SENATE BILL 314

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CF HB 147

By: **Senators Garagiola, Kelley, Astle, DeGrange, Exum, Forehand, Frosh, Gladden, Jones, Kasemeyer, King, Kramer, McFadden, Miller, Peters, Raskin, Robey, and Rosapepe**

Introduced and read first time: January 27, 2010
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers

FOR the purpose of providing that an insured of certain health insurance carriers may not be liable to certain on–call physicians for certain services under certain circumstances; prohibiting certain on–call physicians from taking certain actions against an insured under certain circumstances; authorizing the on–call physicians to collect certain payments from an insured under certain circumstances; requiring certain carriers or their agents to pay certain on–call physicians for certain health care services delivered to an insured at a certain rate under certain circumstances; requiring certain carriers to disclose certain information under certain circumstances; authorizing certain carriers to seek reimbursement from an insured for a claim or portion of a claim submitted by certain on–call physicians under certain circumstances; authorizing certain carriers to require certain on–call physicians to provide certain information under certain circumstances; authorizing the enforcement of certain provisions of this Act in a certain manner under certain circumstances; requiring the Maryland Health Care Commission to review annually payments to certain on–call physicians and report its findings to the Maryland Insurance Administration; authorizing the Administration to take a certain action to investigate and enforce a violation of certain provisions of this Act; requiring the Administration, in consultation with the Maryland Health Care Commission, to adopt certain regulations; providing that certain carriers may not prohibit the assignment of benefits to a provider by an insured, subscriber, or enrollee; prohibiting certain carriers from refusing to directly reimburse a provider under an assignment of benefits; requiring certain carriers to include certain information with a payment to an insured, subscriber, or enrollee under certain circumstances; requiring certain physicians to provide certain information to a patient under certain circumstances; requiring the Maryland

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

Insurance Commissioner to develop certain forms; requiring the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration and the Office of the Attorney General, to conduct a certain study and submit certain reports; defining certain terms; providing for the application of this Act; providing for a delayed effective date for certain provisions of this Act; and generally relating to the assignment of benefits and reimbursement of nonpreferred providers.

BY adding to
Article – Health – General
Section 19–706(cccc)
Annotated Code of Maryland
(2009 Replacement Volume)

BY adding to
Article – Insurance
Section 14–205.2 and 15–134
Annotated Code of Maryland
(2006 Replacement Volume and 2009 Supplement)

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

Article – Health – General

19–706.

(CCCC) THE PROVISIONS OF § 15–134 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

14–205.2.

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

(2) "COVERED SERVICE" MEANS A HEALTH CARE SERVICE THAT IS A COVERED BENEFIT UNDER A PREFERRED PROVIDER INSURANCE POLICY ISSUED BY AN INSURER.

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

(4) "MEDICARE ECONOMIC INDEX" MEANS THE FIXED–WEIGHT INPUT PRICE INDEX THAT:

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

(II) 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.

(5) "NONHOSPITAL–BASED PHYSICIAN" MEANS A PHYSICIAN WHO:

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

(II) IS NOT UNDER CONTRACT WITH A HOSPITAL TO PROVIDE HEALTH CARE SERVICES TO PATIENTS IN THE HOSPITAL.

(6) "ON–CALL PHYSICIAN" MEANS A NONHOSPITAL–BASED PHYSICIAN WHO:

(I) HAS PRIVILEGES AT A HOSPITAL; AND

(II) IS REQUIRED TO RESPOND WITHIN AN AGREED UPON TIME PERIOD TO PROVIDE EMERGENCY HEALTH CARE SERVICES FOR UNASSIGNED PATIENTS WHO PRESENT AT A HOSPITAL EMERGENCY DEPARTMENT.

(7) "SIMILARLY LICENSED PROVIDER" MEANS:

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

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

(B) THIS SECTION APPLIES TO ON–CALL PHYSICIANS WHO:

(1) ARE NONPREFERRED PROVIDERS; AND

(2) OBTAIN A VALID ASSIGNMENT OF BENEFITS FROM AN INSURED.

(C) (1) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, AN INSURED MAY NOT BE LIABLE TO AN ON–CALL PHYSICIAN

SUBJECT TO THIS SECTION FOR COVERED SERVICES RENDERED BY THE ON–CALL PHYSICIAN.

(2) AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION OR A REPRESENTATIVE OF AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION MAY NOT:

(I) COLLECT OR ATTEMPT TO COLLECT FROM AN INSURED OF AN INSURER ANY MONEY OWED TO THE ON–CALL PHYSICIAN BY THE INSURER FOR COVERED SERVICES RENDERED TO THE INSURED BY THE ON–CALL PHYSICIAN; OR

(II) MAINTAIN ANY ACTION AGAINST AN INSURED OF AN INSURER TO COLLECT OR ATTEMPT TO COLLECT ANY MONEY OWED TO THE ON–CALL PHYSICIAN BY THE INSURER FOR COVERED SERVICES RENDERED TO THE INSURED BY THE ON–CALL PHYSICIAN.

(3) AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION OR A REPRESENTATIVE OF AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION MAY COLLECT OR ATTEMPT TO COLLECT FROM AN INSURED OF AN INSURER:

(I) ANY COPAYMENT OR COINSURANCE AMOUNT OWED BY THE INSURED TO THE INSURER FOR COVERED SERVICES RENDERED TO THE INSURED BY THE ON–CALL PHYSICIAN;

(II) IF MEDICARE IS THE PRIMARY INSURER AND THE INSURER IS THE SECONDARY INSURER, ANY AMOUNT UP TO THE MEDICARE APPROVED OR LIMITING AMOUNT, AS SPECIFIED UNDER THE FEDERAL SOCIAL SECURITY ACT, THAT IS NOT OWED TO THE ON–CALL PHYSICIAN BY MEDICARE OR THE INSURER AFTER COORDINATION OF BENEFITS HAS BEEN COMPLETED, FOR MEDICARE COVERED SERVICES RENDERED TO THE INSURED BY THE ON–CALL PHYSICIAN; AND

(III) ANY PAYMENT OR CHARGES FOR SERVICES THAT ARE NOT COVERED SERVICES.

(D) FOR A COVERED SERVICE RENDERED TO AN INSURED OF AN INSURER BY AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION, THE INSURER OR ITS AGENT:

(1) SHALL PAY THE ON–CALL PHYSICIAN WITHIN 30 DAYS AFTER THE RECEIPT OF A CLAIM IN ACCORDANCE WITH THE APPLICABLE PROVISIONS OF THIS TITLE; AND

(2) SHALL PAY A CLAIM SUBMITTED BY THE ON–CALL PHYSICIAN FOR A COVERED SERVICE RENDERED TO AN INSURED IN A HOSPITAL, NO LESS THAN THE GREATER OF:

(I) 140% OF THE AVERAGE RATE THE INSURER PAID AS OF JANUARY 1 OF THE PREVIOUS CALENDAR YEAR IN THE SAME GEOGRAPHIC AREA, AS DEFINED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, FOR THE SAME COVERED SERVICE, TO SIMILARLY LICENSED PROVIDERS UNDER WRITTEN CONTRACT WITH THE INSURER; OR

(II) 140% OF THE RATE PAID BY MEDICARE, AS PUBLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, FOR THE SAME COVERED SERVICE TO A SIMILARLY LICENSED PROVIDER IN THE SAME GEOGRAPHIC AREA AS OF AUGUST 1, 2008, INFLATED BY THE CHANGE IN THE MEDICARE ECONOMIC INDEX FROM 2008 TO THE CURRENT YEAR.

(E) FOR THE PURPOSES OF SUBSECTION (D)(2)(I) OF THIS SECTION, AN INSURER SHALL CALCULATE THE AVERAGE RATE PAID TO SIMILARLY LICENSED PROVIDERS UNDER WRITTEN CONTRACT WITH THE INSURER FOR THE SAME COVERED SERVICE BY SUMMING THE CONTRACTED RATE FOR ALL OCCURRENCES OF THE CURRENT PROCEDURAL TERMINOLOGY CODE FOR THAT COVERED SERVICE AND THEN DIVIDING BY THE TOTAL NUMBER OF OCCURRENCES OF THE CURRENT PROCEDURAL TERMINOLOGY CODE.

(F) AN INSURER SHALL DISCLOSE, ON REQUEST OF AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION, THE REIMBURSEMENT RATE REQUIRED UNDER SUBSECTION (D)(2) OF THIS SECTION.

(G) (1) AN INSURER MAY SEEK REIMBURSEMENT FROM AN INSURED FOR ANY PAYMENT UNDER SUBSECTION (D)(2) OF THIS SECTION FOR A CLAIM OR PORTION OF A CLAIM SUBMITTED BY AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION AND PAID BY THE INSURER THAT THE INSURER DETERMINES IS THE RESPONSIBILITY OF THE INSURED BASED ON THE INSURANCE CONTRACT.

(2) THE INSURER MAY REQUEST AND THE ON–CALL PHYSICIAN SHALL PROVIDE ADJUNCT CLAIMS DOCUMENTATION TO ASSIST IN MAKING THE DETERMINATION UNDER PARAGRAPH (1) OF THIS SUBSECTION OR UNDER SUBSECTION (D) OF THIS SECTION.

(H) (1) AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION MAY ENFORCE THE PROVISIONS OF THIS SECTION BY FILING A COMPLAINT AGAINST AN INSURER WITH THE ADMINISTRATION OR BY FILING A CIVIL ACTION IN A COURT OF COMPETENT JURISDICTION UNDER § 1–501 OR § 4–201 OF THE COURTS ARTICLE.

(2) THE ADMINISTRATION OR A COURT SHALL AWARD REASONABLE ATTORNEY'S FEES IF THE COMPLAINT OF THE ON–CALL PHYSICIAN IS SUSTAINED.

(I) THE MARYLAND HEALTH CARE COMMISSION ANNUALLY SHALL:

(1) REVIEW PAYMENTS TO ON–CALL PHYSICIANS SUBJECT TO THIS SECTION TO DETERMINE THE COMPLIANCE OF INSURERS WITH THE REQUIREMENTS OF THIS SECTION; AND

(2) REPORT ITS FINDINGS TO THE ADMINISTRATION.

(J) THE ADMINISTRATION MAY TAKE ANY ACTION AUTHORIZED UNDER THIS ARTICLE, INCLUDING CONDUCTING AN EXAMINATION UNDER TITLE 2, SUBTITLE 2 OF THIS ARTICLE, TO INVESTIGATE AND ENFORCE A VIOLATION OF THE PROVISIONS OF THIS SECTION.

(K) IN ADDITION TO ANY OTHER PENALTIES UNDER THIS ARTICLE, THE COMMISSIONER MAY IMPOSE A PENALTY NOT TO EXCEED $5,000 ON AN INSURER THAT VIOLATES THE PROVISIONS OF THIS SECTION IF THE VIOLATION IS COMMITTED WITH SUCH FREQUENCY AS TO INDICATE A GENERAL BUSINESS PRACTICE OF THE INSURER.

(L) THE ADMINISTRATION, IN CONSULTATION WITH THE MARYLAND HEALTH CARE COMMISSION, SHALL ADOPT REGULATIONS TO IMPLEMENT THIS SECTION.

15–134.

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

(2) "ASSIGNMENT OF BENEFITS" MEANS THE TRANSFER OF HEALTH CARE COVERAGE REIMBURSEMENT BENEFITS OR OTHER RIGHTS UNDER A HEALTH BENEFIT PLAN BY AN INSURED, SUBSCRIBER, OR ENROLLEE TO A PROVIDER.

(3) (I) "CARRIER" MEANS:

1. AN INSURER THAT PROVIDES BENEFITS ON AN EXPENSE–INCURRED BASIS;

2. A NONPROFIT HEALTH SERVICE PLAN;

3. A HEALTH MAINTENANCE ORGANIZATION;

4. ANY PERSON OR ENTITY ACTING AS A THIRD PARTY ADMINISTRATOR; OR

5. ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS THAT:

A. PROVIDE BENEFITS ON AN EXPENSE–INCURRED BASIS; AND

B. ARE SUBJECT TO REGULATION BY THE STATE.

(II) "CARRIER" INCLUDES AN ENTITY THAT ARRANGES A PROVIDER PANEL FOR A CARRIER.

(4) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15–1201 OF THIS TITLE.

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

(6) "NONHOSPITAL–BASED PHYSICIAN" MEANS A PHYSICIAN WHO:

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

(II) IS NOT UNDER CONTRACT WITH A HOSPITAL TO PROVIDE HEALTH CARE SERVICES TO PATIENTS IN THE HOSPITAL.

(7) "NONPARTICIPATING PROVIDER" MEANS A PROVIDER WHO IS NOT ON A CARRIER'S PROVIDER PANEL.

(8) "PROVIDER" MEANS A PHYSICIAN WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED BY LAW TO PROVIDE HEALTH CARE SERVICES.

(9) "PROVIDER PANEL" HAS THE MEANING STATED IN § 15–112 OF THIS TITLE.

(B) A CARRIER MAY NOT:

(1) PROHIBIT THE ASSIGNMENT OF BENEFITS TO A PROVIDER BY AN INSURED, SUBSCRIBER, OR ENROLLEE; OR

(2) REFUSE TO REIMBURSE DIRECTLY A PROVIDER UNDER A VALID ASSIGNMENT OF BENEFITS.

(C) IF AN INSURED, SUBSCRIBER, OR ENROLLEE OF A CARRIER HAS NOT ASSIGNED A BENEFIT TO A NONPARTICIPATING PROVIDER UNDER A VALID ASSIGNMENT OF BENEFITS, THE CARRIER SHALL INCLUDE THE FOLLOWING INFORMATION WITH THE PAYMENT TO THE INSURED, SUBSCRIBER, OR ENROLLEE FOR HEALTH CARE SERVICES RENDERED BY THE NONPARTICIPATING PROVIDER:

(1) THE SPECIFIC CLAIM COVERED BY THE PAYMENT;

(2) THE AMOUNT PAID FOR THE CLAIM;

(3) THE AMOUNT THAT IS THE INSURED'S, SUBSCRIBER'S, OR ENROLLEE'S RESPONSIBILITY; AND

(4) A STATEMENT INSTRUCTING THE INSURED, SUBSCRIBER, OR ENROLLEE TO USE THE PAYMENT TO PAY THE NONPARTICIPATING PROVIDER IN THE EVENT THE INSURED, SUBSCRIBER, OR ENROLLEE HAS NOT PAID THE NONPARTICIPATING PROVIDER IN FULL FOR THE HEALTH CARE SERVICES RENDERED BY THE NONPARTICIPATING PROVIDER.

(D) (1) THIS SUBSECTION DOES NOT APPLY TO AN ON–CALL PHYSICIAN AS DEFINED IN § 14–205.2 OF THIS ARTICLE.

(2) IF A NONHOSPITAL–BASED PHYSICIAN SEEKS AN ASSIGNMENT OF BENEFITS FROM A PATIENT, THE NONHOSPITAL–BASED PHYSICIAN SHALL PROVIDE THE FOLLOWING INFORMATION TO THE PATIENT:

(I) A STATEMENT INFORMING THE PATIENT THAT THE NONHOSPITAL–BASED PHYSICIAN IS A NONPARTICIPATING PROVIDER; AND

(II) A STATEMENT INFORMING THE PATIENT THAT THE NONHOSPITAL–BASED PHYSICIAN MAY CHARGE THE INSURED, SUBSCRIBER, OR ENROLLEE FOR HEALTH CARE SERVICES NOT COVERED UNDER THE INSURED'S, SUBSCRIBER'S, OR ENROLLEE'S HEALTH BENEFIT PLAN.

(E) THE COMMISSIONER SHALL DEVELOP FORMS TO IMPLEMENT THE REQUIREMENTS UNDER SUBSECTIONS (C) AND (D) OF THIS SECTION.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission, in consultation with the Maryland Insurance Administration and the Office of the Attorney General, shall study:

(1) the benefits and costs associated with the direct reimbursement of nonparticipating providers by health insurance carriers under a valid assignment of benefits;

(2) the impact of enacting a cap on balance billing for nonpreferred, on–call physicians;

(3) the impact on consumers of prohibiting health insurance carriers from refusing to accept a valid assignment of benefits; and

(4) the impact of requiring direct reimbursement of nonparticipating providers by health insurance carriers on a health insurance carrier's ability to maintain an adequate number of providers in their networks.

(b) On or before January 1, 2011, the Maryland Health Care Commission shall determine baseline parameters to conduct the study required under subsection (a) of this section.

(c) (1) On or before July 1, 2012, the Maryland Health Care Commission shall submit an interim report to the General Assembly, in accordance with § 2–1246 of the State Government Article, on its findings under this section.

(2) On or before October 1, 2014, the Maryland Health Care Commission shall submit a final report to the General Assembly, in accordance with § 2–1246 of the State Government Article, on its findings under this section.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2011, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2011.

SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in Section 3 of this Act, this Act shall take effect October 1, 2010.