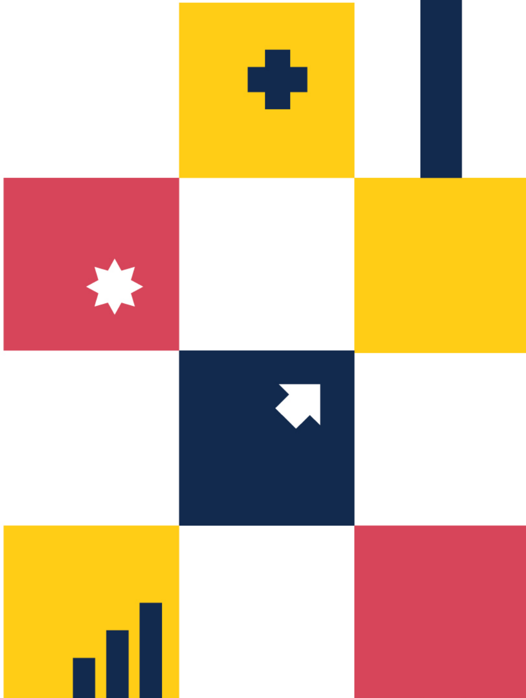
Study on HMO Out-of-Network Provider Payments and Network Participation



January 16, 2025

Randolph Sergent, Esq.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND
Health Care
Commission

MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq, Chairman
Vice President and Deputy General Counsel
CareFirst BlueCross BlueShield

Awawu Agbabiaka, CRNP
Nurse Practitioner
AIM Behavioral Health Services

Arun Bhandari, MD
Chesapeake Oncology Hematology
Associates, PA

Hassanatu Blake, PhD, MPH, MBA
Director, Health Equity & Social Justice
National Association of County & City Health
Officials

Marcia Boyle, MS
Founder
Immune Deficiency Foundation

Kenneth Buczynski, MD
Founder of Wellspring Family Medicine

Tinisha Cheatham, MD
Physician in Chief of the Mid-Atlantic
Permanente Medical Group

Karl Douglas, MBA
Director of Talent Development
Brightview Senior Living

Danielle Stroughton-Duncan, PhD
Education Division Director
COLA, Inc.

Joan L. Gelrud, RN, MSN, FACHE, CPHQ
Member of the AHRQ National Advisory Council,
Court Appointed Special Advocate for Children

Shante Gilmore, DrPH, MPH
Director, Health Equity Initiatives
The Patient Advocate Foundation

Mark T. Jensen, Esq.
Partner
Bowie & Jensen, LLC

Jovonni Spinner, PhD, MPH, CHES
CEO/Founder
Beacon Public Health

Marcus L. Wang, Esq.
Operating Partner
R2C Capital

Karrie M. Wood
Director of Business Development
Community Bank of the Chesapeake

Table of Contents

Executive Summary 2

Introduction. 4

Background. 4

Response to Questions. 7

1. Comparison of Contracted Rates and Proposed Rules for HMO and PPO Participating and Non-participating Provider Payments, with Medicare Economic Index Adjustments 2019-2024. 7

2. Impact of the No Surprises Act on non-participating provider rates 12

3. Provider Network Contract Terminations 14

Conclusion 15

Study Limitations 15

Appendices 17

A. Methodology 17

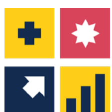
B. Out-Of-Network Claims by Specialty for E&M and Non-E&M Services 18

C. In-Network Contract Terminations by Specialty 18

D. No Surprises Act IDR Outcomes, Air Ambulance Disputes, and Payment Offers 19

E. HMO Payments - Health-General Article, § 19-710.1 22

F. PPO Payments Insurance Article §14–205.2. 25



Executive Summary

At the request of the Maryland House Health and Government Operations Committee, this report examines the complex dynamics of healthcare provider payments and network participation in Maryland, with a particular focus on comparing payment methodologies between Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). The study was prompted by the consideration of HB 570/SB 487 during the 2024 legislative session, which proposed significant changes to HMO payment formulas for out-of-network (OON) providers.

This analysis of payment methodologies reveals disparities between current HMO rates and proposed PPO-based rates. Hospital-based services would see the most substantial increases, with notable variations across specialties. For hospital-based Evaluation and Management (E&M) services, rates would increase from $178 to $208 on average. Emergency medicine shows particularly dramatic changes, with rates increasing from $191 to $247 for E&M services and from $68 to $94 for non-E&M services. Hospital-based medical specialists would see non-E&M rates rise from $76 to $152, while hospital-based surgical specialists would see increases from $465 to $754. In non-hospital settings, Evaluation and Management services would experience an increase from $52 to $120, while non-hospital non-Evaluation and Management services would decrease from $295 to $104.

Maryland's existing laws, including HMO and PPO balance billing laws, continue to apply where they have authority. The No Surprise Act (NSA) fills gaps in Maryland's law, particularly by covering self-insured ERISA plans, which states cannot regulate.[1] In cases where Maryland's All-Payer Model Agreement specifies OON payment amounts, these rates generally supersede the NSA provisions for determining patient cost-sharing and provider reimbursement. Analysis of Independent Dispute Resolution (IDR) data shows that providers/facilities prevailed in (59.4%) of payment disputes, with an even higher success rate (84.8%) in air ambulance disputes.

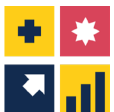
The MIA reports 15,627 terminated in-network contracts between 2019 and 2024. The vast majority (95.4%) of these terminations were provider-initiated. Particularly noteworthy is

---

[1] https://www.congress.gov/bill/116th-congress/house-bill/133/text, See BB DIVISION BB--Private Health Insurance And Public Health Provisions (No Surprises Act). Federal Regulations implementing the No Surprises Act are at: https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing#:~:text=The%20No%20Surprises%20Act%20provides,surprise%20bills%20arise%20most%20frequently

the high rate of terminations among behavioral health providers, who accounted for (23.5%) of non-Kaiser terminations, followed by Internal Medicine at (7.2%). Kaiser Permanente alone accounted for (71.6%) of all terminations during 2021-2023, though they were unable to provide specialty-specific data.

These findings suggest that adopting PPO payment rules for HMO OON services would lead to higher reimbursements for most hospital-based services, while potentially decreasing payments for some non-hospital services. The impact would be particularly pronounced in emergency medicine and ancillary services, where OON utilization is already higher. The overall OON utilization remains relatively low, with total OON claims representing just (0.6%) of all claims for HMOs and (1.6%) for PPOs, indicating that most care is delivered within network for both plan types. While a unified payment formula might simplify administrative processes for payers offering both products, the higher OON payments could incentivize providers to leave networks, creating a cyclic effect as OON payments are derived from in-network rates. Additionally, the high rate of network contract terminations, particularly among behavioral health providers, raises concerns about network adequacy in essential service areas.



Introduction.

At the request of the Maryland House Health and Government Operations Committee (HGO), this report examines the impact of payment methodologies for non-participating providers in Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans. The Maryland General Assembly's consideration of HB 570/SB 487 during the 2024 session underscored a need for further analysis of how these rates influence provider reimbursements and patient costs. Although the bill did not pass, it proposes HMOs to pay non-participating providers either (125%) of their average 2019 rate adjusted for inflation, or (140%) of the 2008 Medicare rate adjusted for inflation (whichever was greater) for evaluation and management services, while for non-evaluation and management services, HMOs would have been required to pay (125%) of their average 2019 rate adjusted for inflation.

This report, prepared by the Maryland Health Care Commission (MHCC), explores contracted rates paid to both participating and non-participating providers, by specialty. The study includes modeling to determine the financial impact of the proposed HMO payment methodology changes, comparing current payment calculations with those proposed under HB 570/SB 487. Additionally, assesses the federal No Surprises Act's impact on non-participating provider rates, and reviews trends of in-network contract terminations.

Background.

In Maryland, payments to non-participating providers by Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are governed by two distinct statutes. Health-General Article § 19-710.1 and Insurance Article § 14-205.2 (detailed in Appendices D and E, respectively). Each statute establishes unique methodologies that impact provider reimbursements and patient out-of-pocket costs for identical services.

HMOs and PPOs have distinct approaches to OON coverage. HMOs generally restrict coverage to in-network providers, offering OON benefits only in emergencies or when subscribers can demonstrate that no suitable in-network provider is available. These exceptions typically involve highly specialized conditions where few specialists maintain significant control over access to their services. Maryland law establishes reimbursement rates for specific hospital and emergency services in these situations. In contrast, PPOs offer defined OON benefits, allowing patients to routinely access non-participating providers, though Maryland law regulates reimbursement rates for certain services. The Maryland Insurance Administration, which oversees the state's network adequacy law, observed that

PPO and HMO carriers have developed more comprehensive networks over the past decade. Healthcare providers may opt out of insurance networks for various reasons, primarily citing inadequate compensation and burdensome administrative requirements, such as prior authorization processes and carrier performance standards. Despite these concerns, the percentage of claims paid for OON services has remained relatively stable since implementing OON payment regulations in 2009. Additionally, since 2022, the federal No Surprises Act (NSA) has provided a payment framework for services not covered by state law.

The distribution of OON claims reveals significant differences between HMO and PPO plans across various specialties and settings (See Table 1 below). Services provided by radiologists and pathologists show a striking disparity between HMO and PPO plans, with HMOs having a higher share of OON claims (29.1%) (radiologists) and (10.7%) (pathologists) respectively compared to PPOs where (6.6%) and (3.5%) are OON. This significant difference in ancillary service OON rates, combined with a higher emergency department share of OON claims in HMOs (29.4% vs 10.8% in PPOs), shows the different network participation patterns between the two plan types. However, OON claims represent a relatively small percentage of total claims across both HMO and PPO plans, though PPOs consistently show higher OON (ranging from 0.9% to 4.5%) compared to HMOs (ranging from 0.1% to 4.9%). This small proportion of OON claims suggests that most care is delivered is still in-network for both plan types.

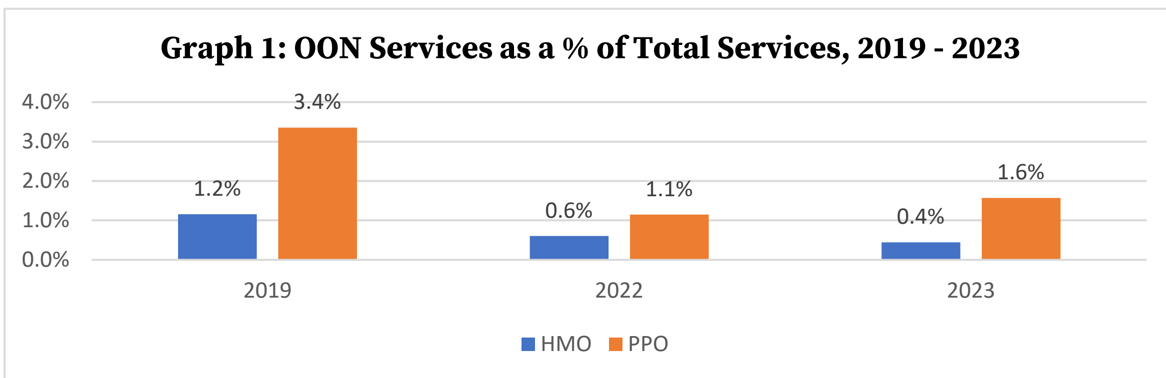
Table 1

Specialties	**Distribution of OON Claims (E&M and Non-E&M) - 2023**		**OON as a % of Total (E&M and Non-E&M) - 2023**	
	Hospital & Non-Hospital		**Hospital & Non-Hospital**	
	HMO	PPO	HMO	PPO
Primary Care	5.7%	44.7%	0.1%	1.3%
Medical Specialists	18.9%	20.3%	1.0%	2.5%
Surgical Specialists	4.9%	13.5%	0.2%	1.5%
Emergency Department	29.4%	10.8%	4.9%	4.5%
Critical Care	1.0%	0.5%	1.9%	2.1%
Neonatology	0.4%	0.2%	2.2%	3.0%
Radiology	29.1%	6.6%	1.4%	0.9%
Pathology	10.7%	3.5%	4.0%	3.1%
Total	100.0%	100.0%	0.6%	1.6%

Kaiser's OON claims reveal that while primary care accounts for the largest portion of OON claims (27.2%), followed by emergency services (20.7%), the actual OON utilization is extremely low across all specialties (0.01-0.05% of total claims). (See Table 2 below)

	Table 2: Kaiser	
	Distribution of OON Claims (E&M and Non-E&M) - 2023	OON as a % of Total (E&M and Non-E&M) - 2023
Specialties	**Hospital & Non-Hospital**	**Hospital & Non-Hospital**
Primary Care	27.2%	0.01%
Medical Specialists	14.1%	0.03%
Surgical Specialists	6.5%	0.02%
Emergency Department	20.7%	0.03%
Critical Care	0.0%	0.00%
Neonatology	0.0%	0.00%
Radiology	17.4%	0.02%
Pathology	14.1%	0.05%
Total	100.0%	0.01%

Looking at the total OON services (no. of claims) across HMO (Kaiser included) and PPO as a percent of Total as shown in the graph (Graph. 1) below, OON share for PPO plans dropped dramatically from (3.4%) in 2019 to (1.1%) in 2022, before rising slightly to (1.6%) in 2023, while HMO share steadily declined from (1.2% to 0.4%) over the same period.



As Table 3 shows, OON services for 2023 are a relatively small percentage of total services, but OON services vary significantly among the three commercial carriers in this study. The share of OON services among payers varies because some payers have expansive networks and sufficient market share to support an expansive network. In contrast, other payers have a smaller market share and have smaller networks, which contributes to a higher share of OON

services. These payers face greater challenges in contracting with physician groups. It is also likely that some physicians and health care practitioners do not contract with a given payer because of compensation levels, smaller market share, historical experience, or administrative factors such as claim denial rates. Some specialties, especially hospital-based emergency medicine physicians and pathologists, are likelier to stay out of payer networks unless participation aligns with the practice's priorities. Patients treated at hospitals, especially those with emergency conditions, cannot select an in-network provider, so OON participation does not limit the provider's access to patients. Emergency medicine (4.9%), pathology (4.0%), neonatology (2.2%), and critical care (1.9%) are hospital-based specialties having the largest OON share. A full exploration of all factors that contribute to market participation decisions is beyond the scope of this study.

Table 3: OON Services as a Percent of All Services by Specialty and in Total (2023)

	Table 3: HMO OON as a % of Total (E&M and NonE&M) (2023)											
	Hospital				Non-Hospital				Hospital & Non-Hospital			
Specialties	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total
Primary Care					0.4%	0.0%	0.3%	0.1%	0.4%	0.0%	0.3%	0.1%
Medical Specialists	5.3%	0.0%	24.2%	3.7%	0.1%	0.0%	1.4%	0.2%	1.2%	0.0%	8.2%	1.0%
Surgical Specialists	0.7%	0.0%	14.3%	1.7%	0.3%	0.0%	0.6%	0.1%	0.4%	0.0%	2.3%	0.2%
Emergency Department	51.4%	0.0%	57.5%	9.5%	2.7%	0.0%	0.8%	0.1%	33.9%	0.0%	33.0%	4.9%
Critical Care	2.9%	0.3%	20.3%	3.9%	0.0%	0.0%	2.1%	0.2%	0.9%	0.2%	13.2%	1.9%
Neonatology	11.7%	0.0%	51.8%	5.3%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	31.5%	2.2%
Radiology	3.9%	0.0%	27.0%	5.0%	0.4%	0.0%	0.4%	0.1%	1.5%	0.0%	9.8%	1.4%
Pathology	31.2%	0.0%	39.1%	7.2%	3.3%	0.0%	5.8%	0.7%	17.1%	0.0%	25.4%	4.0%
Total	14.1%	0.0%	30.7%	5.2%	0.4%	0.0%	0.5%	0.1%	1.8%	0.0%	4.4%	0.6%

Response to Questions.

1. Comparison of Contracted Rates and Proposed Rules for HMO and PPO Participating and Non-participating Provider Payments, with Medicare Economic Index Adjustments 2019-2024.

This section uses data from Maryland's Medical Care Database (MCDB) covering 2018 through the second quarter of 2024. The MCDB contains health insurance enrollment and claims data submitted quarterly by private health insurance carriers, third-party

administrators (TPAs), and pharmacy benefit managers (PBMs). Most major Maryland insurers contribute to the database, including Aetna, CareFirst, Cigna, UnitedHealthcare, and Kaiser Permanente. Due to federal decisions, the MCDB does not include data from self-insured ERISA health plans or Federal Employees Health Benefits (FEHB) plans, which together account for about (44%) of Maryland's privately insured population in the MCDB. Despite these exclusions, previous studies have shown that the MCDB data accurately represent Maryland's broader privately insured population.[2] Services paid by ERISA-exempt and FEHB are not subject to Maryland's OON laws, but they are subject to the NSA.

Contracted rates paid by HMOs and PPOs for evaluation and management (E&M) and non-E&M services are compared. Rates are analyzed across provider types, specialties, and payer groups to evaluate differences in payment methodologies and their impact on provider reimbursements. When applying the Medicare Economic Index (MEI) adjustment, rates from 2019 to the second quarter of 2024 increased by (13.9%).

- The tables compare contracted rates for E&M and Non-E&M services under the Proposed rule (PPO Rules) and Current rule (HMO Law).
- Services follow the Center for Medicare & Medicaid Services (CMS) Berenson-Eggers Type of Service (BETOS) classifications
- **Medical Specialists**: Cardiology, pulmonology, oncology, psychiatry, neurology, hematology, infectious diseases, and nephrology.
- **Surgical Specialists**: General surgery, orthopedics, urology, ENT, neurosurgery, oral surgery, plastic surgery, ophthalmology, thoracic surgery, and vascular surgery.
- Indicates whether proposed rates are higher (**H**) or lower (**L**) than current rates.

Hospital-Based E&M Services For hospital-based E&M services (See Table 4 below), the proposed HMO rates (Proposed rule—PPO Rules) would generally result in higher reimbursements across most specialties than current HMO rates (Current Rule—HMO Law). Emergency medicine shows particularly notable increases, with Aetna's rate rising from $168 to $458, and similar increases for other payers. Critical care services demonstrate more variability - while Aetna and CareFirst would see higher rates under the proposed methodology, UHC's rate would decrease from $340 to $313. Neonatology presents an interesting case where Aetna's rate would increase from $424 to $549, while also showing higher rates for UHC. In this category, providers would generally receive higher payments under the proposed methodology, with all three payers showing higher rates across most

[2] Evaluating Maryland Commercial Experience in the MCDB, conducted by HSCRC, February 12, 2021.

specialties except for critical care under UHC. Note that critical care (both E&M and non-E&M) services are about (1.1%) of OON claims for UHC and (19.4%) for CareFirst. (See Table 1 in Appendix B)

Hospital Only Specialties	Table 4: HMO Hospital-Based E&M Services (2023)										
	Proposed Rule				Current Rule				Proposed Over Current		
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC
Medical Specialists	$153	$128	$146	$131	$109		$136	$136	H		H
Surgical Specialists	$123	$123	$139	$124	$44		$132	$132	H		H
Emergency Dept.	$458	$226	$338	$247	$168	$185	$194	$191	H	H	H
Critical Care	$365	$311	$313	$316	$132	$129	$340	$333	H	H	L
Neonatology	$549	$378	$311	$377	$424		$156	$188	H		H
Radiology		$117	$76	$114			$112	$112			L
Pathology		$136		$136							
Total	$314	$195	$262	$208	$168	$137	$179	$178	H	H	H

Hospital-Based Non-E&M Services The impact on hospital-based non-E&M services (See Table 5 below) is even more pronounced. Medical specialists would see substantial increases across all payers, with Aetna's rate rising dramatically from $10 to $146. OON payments to surgical specialists show similar significant increases, with Aetna's rate increasing from $552 to $854. However, critical care services present a notable exception, showing lower rates under the proposed rules than current rates across payers. The proposed methodology would result in significantly higher payments to providers across most specialties and payers, except for critical care services, where providers would receive lower reimbursements.

Hospital Only Specialties	Table 5 HMO Hospital-based Non-E&M (2023)										
	Proposed Rules				Current Rule				Proposed Over Current		
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC
Medical Specialists	$146	$154	$141	$152	$10	$9	$78	$76	H	H	H
Surgical Specialists	$854	$749	$736	$754	$552		$464	$465	H		H
Emergency Dept.	$139	$87	$104	$94	$52		$70	$68	H		H
Critical Care	$55	$106	$107	$102		$160	$127	$129		L	L
Neonatology		$101	$172	$106			$86	$86			H
Radiology	$76	$73	$96	$76	$46	$72	$75	$74	H	H	H
Pathology	$85	$63	$69	$65	$33		$59	$56	H		H
Total	$177	$166	$166	$166	$40	$64	$84	$82	H	H	H

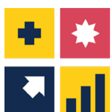
Non-Hospital-Based E&M Services For non-hospital-based E&M services (See Table 6 below), the impact varies considerably by specialty. Primary care would see higher rates across all payers, with the most significant increase for UHC (from $39 to $105). Medical specialists would also experience increases, exemplified by Aetna's rise from $82 to $132. Surgical specialists and emergency medicine show more mixed results, with some payers increasing while others decreasing. Providers would receive higher payments from most payers, particularly for primary care and medical specialist services. However, surgical specialists would see lower OON payments from Aetna and higher OON payments from CareFirst and UHC.

Non-Hospital Specialties	Table 6: HMO Non-Hospital-Based E&M (2023)										
	Proposed OON Rule				Current OON Rule				Proposed Over Current		
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC
Primary Care	$124	$122	$105	$121	$121	$119	$39	$47	H	H	H
Medical Specialists	$132	$118	$113	$119	$82	$81	$104	$102	H	H	H
Surgical Specialists	$137	$113	$124	$115	$146	$103	$70	$77	L	H	H
Emergency Dept.	$126	$125	$150	$128	$186		$63	$101	L		H
Critical Care	$139	$122	$127	$124			$543	$543			L
Neonatology											
Radiology	$130	$92	$98	$95			$59	$59			H
Pathology											
Total	$125	$121	$108	$120	$126	$110	$44	$52	L	H	H

Non-Hospital-Based Non-E&M Services The non-hospital-based non-E&M services (See Table 7 below) demonstrate the most variable impacts. Primary care rates would decrease for Aetna (from $91 to $44) while increasing for UHC. Medical specialists show a complex pattern, with Aetna's rate increasing (from $79 to $193), but UHC's rate decreasing significantly (from $486 to $193). Surgical specialists' rates vary substantially across payers, indicating potential shifts in market dynamics under the proposed methodology. This category shows the most mixed impact on provider payments, with some specialties receiving higher payments from specific payers while experiencing lower payments from others, particularly evident in the variations across primary care and specialist services.

Non-Hospital Specialties	Table 7: HMO Non-Hospital-Based Non-E&M (2023)										
	Proposed Rule				Current Rule				Proposed Over Current		
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC
Primary Care	$44	$50	$65	$50	$91		$53	$55	L		H
Medical Specialists	$193	$176	$193	$178	$79		$486	$482	H		L
Surgical Specialists	$166	$174	$241	$178	$108	$416	$274	$257	H	L	L
Emergency Dept.	$171	$164	$99	$159	$58		$68	$67	H		H
Critical Care	$80	$136	$91	$128			$141	$141			L
Neonatology											
Radiology	$361	$394	$555	$397							
Pathology	$75	$68	$158	$77	$28		$80	$76	H		H
Total	$98	$103	$122	$104	$82	$416	$304	$295	H	L	L

Distribution of OON Claims (E&M and Non-E&M) Among Specialties The distribution of OON claims reveals notable differences in utilization patterns across hospital-based, non-hospital-based, and combined settings by specialty and payer. In Table 8 below - combining hospital and non-hospital settings, emergency department services remain the top category, accounting for (29.4%) of total OON claims. About (48.2%) of all Aetna OON claims are in emergency medicine. About (29.1%) of total OON claims are in radiology services, with 32.2% of all UHC OON claims in radiology. Primary care represents (5.7%) of total combined OON claims. Less than 1% of CareFirst claims are OON, but (38.9%) of these OON claims are in primary care. In summary, emergency department and radiology services dominate OON claims in hospital settings, while primary care takes precedence in non-hospital environments. As noted earlier, OON claims are more with Aetna and UHC.



Specialties	Table 8: HMO Distribution of OON Claims – (E&M and Non-E&M) (2023)											
	Hospital				Non-Hospital				Hospital & Non-Hospital			
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total
Primary Care					63.8%	60.9%	42.5%	48.0%	13.4%	38.9%	4.3%	5.7%
Medical Specialists	9.5%	15.4%	20.2%	18.9%	2.0%	17.4%	24.5%	19.0%	7.9%	16.7%	20.7%	18.9%
Surgical Specialists	0.6%	7.7%	4.5%	4.0%	9.9%	21.7%	11.4%	11.3%	2.6%	16.7%	5.2%	4.9%
Emergency Dept.	59.3%	7.7%	29.2%	32.8%	6.5%	0.0%	2.9%	3.7%	48.2%	2.8%	26.5%	29.4%
Critical Care	0.2%	53.8%	1.2%	1.1%	0.0%	0.0%	0.7%	0.5%	0.1%	19.4%	1.1%	1.0%
Neonatology	0.8%	0.0%	0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.3%	0.4%
Radiology	10.1%	15.4%	34.8%	31.8%	9.9%	0.0%	9.0%	9.0%	10.1%	5.6%	32.2%	29.1%
Pathology	19.5%	0.0%	9.8%	10.9%	7.8%	0.0%	9.0%	8.5%	17.0%	0.0%	9.7%	10.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

2. Impact of the No Surprises Act on Non-participating Provider Rates

The No Surprises Act (NSA) was enacted on December 27, 2020, and took effect on January 1, 2022. It aims to protect patients from surprise medical bills for certain OON services, limiting patient cost-sharing to in-network amounts and establishing a dispute resolution process between providers and insurers. Maryland had comprehensive surprise billing protections in place before the NSA. As of February 2021, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework report (ASPE Report One) categorized Maryland as one of 18 states that had implemented "comprehensive" protections against balance billing. Even before the No Surprises Act, Maryland law covered both emergency and in-network hospital settings, applied to HMO and PPO plans, and provided mechanisms for determining payment amounts. This robust pre-existing regulatory framework is an important consideration when assessing the impact of the new federal law in Maryland.

Data from ASPE report shows that in 2019, prior to the implementation of the No Surprises Act, approximately (3.8%) of professional medical claims in Maryland involved OON providers[3]. However, it is important to note that, according to an analysis by ASPE, hospital markets in Maryland have become more concentrated in recent years, following a trend seen

[3] See ASPE, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis – First Annual Report," July 2023, pp. 27-28.

nationwide[4]. This increasing consolidation may influence market dynamics related to surprise billing and the impact of the No Surprises Act in Maryland. The 2023 CMS Independent Dispute Resolution (IDR) data offers a comprehensive view of how the No Surprises Act (NSA) has influenced OON payment disputes in emergency, non-emergency, and air ambulance services for both HMO and PPO. The analysis shows that most disputes are resolved in favor of providers/facilities, highlighting a trend that suggests a strong position for providers within the NSA framework[5].

The Payment Determinations Outcomes Data - OON Emergency and Non-Emergency Services (Appendix D. Table 1a) provides an overview of OON payment disputes across all quarters in 2023. Notably, the data indicates that most of these disputes were resolved in favor of providers/facilities (59.4%) rather than plans/issuers (40.6%), from a total of 939 cases. Disputes were most frequent in Q1, accounting for (58.5%) (549) of cases, gradually declining to (4.9%) (46) of cases in Q4. This downward trend may suggest either a reduction in the number of disputes or a potential slowdown in resolutions as the year progressed.

In examining disputes by payer (Appendix D. Table 1b), CIGNA shows the highest involvement in OON disputes, representing 65.3% or 609 cases. UnitedHealthcare follows with 12.7% or 118 cases, and Kaiser Permanente at 10.9% or 102 cases. CareFirst demonstrates variability across quarters, with notable spikes in Q2 and Q4.

When looking at the Payment Determinations Outcomes Data - OON Air Ambulance Services (Appendix D. Table 2) which focuses on disputes specific to air ambulance services. Here, providers/facilities prevailed in (84.8% of cases), with 78 out of 92 disputes resolved in their favor. The distribution remains relatively steady across quarters, though Q4 saw a slight uptick in disputes (30.4% of cases). Despite the overall lower volume of air ambulance cases compared to emergency/non-emergency services, providers/facilities maintain a strong position in these disputes.

In the QPA and Offers Data (Appendix D. Table 3), Table 3a highlights a significant discrepancy in outcomes, with providers/facilities prevailing in (69.2% of cases) (2,418 disputes), as opposed to plans/issuers, who prevailed in only (29.0% of cases) (1,013

---

[4] The ASPE Report notes a broad trend of increasing hospital market concentration across the country, with the number of hospital markets classified as moderate or low concentration declining from 23% in 2008 to 12% in 2020. See ASPE, "Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis – First Annual Report," July 2023, p. 22.

[5] Record counts may appear lower than actual totals due to data suppression protocols. Following CMS privacy practices, data is suppressed when service codes occur fewer than 10 times in the same region. Records may also be excluded if line items are deemed ineligible or incorrectly batched.

disputes). A small percentage of cases (1.9%) were not reported, indicating minor gaps in outcome data. Table (3b) reveals the geographic distribution of disputes, with the Baltimore-Columbia-Towson, MD region dominating at (99.3%) of cases, suggesting a high concentration of OON disputes in this metropolitan area. This likely aligns with a greater density of healthcare providers, while more rural areas, like California-Lexington Park, MD, report significantly fewer disputes.

The low volume of NSA-related complaints reflects both Maryland's existing balance billing protections, which require state-regulated carriers to pay providers at statutory rates without using the federal IDR process, and the limited scope of cases where federal protections apply. When Maryland's protections do not apply (e.g., self-insured ERISA plans), providers may use the federal IDR process, though the Health Education and Advocacy Unit (HEAU) maintains authority to protect patients from balance billing regardless of the IDR outcome.

The MHCC also obtained data from the HEAU on Medical Necessity Appeals & Grievances cases. Of 65 cases shown in (Appendix D. Table 4a), most involved "Billing Prohibited by Provider Insurance Contract" (44 cases), followed by the "No Surprises Act" (15 cases) and "Balance Billing HMO or PPO" (6 cases). Out of 60 cases shown in (Appendix D. Table 4b), 38 were mediated which involve Billing Prohibited by Provider Insurance Contract, while 22 had no mediation since they aren't within State jurisdiction.

3. Provider Network Contract Terminations

Through a survey of insurance carriers conducted with assistance from the Maryland Insurance Administration (MIA), MHCC collected data on network participation and contract terminations in Maryland's healthcare market from January 1, 2019, to June 30, 2024. The survey revealed 15,627 terminated in-network contracts across all specialties, with the vast majority (95.4%) (14,910 contracts) being terminated by providers rather than insurers. The remaining (4.6%) (717 contracts) were terminated by insurers.

Kaiser Permanente only provided data between 2021 to 2023 and they were unable to provide specialty specific data. Kaiser's data accounted for 11,196 terminations (10,993 provider-initiated and 203 insurer-initiated). Analysis of the non-Kaiser terminations showed that mental health providers had the highest termination rates, with Psychiatric/Social worker/Licensed professional counselor accounting for (23.5%) of terminations, followed by Internal Medicine (7.2%), Psychiatry/Psychology (6.5%), and both Acupuncture and Physical Therapy at (5.1%) each.

Top specialties by termination rate (excluding Kaiser Permanente data):

1. Psychiatric/Social worker/Licensed professional counselor: 23.5%

2. Internal Medicine: 7.2%

3. Psychiatry/Psychology: 6.5%

4. Acupuncture: 5.1%

5. Physical Therapy: 5.1%

Appendix C provides a full breakdown by specialty and Carrier.

Conclusion

The MHCC's analysis reveals that adopting PPO payment rules for HMO OON services would result in higher reimbursements across most specialties, particularly for hospital-based services. While a single OON formula might simplify administration for payers offering both products, higher OON payments could incentivize providers to leave networks, creating a cyclic effect as OON payments are derived from in-network rates.

The No Surprises Act has had minimal disruptive impact in Maryland due to existing state protections, with providers prevailing in most payment disputes. However, the high rate of network contract terminations among behavioral health providers (23.5% of all terminations) raises concerns about network adequacy in essential service areas. These findings suggest that while Maryland's regulatory framework effectively protects consumers, changes to payment methodologies must carefully balance provider compensation, network stability, and healthcare costs.

Study Limitations

1. Kaiser Permanente provided termination data only for 2021 to 2023 that did not include specialty information.
2. With NSA taking effect in January 2022, there is a limited post-implementation data.
3. Some balance billing complaints may have been categorized differently across systems.
4. CIGNA does not offer an HMO product in Maryland.
5. Anesthesia specialty was excluded due to data issues.

6. MHCC requested HMO payments data from the health insurance carriers via the MIA. However, no carrier responded to the request.
7. Kaiser Permanente was excluded from the HMO OON payments comparison study because it did not report no allowed payments for practitioners for 2022 and prior years due to the payer's closed-panel HMO capitation model.

Appendices

A. Methodology

To establish a baseline, 2018 rates were adjusted to 2019 levels, then projected forward to Q2 2024 using the Medicare Economic Index (MEI) to align with the proposed rule's requirements. For comparison with the current payment methodology, 2023 OON HMO rates inflated to Q2 2024. Specifically, MHCC started with the 2019 allowed unit cost per CPT (allowed dollars divided by the number of units per CPT) and trended forward using the physician professional services MEI to the second quarter of 2024. Then the unit costs per CPT were compared with the exact unit cost per CPT for 2023 for providers in the same geographic area trended to the second quarter of 2024. This allowed direct comparison between the current approach of year-over-year rate adjustments and the proposed method of inflating 2019 rates using MEI. The analysis separates evaluation and management (E&M) services from non-E&M services, with results further categorized by hospital-based specialties (such as emergency medicine, critical care, anesthesiology, neonatology, radiology, and pathology) and non-hospital-based specialties (such as primary care and other office-based practices). This comprehensive analysis, conducted at the individual service level and aggregated by provider taxonomy codes, provides detailed insights into how the proposed payment structure would impact different provider types and practice settings based on the payer group. Medicare rates (physician fee schedule) are only available at the individual service level and cannot be aggregated at the specialty level based on taxonomy codes. While these rates are publicly available, they were excluded from this analysis due to the inability to make direct comparisons at the specialty level. This limitation particularly affects the evaluation of the proposed (140%) of Medicare rates option for E&M services.

B. OON Claims by Specialty for E&M and Non-E&M Services

Appendix B Table 1: Distribution of OON Claims by Specialty for E&M and Non E&M Services

Specialties	Distribution of OON Claims (E&M and Non E&M)											
	Hospital				Non-Hospital				Hospital & Non-Hospital			
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total
Primary Care					63.8%	60.9%	42.5%	48.0%	13.4%	38.9%	4.3%	5.7%
Medical Specialists	9.5%	15.4%	20.2%	18.9%	2.0%	17.4%	24.5%	19.0%	7.9%	16.7%	20.7%	18.9%
Surgical Specialists	0.6%	7.7%	4.5%	4.0%	9.9%	21.7%	11.4%	11.3%	2.6%	16.7%	5.2%	4.9%
Emergency Dept.	59.3%	7.7%	29.2%	32.8%	6.5%	0.0%	2.9%	3.7%	48.2%	2.8%	26.5%	29.4%
Critical Care	0.2%	53.8%	1.2%	1.1%	0.0%	0.0%	0.7%	0.5%	0.1%	19.4%	1.1%	1.0%
Neonatology	0.8%	0.0%	0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.3%	0.4%
Radiology	10.1%	15.4%	34.8%	31.8%	9.9%	0.0%	9.0%	9.0%	10.1%	5.6%	32.2%	29.1%
Pathology	19.5%	0.0%	9.8%	10.9%	7.8%	0.0%	9.0%	8.5%	17.0%	0.0%	9.7%	10.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix B Table 2: OON Number of Services as a % of Total Services by Specialty and Payer

Specialties	OON as a % of Total (E&M and NonE&M)											
	Hospital				Non-Hospital				Hospital & Non-Hospital			
	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total	Aetna	CareFirst	UHC	Total
Primary Care					0.4%	0.0%	0.3%	0.1%	0.4%	0.0%	0.3%	0.1%
Medical Specialists	5.3%	0.0%	24.2%	3.7%	0.1%	0.0%	1.4%	0.2%	1.2%	0.0%	8.2%	1.0%
Surgical Specialists	0.7%	0.0%	14.3%	1.7%	0.3%	0.0%	0.6%	0.1%	0.4%	0.0%	2.3%	0.2%
Emergency Dept.	51.4%	0.0%	57.5%	9.5%	2.7%	0.0%	0.8%	0.1%	33.9%	0.0%	33.0%	4.9%
Critical Care	2.9%	0.3%	20.3%	3.9%	0.0%	0.0%	2.1%	0.2%	0.9%	0.2%	13.2%	1.9%
Neonatology	11.7%	0.0%	51.8%	5.3%	0.0%	0.0%	0.0%	0.0%	6.3%	0.0%	31.5%	2.2%
Radiology	3.9%	0.0%	27.0%	5.0%	0.4%	0.0%	0.4%	0.1%	1.5%	0.0%	9.8%	1.4%
Pathology	31.2%	0.0%	39.1%	7.2%	3.3%	0.0%	5.8%	0.7%	17.1%	0.0%	25.4%	4.0%
Total	14.1%	0.0%	30.7%	5.2%	0.4%	0.0%	0.5%	0.1%	1.8%	0.0%	4.4%	0.6%

C. In-Network Contract Terminations by Specialty

Data collected from Carriers extends from 2019 to 2023

Number of Contracts Terminated by Provider	14910
Number of Contracts Terminated by Carrier	717

Specialty	Number of Providers	Percent of total
Acupuncture	201	5.13%
Psychiatric/Social worker/Licensed Professional Counselor	923	23.56%
Physical Therapy	198	5.05%
Internal Medicine	284	7.25%
Chiropractor	119	3.04%
Pediatrics	120	3.06%
Family Practice	130	3.32%
Psychology/Psychiatry	253	6.46%
Nurse	165	4.21%
General Practice/Surgery	92	2.35%

D. No Surprises Act IDR Outcomes, Air Ambulance Disputes, and Payment Offers

Appendix D (Table 1): The "Payment Determinations Outcomes Data: OON Emergency and Non-Emergency Services" tables provides detailed information on resolved payment disputes for OON emergency and non-emergency services. Only completed determinations are included, with ineligible, withdrawn, or administratively excluded disputes omitted**.** **Appendix D (Table 1a)** categorizes OON emergency and non-emergency disputes by payment determination outcome each quarter, listing the number of cases resolved in favor of either the plan/issuer or the provider/facility/AA provider, along with quarterly and total counts**. Appendix D (Table 1b)** details OON emergency and non-emergency disputes by payer, displaying the number of completed disputes for each payer—AETNA, CareFirst, CIGNA, Kaiser Permanente, and UnitedHealthcare—by quarter**.**

Appendix D (Table 1a): OON Emergency and Non-Emergency Disputes by Payment Determination Outcome

Payment Determination Outcome	Q1	Q2	Q3	Q4	Total
In Favor of Plan/Issuer	235	39	96	11	381
In Favor of Provider/Facility/AA Provider	314	92	117	35	558
Grand Total	**549**	**131**	**213**	**46**	**939**

Appendix D (Table 1b): OON Emergency and Non-Emergency Disputes by Payer

Payers	Q1	Q2	Q3	Q4	Total
AETNA	62	2		4	68
CareFirst	2	15	6	12	35
CIGNA	377	43	162	27	609
Kaiser Permanente	15	52	34	1	102
UnitedHealthcare	90	19	8	1	118
Grand Total	**546**	**131**	**210**	**45**	**932**

Appendix D (Table 2): The Payment Determinations Outcomes Data: OON Air Ambulance Services Appendix Table presents a single summary table showing quarterly data for OON air ambulance payment disputes in Maryland during 2023. The table displays the number of determinations made in favor of plans/issuers versus providers/facilities/air ambulance providers for each quarter, along with the total number of cases for the year.

Appendix D (Table 2): OON Air Ambulance by Payment Determination Outcome

Offer	Q1	Q2	Q3	Q4	Total
In Favor of Plan/Issuer	4	3	2	5	14
In Favor of Provider/Facility/AA Provider	18	21	16	23	78
Grand Total	**22**	**24**	**18**	**28**	**92**

Appendix D (Table 3): The "QPA and Offers Data" tables presents information about qualifying payment amounts (QPAs) and the offers made by each party during disputes. **Appendix D (Table 3a)** shows the distribution of dispute outcomes between healthcare providers and insurance plans/issuers across all four quarters of 2023, including cases where the outcome was not reported (NR). **Appendix D (Table 3b)** breaks down the total number of disputes by specific geographic regions within and around Maryland, showing how cases were distributed across different metropolitan areas by quarter. Together, these tables

provide a quarterly view of both the resolution outcomes and geographic distribution of Federal IDR cases connected to Maryland.

Appendix D (Table 3a): QPA and Offers by Geographic Region

Offer	Q1	Q2	Q3	Q4	Total
In Favor of Plan/Issuer	416	176	258	163	1013
In Favor of Provider/Facility/AA Provider	389	465	510	1054	2418
NR	65				65
Grand Total	**870**	**641**	**768**	**1217**	**3496**

Appendix D (Table 3b): QPA and Offers by Geographic Region

Geographical Regions	Q1	Q2	Q3	Q4	Total
Baltimore-Columbia-Towson, MD	392	59	82	17	550
California-Lexington Park, MD	2			2	4
Cambridge, MD		1			1
Easton, MD				1	1
Hagerstown-Martinsburg, MD-WV	45	61	57	50	213
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	172	213	265	626	1276
Salisbury, MD-DE	100	63	84	5	252
Washington-Arlington-Alexandria, DC-VA-MD-WV	159	244	280	516	1199
Grand Total	**870**	**641**	**768**	**1217**	**3496**

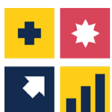
Appendix D (Table 4): The Maryland Health Care Commission (MHCC) obtained Health Education and Advocacy Unit (HEAU) data for Medical Necessity Appeals & Grievances cases. The data includes cases related to applicable practices under different laws and their disposition status.

Appendix D (Table 4a): Number of cases by applicable practice (Law)

Practice	Cases
Balance Billing HMO or PPO	6
Billing Prohibited by Provider Insurance Contract	44
No Surprises Act	15
Grand Total	**65**

Appendix D (Table 4b): Number of cases by status of disposition

Disposition type	Cases
Mediated	38
No Mediation	22
Grand Total	**60**



E. HMO Payments - Health-General Article, § 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 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.

F. PPO Payments Insurance Article §14–205.2.

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

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

(3) An on–call physician or hospital–based physician subject to this section or a representative of an on–call physician or hospital–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 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 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 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) 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 physicians subject to this section.

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

(i) shall pay the hospital–based physician 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 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 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 physician billing under the same federal tax identification number the hospital–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 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 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 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 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.

MARYLAND
Health Care
Commission

4160 Patterson Avenue
Baltimore, MD 21215

mhcc.maryland.gov