SENATE BILL 314

C3 0lr1641
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

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 11, 2010

CHAPTER _____

AN ACT concerning

Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers

FOR the purpose of 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; providing that an insured of certain health ~~insurance carriers~~ insurers 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~~ insurers 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~~ insurers to disclose certain information under certain circumstances; authorizing certain ~~carriers~~ insurers 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~~ insurers 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~~

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

~~annually payments to certain on–call physicians and report its findings to the Maryland Insurance Administration;~~ authorizing the Maryland Insurance Administration to take a certain action to investigate and enforce a violation of certain provisions of this Act; authorizing the Maryland Insurance Commissioner to impose a certain penalty for each 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~~ insurers may not prohibit the assignment of benefits to ~~a provider~~ certain providers by an insured~~, subscriber, or enrollee~~; prohibiting certain ~~carriers~~ insurers from refusing to directly reimburse ~~a provider~~ certain providers under an assignment of benefits; requiring certain ~~carriers~~ insurers 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~~ an insured under certain circumstances; requiring certain physicians to submit a certain disclosure form to an insurer under certain circumstances; requiring the Maryland Insurance Commissioner to develop certain disclosure forms; authorizing an insurer to refuse to directly reimburse a certain provider under certain circumstances; 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; 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; defining certain terms; making a certain conforming change; providing for the application of certain provisions 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 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)

BY adding to
Article – Insurance
Section 14–205.2 and ~~15–134~~ 14–205.3
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

14–201.

(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.

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)~~ (A) **THIS SECTION APPLIES TO ON–CALL PHYSICIANS WHO:**

(1) ARE NONPREFERRED PROVIDERS; AND

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

~~(C)~~ (B) **(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)~~ (C) 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~~ FOR THE 12–MONTH PERIOD THAT ENDS ON 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)~~ (D) FOR THE PURPOSES OF SUBSECTION ~~(D)~~(C)(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)~~ (E) AN INSURER SHALL DISCLOSE, ON REQUEST OF AN ON–CALL PHYSICIAN SUBJECT TO THIS SECTION, THE REIMBURSEMENT RATE REQUIRED UNDER SUBSECTION ~~(D)~~(C)(2) OF THIS SECTION.

~~(G)~~ (F) (1) AN INSURER MAY SEEK REIMBURSEMENT FROM AN INSURED FOR ANY PAYMENT UNDER SUBSECTION ~~(D)~~(C)(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)~~ (C) OF THIS SECTION.

~~(H)~~ (G) (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~~ 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.

~~(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)~~ **(H) 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)~~ **(I) 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~~ FOR EACH VIOLATION OF THIS SECTION.**

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

~~15–134.~~ **14–205.3.**

(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~~ **THIS SECTION DOES NOT APPLY TO ON–CALL PHYSICIANS**.

(B) ~~A CARRIER~~ AN INSURER MAY NOT:

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

(2) REFUSE TO ~~REIMBURSE DIRECTLY~~ DIRECTLY REIMBURSE A NONPREFERRED PROVIDER WHO IS A PHYSICIAN UNDER ~~A VALID~~ AN 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~~ HAS NOT PROVIDED AN ASSIGNMENT OF BENEFITS, THE ~~CARRIER~~ INSURER SHALL INCLUDE THE FOLLOWING INFORMATION WITH THE PAYMENT TO THE INSURED~~, SUBSCRIBER, OR ENROLLEE~~ FOR HEALTH CARE SERVICES RENDERED BY THE ~~NONPARTICIPATING~~ NONPREFERRED PROVIDER WHO IS A PHYSICIAN:

(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~~ NONPREFERRED PROVIDER IN THE EVENT THE INSURED~~, SUBSCRIBER, OR ENROLLEE~~ HAS NOT PAID THE ~~NONPARTICIPATING~~ NONPREFERRED PROVIDER IN FULL FOR THE HEALTH CARE SERVICES RENDERED BY THE ~~NONPARTICIPATING~~ NONPREFERRED 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 WHO IS A NONPREFERRED PROVIDER SEEKS AN ASSIGNMENT OF BENEFITS FROM ~~A PATIENT~~ AN INSURED, THE NONHOSPITAL–BASED PHYSICIAN SHALL PROVIDE THE FOLLOWING INFORMATION TO THE ~~PATIENT~~ INSURED, PRIOR TO PERFORMING A HEALTH CARE SERVICE:

~~(I)~~ (1) A STATEMENT INFORMING THE ~~PATIENT~~ INSURED THAT THE NONHOSPITAL–BASED PHYSICIAN IS A NONPARTICIPATING PROVIDER; ~~AND~~

~~(II)~~ **(2)** **A STATEMENT INFORMING THE ~~PATIENT~~ INSURED 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~~ 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.

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

(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.

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 primary and specialty providers in their ~~networks~~ networks, including the impact on billed charges, allowed charges, and patient responsibility for remaining charges, by specialty.

(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:

(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.

SECTION ~~3.~~ 5. 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.~~ 6. AND BE IT FURTHER ENACTED, That, except as provided in Section ~~3~~ 5 of this Act, this Act shall take effect October 1, 2010.

Approved:

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Governor.

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President of the Senate.

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Speaker of the House of Delegates.