SB 475

Department of Legislative Services

Maryland General Assembly
2025 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 475 (Senator Beidle)
Finance

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

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This bill prohibits a carrier from imposing 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. **The bill takes effect January 1, 2026, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) in FY 2026 only from the $125 rate and form filing fee; any additional workload relating to complaints is assumed to be minimal and absorbable within existing MIA resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program as it does not participate in a value-based care arrangement.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Current Law: Chapters 297 and 298 of 2022 authorize a carrier to enter into a "two-sided incentive arrangement" with an eligible provider and specify what is permitted, prohibited, and required under a bonus or other incentive-based compensation program or two-sided incentive arrangement.

Bonus or Other Incentive-based Compensation or Two-sided Incentive Arrangement

A bonus or other incentive-based compensation program or two-sided incentive arrangement:

- must be voluntary;
- may not create a disincentive to the provision of medically appropriate or medically necessary health care services;
- must, if applicable, promote health equity, improvement of health care outcomes, and the provision of preventive health care services; and
- may reward a health care practitioner, set of health care practitioners, or eligible provider, based on satisfaction of performance measures, if all parties agree on (1) the performance measures; (2) the method and the time period for calculating whether the performance measures have been satisfied; (3) the method by which a reconsideration of the calculations by the carrier may be requested; and (4) if applicable, the risk-adjustment method used.

Participation in a two-sided incentive arrangement may not be the sole opportunity for a heath care practitioner or set of health care practitioners to be eligible to receive increases in reimbursement.

A carrier may not:

- reduce a fee schedule because a health care practitioner or a set of health care practitioners does not participate in the carrier's bonus or other incentive-based compensation or two-sided incentive arrangement program; or
- require as a condition of participation in the carrier's provider network that a health care practitioner or set of health care practitioners participate.

An eligible provider (or designee) may file a complaint with MIA regarding a violation of these provisions.

A carrier must provide a health care practitioner, set of health care practitioners, or eligible provider with a copy of a schedule of all applicable fees or the 50 most common services billed by a health care practitioner in that specialty, whichever is less. The carrier must also provide the information about the practitioner and the methodology that the carrier uses to determine whether to recoup compensation from an eligible provider under a two-sided incentive arrangement and a summary of the terms of a two-sided incentive arrangement program.

A carrier that compensates health care practitioners or a set of health care practitioners wholly or partly on a capitated basis may not retain any capitated fee attributable to an enrollee or covered person during an enrollee's or covered person's contract year.

Under a two-sided incentive arrangement, a carrier may recoup funds paid to an eligible provider based on the terms of a written contract that, at a minimum:

- establish a target budget for the total cost of care of a population of patients adjusted for risk and population size or the cost of an episode of care;
- limit recoupment to not more than 50% of the excess above the mutually agreed on target;
- 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;
- provide an opportunity for gains by an eligible provider that is greater than the opportunity for recoupment by the carrier;
- following good faith negotiations, provide an opportunity for an audit by an independent third party and an independent third-party dispute resolution process;
- require the carrier and the eligible provider to negotiate in good faith adjustments to the target budget under specified conditions; and
- require the carrier to pay any incentive to or request any recoupment from the eligible provider within six months after the end of the contract year, except as specified.

Unless mutually agreed to, an arrangement 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. A carrier that enters into a two-sided incentive arrangement 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, must, at least quarterly, disclose specified information to the eligible provider. Unless mutually agreed to, a two-sided incentive arrangement may not be amended during the term of the contract.

Capitated Payments

Chapters 297 and 298 also specify that arrangements under a health benefit plan offered by a carrier or a self-funded group health insurance plan in which a capitated payment is made as specified and specified contracts between a health care practitioner or set of health care practitioners and a carrier that include capitated payments for services are not considered acts of an insurance business.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the past three years.

Designated Cross File: HB 659 (Delegate Cullison) - Health and Government Operations.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Insurance Administration; Department of Legislative Services

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