SENATE BILL 803

C3 5lr2854
CF 5lr2890

By: **Senator Astle**
Introduced and read first time: February 19, 2015
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Health Insurance – Nonpreferred Providers – Assignment of Benefits, Reimbursement, and Fraudulent Insurance Acts

FOR the purpose of altering the maximum difference between the coinsurance percentage applicable to certain nonpreferred providers and the coinsurance percentage applicable to certain preferred providers; altering the reimbursement amount payable by certain insurers to certain on–call physicians or hospital–based physicians who are nonpreferred providers; providing that it is a fraudulent insurance act for a nonpreferred provider to knowingly or willfully waive, forgive, or fail to collect certain deductibles, copayments, coinsurance, or other cost sharing amounts; providing certain penalties for a violation of certain provisions of this Act; repealing the termination date of certain provisions of law relating to the assignment of benefits and reimbursement of nonpreferred providers; and generally relating to health insurance and nonpreferred providers.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 14–201(a) and (k)
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–205 and 14–205.2
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY adding to
Article – Insurance
Section 27–407.3
Annotated Code of Maryland

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

(2011 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 27–408
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)
(As enacted by Chapter 35 of the Acts of the General Assembly of 1997)

BY repealing and reenacting, with amendments,
Chapter 537 of the Acts of the General Assembly of 2010
Section 7

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

Article – Insurance

14–201.

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

(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.

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, 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**]** **50** 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 or a

hospital–based 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 similarly licensed provider who is 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) Except as otherwise provided, this section applies to both on–call physicians and hospital–based physicians who:

(1) are nonpreferred providers;

(2) obtain an assignment of benefits from an insured; and

(3) notify the insurer of an insured in a manner specified by the Commissioner that the on–call physician or hospital–based physician has obtained and accepted the assignment of benefits from the insured.

(b) (1) Except as provided in paragraph (3) of this subsection, an insured may not be liable to an on–call physician or a hospital–based physician subject to this section for covered services rendered by the on–call physician or hospital–based physician.

(2) An on–call physician or hospital–based physician subject to this section or a representative of an on–call physician or hospital–based 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 or hospital–based physician by the insurer for covered services rendered to the insured by the on–call physician or hospital–based 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 or hospital–based physician by the insurer for covered services rendered to the insured by the on–call physician or hospital–based physician.

(3) An on–call physician or hospital–based physician subject to this section or a representative of an on–call physician or hospital–based physician subject to this section may collect or attempt to collect from an insured of an insurer:

(i) any deductible, copayment, or coinsurance amount owed by the insured for covered services rendered to the insured by the on–call physician or hospital–based 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 or hospital–based 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 or hospital–based physician; and

(iii) any payment or charges for services that are not covered services.

(c) (1) This subsection applies only to on–call physicians subject to this section.

(2) 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:

(i) 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

(ii) 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:

1.**]** 140% of the average rate the insurer paid 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

2. the average rate the insurer paid for the 12–month period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider not under written contract with the insurer, inflated by the change in the Medicare Economic Index from 2010 to the current year**]**.

(d) (1) This subsection applies only to hospital–based physicians subject to this section.

(2) For a covered service rendered to an insured of an insurer by a hospital–based physician subject to this section, the insurer or its agent:

(i) shall pay the hospital–based physician within 30 days after the receipt of the claim in accordance with the applicable provisions of this title; and

(ii) shall pay a claim submitted by the hospital–based physician for a covered service rendered to an insured no less than **[**the greater of:

1.**]** 140% of the average rate the insurer paid 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, who are hospital–based physicians, under written contract with the insurer**[**; or

2. the final allowed amount of the insurer for the same covered service for the 12–month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the hospital–based physician billing under the same federal tax identification number the hospital–based physician used in calendar year 2009**]**.

(e) **[**(1)**]** For the purposes of subsections **[**(c)(2)(ii)1**] (C)(2)(II)** and **[**(d)(2)(ii)1**] (D)(2)(II)** 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.

[(2) For the purposes of subsection (c)(2)(ii)2 of this section, an insurer shall calculate the average rate paid to similarly licensed providers not under written contract with the insurer for the same covered service by summing the rates paid to similarly licensed providers not under written contract with the insurer 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 or hospital–based physician subject to this section, the reimbursement rate required under subsection (c)(2)(ii) or (d)(2)(ii) of this section.

(g) (1) An insurer may seek reimbursement from an insured for any payment under subsection (c)(2)(ii) or (d)(2)(ii) of this section for a claim or portion of a claim submitted by an on–call physician or hospital–based 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 or hospital–based physician shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (c) of this section.

(h) (1) An on–call physician or hospital–based 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 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 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.

(j) In addition to any other penalties under this article, the Commissioner may impose a penalty not to exceed $5,000 on an insurer for each violation of this section.

(k) The Administration, in consultation with the Maryland Health Care Commission, shall adopt regulations to implement this section.

27–407.3.

(A) IN THIS SECTION, "NONPREFERRED PROVIDER" HAS THE MEANING STATED IN § 14–201 OF THIS ARTICLE.

(B) IT IS A FRAUDULENT INSURANCE ACT FOR A NONPREFERRED PROVIDER TO KNOWINGLY OR WILLFULLY WAIVE, FORGIVE, OR FAIL TO COLLECT ANY PORTION OF A DEDUCTIBLE, COPAYMENT, COINSURANCE, OR OTHER COST SHARING AMOUNT OWED BY AN INSURED FOR SERVICES RENDERED TO THE INSURED BY THE NONPREFERRED PROVIDER.

27–408.

(a) (1) A person that violates § 27–407 of this subtitle, or another provision of this subtitle in which the claim or act that is the subject of the fraud has a value of $300 or more is guilty of a felony and on conviction, for each violation, is subject to:

(i) liability for restoring to the victim the property taken or the value of the property taken; and

(ii) 1. for a violation of any provision of § 27–403 of this subtitle, a fine, the maximum of which is the greater of three times the value of the claim or act that is the subject of the fraud and $10,000 and the minimum of which is $500, or imprisonment not exceeding 15 years or both; and

2. for a violation of any provision of § 27–404, § 27–405, § 27–406, § 27–406.1, § 27–407, § 27–407.1, **[**or**]** § 27–407.2**, OR § 27–407.3** of this subtitle, a fine not exceeding $10,000 or imprisonment not exceeding 15 years or both.

(2) A person that violates a provision of this subtitle in which the claim or act that is the subject of the fraud has a value of less than $300 is guilty of a misdemeanor and on conviction, for each violation, is subject to:

(i) liability for restoring to the victim the property taken or the value of the property taken; and

(ii) 1. for a violation of any provision of § 27–403 of this subtitle, a fine, the maximum of which is the greater of three times the value of the claim or act that is the subject of the fraud and $10,000 and the minimum of which is $500, or imprisonment not exceeding 18 months or both; and

2. for a violation of any provision of § 27–404, § 27–405, § 27–406, § 27–406.1, § 27–407, § 27–407.1, **[**or**]** § 27–407.2**, OR § 27–407.3** of this subtitle, a fine not exceeding $10,000 or imprisonment not exceeding 18 months or both.

(b) (1) The penalties imposed under this section may be imposed separately from and consecutively to or concurrently with a sentence for another offense based on the act that constitutes a violation of this subtitle.

(2) Each act of solicitation under § 27–407 of this subtitle constitutes a separate violation for purposes of the penalties imposed under this section.

(3) Notwithstanding any other provision of law, a fine imposed under subsection (a) of this section is mandatory and not subject to suspension.

(c) (1) In addition to any criminal penalties that may be imposed under this section, on a showing by clear and convincing evidence that a violation of this subtitle has occurred, the Commissioner may:

(i) impose an administrative penalty not exceeding $25,000 for each act of insurance fraud; and

(ii) order restitution to an insurer or self–insured employer of any insurance proceeds paid relating to a fraudulent insurance claim.

(2) In determining the amount of an administrative penalty, the Commissioner shall consider:

(i) the nature, circumstances, extent, gravity, and number of violations;

(ii) the degree of culpability of the violator;

(iii) prior offenses and repeated violations of the violator; and

(iv) any other matter that the Commissioner considers appropriate and relevant.

(3) If an administrative penalty is not paid after all rights of appeal have been waived or exhausted, the Commissioner may bring a civil action in a court of competent jurisdiction to collect the administrative penalty, including expenses and litigation costs, reasonable attorney's fees, and interest.

(d) This section does not affect an insurer's right to take any independent action to seek recovery against a person that violates this subtitle.

Chapter 537 of the Acts of 2010

SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Section 6 of this Act, this Act shall take effect October 1, 2010. **[**It shall remain effective for a period of 5 years and, at the end of September 30, 2015, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2015.