Department of Legislative Services

Maryland General Assembly
2011 Session

FISCAL AND POLICY NOTE

Revised

House Bill 83 (Delegate K. Kelly, *et al.*)

Health and Government Operations | Finance

Health Insurance - Ambulance Service Providers - Direct Reimbursement

This bill requires insurers, health maintenance organizations (HMOs), and nonprofit health service plans (carriers) to *directly* reimburse certain ambulance service providers for covered services provided. A carrier, except for an HMO, must obtain an assignment of benefits from the insured. An ambulance service provider that receives direct reimbursement from a carrier may not balance bill an insured, subscriber, or enrollee, other than to collect (1) any copayment, deductible, or coinsurance amount owed; (2) if Medicare is the primary insurer, any amount not owed by Medicare after coordination of benefits; and (3) any payment or charge for noncovered services. The bill includes reporting requirements for the Maryland Health Care Commission (MHCC).

The bill takes effect January 1, 2012, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date. The bill terminates June 30, 2015.

Fiscal Summary

State Effect: Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) in FY 2012 from the $125 rate and form filing fee. Review and approval of form filings can be handled with existing budgeted resources. Likewise, MHCC can handle the bill's reporting requirements with existing resources.

Local Effect: Potentially significant increase in revenues for local jurisdictions that provide and bill for emergency medical services.

Small Business Effect: None.

Analysis

Bill Summary: "Ambulance service provider" includes only those providers that are owned, operated, under the jurisdiction of, or contracted with, a political subdivision of the State, or a volunteer fire company or rescue squad.

Notwithstanding existing law regarding reimbursement by HMOs, an HMO's allowed amount for a covered health care service provided by an ambulance service provider that is not under written contract with the HMO may not be less than the allowed amount paid to an ambulance service provider that is under written contract with the HMO for the same covered service in the same geographic region, as defined by the federal Centers for Medicare and Medicaid Services (CMS). An insurer's or nonprofit health service plan's allowed amount for a health care service covered under a preferred provider insurance policy and provided by an ambulance service provider that is a nonpreferred provider may not be less than the allowed amount paid to an ambulance service provider that is a preferred provider in the same geographic region as defined by CMS.

The Insurance Commissioner may adopt regulations to implement the bill.

Uncodified language requires MHCC, by January 1, 2014, and January 1, 2015, to submit an interim and a final report, respectively, to specified committees of the General Assembly regarding changes in claims for ambulance service providers under the bill.

Current Law: Current law does not require carriers to reimburse ambulance service providers directly. With the exception of HMO enrollees, ambulance service providers may balance bill patients for the difference between the participating provider (in-network) and nonparticipating provider (out-of-network) reimbursement rate the provider receives from a carrier.

Beginning July 1, 2011, Chapter 537 of 2010, with certain exceptions, prohibits preferred provider organization (PPO) policies from refusing to honor an assignment of benefits to a physician. The Act also imposes specific billing, disclosure, and payment rate requirements for specified physicians in cases where they are considered out-of-network by a PPO.

Under § 19-710.1 of the Health – General Article, an HMO must pay a health care provider, for a covered service rendered to an enrollee by a provider not under written contract with the HMO, within 30 days of receipt of a claim. Claims from hospitals and trauma physicians must be paid at a specified rate. For an evaluation and management service provided by any other health care provider, an HMO must pay (1) no less than the greater of 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, as defined by CMS, for the same covered service, to similarly licensed providers under written contract with the HMO; or (2) 140%

of the rate paid by Medicare, as published by CMS, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year. For a service that is not an evaluation and management service, an HMO must pay 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, as defined by CMS, to a similarly licensed provider under written contract with the HMO for the same covered service. A health care provider may file a complaint with MIA or file a civil action in a court of competent jurisdiction if an HMO does not comply with these payment provisions.

Background: Many Maryland jurisdictions, including some volunteer companies, bill for ambulance service. The amount billed depends on the severity of the call and can range from approximately $200 to more than $500, with additional mileage charges in some jurisdictions.

Most ambulance companies do not contract with or become participating providers with every carrier. If an ambulance service provider is a nonparticipating provider with a carrier, reimbursement for covered services is typically provided directly to the insured, subscriber, or enrollee. Ambulance service providers then bill the insured, subscriber, or enrollee, but frequently reimbursement is never received.

At least six states (Arkansas, Nevada, New Jersey, North Carolina, Oregon, and Virginia) currently authorize direct reimbursement for ambulance services, while no fewer than five states (Massachusetts, New York, Ohio, Pennsylvania, and South Dakota) have considered or are currently considering similar legislation.

Additional Information

Prior Introductions: Similar legislation was considered in the 2010 session. HB 1524 received a hearing in the House Health and Government Operations Committee, but no further action was taken on the bill. Its cross file, SB 745, received a favorable with amendments report from the Senate Finance Committee. While the committee amendments were adopted by the Senate, no further action was taken.

Cross File: None designated; however, SB 154 (Senator Colburn, *et al*. – Finance) is identical.

Information Source(s): Towns of Bel Air, Leonardtown, and Riverdale Park; cities of Bowie, Salisbury, and Takoma Park; Baltimore City; Baltimore, Calvert, Caroline, Carroll, Harford, Montgomery, Prince George's, Queen Anne's, and St. Mary's counties; Board of Public Works; Department of Budget and Management; Department of Health

and Mental Hygiene; Maryland Institute for Emergency Medical Services Systems; Maryland Insurance Administration; Department of Legislative Services

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