HOUSE BILL 1021

C3 1lr2216
CF SB 758

By: **Delegate Pendergrass**
Introduced and read first time: February 5, 2021
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Incentive Arrangements – Authorization

FOR the purpose of providing that a certain provision of law prohibiting a person from doing acts of an insurance business except under certain circumstances does not apply to a primary care provider that accepts capitated payments in a certain manner but does not perform certain other acts considered acts of an insurance business; authorizing certain bonus or incentive–based compensation to include a certain two–sided incentive arrangement; exempting certain carriers who recoup funds in accordance with a certain provision of this Act from the prohibition on certain carriers retaining certain capitated fees; authorizing a certain carrier to recoup funds paid to an eligible provider under a two–sided incentive arrangement that meets certain requirements and criteria; requiring a carrier that enters into a certain two–sided incentive arrangement with an eligible provider to disclose certain information; providing that a certain provision of law regarding retroactive denials of reimbursement does not apply to a two–sided incentive arrangement that complies with a certain provision of this Act; providing that a certain primary care provider is not engaged in certain acts of an insurance business if certain requirements are met solely because the primary care provider enters into a certain contract that includes certain capitated payments; providing for the application of certain provisions of this Act; defining certain terms; altering a certain definition; and generally relating to health insurance, two–sided incentive arrangements, and capitated payments.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 4–205(a), 15–113(a), (c), and (e), and 15–1008(b)
Annotated Code of Maryland
(2017 Replacement Volume and 2020 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance

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

Section 4–205(b) and (c), 15–113(b), and 15–1008(c)
Annotated Code of Maryland
(2017 Replacement Volume and 2020 Supplement)

BY adding to
Article – Insurance
Section 15–113(f); and 15–2101 and 15–2102 to be under the new subtitle "Subtitle 21. Self–Funded Group Capitated Payments"
Annotated Code of Maryland
(2017 Replacement Volume and 2020 Supplement)

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

Article – Insurance

4–205.

(a) This section does not apply to:

(1) the lawful transaction of surplus lines insurance;

(2) the lawful transaction of reinsurance by insurers;

(3) transactions in the State that involve, and are subsequent to the issuance of, a policy that was lawfully solicited, written, and delivered outside of the State covering only a subject of insurance not resident, located, or expressly to be performed in the State at the time of issuance of the policy;

(4) transactions that involve insurance contracts that are independently procured through negotiations occurring entirely outside of the State and that are reported and on which the premium tax is paid in accordance with §§ 4–210 and 4–211 of this subtitle;

(5) an attorney while acting in the ordinary relation of attorney and client in the adjustment of claims or losses; **[**or**]**

(6) unless otherwise determined by the Commissioner, transactions in the State that involve group or blanket insurance or group annuities if the master policy of the group was lawfully issued and delivered in another state in which the person was authorized to engage in insurance business**; OR**

(7) A PRIMARY CARE PROVIDER THAT ACCEPTS CAPITATED PAYMENTS IN ACCORDANCE WITH § 15–2102 OF THIS ARTICLE, BUT PERFORMS NO OTHER ACTS CONSIDERED ACTS OF AN INSURANCE BUSINESS.

(b) An insurer or other person may not, directly or indirectly, do any of the acts of an insurance business set forth in subsection (c) of this section, except as provided by and in accordance with the specific authorization of statute.

(c) Any of the following acts in the State, effected by mail or otherwise, is considered to be doing an insurance business in the State:

(1) making or proposing to make, as an insurer, an insurance contract;

(2) making or proposing to make, as guarantor or surety insurer, a contract of guaranty or suretyship as a vocation and not merely incidental to another legitimate business or activity of the guarantor or surety insurer;

(3) taking or receiving an application for insurance;

(4) receiving or collecting premiums, commissions, membership fees, assessments, dues, or other consideration for insurance;

(5) issuing or delivering an insurance contract to a resident of the State or a person authorized to do business in the State;

(6) except as provided in subsection (d) of this section, with respect to a subject of insurance resident, located, or to be performed in the State, directly or indirectly acting as an insurance producer for, or otherwise representing or helping on behalf of another, an insurer or other person to:

(i) solicit, negotiate, procure, or effect insurance or the renewal of insurance;

(ii) disseminate information about coverage or rates;

(iii) forward an application;

(iv) deliver a policy or insurance contract;

(v) inspect risks;

(vi) fix rates;

(vii) investigate or adjust claims or losses;

(viii) transact matters arising out of an insurance contract after the insurance contract becomes effective; or

(ix) in any other manner represent or help an insurer or other person to transact insurance business;

(7) doing any kind of insurance business specifically recognized as doing an insurance business under statutes relating to insurance;

(8) doing or proposing to do any insurance business that is substantially equivalent to any act listed in this subsection in a manner designed to evade the statutes relating to insurance; or

(9) as an insurer transacting any other business in the State.

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;

(II) A GROUP OF LICENSED PHYSICIANS;

(III) AN ACCOUNTABLE CARE ORGANIZATION ESTABLISHED IN ACCORDANCE WITH 42 U.S.C. § 1395JJJ AND ANY APPLICABLE FEDERAL REGULATIONS; OR

(IV) A PROVIDER ENTITY THAT MEETS THE CRITERIA OF A CLINICALLY INTEGRATED NETWORK UNDER GUIDANCE ISSUED BY THE FEDERAL TRADE COMMISSION.

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

(b) A carrier may not reimburse a health care practitioner in an amount less than

the sum or rate negotiated in the carrier's provider contract with the health care practitioner.

(c) (1) In this subsection, "set of health care practitioners" means:

(i) a group practice;

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

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

(IV) A PROVIDER ENTITY THAT MEETS THE CRITERIA OF A CLINICALLY INTEGRATED NETWORK UNDER GUIDANCE ISSUED BY THE FEDERAL TRADE COMMISSION.

(2) This section does not prohibit a carrier from providing bonuses or other incentive–based compensation to a health care practitioner or a set of health care practitioners if the bonus or other incentive–based compensation:

(i) does not create a disincentive to the provision of medically appropriate or medically necessary health care services; and

(ii) if the carrier is a health maintenance organization, complies with the provisions of § 19–705.1 of the Health – General Article.

(3) A bonus or other incentive–based compensation under this subsection:

(i) if applicable, shall promote the provision of preventive health care services; **[**or**]**

(ii) may reward a health care practitioner or a set of health care practitioners, based on satisfaction of performance measures, if the following is agreed on in writing by the carrier and the health care practitioner or set of health care practitioners:

1. the performance measures;

2. the method for calculating whether the performance measures have been satisfied; and

3. the method by which the health care practitioner or set of health care practitioners may request reconsideration of the calculations by the carrier**; OR**

(III) MAY INCLUDE A TWO–SIDED INCENTIVE ARRANGEMENT IN WHICH A CARRIER MAY RECOUP FUNDS PAID TO AN ELIGIBLE PROVIDER IN

ACCORDANCE WITH SUBSECTION (F) OF THIS SECTION.

(4) Acceptance of a bonus or other incentive–based compensation under this subsection shall be voluntary.

(5) A carrier may not require a health care practitioner or a set of health care practitioners to participate in the carrier's bonus or incentive–based compensation program as a condition of participation in the carrier's provider network.

(6) A health care practitioner, a set of health care practitioners, a health care practitioner's designee, or a designee of a set of health care practitioners may file a complaint with the Administration regarding a violation of this subsection.

(e) (1) A carrier that compensates 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**, UNLESS THE CARRIER RECOUPS FUNDS IN ACCORDANCE WITH SUBSECTION (F) OF THIS SECTION**.

(2) A carrier is in compliance with paragraph (1) of this subsection if, within 45 days after an enrollee or covered person chooses or obtains health care from a health care practitioner, the carrier pays to the health care practitioner all accrued but unpaid capitated fees attributable to that enrollee or person that the health care practitioner would have received had the enrollee or person chosen the health care practitioner at the beginning of the enrollee's or covered person's contract year.

(F) (1) A CARRIER MAY RECOUP FUNDS PAID TO AN ELIGIBLE PROVIDER UNDER A TWO–SIDED INCENTIVE ARRANGEMENT THAT MEETS:

(I) THE REQUIREMENTS FOR BONUSES AND INCENTIVE–BASED COMPENSATION UNDER SUBSECTION (C) OF THIS SECTION; AND

(II) THE CRITERIA DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION.

(2) A TWO–SIDED INCENTIVE ARRANGEMENT AUTHORIZED UNDER THIS SUBSECTION SHALL BE BASED ON TERMS OF A WRITTEN CONTRACT BETWEEN THE CARRIER AND THE ELIGIBLE PROVIDER THAT:

(I) ESTABLISH A TARGET FOR:

1. THE 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 NO MORE THAN 50% OF THE EXCESS ABOVE THE MUTUALLY AGREED UPON TARGET ESTABLISHED IN ACCORDANCE WITH ITEM (I) OF THIS PARAGRAPH;

(III) SPECIFY A MUTUALLY AGREED UPON 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; AND

(V) REQUIRE THE CARRIER TO REQUEST ANY RECOUPMENT FROM THE ELIGIBLE PROVIDER WITHIN 6 MONTHS AFTER THE END OF THE CONTRACT YEAR.

(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 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 COST OF CARE OF A PATIENT IN THE POPULATION OR AN 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 AN EPISODE OF CARE.

15–1008.

(b) This section does not apply to an adjustment to reimbursement**:**

(1) made as part of an annual contracted reconciliation of a risk sharing arrangement under an administrative service provider contract**; OR**

(2) MADE AS PART OF A TWO–SIDED INCENTIVE ARRANGEMENT THAT COMPLIES WITH § 15–113(F) OF THIS TITLE.

(c) (1) If a carrier retroactively denies reimbursement to a health care provider, the carrier:

(i) may only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18–month period after the date that the carrier paid the health care provider; and

(ii) except as provided in item (i) of this paragraph, may only retroactively deny reimbursement during the 6–month period after the date that the carrier paid the health care provider.

(2) (i) A carrier that retroactively denies reimbursement to a health care provider under paragraph (1) of this subsection shall provide the health care provider with a written statement specifying the basis for the retroactive denial.

(ii) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

SUBTITLE 21. SELF–FUNDED GROUP CAPITATED PAYMENTS.

15–2101.

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

(B) "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A DENTAL PLAN ORGANIZATION; OR

(5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(C) "NETWORK" HAS THE MEANING STATED IN § 15–112 OF THIS TITLE.

(D) "PRIMARY CARE PROVIDER" MEANS A HEALTH CARE PRACTITIONER OR AN ENTITY THAT:

(1) IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE OR HEALTH – GENERAL ARTICLE TO PROVIDE PRIMARY HEALTH CARE SERVICES IN THE STATE;

(2) IS THE PRIMARY COORDINATOR OF CARE FOR AN ENROLLEE, A MEMBER, OR A SUBSCRIBER; AND

(3) PROVIDES ACCESSIBLE, CONTINUOUS, COMPREHENSIVE, AND COORDINATED HEALTH CARE SERVICES TO AN ENROLLEE, A MEMBER, OR A SUBSCRIBER.

15–2102.

(A) THIS SECTION APPLIES ONLY WITH RESPECT TO ARRANGEMENTS UNDER A SELF–FUNDED GROUP HEALTH INSURANCE PLAN IN WHICH A CAPITATED PAYMENT IS:

(1) CALCULATED AS A FIXED AMOUNT PER MEMBER ASSIGNED OR ATTRIBUTED TO THE PRIMARY CARE PROVIDER;

(2) TO COVER A SET OF SERVICES DEFINED IN THE PRIMARY CARE PROVIDER CONTRACT; AND

(3) PAID PERIODICALLY REGARDLESS OF UTILIZATION OF THE SERVICES BY THE MEMBERS.

(B) A PRIMARY CARE PROVIDER IS NOT ENGAGED IN ACTS OF AN INSURANCE BUSINESS AS DESCRIBED IN § 4–205(C) OF THIS ARTICLE SOLELY BECAUSE THE PRIMARY CARE PROVIDER ENTERS INTO A CONTRACT THAT INCLUDES CAPITATED PAYMENTS FOR SERVICES PROVIDED BY THE PRIMARY CARE PROVIDER IF:

(1) A SELF–FUNDED EMPLOYER GROUP LEASES A CARRIER'S NETWORK IN WHICH THE PRIMARY CARE PROVIDER PARTICIPATES AND ACCEPTS CAPITATED PAYMENTS;

(2) THE SELF–FUNDED EMPLOYER GROUP RETAINS THE OBLIGATION TO PROVIDE ACCESS TO COVERED HEALTH CARE BENEFITS TO ENROLLEES, MEMBERS, OR SUBSCRIBERS; AND

(3) THE CONTRACT DOES NOT INCLUDE OTHER REIMBURSEMENT ARRANGEMENTS THAT ARE CONSIDERED ACTS OF AN INSURANCE BUSINESS UNDER § 4–205(C) OF THIS ARTICLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2021.