**SB 642**

# Department of Legislative Services

Maryland General Assembly
2014 Session

## FISCAL AND POLICY NOTE

Senate Bill 642 (Senator Mathias)
Finance

**Health Insurance - Assignment of Benefits and Reimbursement of Nonpreferred Providers - Repeal of Reporting Requirement and Termination Date**

This bill makes permanent most provisions of Chapter 537 of 2010, which governs assignment of benefits and reimbursement of nonpreferred providers (by repealing the termination date). However, the bill also repeals the requirement that the Maryland Health Care Commission (MHCC) study the impact of the Act and submit a specified report to the General Assembly.

The bill takes effect June 1, 2014.

## Fiscal Summary

**State Effect:** Special fund expenditures for MHCC decline by $40,000 in FY 2014 due to repeal of the study and reporting requirement. To the extent payments to on-call physicians and hospital-based physicians exceed rates that would otherwise take effect, expenditures (all funds) may increase for the State Employee and Retiree Health and Welfare Benefits Program (State plan) beginning in FY 2016.

| (in dollars) | FY 2014 | FY 2015 | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|---|---|
| Revenues | $0 | $0 | $0 | $0 | $0 |
| GF Expenditure | 0 | 0 | - | - | - |
| SF Expenditure | (40,000) | (-) | 0 | 0 | 0 |
| FF Expenditure | 0 | 0 | - | - | - |
| Net Effect | $40,000 | $0 | $0 | $0 | $0 |

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

**Local Effect:** To the extent payments to on-call physicians and hospital-based physicians exceed rates that would otherwise take effect, health insurance expenditures may increase for some local governments beginning in FY 2016. No effect on revenues.

**Small Business Effect:** Potential meaningful. To the extent payments to on-call physicians and hospital-based physicians exceed rates that would otherwise take effect, health insurance costs may increase in the small group market beginning in FY 2016. Small business health care providers may continue to receive assignments of benefits under the bill.

## Analysis

**Current Law:** An assignment of benefits (AOB) means the transfer of health care coverage reimbursement benefits or other rights under a preferred provider organization (PPO) insurance policy by an insured. Chapter 537 of 2010 prohibits PPO policies provided by health insurers from refusing to honor an AOB to a health care provider and imposes specific billing, disclosure, and payment rate requirements for certain physicians when they are considered out-of-network by a PPO.

A PPO may not prohibit AOB to a provider by an insured or refuse to directly reimburse a nonpreferred provider under an AOB. The difference between the coinsurance percentage applicable to nonpreferred providers in a PPO policy and the coinsurance percentage applicable to preferred providers can be no greater than 20 percentage points. An insurer's allowed amount for a service provided by a nonpreferred provider under a PPO may not be 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.

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

For a covered service rendered to an insured by an on-call physician who is a nonpreferred provider and obtains an AOB, the insurer must provide payment at the greater of (1) 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 (2) 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 AOB, the insurer must provide payment at the

greater of (1) 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 (2) 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.

A penalty of up to $5,000 applies for an insurer that violates these provisions. If an insured has not provided an AOB 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 AOB 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.

Under Chapter 537, MHCC, in consultation with the Maryland Insurance Administration and the Office of the Attorney General, must study (1) the benefits and costs associated with the direct reimbursement of nonparticipating providers by carriers under a valid AOB; (2) the impact of enacting a cap on balance billing for nonpreferred, on-call physicians and hospital-based physicians; (3) the impact on consumers of prohibiting carriers from refusing to accept a valid AOB; and (4) the impact of requiring direct reimbursement of nonparticipating providers by carriers on their networks, including the impact of charges by specialty. The Act required MHCC to determine baseline parameters to conduct the study by January 1, 2011, submit an interim report by July 1, 2012, and submit a final report to the General Assembly by October 1, 2014. The bill repeals these study and reporting provisions.

Chapter 537 applied to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after July 1, 2011. It also included a termination provision (September 30, 2015), which is repealed by this bill.

**Background:** In December 2012, MHCC issued a report, *Impact of Assignment of Benefits Legislation Baseline Analysis*. The report examined the baseline impact of Chapter 537 on the three different stakeholders affected by the law. The report found that participation by physicians in at least one private insurance network was greater than 80% for almost all specialties, with the exception of psychiatrists.

In terms of reimbursement for out-of-network services, the report noted that hospital-based specialties were reimbursed at the highest rate compared to on-call surgical or medical specialists and primary care. Almost one in every five patients used some out-of-network services (either hospital or nonhospital), and user out-of-pocket spending for copayments, deductibles, and balance billing increased in direct proportion to the proportion of spending on professional services allocated to out-of-network services. For payors, in general, the share of out-of-network services did not differ much between hospital and nonhospital locations, nor did the ratio of payor reimbursement for out-of-network services to total payer reimbursement; however, there were differences between hospital and nonhospital locations in the ratio of reimbursement to billed charges.

**State Fiscal Effect:** MHCC special fund expenditures decline by $40,000 in fiscal 2014 as contractual services are no longer required to complete the study of the impact of Chapter 537 and report to the General Assembly. This report is otherwise due October 1, 2014. MHCC advised in 2010 that it would conduct the required study over multiple years and complete it in fiscal 2014 (despite a slightly later due date). Thus, the Department of Legislative Services assumes MHCC realizes savings in fiscal 2014.

Absent the report (the requirement for which is repealed by the bill), the impact on the State plan due to making the reimbursement of nonpreferred providers and AOB provisions of Chapter 537 permanent cannot be reliably estimated.

## Additional Information

**Prior Introductions:** None.

**Cross File:** HB 709 (Delegate Kach) - Health and Government Operations.

**Information Source(s):** Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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