HB 1157

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 1157 (Delegate Krebs)
Rules and Executive Nominations

Health Insurance - Nonpreferred Providers - Assignment of Benefits, Reimbursement, and Fraudulent Insurance Acts

This bill specifies the minimum reimbursement level an insurer must pay for a covered service rendered to an insured by an on-call physician or a hospital-based physician who is a nonpreferred provider and obtains an assignment of benefits (AOB). The bill prohibits the difference between the coinsurance percentage applicable to nonpreferred providers and preferred providers in a preferred provider insurance policy from being greater than 50 percentage points. The bill also establishes that it is a fraudulent insurance act for a nonpreferred provider to knowingly or willfully waive, forgive, or fail to collect any portion of cost sharing owed by an insured for services rendered. Violation of this provision is either a felony or misdemeanor, subject to a fine of up to $10,000 and/or specified imprisonment, depending on the value of the cost sharing owed.

The bill takes effect July 1, 2015.

Fiscal Summary

State Effect: Special fund expenditures increase for the Maryland Insurance Administration (MIA) by at least $156,500 beginning in FY 2016 to hire two additional personnel to review and investigate complaints associated with the new fraudulent insurance act. Minimal special fund revenue increase in FY 2016 for MIA from the $125 rate and form filing fee. General fund revenues and expenditures increase minimally beginning in FY 2016 due to the criminal penalty provisions established under the bill.

(in dollars)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
GF Revenue	-	-	-	-	-
SF Revenue	-	$0	$0	$0	$0
GF Expenditure	-	-	-	-	-
SF Expenditure	$156,500	$151,200	$158,100	$165,400	$172,900
Net Effect	($156,500)	($151,200)	($158,100)	($165,400)	($172,900)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Local revenues and expenditures increase minimally due to the criminal penalty provisions established by the bill.

Small Business Effect: Potential meaningful for small business health care practitioners who are nonpreferred providers.

Analysis

Bill Summary: For a covered service rendered to an insured by an on-call physician or a hospital-based physician who is a nonpreferred provider and obtains an AOB, the insurer must provide payment of no less than 140% of the average rate for the 12-month period that ends on January 1 of the previous calendar year that the carrier paid in the same geographic area for the same covered service to a similarly licensed provider under written contract with the insurer.

The bill makes permanent Chapter 537 of 2010, which governs AOB and reimbursement of nonpreferred providers, by repealing the termination date.

A nonpreferred provider (a provider that is eligible for payment under a preferred provider insurance policy, but that is not a preferred provider under the applicable service contract) that knowingly or willfully waives, forgives, or fails to collect any portion of a deductible, copayment, coinsurance, or other cost-sharing amount owed by an insured for services rendered by the nonpreferred provider has committed a fraudulent insurance act. A person who commits this fraudulent insurance act is subject to a fine of up to $10,000 and/or imprisonment for up to 18 months (if the value of the fraud is less than $300) or up to 15 years (if the value of the fraud is $300 or greater).

Current Law: An AOB means the transfer of health care coverage reimbursement benefits or other rights under a preferred provider organization (PPO) insurance policy by an insured. Chapter 537 of 2010 prohibits PPO policies provided by health insurers from refusing to honor an AOB to a health care provider and imposes specific billing, disclosure, and payment rate requirements for certain physicians when they are considered out-of-network by a PPO.

A PPO may not prohibit AOB to a provider by an insured or refuse to directly reimburse a nonpreferred provider under an AOB. The difference between the coinsurance percentage applicable to nonpreferred providers in a PPO policy and the coinsurance percentage applicable to preferred providers can be no greater than 20 percentage points. An insurer's allowed amount for a service provided by a nonpreferred provider under a PPO may not be

less than the amount paid to a similarly licensed provider who is a preferred provider for the same health care service in the same geographic region.

An insured may not be liable to an on-call physician or a hospital-based physician who is a nonpreferred provider and obtains an AOB from an insured for rendered covered services and notifies the insurer of the accepted AOB. The physician must refrain from collecting or attempting to collect any money, other than a deductible, copayment, or coinsurance, owed to the physician by the insured for covered services rendered.

For a covered service rendered to an insured by an on-call physician who is a nonpreferred provider and obtains an AOB, the insurer must provide payment at the greater of (1) 140% of the average rate for the 12-month period that ends on January 1 of the previous calendar year that the carrier paid in the same geographic area for the same covered service to a similarly licensed provider under written contract with the insurer or (2) the average rate for the 12-month period that ended on January 1, 2010, inflated by the Medicare Economic Index (MEI) from 2010 to the current year, for the same covered service in the same geographic area to a similarly licensed provider *not* under written contract with the insurer.

For a covered service rendered to an insured by a hospital-based physician who is a nonpreferred provider and obtains an AOB, the insurer must provide payment at the greater of (1) 140% of the average rate for the 12-month period that ends on January 1 of the previous calendar year that the carrier paid in the same geographic area for the same covered service to a similarly licensed provider who is a hospital-based physician 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 to the current year by MEI to the hospital-based physician billing under the same federal tax identification number the hospital-based physician used in calendar 2009.

A penalty of up to $5,000 applies for an insurer that violates these provisions.

If an insured has not provided an AOB and receives a check from an insurer, the insurer must provide information that the check is to pay for health care services received and should be provided to the nonpreferred physician. If a physician who is a nonpreferred provider seeks an AOB from an insured, the physician must, prior to rendering a health care service, disclose to the insured that the physician is a nonpreferred provider; that the insured will be responsible for payments that exceed the amount that the insurer will pay for services rendered; an estimate of the amount of the billed charge for which the insurer will be responsible; any applicable payment terms; and whether any interest will apply, including the amount.

Chapter 537 applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after July 1, 2011. It also includes a termination provision (September 30, 2015), which is repealed by this bill.

Background: Chapter 537 required the Maryland Health Care Commission (MHCC) to study and report on the impact of the legislation. MHCC issued an interim report in December 2012 and a final report in January 2015. The final report concluded that, overall, Chapter 537 achieved its purpose to ease the financial burden on patients who use out-of-network providers in hospital settings by reducing reliance on balance billing. Data indicated that AOB was chosen by the majority of providers who elected not to participate in private payor networks. Income uncertainty for those providers was likely reduced due to less reliance on balance billing. While impacts vary by payor, the report found no evidence that provider participation rates in payor networks systematically declined. MHCC recommends that the General Assembly repeal the termination date of Chapter 537 but make no additional changes to statute.

The report identified some dissatisfaction among payors regarding payment formulas. Payors must reimburse at either the greater of what was paid in 2009 adjusted to the current year by MEI or 140% of the average allowed charges for a similar provider in the same area. Payors that paid billed charges in 2009 reimburse by the first option. Payors that only paid in-network charges for out-of-network services in 2009 pay by the second option. Carriers subject to the first option argue that the law requires them to pay more. The bill repeals this option and requires all insurers to pay 140% of the average allowed charges for a similar provider in the same area.

Under some PPO plans, an out-of-network provider may perform services, waive the higher co-payment required of the insured, but still bill as an out-of-network provider. By establishing that such practice is a fraudulent insurance act, this practice will be curtailed.

State Revenues: General fund revenues increase minimally as a result of the bill's monetary penalty provisions from cases heard in the District Court.

State Expenditures: MIA special fund expenditures increase by at least $152,148 in fiscal 2016, which accounts for the bill's July 1, 2015 effective date. This estimate reflects the cost of hiring a minimum of two positions (one fraud investigator and one fraud auditor) to review and investigate an anticipated high volume of complaints from the industry regarding collection of cost sharing by nonpreferred providers. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	2
Salaries and Fringe Benefits	$140,908
One-time Start-up Expenses	8,570
Ongoing Operating Expenses	7,070
Total FY 2016 State Expenditures	**$156,548**

Future year expenditures reflect full salaries with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Any impact on the State Employee and Retiree Health and Welfare Benefits Program cannot be reliably estimated.

General fund expenditures increase minimally as a result of the bill's incarceration penalties due to more people being committed to State correctional facilities and increased payments to counties for reimbursement of inmate costs. The number of people convicted of this proposed crime is expected to be minimal.

Persons serving a sentence longer than 18 months are incarcerated in State correctional facilities. Currently, the average total cost per inmate, including overhead, is estimated at $3,100 per month. This bill alone, however, should not create the need for additional beds, personnel, or facilities. Excluding overhead, the average cost of housing a new State inmate (including variable health care costs) is about $770 per month. Excluding all health care, the average variable costs total $200 per month.

Persons serving a sentence of one year or less in a jurisdiction other than Baltimore City are sentenced to local detention facilities. For persons sentenced to a term of between 12 and 18 months, the sentencing judge has the discretion to order that the sentence be served at a local facility or a State correctional facility. Prior to fiscal 2010, the State reimbursed counties for part of their incarceration costs, on a per diem basis, after a person had served 90 days. Currently, the State provides assistance to the counties for locally sentenced inmates and for inmates who are sentenced to and awaiting transfer to the State correctional system. A $45 per diem grant is provided to each county for each day between 12 and 18 months that a sentenced inmate is confined in a local detention center. Counties also receive an additional $45 per day grant for inmates who have been sentenced to the custody of the State but are confined in a local facility. The State does not pay for pretrial detention time in a local correctional facility. Persons sentenced in Baltimore City are generally incarcerated in State correctional facilities. The Baltimore City Detention Center, a State-operated facility, is used primarily for pretrial detentions.

Local Revenues: Revenues increase minimally as a result of the bill's monetary penalty provisions from cases heard in the circuit courts.

Local Expenditures: Expenditures increase minimally as a result of the bill's incarceration penalties. Counties pay the full cost of incarceration for people in their facilities for the first 12 months of the sentence. A $45 per diem State grant is provided to each county for each day between 12 and 18 months that a sentenced inmate is confined in a local detention center. Counties also receive an additional $45 per day grant for inmates who have been sentenced to the custody of the State but are confined in a local facility. Per diem operating costs of local detention facilities have ranged from approximately $60 to $160 per inmate in recent years.

Additional Comments: SB 92/HB 230 of 2015 would also make permanent Chapter 537 of 2010 by repealing the termination date.

Additional Information

Prior Introductions: None.

Cross File: SB 803 (Senator Astle) - Finance.

Information Source(s): Department of Budget and Management, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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