filed by insureds with insurers and the Administration regarding balance billing.

(b) On or before December 1, 2011, the Administration shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on its findings under this section and any recommendations.

SECTION 4. AND BE IT FURTHER ENACTED, That the Maryland Insurance Administration may not impose any monetary penalties on a health insurer for a

violation of § 14-205.2 of the Insurance Article, as enacted by Section 1 of this Act, until July 1, 2012.";

in lines 24 and 27, strike "3." and "4.", respectively, and substitute "5." and "6.", respectively; and in line 28, strike "3" and substitute "5".