SENATE BILL 335

C3 6lr0596

By: **Senators Kelley, Benson, Currie, Madaleno, Pugh, and Rosapepe**
Introduced and read first time: January 27, 2016
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Assignment of Benefits and Reimbursement of Nonpreferred Providers – Modifications

FOR the purpose of making certain provisions of law relating to the assignment of benefits and the reimbursement of nonpreferred providers who are physicians applicable to certain other health care practitioners; altering the circumstances under which a certain provision for an insured to pay a balance bill may not apply; altering the scope of certain provisions of law relating to the reimbursement of nonpreferred providers; requiring a certain nonpreferred provider who seeks an assignment of benefits from an insured to provide certain information to the insured within a certain period of time before a health care service is performed; prohibiting a certain nonpreferred provider from billing an insured more than a certain amount under certain circumstances; altering certain definitions; defining certain terms; making conforming changes; providing for the application of this Act; and generally relating to the assignment of benefits and reimbursement of nonpreferred providers under preferred provider insurance policies.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–201, 14–205, 14–205.2, and 14–205.3
Annotated Code of Maryland
(2011 Replacement Volume and 2015 Supplement)

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.

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

(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 PRACTITIONER" MEANS AN INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO PROVIDE HEALTH CARE SERVICES UNDER THE LAWS OF THE JURISDICTION IN WHICH THE HEALTH CARE SERVICES ARE PROVIDED.

[(g)**] (H)** "Health care services" has the meaning stated in § 19–701 of the Health – General Article.

[(h)**] (I)** "Hospital–based **[**physician**] HEALTH CARE PRACTITIONER**" means:

(1) a **[**physician licensed in the State who is under contract to provide**] HEALTH CARE PRACTITIONER WHO PROVIDES** health care services to patients at a hospital; or

(2) a group **[**physician practice that includes physicians licensed in the State that is under contract to provide**] PRACTICE OF HEALTH CARE PRACTITIONERS THAT PROVIDES** health care services to patients at a hospital.

[(i)**] (J)** "Insured" means a person covered for benefits under a preferred provider insurance policy offered or administered by an insurer.

[(j)**] (K)** "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.

[(k)**] (L)** "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)**] (M)** "On–call **[**physician**] HEALTH CARE PRACTITIONER**" means a **[**physician**] HEALTH CARE PRACTITIONER** who:

(1) has privileges at a hospital;

(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; and

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

[(m)**] (N)** "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.

[(n)**] (O)** "Preferred provider" means a provider that has entered into a provider service contract.

[(o)**] (P)** "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.

[(p)**] (Q)** "Provider" means**:**

(1) a **[**physician,**]** hospital**[**, or**];**

(2) A HEALTH CARE PRACTITIONER; OR

(3) ANY other person that is licensed or otherwise authorized to provide health care services.

[(q)**] (R)** "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)**] (S)** "Similarly licensed provider" means:

(1) for a physician:

(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; or

(2) for a health care provider **[**who**] THAT** is not a physician, a health care provider **[**who**] THAT** holds the same type of license **[**or**],** certification**, OR OTHER AUTHORIZATION TO PROVIDE HEALTH CARE SERVICES**.

[(s)**] (T)** "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**] PRACTITIONER**, 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**] PRACTITIONER** 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 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**] HEALTH CARE PRACTITIONER** or a hospital–based **[**physician who has accepted an assignment of benefits in accordance with**] HEALTH CARE PRACTITIONER, EXCEPT AS PROVIDED IN** § 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**, CERTIFIED, OR OTHERWISE AUTHORIZED** provider **[**who**]** **THAT** 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**]** **HEALTH CARE PRACTITIONERS** and hospital–based **[**physicians**]** **HEALTH CARE PRACTITIONERS** 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**]** **HEALTH CARE PRACTITIONER** or a hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** subject to this section for covered services rendered by the on–call **[**physician**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER**.

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

(3) An on–call **[**physician**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** subject to this section or a representative of an on–call **[**physician**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER**;

(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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER**; and

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

(c) (1) This subsection applies only to on–call **[**physicians**]** **HEALTH CARE PRACTITIONERS** subject to this section.

(2) For a covered service rendered to an insured of an insurer by an on–call **[**physician**]** **HEALTH CARE PRACTITIONER** subject to this section, the insurer or its agent:

(i) shall pay the on–call **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** 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**], CERTIFIED, OR OTHERWISE AUTHORIZED HEALTH CARE PRACTITIONERS** 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**], CERTIFIED, OR OTHERWISE AUTHORIZED HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONERS** subject to this section.

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

(i) shall pay the hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** 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**], CERTIFIED, OR OTHERWISE AUTHORIZED HEALTH CARE PRACTITIONERS**, who are hospital–based **[**physicians**]** **HEALTH CARE PRACTITIONERS**, 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**]** **HEALTH CARE PRACTITIONER** billing under the same federal tax

identification number the hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** used in calendar year 2009.

(e) (1) For the purposes of subsections (c)(2)(ii)1 and (d)(2)(ii)1 of this section, an insurer shall calculate the average rate paid to similarly licensed **[**providers**],** **CERTIFIED, OR OTHERWISE AUTHORIZED HEALTH CARE PRACTITIONERS** 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**],** **CERTIFIED, OR OTHERWISE AUTHORIZED HEALTH CARE PRACTITIONERS** not under written contract with the insurer for the same covered service by summing the rates paid to similarly licensed **[**providers**],** **CERTIFIED, OR OTHERWISE AUTHORIZED HEALTH CARE PRACTITIONERS** 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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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**]** **HEALTH CARE PRACTITIONER** or hospital–based **[**physician**]** **HEALTH CARE PRACTITIONER** 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.

14–205.3.

(a) This section does not apply to on–call **[**physicians**]** **HEALTH CARE PRACTITIONERS** or hospital–based **[**physicians**]** **HEALTH CARE PRACTITIONERS WHO ARE PAID IN ACCORDANCE WITH § 14–205.2(C) OR (D) OF THIS SUBTITLE**.

(b) An insurer may not:

(1) prohibit the assignment of benefits to a **[**provider who is a physician**]** **HEALTH CARE PRACTITIONER** by an insured; or

(2) refuse to directly reimburse a nonpreferred provider who is a **[**physician**]** **HEALTH CARE PRACTITIONER** under an assignment of benefits.

(c) If an insured has not provided an assignment of benefits, the insurer shall include the following information with the payment to the insured for health care services rendered by the nonpreferred provider who is a **[**physician**]** **HEALTH CARE PRACTITIONER**:

(1) the specific claim covered by the payment;

(2) the amount paid for the claim;

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

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

(d) If a **[**physician**]** **HEALTH CARE PRACTITIONER** who is a nonpreferred provider seeks an assignment of benefits from an insured, the **[**physician**]** **HEALTH CARE**

PRACTITIONER shall provide the following information to the insured, **EXCEPT IN EMERGENCY CIRCUMSTANCES, AT LEAST 24 HOURS** prior to performing a health care service:

(1) a statement informing the insured that the **[**physician**]** **HEALTH CARE PRACTITIONER** is a nonpreferred provider;

(2) a statement informing the insured that the **[**physician**]** **HEALTH CARE PRACTITIONER** may charge the insured for noncovered services;

(3) a statement informing the insured that the **[**physician**]** **HEALTH CARE PRACTITIONER** may charge the insured the balance bill for covered services;

(4) an estimate of the cost of services that the **[**physician**]** **HEALTH CARE PRACTITIONER** 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 **[**physician**]** **HEALTH CARE PRACTITIONER**.

(e) A **[**physician**]** **HEALTH CARE PRACTITIONER** 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.

(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.

(H) IF A HEALTH CARE PRACTITIONER WHO IS A NONPREFERRED PROVIDER SEEKING AN ASSIGNMENT OF BENEFITS FROM AN INSURED FAILS TO COMPLY WITH

SUBSECTION (D) OF THIS SECTION, THE HEALTH CARE PRACTITIONER MAY NOT BILL THE INSURED MORE THAN THE ALLOWED AMOUNT FOR THE COVERED HEALTH CARE SERVICE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed by insurers and nonprofit health service plans in the State on or after October 1, 2016.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2016.