HB 1505

Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1505 (Delegate Hayes)
Rules and Executive Nominations

Health Insurance - Assignment of Benefits and Reimbursement of Nonpreferred Providers - Modifications

This bill expands provisions of law regarding assignment of benefits (AOB) and reimbursement of nonpreferred providers, including consumer protections against balance billing, to apply to all nonpreferred on-call and hospital-based "health care practitioners" rather than only to physicians. The bill removes the requirement that on-call and hospital-based providers obtain an AOB and notify the insurer that they have obtained and accepted the AOB in order for balance billing provisions to apply. A nonpreferred provider seeking an AOB must provide specified information to the insured, *except in emergency circumstances, at least 24 hours* prior to performing a health care service. A heath care practitioner who fails to comply with this requirement is prohibited from billing the insured more than the allowed amount for the covered health care service.

The bill applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after its October 1, 2016 effective date.

Fiscal Summary

State Effect: Minimal increase in special fund revenues for the Maryland Insurance Administration from the $125 rate and form filing fee. Review of form filings can be handled within existing budgeted resources.

Local Effect: None.

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

Analysis

Bill Summary: "Health care practitioner" means an individual who is licensed, certified, or otherwise authorized to provide health care services under the laws of the jurisdiction in which the health care services are provided.

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 an 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.

Background: Chapter 537 of 2010, which established AOB and reimbursement of nonpreferred provider provisions, required the Maryland Health Care Commission (MHCC) to study and report on the impact of the legislation. MHCC issued a final report in January 2015, which 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 an AOB was chosen by the majority of providers who elected not to participate in private payer networks. Income uncertainty for those providers was likely reduced due to less reliance on balance billing. Chapter 79 of 2015 made the provisions governing AOB and reimbursement of nonpreferred providers permanent, by repealing the termination date.

Balance billing occurs when a health care provider seeks to collect from an insured or enrollee the difference between the provider's billed charges for a service and the amount that the carrier paid on that claim. Nationally, 49 states plus the District of Columbia prohibit balance billing in health maintenance organizations or PPOs. In 13 states, including Maryland, this restriction applies to nonpreferred (or out-of-network) providers.

"Surprise medical bill" describes charges arising when an enrollee or insured inadvertently receives care from a nonpreferred (or out-of-network) provider, most commonly in an emergency situation when the patient does not have the ability to select the facility or provider. A surprise medical bill can involve both increased cost sharing for a PPO enrollee as well as balance billing from the provider. Data on the prevalence of surprise medical bills and costs to consumers is limited; however, one national survey found that 8% of privately insured individuals used out-of-network care in 2011, 40% involving surprise (involuntary) out-of-network claims, primarily due to emergency care.

Additional Information

Prior Introductions: None.

Cross File: SB 335 (Senator Kelley, *et al.*) - Finance.

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

Fiscal Note History: First Reader - March 29, 2016
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