SENATE BILL 776

C3, J3, J4 0lr3063

By: **Senator Kelley**
Introduced and read first time: February 3, 2020
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance, Health Care Facilities, and Providers – Balance Billing – Limitations

FOR the purpose of defining "health care facility–based physician" for the purpose of applying certain provisions of law relating to the assignment of benefits and the reimbursement of nonpreferred providers who are physicians to physicians based in certain health care facilities; altering the circumstances under which the Maryland Insurance Commissioner may authorize an insurer or a nonprofit health service plan to offer a certain preferred provider insurance policy; altering the scope of certain provisions of law relating to the reimbursement of nonpreferred providers; prohibiting a carrier from requiring an insured to obtain prior authorization and imposing certain limitations on coverage for certain services under certain circumstances; requiring a carrier to provide certain coverage and require certain cost–sharing for certain services under certain circumstances; requiring a carrier to count certain cost–sharing amounts required by the carrier toward a certain deductible and certain out–of–pocket maximum; requiring that a certain cost–sharing requirement for certain out–of–network services be the same as the cost–sharing requirement for certain in–network services unless an insured has been provided certain notification and information by certain entities, has acknowledged in a certain manner receiving certain notification of certain information, and has assumed in a certain manner certain responsibility for certain costs; establishing requirements for a certain notification; prohibiting a facility and a health care practitioner from billing a certain individual for certain amounts for certain services; requiring a certain facility to provide a certain patient with a certain notice and obtain a certain acknowledgment; requiring a carrier to pay certain facilities and certain health care practitioners certain rates for certain services; requiring a health maintenance organization to pay certain health care providers a certain rate for certain services; requiring a carrier to disclose certain rates to certain facilities and certain health care practitioners under certain circumstances; requiring a carrier to use a certain database for a certain purpose under a certain circumstance; requiring the Maryland Insurance Administration, in collaboration with certain commissions,

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

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

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

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

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

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

Article – Health – General

19–710.1.

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

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

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

(4) "Enrollee" means a subscriber or member of a health maintenance organization.

(5) "Evaluation and management service" means any service with a

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

(6) "Institute" means the Maryland Institute for Emergency Medical Services Systems.

(7) "Medicare Economic Index" means the fixed–weight input price index that:

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

(ii) 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.

(8) "Similarly licensed provider" means:

(i) For a physician:

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

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

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

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

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

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

(11) "Trauma physician" means a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

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

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

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

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

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

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

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

(iii) Any other health care provider:

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

A. 125% of the average rate the health maintenance organization paid as of 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 health maintenance organization; or

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

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

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

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

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

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

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

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

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

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

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

(g) (1) A health care provider may enforce the provisions of this section by filing a complaint against a health maintenance organization with the Maryland Insurance 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 Maryland Insurance Administration or a court shall award reasonable attorney fees if the complaint of the health care provider is sustained.

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

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

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

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

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

Article – Insurance

14–201.

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

(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 FACILITY–BASED PHYSICIAN" MEANS:

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

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

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

[(h) "Hospital–based physician" means:

(1) a physician licensed in the State who is under contract to provide 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 health care services to patients at a hospital.**]**

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

(j) "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) "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) "On–call physician" means a physician 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**] HEALTH CARE FACILITY–BASED** physician.

(m) "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) "Preferred provider" means a provider that has entered into a provider service contract.

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

(q) "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) "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 is not a physician, a health care provider who holds the same type of license or certification.

(s) "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, 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**]** **SUBJECT TO THE REQUIREMENTS FOR SERVICES RENDERED UNDER TITLE 15, SUBTITLE 6A OF THIS ARTICLE, 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 or a **[**hospital–based**]** **HEALTH CARE FACILITY–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.

14–205.1.

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

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

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

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

14–205.2.

(a) Except as otherwise provided, this section applies to both on–call physicians and **[**hospital–based**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–BASED** physician subject to this section for covered services rendered by the on–call physician or **[**hospital–based**]** **HEALTH CARE FACILITY–BASED** physician.

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

(3) An on–call physician or **[**hospital–based**]** **HEALTH CARE FACILITY–BASED** physician subject to this section or a representative of an on–call physician or **[**hospital–based**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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) **SUBJECT TO § 15–6A–06 OF THIS ARTICLE,** 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**]** **HEALTH CARE FACILITY–BASED** physicians subject to this section.

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

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

with the applicable provisions of this title; and

(ii) **SUBJECT TO § 15–6A–06 OF THIS ARTICLE,** shall pay a claim submitted by the **[**hospital–based**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–BASED** physician billing under the same federal tax identification number the **[**hospital–based**]** **HEALTH CARE FACILITY–BASED** physician 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 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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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**]** **HEALTH CARE FACILITY–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.

14–205.3.

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

(b) An insurer may not:

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

(2) refuse to directly reimburse a nonpreferred provider who is a physician 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:

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

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

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

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

(4) an estimate of the cost of services that the physician 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.

(e) A physician 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.

SUBTITLE 6A. SURPRISE MEDICAL BILLS.

15–6A–01.

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

(B) "CARRIER" MEANS:

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

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

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

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

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

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

(2) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR

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

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

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

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

PATIENT THAT IS NECESSARY TO STABILIZE THE PATIENT.

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

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

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

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

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

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

15–6A–02.

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

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

(2) SHALL PROVIDE COVERAGE FOR THE EMERGENCY SERVICES

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

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

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

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

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

15–6A–03.

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

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

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

15–6A–04.

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

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

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

(I) NOTIFICATION THAT THE FACILITY IS AN OUT–OF–NETWORK PROVIDER; AND

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

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

(I) NOTIFICATION THAT THE FACILITY IS AN OUT–OF–NETWORK PROVIDER;

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

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

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

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

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

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

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

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

(4) CLEARLY STATE THAT CONSENT IS OPTIONAL;

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

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

15–6A–05.

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

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

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

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

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

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

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

15–6A–06.

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

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

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

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

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

(II) THE MEDIAN IN–NETWORK RATE FOR THE SERVICE.

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

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

(II) THE MEDIAN IN–NETWORK RATE FOR THE SERVICE.

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

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

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

15–6A–07.

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

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, 2021.

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