Department of Legislative Services

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FISCAL AND POLICY NOTE
First Reader

House Bill 837 (Delegate Sample-Hughes, *et al.*)
Health and Government Operations

Health Insurance - Payments to Noncontracting Specialists and Noncontracting Nonphysician Specialists

This bill requires each carrier to inform members and beneficiaries, in a specified manner, of the procedure to request a referral to a specialist or nonphysician specialist that is not part of the carrier's provider panel. A carrier must pay a specified rate for a covered mental health or substance use disorder service provided to a member by a noncontracting specialist or nonphysician specialist because a network provider is not available. A carrier must disclose these reimbursement rates as specified. A carrier may not balance bill a member after obtaining and accepting an "assignment of benefits." **The bill takes effect January 1, 2020, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Although the bill likely reduces the number of complaints from consumers regarding balance billing by noncontracting specialists or nonphysician specialists, any impact on the workload of the Maryland Insurance Administration is anticipated to be minimal. No material impact on the State Employee and Retiree Health and Welfare Benefits Program due to high in-network utilization. Revenues are not affected.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: "Assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under a preferred provider insurance policy by an insured. The definition of "nonphysician specialist" is expanded to include a health care provider that is licensed as a behavioral health program under § 7.5-401 of the Health-General Article.

An insurer or nonprofit health service plan must pay the greater of either:

- 140% of the average rate the insurer or nonprofit health service plan paid for the 12-month period that ends January 1 of the previous calendar year in the same geographic area, for the same covered service, to similarly licensed contracting providers; or

- 140% of the Medicare rate as of January 1 each calendar year for the same covered service to a similarly licensed provider in the same geographic area.

Similarly, a health maintenance organization (HMO) must pay the greater of:

- 140% of the average rate the HMO paid for the 12-month period that ends January 1 of the previous calendar year, in the same geographic area, for the same covered service, to similarly licensed contracting providers;

- 140% of the Medicare rate as of January 1 each calendar year for the same covered service, to a similarly licensed provider, in the same geographic area; or

- the amount required to be paid under § 19-710.1 of the Health-General Article.

A carrier must disclose these reimbursement rates (1) on request of a noncontracting health care provider; (2) to the Insurance Commissioner by February 1, 2020, and each January 1 thereafter; and (3) to the member or beneficiary at the time the service is approved.

A specialist or nonphysician specialist that informs the carrier that they have obtained and accepted an assignment of benefits from the member (to provide covered mental health and substance use disorder services) may not bill the member the difference between the specialist's bill and the allowable amount of the carrier for the covered service.

Current Law: Each carrier must establish and implement a procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the

carrier's provider panel. The procedure must provide for such a referral if (1) the member is diagnosed with a condition or disease that requires specialized health care services or medical care and (2) the carrier either does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease, or the carrier cannot provide reasonable access to such a specialist or nonphysician specialist without unreasonable delay or travel.

Section 19-710.1 of the Health-General Article specifies how much an HMO must pay for a covered service rendered to an enrollee by a noncontracting provider. For an evaluation and management service, an HMO must pay the greater of (1) 125% of the average rate the HMO paid as of January 1 of the previous calendar year, in the same geographic area, for the same covered service, to similarly licensed contracting providers or (2) 140% of the Medicare rate for the same covered service, to a similarly licensed provider, in the same geographic area. For a service that is not an evaluation and management service, an HMO must pay at least 125% of the average rate the HMO paid as of January 1 of the previous calendar year, in the same geographic area, to a similarly licensed contracting provider for the same covered service. An HMO must pay a noncontracting trauma physician the greater of (1) 140% of the Medicare rate or (2) the rate the HMO paid, as of January 1, 2001, in the same geographic area, for the same covered service, to a similarly licensed provider.

Background: Although current law provides access to noncontracting specialists if a contracting provider is not available, it does not establish an allowed amount or minimum that carriers must pay. Therefore, carriers often pay noncontracting specialists much less than the billed amounts, and noncontracting specialists balance bill the remainder to the patient (with the exception of HMO members, for which balance billing is prohibited).

In the *Final Report of the Heroin and Opioid Emergency Task Force*, issued in December 2015, the task force recommended legislation intended to expand access to substance use treatment by requiring that the allowed amount a carrier uses to pay benefits to noncontracting providers (when the provider network is inadequate, not when a patient voluntarily goes out-of-network for services) be no less than 140% of the allowed Medicare amount.

Additional Information

Prior Introductions: A related bill, HB 800 of 2016, received a hearing in the House Health and Government Operations Committee but was withdrawn.

Cross File: SB 761 (Senator Klausmeier) - Finance.

Information Source(s): Department of Budget and Management; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

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