Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 661 (Senator Garagiola, *et al.*)
Finance Health and Government Operations

Health Insurance - Use of Physician Rating Systems by Carriers

This bill establishes requirements for the Maryland Health Care Commission (MHCC) to approve "ratings examiners" to review "physician rating systems." The bill prohibits carriers from using a physician rating system unless the system is approved by a ratings examiner. To use a physician rating system, carriers must establish an appeals process for physicians and disclose specified information to physicians at least 45 days in advance of making evaluations available to enrollees or altering a physician rating system. The Insurance Commissioner is authorized to take specified action against carriers that use physician rating systems that are not in compliance with the bill.

The bill takes effect January 1, 2010.

Fiscal Summary

State Effect: The bill's requirements can be handled by MHCC and the Maryland Insurance Administration (MIA) with existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: "Physician rating system" means any program that measures, rates, or tiers the performance of physicians under contract with the carrier and discloses the measures, rates, or tiers to enrollees or the public. "Ratings examiner" means an independent entity that is approved by MHCC to review physician rating systems.

To be approved by MHCC, a ratings examiner has to require a physician rating system to (1) use only quality of performance and cost efficiency as measurement categories; (2) calculate and disclose those measures separately; (3) disclose clearly to physicians and enrollees the proportion of the component score for cost efficiency and quality of performance; (4) use specified measures for determining quality of performance; (5) make certain disclosures to physicians subject to the rating system; (6) use appropriate risk adjustments to account for the physician's patient population; (7) measure cost efficiency in a specified manner; (8) include an appeals process for physicians; and (9) disclose to physicians and enrollees how stakeholder perspectives were incorporated into the rating system.

An entity that has a physician performance rating certification program approved after August 1, 2008, by a specified consortium is deemed to be a ratings examiner and to meet the requirements of the bill.

A carrier must contract with and pay for a ratings examiner to review any physician rating system of the carrier. A carrier's physician rating system is deemed to be approved if it is approved by a ratings examiner as of January 1, 2010, and maintains its approval by the ratings examiner.

If a physician files a timely appeal of a rating, a carrier may not disclose or change the physician's rating until the carrier completes its investigation and renders a decision on the appeal. A carrier must post specific information on the section of its web site that discloses physician ratings to enrollees.

A carrier has to notify the Insurance Commissioner of the results of any final review conducted by a ratings examiner of the carrier's physician rating system within a specified timeframe. If the physician rating system is found not to comply, the Insurance Commissioner may order the carrier to correct the deficiency or cease the use of the physician rating system. A carrier using a physician rating system has to report annually to the Insurance Commissioner on the number of appeals filed by physicians and the outcome of the appeals.

By December 1 annually, the Insurance Commissioner and MHCC have to report on the number and types of appeals filed by physicians and the number of entities approved by MHCC as ratings examiners.

Current Law: Chapter of 1999 required MHCC to develop and implement a system to comparatively evaluate the quality of care and performance of nursing homes on an objective basis and annually publish the summary findings of the evaluation. MHCC currently produces several annual performance evaluation guides to assist

consumers in comparing nursing homes, hospitals, ambulatory surgery facilities, health maintenance organizations, and point of service organizations.

Background: This bill is based on one of eight recommendations of the Task Force on Health Care Access and Reimbursement, which issued its final report in December 2008. The task force found that meaningful efforts to measure and publicly report the comparative quality of physician practices are needed to help consumers make informed choices of where and from whom to seek care. Physician performance measurement is relatively new, complex, and rapidly evolving. The need for transparency, accuracy, and oversight in the process is significant. Potential conflicts exist when the sponsor of performance measurement is an insurer; the profit motive may affect its program of physician measurement and/or reporting. This potential conflict of interest requires scrutiny, disclosure, and oversight by appropriate authorities if physicians, consumers, and purchasers are to have confidence in these systems.

The task force recommended that the General Assembly pass legislation requiring health plans licensed by MIA to fully disclose to consumers and physicians important aspects of their ranking system, with the Office of the Attorney General (OAG) and MIA jointly developing regulations needed to enforce the statute, and the General Assembly providing funding to support any incremental increase in workload at OAG and MIA. The task force specifically recommended that any legislation reflect the November 2007 consent agreement between the Office of the Attorney General of the State of New York and United HealthCare, which prescribes United's physician performance measurement system. This bill is largely based on that consent agreement.

Physician rating systems provide carriers with a basis for quality-based programs and may lead to pay for performance initiatives that reward physicians for care practices that improve patients' health. In Maryland, United HealthCare relies on a physician-tiering program in which physicians are rated on quality and efficiency, but there is no direct link to payment. CareFirst has a Quality Rewards program that allows for reimbursement levels up to 7% of the base fee schedule based on adherence to a set of quality and service-oriented business practice measures. Aetna has implemented a physician-tiering program in which consumers face a lower copayment for choosing top-tier physicians and a Bridges to Excellence pay for performance program. Both the Aetna and CareFirst programs are currently limited to a small number of physician specialties.

Currently, the National Committee for Quality Assurance (NCQA) is the only organization to have nationally recognized standards for physician performance measurement. On August 13, 2008, the Consumer-Purchaser Disclosure Project, a consortium of leading consumer, employer, and labor organizations funded by the Robert Wood Johnson Foundation, named NCQA as an independent reviewer to certify that health insurers assess and report on the quality of physicians in an effective and fair

manner. The bill establishes that any physician rating system approved by NCQA would be deemed to be approved under Maryland law.

Additional Information

Prior Introductions: None.

Cross File: HB 585 (Delegates Costa and Pena-Melnyk) – Health and Government Operations.

Information Source(s): Task Force on Health Care Access and Reimbursement *Final Report and Recommendations*, December 2008; Office of the Attorney General; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - February 26, 2009
mlm/mwc Revised - Senate Third Reader - April 7, 2009
Revised - Updated Information - May 13, 2009

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