

SENATE BILL 776

C3, J3, J4

0lr3063

By: **Senator Kelley**

Introduced and read first time: February 3, 2020

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance, Health Care Facilities, and Providers – Balance Billing –**
3 **Limitations**

4 FOR the purpose of defining “health care facility–based physician” for the purpose of
5 applying certain provisions of law relating to the assignment of benefits and the
6 reimbursement of nonpreferred providers who are physicians to physicians based in
7 certain health care facilities; altering the circumstances under which the Maryland
8 Insurance Commissioner may authorize an insurer or a nonprofit health service plan
9 to offer a certain preferred provider insurance policy; altering the scope of certain
10 provisions of law relating to the reimbursement of nonpreferred providers;
11 prohibiting a carrier from requiring an insured to obtain prior authorization and
12 imposing certain limitations on coverage for certain services under certain
13 circumstances; requiring a carrier to provide certain coverage and require certain
14 cost–sharing for certain services under certain circumstances; requiring a carrier to
15 count certain cost–sharing amounts required by the carrier toward a certain
16 deductible and certain out–of–pocket maximum; requiring that a certain
17 cost–sharing requirement for certain out–of–network services be the same as the
18 cost–sharing requirement for certain in–network services unless an insured has been
19 provided certain notification and information by certain entities, has acknowledged
20 in a certain manner receiving certain notification of certain information, and has
21 assumed in a certain manner certain responsibility for certain costs; establishing
22 requirements for a certain notification; prohibiting a facility and a health care
23 practitioner from billing a certain individual for certain amounts for certain services;
24 requiring a certain facility to provide a certain patient with a certain notice and
25 obtain a certain acknowledgment; requiring a carrier to pay certain facilities and
26 certain health care practitioners certain rates for certain services; requiring a health
27 maintenance organization to pay certain health care providers a certain rate for
28 certain services; requiring a carrier to disclose certain rates to certain facilities and
29 certain health care practitioners under certain circumstances; requiring a carrier to
30 use a certain database for a certain purpose under a certain circumstance; requiring
31 the Maryland Insurance Administration, in collaboration with certain commissions,

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 to adopt certain regulations; making conforming changes; defining certain terms;
2 repealing a certain definition; providing for a delayed effective date; and generally
3 relating to health insurance carriers, health care providers, and reimbursement for
4 health care services.

5 BY repealing and reenacting, with amendments,
6 Article – Health – General
7 Section 19–710.1
8 Annotated Code of Maryland
9 (2019 Replacement Volume)

10 BY repealing and reenacting, with amendments,
11 Article – Insurance
12 Section 14–201, 14–205, 14–205.1(a), 14–205.2, and 14–205.3
13 Annotated Code of Maryland
14 (2017 Replacement Volume and 2019 Supplement)

15 BY adding to
16 Article – Insurance
17 Section 15–6A–01 through 15–6A–07 to be under the new subtitle “Subtitle 6A.
18 Surprise Medical Bills”
19 Annotated Code of Maryland
20 (2017 Replacement Volume and 2019 Supplement)

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

23 **Article – Health – General**

24 19–710.1.

25 (a) (1) In this section the following words have the meanings indicated.

26 (2) “Adjunct claims documentation” means an abstract of an enrollee’s
27 medical record which describes and summarizes the diagnosis and treatment of, and
28 services rendered to, the enrollee, including, in the case of trauma rendered in a trauma
29 center, an operative report, a discharge summary, a Maryland Ambulance Information
30 Systems form, or a medical record.

31 (3) “Berenson–Eggers Type of Service Code” means a code in a
32 classification system developed by the Centers for Medicare and Medicaid Services that
33 groups Current Procedural Terminology codes together based on clinical consistency.

34 (4) “Enrollee” means a subscriber or member of a health maintenance
35 organization.

36 (5) “Evaluation and management service” means any service with a

1 Berenson–Eggers Type of Service Code in the category of evaluation and management.

2 (6) “Institute” means the Maryland Institute for Emergency Medical
3 Services Systems.

4 (7) “Medicare Economic Index” means the fixed–weight input price index
5 that:

6 (i) Measures the weighted average annual price change for various
7 inputs needed to produce physician services; and

8 (ii) Is used by the Centers for Medicare and Medicaid Services in the
9 calculation of reimbursement of physician services under Title XVIII of the federal Social
10 Security Act.

11 (8) “Similarly licensed provider” means:

12 (i) For a physician:

13 1. A physician who is board certified or eligible in the same
14 practice specialty; or

15 2. A group physician practice that contains board certified or
16 eligible physicians in the same practice specialty;

17 (ii) For a health care provider that is not a physician, a health care
18 provider that holds the same type of license.

19 (9) (i) “Trauma center” means a primary adult resource center, level I
20 trauma center, level II trauma center, level III trauma center, or pediatric trauma center
21 that has been designated by the institute to provide care to trauma patients.

22 (ii) “Trauma center” includes an out–of–state pediatric facility that
23 has entered into an agreement with the institute to provide care to trauma patients.

24 (10) “Trauma patient” means a patient that is evaluated or treated in a
25 trauma center and is entered into the State trauma registry as a trauma patient.

26 (11) “Trauma physician” means a licensed physician who has been
27 credentialed or designated by a trauma center to provide care to a trauma patient at a
28 trauma center.

29 (b) In addition to any other provisions of this subtitle, for a covered service
30 rendered to an enrollee of a health maintenance organization by a health care provider not
31 under written contract with the health maintenance organization, the health maintenance
32 organization or its agent:

1 (1) Shall pay the health care provider within 30 days after the receipt of a
2 claim in accordance with the applicable provisions of this subtitle; and

3 (2) [Shall] **SUBJECT TO § 15-6A-06 OF THE INSURANCE ARTICLE,**
4 **SHALL** pay the claim submitted by:

5 (i) A hospital at the rate approved by the Health Services Cost
6 Review Commission;

7 (ii) A trauma physician for trauma care rendered to a trauma
8 patient in a trauma center, at the greater of:

9 1. 140% of the rate paid by the Medicare program, as
10 published by the Centers for Medicare and Medicaid Services, for the same covered service,
11 to a similarly licensed provider; or

12 2. The rate as of January 1, 2001 that the health
13 maintenance organization paid in the same geographic area, as published by the Centers
14 for Medicare and Medicaid Services, for the same covered service, to a similarly licensed
15 provider; and

16 (iii) Any other health care provider:

17 1. For an evaluation and management service, no less than
18 the greater of:

19 A. 125% of the average rate the health maintenance
20 organization paid as of January 1 of the previous calendar year in the same geographic
21 area, as defined by the Centers for Medicare and Medicaid Services, for the same covered
22 service, to similarly licensed providers under written contract with the health maintenance
23 organization; or

24 B. 140% of the rate paid by Medicare, as published by the
25 Centers for Medicare and Medicaid Services, for the same covered service to a similarly
26 licensed provider in the same geographic area as of August 1, 2008, inflated by the change
27 in the Medicare Economic Index from 2008 to the current year; and

28 2. For a service that is not an evaluation and management
29 service, no less than 125% of the average rate the health maintenance organization paid as
30 of January 1 of the previous calendar year in the same geographic area, as defined by the
31 Centers for Medicare and Medicaid Services, to a similarly licensed provider under written
32 contract with the health maintenance organization for the same covered service.

33 (c) For the purposes of subsection (b)(2)(iii) of this section, a health maintenance
34 organization shall calculate the average rate paid to similarly licensed providers under
35 written contract with the health maintenance organization for the same covered service by
36 summing the contracted rate for all occurrences of the Current Procedural Terminology

1 Code for that service and then dividing by the total number of occurrences of the Current
2 Procedural Terminology Code.

3 (d) A health maintenance organization shall disclose, on request of a health care
4 provider not under written contract with the health maintenance organization, the
5 reimbursement rate required under subsection (b)(2)(ii) and (iii) of this section.

6 (e) (1) Subject to paragraph (2) of this subsection, a health maintenance
7 organization may require a trauma physician not under contract with the health
8 maintenance organization to submit appropriate adjunct claims documentation and to
9 include on the uniform claim form a provider number assigned to the trauma physician by
10 the health maintenance organization.

11 (2) If a health maintenance organization requires a trauma physician to
12 include a provider number on the uniform claim form in accordance with paragraph (1) of
13 this subsection, the health maintenance organization shall assign a provider number to a
14 trauma physician not under contract with the health maintenance organization at the
15 request of the physician.

16 (3) A trauma center, on request from a health maintenance organization,
17 shall verify that a licensed physician is credentialed or otherwise designated by the trauma
18 center to provide trauma care.

19 (4) Notwithstanding the provisions of § 19-701(d) of this subtitle, for
20 trauma care rendered to a trauma patient in a trauma center by a trauma physician, a
21 health maintenance organization may not require a referral or preauthorization for a
22 service to be covered.

23 (f) (1) A health maintenance organization may seek reimbursement from an
24 enrollee for any payment under subsection (b) of this section for a claim or portion of a claim
25 submitted by a health care provider and paid by the health maintenance organization that
26 the health maintenance organization determines is the responsibility of the enrollee.

27 (2) The health maintenance organization may request and the health care
28 provider shall provide adjunct claims documentation to assist in making the determination
29 under paragraph (1) of this subsection or under subsection (b) of this section.

30 (g) (1) A health care provider may enforce the provisions of this section by
31 filing a complaint against a health maintenance organization with the Maryland Insurance
32 Administration or by filing a civil action in a court of competent jurisdiction under § 1-501
33 or § 4-201 of the Courts Article.

34 (2) The Maryland Insurance Administration or a court shall award
35 reasonable attorney fees if the complaint of the health care provider is sustained.

36 (h) The Maryland Health Care Commission annually shall review payments to
37 health care providers to determine the compliance of health maintenance organizations

1 with the requirements of this section and report its findings to the Maryland Insurance
2 Administration.

3 (i) The Maryland Insurance Administration may take any action authorized
4 under this subtitle or the Insurance Article, including conducting an examination under
5 Title 2, Subtitle 2 of the Insurance Article, to investigate and enforce a violation of the
6 provisions of this section.

7 (j) In addition to any other penalties under this subtitle, the Commissioner may
8 impose a penalty not to exceed \$5,000 on any health maintenance organization which
9 violates the provisions of this section if the violation is committed with such frequency as
10 to indicate a general business practice of the health maintenance organization.

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

13 Article – Insurance

14 14–201.

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

16 (b) “Allowed amount” means the dollar amount that an insurer determines is the
17 value of the health care service provided by a provider before any cost sharing amounts are
18 applied.

19 (c) “Assignment of benefits” means the transfer of health care coverage
20 reimbursement benefits or other rights under a preferred provider insurance policy by an
21 insured.

22 (d) “Balance bill” means the difference between a nonpreferred provider’s bill for
23 a health care service and the insurer’s allowed amount.

24 (e) “Cost sharing amounts” means the amounts that an insured is responsible for
25 under a preferred provider insurance policy, including any deductibles, coinsurance, or
26 copayments.

27 (f) “Covered service” means a health care service that is a covered benefit under
28 a preferred provider insurance policy.

29 (G) **“HEALTH CARE FACILITY–BASED PHYSICIAN” MEANS:**

30 **(1) A PHYSICIAN LICENSED IN THE STATE WHO IS UNDER CONTRACT**
31 **TO PROVIDE HEALTH CARE SERVICES TO PATIENTS AT A HOSPITAL, FREESTANDING**
32 **MEDICAL FACILITY, OR FREESTANDING AMBULATORY CARE FACILITY; OR**

1 **(2) A GROUP PHYSICIAN PRACTICE THAT INCLUDES PHYSICIANS**
2 **LICENSED IN THE STATE THAT IS UNDER CONTRACT TO PROVIDE HEALTH CARE**
3 **SERVICES TO PATIENTS AT A HOSPITAL, FREESTANDING MEDICAL FACILITY, OR**
4 **FREESTANDING AMBULATORY CARE FACILITY.**

5 **[(g) (H)** “Health care services” has the meaning stated in § 19–701 of the Health
6 – General Article.

7 **[(h)** “Hospital–based physician” means:

8 (1) a physician licensed in the State who is under contract to provide health
9 care services to patients at a hospital; or

10 (2) a group physician practice that includes physicians licensed in the State
11 that is under contract to provide health care services to patients at a hospital.]

12 (i) “Insured” means a person covered for benefits under a preferred provider
13 insurance policy offered or administered by an insurer.

14 (j) “Medicare economic index” means the fixed–weight input price index that:

15 (1) measures the weighted average annual price change for various inputs
16 needed to produce physician services; and

17 (2) is used by the Centers for Medicare and Medicaid Services in the
18 calculation of reimbursement of physician services under Title XVIII of the federal Social
19 Security Act.

20 (k) “Nonpreferred provider” means a provider that is eligible for payment under
21 a preferred provider insurance policy, but that is not a preferred provider under the
22 applicable provider service contract.

23 (l) “On–call physician” means a physician who:

24 (1) has privileges at a hospital;

25 (2) is required to respond within an agreed upon time period to provide
26 health care services for unassigned patients at the request of a hospital or a hospital
27 emergency department; and

28 (3) is not a **[hospital–based] HEALTH CARE FACILITY–BASED** physician.

29 (m) “Preferential basis” means an arrangement under which the insured or
30 subscriber under a preferred provider insurance policy is entitled to receive health care
31 services from preferred providers at no cost, at a reduced fee, or under more favorable terms
32 than if the insured or subscriber received similar services from a nonpreferred provider.

1 (n) "Preferred provider" means a provider that has entered into a provider service
2 contract.

3 (o) "Preferred provider insurance policy" means:

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

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

10 (p) "Provider" means a physician, hospital, **FREESTANDING MEDICAL**
11 **FACILITY, FREESTANDING AMBULATORY CARE FACILITY**, or other person that is
12 licensed or otherwise authorized to provide health care services.

13 (q) "Provider service contract" means a contract between a provider and an
14 insurer, employer, third party administrator, or other entity, under which the provider
15 agrees to provide health care services on a preferential basis under specific preferred
16 provider insurance policies.

17 (r) "Similarly licensed provider" means:

18 (1) for a physician:

19 (i) a physician who is board certified or eligible in the same practice
20 specialty; or

21 (ii) a group physician practice that contains board certified or
22 eligible physicians in the same practice specialty; or

23 (2) for a health care provider who is not a physician, a health care provider
24 who holds the same type of license or certification.

25 (s) "Subscriber" means a person covered for benefits under a preferred provider
26 insurance policy issued by a person that is not an insurer.

27 14–205.

28 (a) If a preferred provider insurance policy offered by an insurer provides benefits
29 for a service that is within the lawful scope of practice of a health care provider licensed
30 under the Health Occupations Article, an insured covered by the preferred provider
31 insurance policy is entitled to receive the benefits for that service either through direct
32 payments to the health care provider or through reimbursement to the insured.

1 (b) (1) **[A] SUBJECT TO THE REQUIREMENTS FOR SERVICES RENDERED**
2 **UNDER TITLE 15, SUBTITLE 6A OF THIS ARTICLE,** A preferred provider insurance policy
3 offered by an insurer under this subtitle shall provide for payment of services rendered by
4 nonpreferred providers as provided in this subsection.

5 (2) Unless the insurer demonstrates to the satisfaction of the
6 Commissioner that an alternative level of payment is more appropriate, for each covered
7 service under a preferred provider insurance policy, the difference between the coinsurance
8 percentage applicable to nonpreferred providers and the coinsurance percentage applicable
9 to preferred providers may not be greater than 20 percentage points.

10 (3) If the preferred provider insurance policy contains a provision for the
11 insured to pay the balance bill, the provision may not apply to an on-call physician or a
12 **[hospital-based] HEALTH CARE FACILITY-BASED** physician who has accepted an
13 assignment of benefits in accordance with § 14-205.2 of this subtitle.

14 (4) The insurer's allowed amount for a health care service covered under
15 the preferred provider insurance policy provided by nonpreferred providers may not be less
16 than the allowed amount paid to a similarly licensed provider who is a preferred provider
17 for the same health care service in the same geographic region.

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

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

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

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

28 14-205.1.

29 (a) The Commissioner may authorize an insurer or nonprofit health service plan
30 to offer a preferred provider insurance policy that conditions the payment of benefits on the
31 use of preferred providers if the insurer or nonprofit health service plan does not restrict
32 payment for covered services provided by nonpreferred providers:

33 (1) for emergency services, as **[defined in § 19-701 of the Health – General**
34 **Article] REQUIRED UNDER § 15-6A-02 OF THIS ARTICLE;**

35 (2) for an unforeseen illness, injury, or condition requiring immediate care;
36 or

1 (3) as required under § 15–830 of this article.

2 14–205.2.

3 (a) Except as otherwise provided, this section applies to both on–call physicians
4 and [hospital–based] **HEALTH CARE FACILITY–BASED** physicians who:

5 (1) are nonpreferred providers;

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

7 (3) notify the insurer of an insured in a manner specified by the
8 Commissioner that the on–call physician or [hospital–based] **HEALTH CARE**
9 **FACILITY–BASED** physician has obtained and accepted the assignment of benefits from
10 the insured.

11 (b) (1) Except as provided in paragraph (3) of this subsection, an insured may
12 not be liable to an on–call physician or a [hospital–based] **HEALTH CARE**
13 **FACILITY–BASED** physician subject to this section for covered services rendered by the
14 on–call physician or [hospital–based] **HEALTH CARE FACILITY–BASED** physician.

15 (2) An on–call physician or [hospital–based] **HEALTH CARE**
16 **FACILITY–BASED** physician subject to this section or a representative of an on–call
17 physician or [hospital–based] **HEALTH CARE FACILITY–BASED** physician subject to this
18 section may not:

19 (i) collect or attempt to collect from an insured of an insurer any
20 money owed to the on–call physician or [hospital–based] **HEALTH CARE FACILITY–BASED**
21 physician by the insurer for covered services rendered to the insured by the on–call
22 physician or [hospital–based] **HEALTH CARE FACILITY–BASED** physician; or

23 (ii) maintain any action against an insured of an insurer to collect or
24 attempt to collect any money owed to the on–call physician or [hospital–based] **HEALTH**
25 **CARE FACILITY–BASED** physician by the insurer for covered services rendered to the
26 insured by the on–call physician or [hospital–based] **HEALTH CARE FACILITY–BASED**
27 physician.

28 (3) An on–call physician or [hospital–based] **HEALTH CARE**
29 **FACILITY–BASED** physician subject to this section or a representative of an on–call
30 physician or [hospital–based] **HEALTH CARE FACILITY–BASED** physician subject to this
31 section may collect or attempt to collect from an insured of an insurer:

32 (i) any deductible, copayment, or coinsurance amount owed by the
33 insured for covered services rendered to the insured by the on–call physician or

1 ~~[hospital-based]~~ **HEALTH CARE FACILITY-BASED** physician;

2 (ii) if Medicare is the primary insurer and the insurer is the
3 secondary insurer, any amount up to the Medicare approved or limiting amount, as
4 specified under the federal Social Security Act, that is not owed to the on-call physician or
5 ~~[hospital-based]~~ **HEALTH CARE FACILITY-BASED** physician by Medicare or the insurer
6 after coordination of benefits has been completed, for Medicare covered services rendered
7 to the insured by the on-call physician or ~~[hospital-based]~~ **HEALTH CARE**
8 **FACILITY-BASED** physician; and

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

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

12 (2) For a covered service rendered to an insured of an insurer by an on-call
13 physician subject to this section, the insurer or its agent:

14 (i) shall pay the on-call physician within 30 days after the receipt
15 of a claim in accordance with the applicable provisions of this title; and

16 (ii) **SUBJECT TO § 15-6A-06 OF THIS ARTICLE**, shall pay a claim
17 submitted by the on-call physician for a covered service rendered to an insured in a
18 hospital, no less than the greater of:

19 1. 140% of the average rate the insurer paid for the
20 12-month period that ends on January 1 of the previous calendar year in the same
21 geographic area, as defined by the Centers for Medicare and Medicaid Services, for the
22 same covered service, to similarly licensed providers under written contract with the
23 insurer; or

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

29 (d) (1) This subsection applies only to ~~[hospital-based]~~ **HEALTH CARE**
30 **FACILITY-BASED** physicians subject to this section.

31 (2) For a covered service rendered to an insured of an insurer by a
32 ~~[hospital-based]~~ **HEALTH CARE FACILITY-BASED** physician subject to this section, the
33 insurer or its agent:

34 (i) shall pay the ~~[hospital-based]~~ **HEALTH CARE**
35 **FACILITY-BASED** physician within 30 days after the receipt of the claim in accordance

1 with the applicable provisions of this title; and

2 (ii) **SUBJECT TO § 15-6A-06 OF THIS ARTICLE**, shall pay a claim
3 submitted by the **[hospital-based] HEALTH CARE FACILITY-BASED** physician for a
4 covered service rendered to an insured no less than the greater of:

5 1. 140% of the average rate the insurer paid for the
6 12-month period that ends on January 1 of the previous calendar year in the same
7 geographic area, as defined by the Centers for Medicare and Medicaid Services, for the
8 same covered service, to similarly licensed providers, who are **[hospital-based] HEALTH**
9 **CARE FACILITY-BASED** physicians, under written contract with the insurer; or

10 2. the final allowed amount of the insurer for the same
11 covered service for the 12-month period that ended on January 1, 2010, inflated by the
12 change in the Medicare Economic Index to the current year, to the **[hospital-based]**
13 **HEALTH CARE FACILITY-BASED** physician billing under the same federal tax
14 identification number the **[hospital-based] HEALTH CARE FACILITY-BASED** physician
15 used in calendar year 2009.

16 (e) (1) For the purposes of subsections (c)(2)(ii)1 and (d)(2)(ii)1 of this section,
17 an insurer shall calculate the average rate paid to similarly licensed providers under
18 written contract with the insurer for the same covered service by summing the contracted
19 rate for all occurrences of the Current Procedural Terminology Code for that covered service
20 and then dividing by the total number of occurrences of the Current Procedural
21 Terminology Code.

22 (2) For the purposes of subsection (c)(2)(ii)2 of this section, an insurer shall
23 calculate the average rate paid to similarly licensed providers not under written contract
24 with the insurer for the same covered service by summing the rates paid to similarly
25 licensed providers not under written contract with the insurer for all occurrences of the
26 Current Procedural Terminology Code for that covered service and then dividing by the
27 total number of occurrences of the Current Procedural Terminology Code.

28 (f) An insurer shall disclose, on request of an on-call physician or
29 **[hospital-based] HEALTH CARE FACILITY-BASED** physician subject to this section, the
30 reimbursement rate required under subsection (c)(2)(ii) or (d)(2)(ii) of this section.

31 (g) (1) An insurer may seek reimbursement from an insured for any payment
32 under subsection (c)(2)(ii) or (d)(2)(ii) of this section for a claim or portion of a claim
33 submitted by an on-call physician or **[hospital-based] HEALTH CARE FACILITY-BASED**
34 physician subject to this section and paid by the insurer that the insurer determines is the
35 responsibility of the insured based on the insurance contract.

36 (2) The insurer may request and the on-call physician or **[hospital-based]**
37 **HEALTH CARE FACILITY-BASED** physician shall provide adjunct claims documentation
38 to assist in making the determination under paragraph (1) of this subsection or under

1 subsection (c) of this section.

2 (h) (1) An on-call physician or [hospital-based] **HEALTH CARE**
3 **FACILITY-BASED** physician subject to this section may enforce the provisions of this
4 section by filing a complaint against an insurer with the Administration or by filing a civil
5 action in a court of competent jurisdiction under § 1-501 or § 4-201 of the Courts Article.

6 (2) The Administration or a court shall award reasonable attorney's fees if
7 the Administration or court finds that:

8 (i) the insurer's conduct in maintaining or defending the proceeding
9 was in bad faith; or

10 (ii) the insurer acted willfully in the absence of a bona fide dispute.

11 (i) The Administration may take any action authorized under this article,
12 including conducting an examination under Title 2, Subtitle 2 of this article, to investigate
13 and enforce a violation of the provisions of this section.

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

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

18 14-205.3.

19 (a) This section does not apply to on-call physicians or [hospital-based] **HEALTH**
20 **CARE FACILITY-BASED** physicians.

21 (b) An insurer may not:

22 (1) prohibit the assignment of benefits to a provider who is a physician by
23 an insured; or

24 (2) refuse to directly reimburse a nonpreferred provider who is a physician
25 under an assignment of benefits.

26 (c) If an insured has not provided an assignment of benefits, the insurer shall
27 include the following information with the payment to the insured for health care services
28 rendered by the nonpreferred provider who is a physician:

29 (1) the specific claim covered by the payment;

30 (2) the amount paid for the claim;

31 (3) the amount that is the insured's responsibility; and

1 (4) a statement instructing the insured to use the payment to pay the
2 nonpreferred provider in the event the insured has not paid the nonpreferred provider in
3 full for the health care services rendered by the nonpreferred provider.

4 (d) If a physician who is a nonpreferred provider seeks an assignment of benefits
5 from an insured, the physician shall provide the following information to the insured, prior
6 to performing a health care service:

7 (1) a statement informing the insured that the physician is a nonpreferred
8 provider;

9 (2) a statement informing the insured that the physician may charge the
10 insured for noncovered services;

11 (3) a statement informing the insured that the physician may charge the
12 insured the balance bill for covered services;

13 (4) an estimate of the cost of services that the physician will provide to the
14 insured;

15 (5) any terms of payment that may apply; and

16 (6) whether interest will apply and, if so, the amount of interest charged
17 by the physician.

18 (e) A physician who is a nonpreferred provider shall submit the disclosure form
19 developed by the Commissioner under subsection (f) of this section to document to the
20 insurer the assignment of benefits by an insured.

21 (f) The Commissioner shall develop disclosure forms to implement the
22 requirements under subsections (c) and (d) of this section.

23 (g) Notwithstanding the provisions of subsection (b) of this section, an insurer
24 may refuse to directly reimburse a nonpreferred provider under an assignment of benefits
25 if:

26 (1) the insurer receives notice of the assignment of benefits after the time
27 the insurer has paid the benefits to the insured;

28 (2) the insurer, due to an inadvertent administrative error, has previously
29 paid the insured;

30 (3) the insured withdraws the assignment of benefits before the insurer
31 has paid the benefits to the nonpreferred provider; or

32 (4) the insured paid the nonpreferred provider the full amount due at the

1 time of service.

2 **SUBTITLE 6A. SURPRISE MEDICAL BILLS.**

3 **15-6A-01.**

4 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS
5 INDICATED.

6 (B) "CARRIER" MEANS:

7 (1) AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE
8 STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

9 (2) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO
10 OPERATE IN THE STATE;

11 (3) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO
12 OPERATE IN THE STATE; OR

13 (4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH
14 BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

15 (C) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION
16 THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUCH SEVERITY, INCLUDING
17 SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD
18 REASONABLY BE EXPECTED BY A PRUDENT LAYPERSON, WHO POSSESSES AN
19 AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, TO RESULT IN:

20 (1) PLACING THE PATIENT'S HEALTH IN SERIOUS JEOPARDY;

21 (2) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

22 (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.

23 (D) (1) "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN
24 EMERGENCY MEDICAL CONDITION:

25 (I) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE
26 CAPABILITY OF THE EMERGENCY DEPARTMENT OF A FACILITY; OR

27 (II) ANY OTHER EXAMINATION OR TREATMENT WITHIN THE
28 CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE FOR TREATMENT OF THE

1 PATIENT THAT IS NECESSARY TO STABILIZE THE PATIENT.

2 (2) "EMERGENCY SERVICES" INCLUDES, WITH RESPECT TO AN
3 EMERGENCY MEDICAL CONDITION, ANCILLARY SERVICES ROUTINELY AVAILABLE
4 TO THE EMERGENCY DEPARTMENT TO EVALUATE AN EMERGENCY MEDICAL
5 CONDITION.

6 (E) "FACILITY" INCLUDES A HOSPITAL, A HOSPITAL OUTPATIENT
7 DEPARTMENT, AN AMBULATORY SURGERY CENTER, A FREESTANDING MEDICAL
8 FACILITY, A LABORATORY, A RADIOLOGY CLINIC, AND ANY OTHER FACILITY THAT
9 PROVIDES SERVICES THAT ARE COVERED UNDER AN INDIVIDUAL OR
10 GROUP HEALTH BENEFIT PLAN.

11 (F) "HEALTH CARE PRACTITIONER" MEANS AN INDIVIDUAL WHO IS
12 LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH
13 OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES.

14 (G) "INSURED INDIVIDUAL" MEANS AN INSURED, AN ENROLLEE, A
15 SUBSCRIBER, A POLICY HOLDER, A PARTICIPANT, OR A BENEFICIARY.

16 (H) "MEDIAN IN-NETWORK RATE" MEANS, WITH RESPECT TO HEALTH CARE
17 SERVICES COVERED BY AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN, THE
18 MEDIAN NEGOTIATED RATE UNDER THE APPLICABLE PLAN FOR THE SAME OR A
19 SIMILAR SERVICE THAT IS PROVIDED BY A HEALTH CARE PRACTITIONER IN THE
20 SAME OR A SIMILAR SPECIALTY, IN THE GEOGRAPHIC REGION WHERE THE SERVICE
21 IS PROVIDED.

22 (I) "STABILIZE" MEANS TO PROVIDE MEDICAL TREATMENT OF AN
23 EMERGENCY MEDICAL CONDITION THAT IS NECESSARY TO ENSURE, WITHIN
24 REASONABLE MEDICAL PROBABILITY, THAT NO MATERIAL DETERIORATION OF THE
25 EMERGENCY MEDICAL CONDITION IS LIKELY TO RESULT FROM OR OCCUR DURING
26 THE TRANSFER OF THE PATIENT FROM A FACILITY.

27 15-6A-02.

28 (A) IF A CARRIER COVERS ANY BENEFITS FOR EMERGENCY SERVICES TO
29 TREAT EMERGENCY MEDICAL CONDITIONS IN AN EMERGENCY DEPARTMENT OF A
30 FACILITY, THE CARRIER:

31 (1) MAY NOT REQUIRE AN INSURED INDIVIDUAL TO OBTAIN PRIOR
32 AUTHORIZATION FOR THE EMERGENCY SERVICES; AND

33 (2) SHALL PROVIDE COVERAGE FOR THE EMERGENCY SERVICES

1 REGARDLESS OF WHETHER THE FACILITY OR HEALTH CARE PRACTITIONER
2 PROVIDING THE EMERGENCY SERVICES HAS A CONTRACTUAL RELATIONSHIP WITH
3 THE CARRIER TO PROVIDE EMERGENCY SERVICES.

4 (B) IF A FACILITY OR HEALTH CARE PRACTITIONER THAT PROVIDES
5 EMERGENCY SERVICES DOES NOT HAVE A CONTRACTUAL RELATIONSHIP WITH THE
6 CARRIER TO PROVIDE EMERGENCY SERVICES, THE CARRIER:

7 (1) MAY NOT IMPOSE ANY LIMITATION ON COVERAGE THAT WOULD BE
8 MORE RESTRICTIVE THAN LIMITATIONS IMPOSED ON COVERAGE FOR EMERGENCY
9 SERVICES PROVIDED BY A FACILITY OR HEALTH CARE PRACTITIONER WITH A
10 CONTRACTUAL RELATIONSHIP WITH THE CARRIER;

11 (2) SHALL REQUIRE THE SAME COST-SHARING AMOUNTS OR RATES
12 THAT WOULD APPLY IF THE EMERGENCY SERVICES WERE PROVIDED BY A FACILITY
13 OR HEALTH CARE PRACTITIONER WITH A CONTRACTUAL RELATIONSHIP WITH THE
14 CARRIER; AND

15 (3) COUNT ANY COST-SHARING AMOUNT TOWARD THE
16 IN-NETWORK DEDUCTIBLE AND IN-NETWORK OUT-OF-POCKET MAXIMUM FOR THE
17 PLAN YEAR.

18 15-6A-03.

19 IF AN INSURED INDIVIDUAL RECEIVES OUT-OF-NETWORK NONEMERGENCY
20 ANCILLARY SERVICES AT AN IN-NETWORK FACILITY, INCLUDING ANY REFERRALS
21 FOR DIAGNOSTIC SERVICES:

22 (1) THE COST-SHARING AMOUNTS AND RATES REQUIRED BY THE
23 CARRIER FOR THE ANCILLARY SERVICES SHALL BE THE SAME AS IF THE ANCILLARY
24 SERVICES WERE PROVIDED IN-NETWORK; AND

25 (2) THE COST-SHARING AMOUNTS SHALL BE COUNTED TOWARD THE
26 IN-NETWORK DEDUCTIBLE AND IN-NETWORK OUT-OF-POCKET MAXIMUM AMOUNT
27 FOR THE PLAN YEAR.

28 15-6A-04.

29 (A) IF AN INSURED INDIVIDUAL RECEIVES EMERGENCY SERVICES, OR
30 MATERNAL CARE FOR A WOMAN IN LABOR, IN THE EMERGENCY DEPARTMENT OF AN
31 OUT-OF-NETWORK FACILITY AND HAS BEEN STABILIZED AND ADMITTED TO THE
32 OUT-OF-NETWORK FACILITY, THE COST-SHARING REQUIREMENT OF THE CARRIER
33 FOR ANY SERVICES RECEIVED BY THE INSURED INDIVIDUAL SHALL BE THE SAME AS

1 IF THE SERVICES WERE PROVIDED IN NETWORK, UNLESS THE INSURED INDIVIDUAL,
2 ONCE STABILIZED AND IN A CONDITION TO RECEIVE INFORMATION:

3 (1) HAS BEEN PROVIDED BY THE FACILITY, BEFORE RECEIVING ANY
4 POSTSTABILIZATION OUT-OF-NETWORK SERVICE:

5 (I) NOTIFICATION THAT THE FACILITY IS AN
6 OUT-OF-NETWORK PROVIDER; AND

7 (II) THE ESTIMATED AMOUNT THAT THE FACILITY OR HEALTH
8 CARE PRACTITIONERS AT THE FACILITY MAY CHARGE THE INSURED INDIVIDUAL
9 FOR ANY OUT-OF-NETWORK SERVICE;

10 (2) HAS BEEN PROVIDED BY THE CARRIER, BEFORE RECEIVING ANY
11 POSTSTABILIZATION OUT-OF-NETWORK SERVICE:

12 (I) NOTIFICATION THAT THE FACILITY IS AN
13 OUT-OF-NETWORK PROVIDER;

14 (II) A LIST OF IN-NETWORK FACILITIES OR HEALTH CARE
15 PRACTITIONERS THAT COULD PROVIDE THE SAME SERVICES AND THE OPTION FOR
16 REFERRAL TO AN IN-NETWORK FACILITY OR HEALTH CARE PRACTITIONER; AND

17 (III) INFORMATION ABOUT WHETHER PRIOR AUTHORIZATION OR
18 OTHER CARE MANAGEMENT LIMITATIONS MAY BE REQUIRED IN ADVANCE OF
19 RECEIVING IN-NETWORK SERVICES AT THE FACILITY OR FROM THE HEALTH CARE
20 PRACTITIONER;

21 (3) HAS ACKNOWLEDGED, IN WRITING, HAVING RECEIVED
22 NOTIFICATION THAT POSTSTABILIZATION OUT-OF-NETWORK SERVICES MAY NOT
23 BE COVERED OR MAY BE COVERED SUBJECT TO AN OUT-OF-NETWORK
24 COST-SHARING REQUIREMENT; AND

25 (4) HAS ASSUMED, IN WRITING, FULL RESPONSIBILITY FOR THE
26 OUT-OF-POCKET COSTS ASSOCIATED WITH THE POSTSTABILIZATION
27 OUT-OF-NETWORK SERVICES.

28 (B) THE NOTIFICATION REQUIRED UNDER SUBSECTION (A) OF THIS
29 SECTION SHALL:

30 (1) BE IN A FORMAT DETERMINED BY THE COMMISSIONER AND THE
31 HEALTH SERVICES COST REVIEW COMMISSION;

1 (2) GIVE A PATIENT CLEAR COMPREHENSION OF THE TERMS OF THE
2 AGREEMENT;

3 (3) BE READILY IDENTIFIABLE FOR ITS PURPOSE AS A CONTRACT OF
4 CONSENT;

5 (4) CLEARLY STATE THAT CONSENT IS OPTIONAL;

6 (5) INCLUDE AN ESTIMATE OF THE AMOUNT THAT THE FACILITY OR
7 HEALTH CARE PRACTITIONER WILL CHARGE THE ENROLLEE FOR
8 POSTSTABILIZATION SERVICES; AND

9 (6) BE AVAILABLE IN THE 10 MOST COMMON LANGUAGES IN THE
10 FACILITY'S GEOGRAPHIC AREA.

11 **15-6A-05.**

12 (A) A FACILITY OR HEALTH CARE PRACTITIONER MAY NOT SEND AN
13 INSURED INDIVIDUAL A BILL FOR AMOUNTS BEYOND THE COST-SHARING
14 REQUIREMENTS THAT APPLY TO THE INSURED INDIVIDUAL UNDER:

15 (1) § 15-6A-02 FOR EMERGENCY SERVICES;

16 (2) § 15-6A-03 FOR NONEMERGENCY ANCILLARY SERVICES
17 PROVIDED AT AN IN-NETWORK FACILITY; OR

18 (3) § 15-6A-04 FOR OUT-OF-NETWORK SERVICES PROVIDED AFTER
19 THE INSURED INDIVIDUAL HAS BEEN STABILIZED, IF THE NOTICE AND OPTION FOR
20 REFERRAL HAS NOT BEEN PROVIDED AND THE ASSUMPTION OF RESPONSIBILITY
21 FOR OUT-OF-POCKET COSTS BY THE INSURED INDIVIDUAL HAS NOT BEEN
22 OBTAINED FROM THE INSURED INDIVIDUAL BY THE FACILITY.

23 (B) A FACILITY THAT PROVIDES EMERGENCY SERVICES TO A PATIENT
24 SHALL:

25 (1) ON INTAKE AT THE EMERGENCY ROOM OR ADMISSION TO THE
26 FACILITY, PROVIDE THE PATIENT A WRITTEN NOTICE STATING THE PROHIBITION
27 UNDER SUBSECTION (A) OF THIS SECTION AGAINST BILLING FOR AMOUNTS BEYOND
28 THE COST-SHARING REQUIREMENTS OF AN INSURED INDIVIDUAL; AND

29 (2) OBTAIN AN ACKNOWLEDGMENT FROM THE PATIENT THAT THE
30 PATIENT HAS RECEIVED THE NOTICE DESCRIBED UNDER ITEM (1) OF THIS
31 SUBSECTION.

1 **15-6A-06.**

2 (A) (1) SUBJECT TO PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, A
3 CARRIER SHALL PAY A FACILITY OR A HEALTH CARE PRACTITIONER THAT PROVIDES
4 A SERVICE FOR WHICH THE FACILITY OR HEALTH CARE PRACTITIONER IS
5 PROHIBITED FROM BILLING UNDER § 15-6A-05 OF THIS SUBTITLE:

6 (I) IF THE FACILITY OR HEALTH CARE PRACTITIONER IS NOT
7 PROVIDING A SERVICE REGULATED UNDER TITLE 19, SUBTITLE 2 OF THE HEALTH
8 - GENERAL ARTICLE, THE MEDIAN IN-NETWORK RATE FOR THE SERVICE; OR

9 (II) IF THE FACILITY OR HEALTH CARE PRACTITIONER IS
10 PROVIDING A SERVICE REGULATED UNDER TITLE 19, SUBTITLE 2 OF THE HEALTH
11 - GENERAL ARTICLE, THE RATE SET BY THE HEALTH SERVICES COST REVIEW
12 COMMISSION FOR THE SERVICE.

13 (2) IF A SERVICE IS PROVIDED BY A PHYSICIAN WHO HAS OBTAINED
14 AN ASSIGNMENT OF BENEFITS FROM AN INSURED AND IS SUBJECT TO THE PAYMENT
15 REQUIREMENTS UNDER § 14-205.2 OF THIS ARTICLE, A CARRIER SHALL PAY THE
16 PHYSICIAN AN AMOUNT NOT LESS THAN THE GREATER OF:

17 (I) THE APPLICABLE RATE FOR THE SERVICE AS PROVIDED
18 UNDER § 14-205.2 OF THIS ARTICLE; OR

19 (II) THE MEDIAN IN-NETWORK RATE FOR THE SERVICE.

20 (3) IF A SERVICE IS PROVIDED TO AN ENROLLEE OF A HEALTH
21 MAINTENANCE ORGANIZATION BY A HEALTH CARE PROVIDER NOT UNDER WRITTEN
22 CONTRACT WITH THE HEALTH MAINTENANCE ORGANIZATION, THE HEALTH
23 MAINTENANCE ORGANIZATION SHALL PAY THE HEALTH CARE PROVIDER AN
24 AMOUNT NOT LESS THAN THE GREATER OF:

25 (I) THE APPLICABLE RATE FOR THE SERVICE AS PROVIDED
26 UNDER § 19-710.1 OF THE HEALTH - GENERAL ARTICLE; OR

27 (II) THE MEDIAN IN-NETWORK RATE FOR THE SERVICE.

28 (B) (1) A CARRIER SHALL DISCLOSE, ON REQUEST OF A FACILITY OR
29 HEALTH CARE PRACTITIONER SUBJECT TO THIS SECTION, THE REIMBURSEMENT
30 RATE REQUIRED UNDER SUBSECTION (A) OF THIS SECTION.

31 (2) IF A CARRIER DOES NOT HAVE SUFFICIENT INFORMATION TO

1 CALCULATE A MEDIAN IN-NETWORK RATE FOR A SERVICE OR PROVIDER TYPE IN A
2 PARTICULAR GEOGRAPHIC AREA, THE CARRIER SHALL USE THE ALL-PAYER
3 CLAIMS DATA BASE MAINTAINED BY THE MARYLAND HEALTH CARE COMMISSION
4 TO DETERMINE A MEDIAN IN-NETWORK RATE.

5 **15-6A-07.**

6 THE ADMINISTRATION, IN COLLABORATION WITH THE HEALTH SERVICES
7 COST REVIEW COMMISSION AND THE MARYLAND HEALTH CARE COMMISSION,
8 SHALL ADOPT REGULATIONS TO IMPLEMENT THIS SUBTITLE.

9 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all
10 policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or
11 after January 1, 2021.

12 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
13 January 1, 2021.