In subsection (f)(2) of this section, the reference to "§§ 15–1004 and 15–1005 of this title" is substituted for the former references to Art. 48A, §§ "354Z", "470U", and "477AA". The substituted reference is more specific than the former general reference. No substantive change is intended.

In subsection (g) of this section, the reference to a claim, bill, or "other demand or" request for payment is added for consistency within this section.

Also in subsection (g) of this section, the reference to a claim, bill, or other demand or request for payment determined to be "for a health care service provided as" a result of a prohibited referral is added for clarity.

Defined terms: "Commissioner" § 1–101
"Health insurance" § 1–101
"Insurer" § 1–101
"Policy" § 1–101

15–111. ASSESSMENT OF FEES ON PAYORS.

(A) DEFINITIONS.

(1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15–1201 OF THIS TITLE.

(3) "PAYOR" MEANS:

(I) A HEALTH INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT HOLDS A CERTIFICATE OF AUTHORITY AND PROVIDES HEALTH INSURANCE POLICIES OR CONTRACTS IN THE STATE UNDER THIS ARTICLE;

(II) A HEALTH MAINTENANCE ORGANIZATION THAT IS AUTHORIZED BY THE COMMISSIONER TO OPERATE IN THE STATE; OR

(III) A THIRD PARTY ADMINISTRATOR.

(4) "THIRD PARTY ADMINISTRATOR" MEANS A PERSON THAT IS REGISTERED AS AN ADMINISTRATOR UNDER THIS ARTICLE.

(B) IN GENERAL.

(1) ON OR BEFORE JUNE 30 OF EACH YEAR, THE COMMISSIONER SHALL ASSESS EACH PAYOR A FEE FOR THE NEXT FISCAL YEAR.

(2) THE FEE SHALL BE ESTABLISHED IN ACCORDANCE WITH THIS SECTION AND § 19–1515 OF THE HEALTH – GENERAL ARTICLE.

(C) AMOUNT OF ASSESSMENT.

(1) FOR EACH FISCAL YEAR, THE TOTAL ASSESSMENT FOR ALL PAYORS SHALL BE: