Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 314 (Senator Garagiola, *et al.*)

Finance Health and Government Operations

Health Insurance - Assignment of Benefits and Reimbursement of Nonpreferred Providers

This bill, with certain exceptions, prohibits preferred provider organization (PPO) policies provided by health insurers from refusing to honor an assignment of benefits to a health care provider. The bill also imposes specific billing, disclosure, and payment rate requirements for specified physicians in cases where they are considered out-of-network by a PPO. Penalties apply in some cases. In addition, the bill requires the Maryland Health Care Commission (MHCC), in consultation with the Maryland Insurance Administration (MIA) and Office of the Attorney General (OAG), to study the impact of the bill on carrier network adequacy, physician reimbursement and access, and balance billing. MHCC must submit a final report to the General Assembly by October 1, 2014. MIA must report to the Governor and General Assembly on the benefits provided by insurers before the bill's assignment of benefit provisions take effect and their impact on complaints filed by insureds regarding balance billing, and a specified payment methodology, by December 1, 2010.

The bill's provisions take effect and apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after July 1, 2011, with the exception of the study requirements, which take effect October 1, 2010. The bill terminates September 30, 2015.

Fiscal Summary

State Effect: Special fund expenditures increase by $37,500 in FY 2011 for MHCC to hire a contractor to conduct the required study. Future years reflect continuing requirements, annualization, and the completion of the study report at the end of FY 2014. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State plan) may increase beginning in FY 2012 if payments to on-call physicians and hospital-based physicians exceed current rates. Minimal special fund revenue increase for MIA from the $125 rate and form filing fee in FY 2012. Review of

filings can be handled with existing budgeted MIA resources. No measurable impact is expected from the bill's penalty provisions.

(in dollars)	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
SF Revenue	$0	-	$0	$0	$0
GF Expenditure	$0	-	-	-	-
SF Expenditure	$37,500	$50,000	$50,000	$50,000	-
FF Expenditure	$0	-	-	-	-
Net Effect	($37,500)	($50,000)	($50,000)	($50,000)	$0

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

Local Effect: Expenditures may increase for some local governments if payments to on-call physicians and hospital-based physicians exceed current rates.

Small Business Effect: Potential increase in expenditures for the Comprehensive Standard Health Benefit Plan (CSHBP) if payments to on-call physicians and hospital-based physicians exceed current rates. Potentially meaningful for small business health care providers as well.

Analysis

Bill Summary: "Assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under a PPO by an insured.

A PPO may not prohibit the assignment of benefits to a provider by an insured or refuse to directly reimburse a nonprefered provider under an assignment of benefits. The bill requires the difference between the coinsurance percentage applicable to nonpreferred providers in a PPO policy and the coinsurance percentage applicable to preferred providers to be no greater than 20 percentage points. The bill also prohibits an insurer's allowed amount for a service provided by a nonpreferred provider under a PPO from being 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.

On-call and Hospital-based Physicians

The bill contains specific requirements for payments to on-call physicians and hospital-based physicians by PPO contracts.

"Hospital-based physician" means a physician licensed by the State who is under contract to provide health care services to patients at a hospital or a group physician practice that includes physicians licensed in the State and is under contract to provide health care services to patients at a hospital.

"On-call physician" means a physician who has hospital privileges, must respond within an agreed-upon time period to provide emergency health care at a hospital emergency department, and is not a hospital-based physician.

An insured may not be liable to an on-call physician or a hospital-based physician who is a nonpreferred provider and obtains an assignment of benefits from an insured for rendered covered services and notifies the insurer of the accepted assignment of benefits. 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.

The bill also outlines specified complaint procedures and payment timeframe requirements for on-call physicians, and hospital-based physicians, and insurers affected by the bill.

For a covered service rendered to an insured by an on-call physician who is a nonpreferred provider and obtains an assignment of benefits, the insurer must provide payment at the greater of:

- 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
- the average rate for the 12-month period that ended on January 1, 2010, inflated by the Medicare economic index 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 assignment of benefits, the insurer must provide payment at the greater of:

- 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
- 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 the Medicare economic index to the hospital-based physician billing under the same

federal tax identification number the hospital-based physician used in calendar 2009.

The bill expresses legislative intent that the rate paid by an insurer to a nonpreferred provider who is an on-call physician or a hospital-based physician under the payment provisions outlined above be no less than the rate paid by the insurer to the nonpreferred provider as of December 31, 2009.

A penalty of up to $5,000 applies for an insurer that violates the bill. However, MIA may not impose the penalty until July 1, 2012. MIA, in consultation with MHCC, must adopt regulations to implement these provisions.

Other Physicians

If an insured has not provided an assignment of benefits 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 assignment of benefits 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.

Maryland Health Care Commission Study

MHCC must set parameters to conduct a review of payments to on-call physicians by January 1, 2011, and submit an interim report to the General Assembly by July 1, 2012, and a final report by October 1, 2014.

Current Law: "Nonpreferred provider" means a provider that is eligible for payment under a preferred provider insurance policy but that is not a preferred provider under the applicable provider service contract.

A preferred provider insurance policy is a policy or insurance contract issued or delivered in the State by an insurer, or another contract offered by an employer, third-party administrator, or other entity, under which health care services are provided to the insured by a preferred provider on a preferential basis.

Unless an insurer offering a PPO demonstrates to the Insurance Commissioner that an alternative level of payment is more appropriate, aggregate payments made in a full

calendar year to nonpreferred providers, after all deductible and copayment provisions have been applied, on average may not be less than 80% of the aggregate payments made in that full calendar year to preferred providers for similar services, in the same geographic area, under the provider service contracts.

Providers that participate in health maintenance organization (HMO) or PPO networks must accept as payment in full the rate they negotiated with the HMO or PPO. Noncontracting (out-of-network) providers must accept the amount defined in statute.

Chapter 664 of 2009 altered the rates that an HMO must pay for a covered service rendered to an HMO enrollee by certain noncontracting health care providers. For a nonevaluation and management service, an HMO must pay noncontracting health care providers no less than 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. In calculating the rate to be paid for an evaluation and management service, an HMO must calculate the average rate paid to similarly licensed providers under written contract with the HMO for the same covered service using a specified calculation.

Background: Generally, a carrier contracts with a physician or other health care provider to deliver health care services to the carrier's enrollees. Often, these contracts include negotiated reimbursement amounts that are far lower than what a provider would normally charge. When a health care provider rejects these contracts, the provider is considered a nonparticipating provider with that particular carrier. Some nonparticipating providers will still accept patients from the carrier, allowing the patient to assign his or her benefits to the provider. Some carriers, however, may ignore the assignment of benefits and pay the benefits directly to the patient, increasing the chance that the health care provider gets paid late or not at all.

During the 2009 legislative session, SB 852 and HB 1366 were introduced to require carriers to honor an assignment of benefits. SB 852 was amended to require a carrier to provide notice to its insureds, subscribers, or enrollees about the carrier's policy regarding the honoring of an assignment of benefits. The amendments also required the Joint Committee on Health Care Delivery and Financing to study issues associated with prohibiting carriers from refusing to accept a patient's assignment of benefits and to report its findings by December 1, 2009.

Although neither bill became law, the Joint Committee on Health Care Delivery and Financing studied the benefits, costs, and other policy issues associated with the assignment of benefits and developed a legislative proposal outline for assignment of benefits. This bill is largely based on the committee's proposal.

According to OAG, 31 states (plus Iowa under private agreement) have assignment of benefit laws that vary in nature and scope. For example, Florida's assignment of benefits law applies to a recognized hospital, licensed ambulance provider, physician, dentist, or other person who provided services according to the insurance policy. Insurers must make payments to these providers under an assignment of benefits, although an insurer may require a written confirmation of the assignment.

State Expenditures: Special fund expenditures increase by $37,500 in fiscal 2011 for MHCC to hire a contractor to set parameters and conduct the required study. While MHCC's final report is due October 1, 2014, it advises that it will complete the study and report by the end of fiscal 2014. Therefore, future year expenditures of $50,000 per year reflect annualization and the completion of the study and report at the end of fiscal 2014.

Expenditures for the State plan may increase beginning in fiscal 2012 if payments to on-call physicians and hospital-based physicians mandated under the bill exceed current rates until the termination of the bill at the end of September 2015. However, the amount of any increase cannot be determined at this time. State plan expenditures are split 59% general funds, 30% special funds, and 11% federal funds.

Local Expenditures: Local government expenditures (for those that purchase fully insured plans from an insurance company) increase for some local governments beginning in fiscal 2012 if payments to on-call physicians and hospital-based physicians exceed current rates.

Small Business Effect: CSHBP is generally not subject to mandated benefits applicable to the large group market. Rather, MHCC reviews CSHBP on an annual basis and considers making benefit or cost sharing changes at that time. However, Legislative Services advises that this bill applies to the small group market. Therefore, expenditures for CSHBP potentially increase if payments to on-call physicians and hospital-based physicians exceed current rates.

In addition, small business health care providers may receive more assignments of benefits, potentially drawing in more patients and streamlining their billing and collections processes.

Additional Information

Prior Introductions: None.

Cross File: HB 147 (Delegate Morhaim, *et al.*) - Health and Government Operations.

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

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