HOUSE BILL 659

J5 5lr2018
CF SB 475

By: **Delegate Cullison**
Introduced and read first time: January 24, 2025
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Utilization Review – Exemption for Participation in Value–Based Care Arrangements

FOR the purpose of prohibiting certain carriers from imposing a prior authorization, step therapy, or quantity limit requirement on eligible providers for health care services that are included in a two–sided incentive arrangement; and generally relating to utilization review and value–based care arrangements.

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–113(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–113(f)
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

BY adding to
Article – Insurance
Section 15–147
Annotated Code of Maryland
(2017 Replacement Volume and 2024 Supplement)

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

Article – Insurance

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

15–113.

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

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(3) "Eligible provider" means:

(i) a licensed physician, as defined in § 14–101 of the Health Occupations Article, who voluntarily participates in a two–sided incentive arrangement; or

(ii) a set of health care practitioners that voluntarily participate in a two–sided incentive arrangement.

(4) "Health care practitioner" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

(5) "Set of health care practitioners" means:

(i) a group practice;

(ii) a clinically integrated organization established in accordance with Subtitle 19 of this title;

(iii) an accountable care organization established in accordance with 42 U.S.C. § 1395jjj and any applicable federal regulations; or

(iv) a clinically integrated network that is a provider entity that meets the criteria established in guidance issued by the Federal Trade Commission, including a network of behavioral health care programs licensed under § 7.5–401 of the Health – General Article.

(6) "Two–sided incentive arrangement" means an arrangement between an eligible provider and a carrier in which the eligible provider may earn an incentive and a

carrier may recoup funds from the eligible provider in accordance with the terms of a contract entered into with the eligible provider that meets the requirements of this section.

(f) (1) Under a two–sided incentive arrangement that complies with the requirements of this section, a carrier may recoup funds paid to an eligible provider based on the terms of a written contract between the carrier and the eligible provider that at a minimum:

(i) establish a target budget for:

1. the total cost of care of a population of patients adjusted for risk and population size; or

2. the cost of an episode of care;

(ii) limit recoupment to not more than 50% of the excess above the mutually agreed on target established in accordance with item (i) of this paragraph;

(iii) specify a mutually agreed on maximum liability for total recoupment that may not exceed 10% of the annual payments from the carrier to the eligible provider;

(iv) provide an opportunity for gains by an eligible provider that is greater than the opportunity for recoupment by the carrier;

(v) following good faith negotiations, provide an opportunity for an audit by an independent third party and an independent third–party dispute resolution process;

(vi) require the carrier and the eligible provider to negotiate in good faith adjustments to the target budget when:

1. certain circumstances beyond the control of the carrier or the eligible provider arise, including changes in hospital rates; and

2. material changes occur in health care economics, health care delivery, or regulations that impact the arrangement; and

(vii) require the carrier to pay any incentive to or request any recoupment from the eligible provider within 6 months after the end of the contract year, unless the carrier or eligible provider initiates a dispute relating to the recoupment or incentive amount.

(2) Unless mutually agreed to by an eligible provider and a carrier, an arrangement entered into under this subsection may not provide an opportunity for recoupment by the carrier based on the eligible provider's performance during the first 12 months of the arrangement.

(3) A carrier that enters into a two–sided incentive arrangement with an eligible provider in which the amount of any payment is determined, in whole or in part, on the total cost of care of a population of patients or an episode of care, shall, at least quarterly, disclose to the eligible provider the following information in a manner that meets federal and State data use and privacy standards:

(i) any amount paid to another health care provider that is included in the total cost of care of a patient in the population or episode of care; and

(ii) any copayment, coinsurance, or deductible that is included in the total cost of care of a patient in the population or episode of care.

(4) Unless mutually agreed to by the carrier and eligible provider, a two–sided incentive arrangement may not be amended during the term of the contract.

(5) A CARRIER MAY NOT IMPOSE A PRIOR AUTHORIZATION, STEP THERAPY, OR QUANTITY LIMIT REQUIREMENT ON AN ELIGIBLE PROVIDER FOR A HEALTH CARE SERVICE THAT IS INCLUDED IN A TWO–SIDED INCENTIVE ARRANGEMENT.

[(5)**] (6)** The opportunity for independent third–party dispute resolution provided for in paragraph (1)(v) of this subsection may not be required to be exhausted before a member or member's representative is allowed to file an appeal of a coverage decision under § 15–10D–02 of this title.

[(6)**] (7) [**Nothing in this**] THIS** subsection may **NOT** be construed to:

(i) alter any requirement for a carrier to pay a hospital or related institution the rate approved by the Health Services Cost Review Commission for hospital services; or

(ii) supersede the Health Services Cost Review Commission's jurisdiction or authority over rate review and approval for hospital services.

15–147.

(A) IN THIS SECTION, "TWO–SIDED INCENTIVE ARRANGEMENT" HAS THE MEANING STATED IN § 15–113 OF THIS SUBTITLE.

(B) THIS SECTION APPLIES TO:

(1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS ON AN EXPENSE–INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO INDIVIDUALS OR GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(C) AN ENTITY SUBJECT TO THIS SECTION MAY NOT IMPOSE A PRIOR AUTHORIZATION, STEP THERAPY, OR QUANTITY LIMIT REQUIREMENT FOR A HEALTH CARE SERVICE THAT IS INCLUDED IN A TWO–SIDED INCENTIVE ARRANGEMENT.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2026.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2026.