Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

Senate Bill 92 (Senator Middleton)
Finance Health and Government Operations

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

This bill makes permanent Chapter 537 of 2010, which governs assignment of benefits and reimbursement of nonpreferred providers, by repealing the termination date.

The bill takes effect June 1, 2015.

Fiscal Summary

State Effect: There is no anticipated impact on State operations or finances.

Local Effect: There is no anticipated impact on local operations or finances.

Small Business Effect: Minimal. 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 (MEI) 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 MEI 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.

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 It also includes a termination provision (September 30, 2015), which is repealed by this bill.

Background: Chapter 537 required the Maryland Health Care Commission (MHCC) to study and report on the impact of the legislation. MHCC issued an interim report in December 2012 and a final report in January 2015. The final report concluded that, overall, Chapter 537 achieved its purpose to ease the financial burden on patients who use out-of-network providers in hospital settings by reducing reliance on balance billing. Data indicated that AOB was chosen by the majority of providers who elected not to participate in private payor networks. Income uncertainty for those providers was likely reduced due to less reliance on balance billing. While impacts vary by payor, the report found no evidence that provider participation rates in payor networks systematically declined. MHCC recommends that the General Assembly repeal the termination date of Chapter 537 but make no additional changes to statute.

The report identified some dissatisfaction among payors regarding payment formulas. Payors must reimburse at either the greater of what was paid in 2009 adjusted to the current year by MEI or 140% of the average allowed charges for a similar provider in the same area. Payors that paid billed charges in 2009, reimburse by the first option. Payors that only paid in-network charges for out-of-network services in 2009, pay by the second option. Carriers subject to the first option argue that the law requires them to pay more. MHCC notes that the commission can simplify the process for these payors by (1) producing and distributing a 2009 fee schedule derived from the Medical Care Data Base that would meet the requirements of the law and (2) providing consistent MEI annual inflators on an ongoing basis that can be used to adjust the 2009 payment levels to the current year.

Additional Information

Prior Introductions: Substantially similar legislation (SB 642/HB 709) was introduced in 2014. SB 642 was heard by the Senate Finance Committee but later withdrawn. HB 709 was heard by the House Health and Government Operations Committee but later withdrawn.

Cross File: HB 230 (Delegate Hammen) - Health and Government Operations.

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

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