Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE

House Bill 147 (Delegate Morhaim, *et al.*)
Health and Government Operations

Health Insurance - Assignment of Benefits and Reimbursement of Nonpreferred Providers

This bill prohibits carriers 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 health insurance carrier. 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.

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 January 1, 2011, with the exception of the study requirement, which takes effect October 1, 2010.

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 and review payments to on-call physicians. Future years reflect continuing requirements and annualization. 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 exceed current rates. Minimal special fund revenue increase for MIA from the $125 rate and form filing fee in FY 2011. 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	$50,000
FF Expenditure	$0	-	-	-	-
Net Effect	($37,500)	($50,000)	($50,000)	($50,000)	($50,000)

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 exceed current rates.

Small Business Effect: Potential increase in expenditures for the Comprehensive Standard Health Benefit Plan (CSHBP) if payments to on-call 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 health benefit plan by an insured, subscriber, or enrollee to a health care provider. Under the bill, the only health care providers affected are physicians.

A "carrier" means a nonprofit health service plan, health maintenance organization, third-party administrator, or any other person providing health benefit plans on an expense-incurred basis subject to State regulation. A carrier also includes an entity that arranges a provider panel for a carrier.

A carrier may not prohibit the assignment of benefits to a provider, insured, subscriber, or enrollee, or refuse to reimburse directly a provider under a valid assignment of benefits. If an insured, subscriber, or enrollee of a carrier does not assign a benefit to a physician and receives a check from a carrier, the carrier must provide information that the check is to pay for health care services received and should be provided to the health care provider.

Nonhospital-based Physicians

"Nonhospital-based physician" means a physician licensed by the State who does not have hospital privileges. It does not include on-call physicians.

If a nonhospital-based physician seeks an assignment of benefits from a patient, the physician must provide the patient with a statement that includes information explaining

that the physician is out-of-network and that the patient may be charged for health services not covered under his or her health benefit plan.

On-call Physicians

The bill contains specific requirements for payments to on-call physicians by insurer and nonprofit health service plan preferred provider organization contracts.

"On-call physician" means a nonhospital-based physician who has hospital privileges and must respond within an agreed-upon time period to provide emergency health care at a hospital emergency department.

An insured may not be liable to an on-call physician who is a nonpreferred provider and obtains an assignment of benefits from an insured for rendered covered services. The physician must refrain from collecting or attempting to collect any money owed to the physician by the insured for covered services rendered, and the insured's carrier must provide payment at the greater of:

- 140% of the Medicare rate as of August 1, 2008, inflated by the Medicare economic index change from 2008 to the current year, for the same covered service to a similarly licensed provider under contract; or
- 140% of the rate as of 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.

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

MHCC must set parameters to conduct a review of payments to on-call physicians by January 1, 2011. In addition, MHCC must annually review payments to on-call physicians subject to the bill to determine insurer compliance and report its findings to MIA. MHCC must conduct a study of the bill's impact and submit an interim report to the General Assembly by July 1, 2012, and a final report by October 1, 2014. However, MHCC must continue its annual review of payments to on-call physicians after the reports have been submitted.

A penalty of up to $5,000 applies for an insurer that regularly violates the provisions above. MIA, in consultation with MHCC, must adopt regulations to implement these provisions.

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.

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

Chapter 664 of 2009 altered the rates that a health maintenance organization (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, conduct the required study, and annually evaluate payments to on-call physicians. While MHCC's final report is due October 1, 2014, the requirement to annually review payments to on-call physicians to determine compliance continues. Future year expenditures of $50,000 per year reflect annualization.

Expenditures for the State plan may increase beginning in FY 2012 if payments to on-call physicians mandated under the bill exceed current rates. 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 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 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: SB 314 (Senator Garagiola, *et al.*) - Finance.

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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