

V. Study of the Balance Billing Prohibition in Maryland

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Overview

In 2002, the Maryland General Assembly required the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to study several issues regarding health care provider¹ reimbursements by commercial insurers (including health maintenance organizations or HMOs²) and self pay patients in the State.³

One of those issues is whether the State should maintain a prohibition against the balance billing of HMO subscribers⁴ for covered services. Balance billing is a term used by the insurance and provider community which is defined as the practice of a health care provider billing an HMO member⁵ for an amount of the provider's charges not covered by the insurer. A related term used to define protections for consumers from balance billing by providers is 'enrollee hold harmless.' Most, if not all, HMOs have enrollee hold harmless language in physician and other provider contracts. The National Association of Insurance Commissioners (NAIC) has adopted model language that specifies that participating providers may not seek reimbursement from "a covered person" for covered services.⁶ NAIC defines "participating providers" as those providers under contract with an HMO (participating) and those providers who do not contract with the HMO (non-participating/non-contracting) but are under contract with an organization that does contract with the HMO (e.g., a hospital contracts with an HMO, but the hospital-based providers do not contact with the HMO).⁷

Under Maryland law, providers under contract with HMOs (participating providers) as well as non-participating providers may not balance bill HMO members or subscribers for covered services. All HMOs are required under Maryland law to have enrollee hold harmless language in their contracts with providers. All providers, however, may fully bill HMO members for non-covered services (§19-710(i) and (p) of the Health-General Article). In addition, insurers are required to reimburse non-participating providers at a certain rate for covered services, as defined in Maryland statute (§ 19-710.1 of the Health-General Article). See Appendix A for specific language of statutes.

¹ "Provider" means any person, including a physician or hospital, who is licensed or otherwise authorized in this State to provide health care services. Maryland Annotated Code, Health General Article, §19-701(i).

² As defined in Annotated Code of Maryland, Health-General Article § 19-701(f).

³ Laws of Maryland, 2002, Chapter 250, House Bill 805 – *Reimbursement of Health Care Provider*

⁴ "Subscriber" means a person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services. Maryland Annotated Code, Health General Article, § 19-701(j).

⁵ "Member" means a person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services. Maryland Annotated Code, Health General Article, § 19-701(h). Throughout this document, member is substituted for the terms 'subscriber' and 'enrollee.'

⁶ NAIC Health Maintenance Organization Model Act, Section 19, Hold Harmless Provision Requirements for Covered Persons. 2003. www.naic.org

⁷ NAIC Health Maintenance Organization Model Act, Section 3 (BB), "Participating provider" means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract."

In this document, the term non-participating is used synonymously with out-of-network and non-contracting.

Policies or contracts between members enrolled in a traditional HMO and the HMO generally do not include reimbursement for covered services delivered by non-participating providers. Freedom of choice laws, however, allow HMO enrollees to visit non-participating providers. Under Maryland law, HMO members may be covered for a medical service provided by a non-participating provider if certain criteria are satisfied (i.e., the service must be considered a ‘covered service’ as defined in the Maryland Health-General Article § 19-701(d)).⁸ In addition, HMOs are required to offer employers a point-of-service (POS) option when the HMO plan is the only plan offered by an employer. A POS plan allows enrollees to see the same provider network as offered in the HMO plan, as well as non-participating providers, without a referral or preauthorization from the HMO or primary care provider. In that instance, the member would pay a higher out-of-pocket cost for these out-of-network services as defined in the member’s contract.

The crux of the balance billing issue is who is responsible for the monetary difference between the provider’s charge and the amount reimbursed by the insurer. Providers who are part of an HMO network agree to accept a negotiated amount as their reimbursement, whereas providers outside an HMO network have no such agreement. The ‘balance’ is the difference between the amount a provider charges and the amount the provider is reimbursed by the insurer. In most states, HMO members who are treated for a covered service by a non-participating provider may be billed by the provider, so that providers are fully reimbursed for services. In Maryland, this practice is prohibited, meaning that in-network providers must accept as payment in full the rate they negotiated with the HMO, and out-of-network providers must accept an amount as defined in statute or agreed to between the provider and the HMO for a covered service. In Maryland, the methodology to reimburse non-contracting providers for a covered service is currently fixed in statute.⁹

By way of comparison, the federal Medicare and joint federal-state Medicaid programs also prohibit balance billing by providers. Under Medicare, providers who do not accept assignment to treat patients enrolled in the program (non-participating) cannot bill patients the difference between the provider charge and the Medicare provider reimbursement rate. These providers are permitted, however, to bill the patient 15% over reduced (95%) Medicare rates. Those providers that accept Medicare assignment may not balance bill patients. No providers may balance bill for hospitalization and emergency care.¹⁰ Providers that treat Medicaid patients cannot balance bill recipients for any type of service provided.

Background on HMOs

The expansion of HMOs took place during the latter part of the 20th century as a result of increasing costs borne by the consumer and strong support for the concept of the ‘corporate practice of medicine’ in certain states. The popularity of HMOs, however, markedly increased

⁸ Maryland Code, Health General Article § 19-710.2 (b).

⁹ Maryland Code, Health-General Article § 19-710.1

¹⁰ Victoria Stagg Elliott, *Physicians Seek Right to Balance-bill Under Medicare*, AMNews, January 6, 2003. The American Medical Association (AMA) recently adopted a resolution calling for the ability to balance bill Medicare recipients regardless of whether the provider has accepted assignment from Medicare.

after the passage of the HMO Act in 1973.¹¹ Initially, HMOs were one form of managed care that manages patient care through limited provider networks and stricter utilization control. Another form of managed care is the Preferred Provider Organization (PPO). PPOs, as well as managed health insurance contracts, allow greater flexibility with choice of providers. In Maryland, members of PPO plans may be balance billed by non-contracting providers for covered services.

In a traditional HMO plan, the member pays a monthly premium (which may be paid in full by the member or employer, or shared) for a set of medical benefits. Depending upon the plan, copayments and/or deductibles may also be required. The HMO member does not expect to pay any amount above what is specified in the contract. The primary care physician acts as a ‘gatekeeper,’ authorizing referrals for treatment by specialist physicians. The HMO member may seek treatment for medical services from providers and hospitals limited to the HMO network. Unless care or treatment is referred by the primary care provider, or authorized by the HMO, care received from physicians not included in the plan’s network is not covered by the plan (the enrollee assumes full fiscal responsibility). An exception is emergency and out-of-area urgent care. **These services are covered by HMOs even if care is provided out-of-network (it must meet the prudent layperson definition of an emergency).**

Consumer backlash against HMOs has led to less restrictive management practices by these organizations and greater utilization of services by enrollees. One example is emergency room services. In the past, some HMOs have denied coverage on the basis that some care rendered in the emergency department was not truly ‘emergency’ care. Currently, over 40 states, including Maryland¹², have passed legislation allowing the enrollee to use a “prudent layperson” standard to decide a medical emergency,¹³ requiring the HMO to pay for the service if a prudent layperson would consider it to be an emergency.

In 2002, 1.4 million people were enrolled in Maryland HMOs - the 11th highest concentration of enrollees in the country. HMOs comprise 51% of the group market in Maryland, and they make up 43% of the individual market.¹⁴ The HMO penetration rate in 2002 dropped to 34.7% from 38% of the state population in 2001.¹⁵ HMO enrollment in Maryland declined, on average, 6.7% between 2001 and 2002.¹⁶ The rising costs of HMO plans, along with the desire by the public to have the ability to obtain care without the gatekeeper approach, has led to a slowing of growth in

¹¹ Peter Kongstvedt, *Essentials of Managed Health Care*, 1995, The HMO Act of 1973 “enabled managed care plans to increase in numbers and expand enrollments through health care programs financed by grants, contracts, and loans” (2).

¹² Maryland Annotated Code, Health General Article, § 19-701 (d) “ ‘Emergency services’ means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) Placing the patient’s health in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part.”

¹³ Linda R. Brewster, Liza Rudell, Cara S. Lesser, Center for Studying Health Systems Change, *Emergency Room Diversions: A Symptom of Hospitals Under Distress*, Issue Brief Number 38, May 2001.

¹⁴ Deborah Chollet, Fabrice Smieliauskas, and Madeline Konig, “Mapping State Health Insurance Markets, 2001: Structure and Change,” State Coverage Initiatives, Academy Health, September 2003.

¹⁵ The Henry J. Kaiser Family Foundation, State Health Facts Online (2002), <http://www.statehealthfacts.kff.org>. The percentage of Maryland residents enrolled in HMOs ranked Maryland the 5th highest in the nation for a second year.

¹⁶ Maryland-specific data provided to MHCC by InterStudy.

HMO market share. More firms are re-directing employees from HMO and POS plans to higher deductible PPOs,¹⁷ granting members the ability to receive covered services without a referral.

History of the Balance Billing Issue in Maryland

The Maryland General Assembly passed balance billing legislation over 15 years ago to protect the HMO enrollee from additional cost burdens. The legislation was also designed to restrict the ability of those noncontracting providers from billing the enrollee the difference between the HMO's reimbursement and the amount billed by the provider.

Legislation regarding the balance billing of HMO members in Maryland had its origins in 1988, with the adoption of a 'hold harmless' clause, similar to language proposed by the NAIC, applying only to those providers under contract with an HMO. This provision of the law requires contracts between HMOs and providers to contain this clause prohibiting providers from collecting reimbursement for services covered under the member's plan other than copayments or coinsurance.¹⁸ Legislation was enacted in 1989 specifically extending the hold harmless provision for covered services to non-participating providers ("any health care provider for any covered service").¹⁹ Extending the hold harmless provision to non-participating providers carried forward the efforts of the General Assembly to protect the consumer.

Responding to concerns by non-participating providers about low HMO reimbursement rates and the consequent reluctance of non-participating providers to treat HMO patients,²⁰ the Consumer Protection Division of the Maryland Attorney General's Office in 1991 supported proposed legislation that hastened payments and increased reimbursement rates. The legislation specified that "the HMO must pay the provider within 30 days, that hospitals are to be paid at the rate approved by the Health Services Cost Review Commission, and that other providers are to be paid at the rate billed or at the 'usual, customary, and reasonable' (UCR) rate."²¹ Non-contracting providers, therefore, could be reimbursed by HMOs at their normal rate billed or at the UCR rate.

Legislation was subsequently enacted requiring HMOs to offer employers a point-of-service (POS) option when the HMO plan is the only plan offered by an employer. Members of a HMO plan with a POS option (HMO-POS) may receive treatment out-of-network for covered services without a referral; however, the HMO-POS contracts may require that the enrollee or subscriber pay a higher premium as well as the difference between the provider's charges and the amount reimbursed to the provider by the HMO-POS (i.e., may be balance billed).²²

¹⁷ Maryland Health Care Commission, *2003 Policy Report of Maryland Commercial HMO and POS Plans*, January 2003.

¹⁸ "The hold harmless clause shall provide that the provider may not, under any circumstances...bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, member, enrollee, patient, or any persons other than the health maintenance organization acting on their behalf, for services provided in accordance with the provider contract. Chapter 754, Laws of Maryland, 1988.

¹⁹ Chapter 610, Laws of Maryland, 1989.

²⁰ As stated in 83 *Opinions of the Attorney General* ____ (1998) [Opinion No. 98-018 (September 28, 1998)], non-contracting providers are commonly reimbursed less by an HMO for covered services than the provider's normally billed rate.

²¹ Chapter 121 (Senate Bill 701) of the Laws of Maryland 1991. 83 *Opinions of the Attorney General* ____ (1998) [Opinion No. 98-018 (September 28, 1998)]

²² The Maryland Insurance Administration requires that HMOs clearly state what the cost-sharing requirements are for POS plans. Maryland Code, Health General Article § 19-710.2 (c)(2) specifies that "A carrier may impose different cost-sharing

In response to concerns expressed by providers and HMOs over the determination of the UCR rate for payment of covered services to non-contracting providers, legislation was enacted in 2000 requiring HMOs to reimburse non-contracting providers at the greater of: (1) 125% of the rate the HMO pays in the same geographic area for the same covered service to a similarly licensed provider under written contract; or (2) the rate as of January 1, 2000, that the HMO paid in the same geographic area, for the same covered service, to a similarly licensed provider not under written contract with the HMO.²³

The following year, an amendment was introduced altering the reimbursement formula to compensate trauma physicians at a rate higher than the rate for non-participating providers, and also redefining ‘covered service.’²⁴ At that time, “covered service” was defined as “a health care service included in the benefit package of the health maintenance organization and rendered to an enrollee of the health maintenance organization by a health care provider, including a physician or hospital, not under written contract with the health maintenance organization.”²⁵ Also, the covered service definition applied only to the section of law that reflected provider reimbursement (Health-General Article § 19-710.1) and did not apply to the balance billing provisions of § 19-710 Health General Article.

House Bill 805 in 2002 extended the abrogation date for the reimbursement methodologies for those non-contracting trauma physicians and other health care providers from June 30, 2002 to June 30, 2005.²⁶ This bill also added language to the reimbursement formulas for non-participating providers which specifies the geographic areas as published by the federal Centers for Medicare and Medicaid Services (CMS).

In 2000 and 2003, the Maryland Office of the Attorney General issued opinions regarding whether HMO members may enter into private contracts with health care providers for services not covered by the members’ plan. In both years, the Attorney General opined that HMO members may voluntarily enter into private contracts with providers for non-covered services, agreeing to pay the providers’ billed rate.

“HMO members may contract with a health care provider for health care services that are not covered by the member’s HMO. As part of that private contract, the member may agree not to rely on the HMO plan and to pay the provider’s full rate for services. If the HMO member makes an informed and voluntary decision to enter into such a contract, the prohibition against balance billing of HMO members does not apply.” 85

provisions for the point-of-service option based on whether the service is provided through the provider panel of the health maintenance organization or outside the provider panel of the health maintenance organization.”

²³ Chapter 275 of the Acts of 2000 (Senate Bill 405, *Health Maintenance Organizations – Reimbursement of Non-Contracting Providers*). Section 2 of the Chapter 275 of the Acts of 2000 mandated the reimbursement floor for non-contracting providers. Section 4 refers to the Act’s date of enactment

²⁴ Chapter 423 of the Acts of 2001 (Senate Bill 728, *Health Maintenance Organizations – Reimbursement of Non-Contracting Providers for Services Rendered to Trauma Patients at Designated Trauma Centers*). A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of: 140% of the rate paid by the Medicare program, as published by the Health Care Financing Administration, for the same covered service, to a similarly licensed provider, or the rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, for the same covered service, to a similarly licensed provider.

²⁵ Ibid.

²⁶ Chapter 250 of the Acts of 2002 (House Bill 805, *Reimbursement of Health Care Providers*).

The 2003 opinion²⁷ recommended that the General Assembly clarify the definition of ‘covered services’ to alleviate confusion over the ability of HMO members to enter into private contracts with non-contracting providers. In the 2003 legislative session, the definition of ‘covered services’ was clarified to mean those health care services provided by a non-contracting provider to an HMO member: (1) obtained in accordance with the terms of the benefit contract of the member or subscriber; (2) obtained with a verbal or written referral by the HMO or participating provider; or (3) preauthorized by the HMO or a participating provider. Language was also added to the HMO statute specifying that trauma physicians treating HMO members in a trauma center are not required to obtain a referral or preauthorization for a service to be considered covered.²⁸ This means that services, other than emergency care and out-of-area urgent care provided by a non-participating provider to a traditional HMO member which is not within the terms of the benefit contract, or without a referral or preauthorization (with the exception of trauma physicians), may be billed in full by the provider because they are not considered ‘covered services.’

HMO plans with a POS option which require members to receive a referral from a primary care provider for in-network specialty care (gatekeeper) may be considered a “mandatory” POS plan.²⁹ It is important to note that out-of-network services obtained under a POS contract are included in the definition of ‘covered service,’³⁰ and, therefore, members of POS plans cannot be balance billed if the member obtains care from a non-participating provider without a referral or preauthorization unless the contract allows this type of cost sharing provision. **A HMO-POS member’s contract will specify the cost sharing arrangement and whether the member is required to pay non-contracting providers the balance of the bill.**

As mentioned above, two separate Maryland Attorney General Opinions specified that providers may enter into private contracts with HMO (or HMO POS) members for a service that is not a ‘covered service,’ and in this instance, the providers may bill and receive their full rate for the service. The 2000 opinion recommends that the written contact between the provider and the HMO member must clearly and concisely inform the member of the financial consequences of entering into a private contract outside the context of the HMO – i.e., that the member will be solely responsible for the provider’s charges; that the HMO will not pay the provider; that the provider will not accept payment from the HMO; and that the member’s obligation to pay HMO premiums will not be affected.”³¹

²⁷ 88 *Opinions of the Attorney General* ____ (2003) [Opinion No. 03-005 (March 13, 2003)]

²⁸ Chapter 440, House Bill 656 – *Health Maintenance Organization – Definition of a Covered Service*. This legislation recodified the definition of covered service from § 19-710.1 of the Health-General Article to § 19-701.

²⁹ Another type of POS plan is a fee-for-service “open access” plan which provides the member the ability to directly access contracted providers without a referral. Open access POS plans may require the member to pay for a non-contracting provider’s charges above the amount reimbursed by the plan.

³⁰ Maryland Code, Insurance Article § 19-701(d)(2)(i) – Covered service includes a service rendered to a member by a non-contracting provider when the service is “obtained in accordance with the terms of the benefit contract of the member or subscriber.”

³¹ 85 *Opinions of the Attorney General* ____ (2000) [Opinion No. 00-030 (November 21, 2000)].

Experience of Hospitals and Other Health Care Providers with HMO Reimbursement

Hospital Reimbursement: Hospitals and hospital-based providers are obligated to provide care to all patients who seek care in a hospital emergency room, regardless of a patient's insurance status.³² Those providers that treat patients, such as emergency room physicians and anesthesiologists, do so without regard to the insurer's reimbursement rate or contractual arrangement with the insurer.

Since July 1974, Maryland hospitals have been reimbursed under the rate-setting authority of the Health Services Cost Review Commission (HSCRC). The HSCRC sets rates that all payers must reimburse hospitals for hospital services. Each acute care hospital is reimbursed according to a charge-per-case system, specific to the characteristics of each hospital and the patient population served. HMOs must pay hospitals the rates designated by the HSCRC.

Practitioner Reimbursement: Physicians and other health care providers who have signed contracts with an HMO to provide care and services to the HMO's enrolled members agree to be reimbursed according to a certain fee schedule or negotiated rate. According to a report prepared by the Maryland Health Care Commission, commercial insurers' practitioner payment rates averaged four to five percent above Medicare's rates in 2000, with little difference between HMO and non-HMO plans on average.³³ However, commercial insurers' rates in 2001 averaged two percent below Medicare's rates, primarily due to increases in Medicare's rates.³⁴ In 2002, private insurers' rates were on average four percentage points higher than Medicare (see Report 1, table 9).

Geographic Area Reference: It is worth noting that, in 2002, House Bill 805 altered the definition of reimbursement for 'any other health care provider' or non-participating providers to include reference to geographic areas as designated by CMS. The geographic areas referenced are the Washington, D.C. metropolitan area (includes Montgomery and Prince George's counties), the Baltimore metropolitan area (Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, and Howard counties), and all other counties. This language referencing geographic areas was added to the statute as a means of clarifying how non-participating providers are to be reimbursed by referring to the three localities specified by CMS for Medicare payments. However, MedChi, the physicians' medical society in Maryland, asserts that under the current statutory reimbursement formula, the reimbursement rates paid to non-contracting providers are not easily available.³⁵ Therefore, providers are unaware of how much the HMO will reimburse them for a covered service.

Complaints and Legal Action: Statutory language adopted in 2000 specifies that health care providers may file a complaint with the Maryland Insurance Administration (MIA) or a civil

³² Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals that participate in the Medicare program are required to screen patients who present themselves at an emergency room seeking care. If the person requires immediate medical care, the hospital must provide stabilizing treatment or transfer the person to another medical facility. CMS News "Medicare Announces Final Rule on Hospital Responsibilities to Patients Seeking Treatment for Emergency Conditions." August 29, 2003. <http://www.cms.gov>

³³ Maryland Health Care Commission, Practitioner Utilization: Trends within Privately Insured Patients, 2000-2001. Released March 2003.

³⁴ Ibid.

³⁵ Personal communication, September 22, 2003.

action against an HMO for failure to pay according to the formula.³⁶ While the MIA has conducted investigations into complaints filed by providers against HMOs for violation of the statutory reimbursement methodology,³⁷ none of these investigations has found in favor of the providers. A lawsuit was initiated in 2001 by MedChi and two individual physicians against Aetna U.S. Healthcare. The lawsuit claims that Aetna improperly paid those Maryland physicians who did not contract with the insurer. The plaintiffs assert that the physicians were reimbursed at a rate lower than that specified in statute. The case is still active.

Each year, the MIA receives several patient complaints alleging incorrect billing by providers. Between April 1, 2001 and September 4, 2002, the MIA received 55 complaints from patients, with many of the complaints involving insurers rather than HMOs. Approximately 25% of the complaints were filed against out-of-network providers for claims, while 56% were filed for incorrect in-network provider claims. Some of these complaints included providers who balance bill HMO members for covered services. The MIA referred the balance billing complaints to the State of Maryland Office of the Attorney General, Health Education and Advocacy Unit (HEAU), Consumer Protection Division, for resolution of billing disputes.³⁸ Only 23 complaints received by the HEAU between 1999 and 2003 concerned Maryland's balance billing law.³⁹ This number may be understated as other types of complaints filed with the HEAU may include balance billing issues (e.g., Claims-Coordination of Benefits Disputes and Consumer Challenging Carrier Adverse Decision (Medical Necessity Appeals & Grievances Cases Only)).

Hospital-based Practitioners: In Maryland, hospitals generally request that those physicians who contract to provide hospital-based services participate with the same major insurers as the hospitals.⁴⁰ While not a requirement, the Association of Maryland Hospitals and Health Systems (MHA) reports that emergency room physicians do contract with the same major insurers as the hospital. It is noted, however, that certain physician groups may not contract with the same insurers as hospitals. Providers, such as anesthesiologists, that have contracted with a hospital to provide their services do not necessarily contract with the same insurers as the hospital. In addition, one neonatology group in Maryland does not contract with HMOs.⁴¹ Hospitals and the physicians and other providers that contract with the hospitals separately bill HMOs for services provided to HMO members. Many managed care enrollees are not aware that the hospital and hospital-based physicians charge separately and are reimbursed by the HMO or insurer separately.

Statutory Reimbursement Methodology: Prior to the year 2000, providers who did not contract with HMOs and served HMO members were paid substantially lower amounts per relative value

³⁶ Maryland Code, Insurance Article § 19-710.1(d) – ‘filing of complaint or civil action’ (1) a health care provider may enforce the provisions of this section by filing a complaint against an HMO with the MIA or by filing a civil action in a court of competent jurisdiction under § 1-501 or § 4-201 of the Courts Article.

³⁷ Personal communication 8-28-03. The complaints did not satisfy the definition for investigation.

³⁸ Created in 1996, the mission of the HEAU is to “assist health care consumers in understanding health care bills; third party coverage; identifying improper billing or coverage determinations; to report billing and/or coverage problems to appropriate agencies; and, to assist patients with health equipment warranty issues.” State of Maryland, Office of the Attorney General, Annual Report on the Health Insurance Carrier Appeals and Grievances Process, Prepared by the Health Education and Advocacy Unit, Consumer Protection Division, Office of the Attorney General. November 2002.

³⁹ Personal communication with HEAU staff.

⁴⁰ Personal communication with MHA staff.

⁴¹ Personal communication with MIA staff.

unit (RVU) of care as compared with the non-HMO plans. The passage of legislation in the 2000 Maryland General Assembly requiring HMOs to pay non-participating providers at least 125% of the rate paid to participating providers led to a substantial increase in HMO reimbursements to the non-participating providers. In 2001, the median HMO payment to nonparticipating physicians exceeded the minimum payment amount of 125% of the rate paid to participating physicians; however, there was a significant proportion of bills that did not meet the statutory requirement.⁴² Analysis of 2002 data indicates that over two-thirds of the HMO payments to non-participating physicians are in compliance with statutory payment formula (68%).⁴³ See Report 1, table 16. It should be noted that the data analysis shows the extent to which HMOs *appear* to be complying with the minimum payment standards for non-participating physicians. This analysis is based on the statutory formula of 125 percent of private rates paid by an insurer in an area using payment rates at the 25th percentile as the base.

Other States' Statutes and Regulations

Most, if not all, contracts between HMOs and their participating providers contain “hold harmless” language that does not allow providers to seek reimbursement from HMO members for covered services. States are strongly encouraged to adopt the hold harmless language developed by the National Association of Insurance Commissioners.⁴⁴ This model language is contained in their “Health Maintenance Organization Model Act” and specifies that providers may not seek reimbursement from “a covered person” for covered services.⁴⁵ NAIC defines “participating providers” as those providers under contract with an HMO (participating) and those providers who do not contract with the HMO (non-participating/non-contracting) but are under contract with an organization that does contract with the HMO (e.g., a hospital contracts with an HMO, but the hospital-based providers do not contract with the HMO).⁴⁶

In order to better analyze the issue of whether Maryland should maintain a prohibition against the balance billing of HMO members for covered services, MHCC staff, with the assistance of the Maryland Insurance Administration, submitted a list of questions to the NAIC for distribution to the 50 states and the District of Columbia. The questions were drafted to determine state’s laws and regulations regarding balance billing of HMO members. Twenty-two responses were received. All of the states, including the District of Columbia, that responded (with the exception of Wyoming)⁴⁷ either require HMO contracts to contain an enrollee hold harmless clause or have a balance billing prohibition in statute for covered services by participating providers (Illinois’

⁴² Maryland Health Care Commission, *Practitioner Utilization: Trends Within Privately Insured Patients, 2000-2001*, March 2003. HMO fee-for-service payments were extracted and separated for participating and non-participating physicians.

⁴³ The threshold is based on the statutory formula calculated using payments at the 25th percentile.

⁴⁴ NAIC Health Maintenance Organization Model Act, Section 19, Hold Harmless Provision Requirements for Covered Persons. 2003. The NAIC represents insurance regulators from the 50 states, the District of Columbia and the four U.S. territories. www.naic.org

⁴⁵ NAIC Health Maintenance Organization Model Act, III-430-1, Section 19, Hold Harmless Provision Requirements for Covered Persons. 2003. www.naic.org

⁴⁶ NAIC Health Maintenance Organization Model Act, Section 3 (BB), ““Participating provider” means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.”

In this document, the term non-participating is used synonymously with out-of-network and non-contracting.

⁴⁷ Wyoming statute contains a hold harmless provision for insolvent HMOs.

requirement applies to only participating hospital providers). Three states (other than Maryland) have balance billing prohibitions in statute that specifically disallow participating **AND** non-participating providers from balance billing HMO members for covered services.

Those respondent states with balance billing prohibitions for both contracting and non-contracting providers are Florida, Rhode Island, and West Virginia. In these states, the balance billing prohibition applies to all services and settings (including emergency services). All providers, however, bill in full for those services that are not covered under the HMO member's plan. Listed below are selected excerpts from these states' balance billing prohibitions:

Florida: Florida's balance billing prohibition applies to both HMO participating providers and those providers that do not contract with the HMO for services that are considered authorized by the HMO. The Florida statute specifies that "if a health maintenance organization is liable for services rendered to a member by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the member is not liable for payment of fees to the provider."⁴⁸ It also states that "a health maintenance organization is liable for services rendered to an eligible member by a provider if the provider follows the health maintenance organization's authorization procedures and receives authorization for a covered service for an eligible member... ."⁴⁹

In addition, emergency services and care provided by a non-contracting provider must be reimbursed "at the lesser of: (1) the provider's charges; (2) the usual and customary provider charges for similar services in the community where the services were provided; or (3) the charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim."⁵⁰ Florida maintains a separate reimbursement formula for non-contracting providers that provide emergency services and care.

Rhode Island: The balance billing prohibition in Rhode Island applies to both participating and non-participating providers and applies to all services and settings. Rhode Island does not maintain a reimbursement formula for non-contracting providers. The Rhode Island Medical Society attempted to overturn the state's 'hold-harmless' provision this year but failed.⁵¹

West Virginia: The West Virginia statute reads that any provider (contracting and non-contracting) may not balance bill an enrollee of an HMO if the provider is aware that the patient is enrolled in an HMO.⁵² The referencing statute also requires contracts between providers and HMOs to contain 'hold harmless' language. For emergency care and services, HMOs are required to reimburse the non-contracting emergency care providers normal charges.⁵³

⁴⁸ The 2002 Florida Statutes, Insurance, § 641.3154 (1)

⁴⁹ The 2002 Florida Statutes, Insurance, § 641.3154 (2) *Organization liability; provider billing prohibited.*

⁵⁰ The 2002 Florida Statutes, Insurance, § 641.513, *Requirements for providing emergency services and care.*

⁵¹ Personal communication with a representative of the Rhode Island Insurance Department.

⁵² West Virginia Code § 33-25A-7a (2) *Contracts with providers*

⁵³ West Virginia Code § 33-25A-7a (6) "When a subscriber receives covered emergency health care services from a noncontracting provider, the health maintenance organization shall be responsible for payment of the providers normal charges for those health care services, exclusive of any applicable deductibles or copayments."

Other States: Non-participating providers in Massachusetts are reimbursed according to the type of HMO plan,⁵⁴ whereas in Minnesota, non-participating providers may bill the HMO for their usual and customary services. The California Department of Managed Care has considered regulations barring hospital-based physicians from balance billing HMO enrollees for emergency care and services. Currently, California statute contains a ‘hold harmless’ clause and a requirement that HMOs reimburse hospitals for emergency care regardless of whether a contract exists between the HMO and hospital. While the statute does not contain explicit language specifying that HMOs must reimburse hospitals for the full charge of emergency service, state officials believe that the law creates an ‘implied contract’ that HMOs must do so. Hospitals, however, often bill patients for the balance between what the hospital charged and the amount reimbursed by the HMO.⁵⁵

Emergency Care and Services: As mentioned earlier in the report, currently over 40 states, including Maryland⁵⁶, have passed legislation allowing the enrollee to use a “prudent layperson” standard to decide a medical emergency,⁵⁷ requiring the HMO to pay for the service if a prudent layperson would consider it to be an emergency. Of those states responding to the MHCC/MIA survey, most indicated that their states’ balance billing prohibitions or hold harmless clauses apply to only participating providers;⁵⁸ and some of the states surveyed have language in statute specifying the type of payments to non-contracting providers, or in a few examples, to HMO members who have paid for their care. These states do not prohibit non-contracting providers from balance billing the HMO member.

- In Michigan, enrollees may be billed by a non-participating hospital and other types of health care providers. In this instance, the law requires HMOs to pay the “reasonable expenses or fees to the provider or enrollee.”⁵⁹
- New Jersey’s statute specifies that HMO members are responsible for the in-network cost-sharing arrangement with the insurer if care is received from a non-contracting provider; however, the cost-sharing arrangement would not act as a deterrent to the non-participating provider from balance billing the HMO member.

⁵⁴ Massachusetts Division of Insurance. Personal communication. For a non-group guaranteed issue medical plan or a preferred provider plan, the HMO may make payments to non-contracting providers based on the usual and customary charges for non-contracting providers. An actuarial opinion certifying that the methodology used to determine the usual and customary rate are, in aggregate, at least comparable to, and not lower than the 80th percentile of charges based on HIAA data (211 CMR 41.06(2)(i)). HMOs that offer a preferred provider plan may make payments to non-contracting providers as a percentage of the provider’s fee, up to a usual and customary charge. The ‘usual and customary charge’ is not defined in Massachusetts code and regulations.

⁵⁵ Kaiser Health Policy Report, “California Rule Says Hospitals Cannot Bill People for Emergency Services Their HMOs Will Not Cover,” September 4, 2003.

⁵⁶ Maryland Annotated Code, Health General Article, § 19-701 (d) “ ‘Emergency services’ means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) Placing the patient’s health in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part.”

⁵⁷ Linda R. Brewster, Liza Rudell, Cara S. Lesser, Center for Studying Health Systems Change, *Emergency Room Diversions: A Symptom of Hospitals Under Distress*, Issue Brief Number 38, May 2001.

⁵⁸ MHCC survey. CT, DC, DE, HI, KS, KY, MA, MN, OH, SD, and TX statutes and/or regulations prohibit participating providers only from balance billing HMO subscribers.

⁵⁹ MCL 500.3517. Personal communication with the Michigan Office of Financial and Insurance Services

- Massachusetts requires HMOs that offer a plan that is not an insured preferred provider plan to “provide or arrange for indemnity payments to a member or provider for a reasonable amount charged for the cost of emergency medical services by a provider who is not normally affiliated with the health maintenance organization when the member requires services for an emergency medical condition.”⁶⁰ HMO insured preferred provider plans must reimburse non-participating emergency care providers “at the same level and in the same manner as if the covered person had been treated by a preferred provider.”⁶¹
- In Minnesota, non-participating providers may bill the HMO for their usual and customary services.
- Ohio statute requires carriers to compensate either non-contracting providers or HMO members (if the provider bills the HMO member) for covered health care services delivered out-of-network.⁶² In addition, HMOs in Ohio are required to have “provisions for transportation and indemnity payments or service agreements for out-of-area [emergency care] coverage”.⁶³
- In Texas, non-participating providers are reimbursed at the UCR or an agreed rate between the HMO and provider for emergency services or approved out-of-network referrals.⁶⁴
- And in Virginia, while no reimbursement definition is in statute, non-contracting emergency care providers are usually paid the HMO contracted rate.

In Pennsylvania, insurers usually reimburse non-participating providers the insurer’s contracted rate; however, they may pay the provider’s actual charges in order to prevent the HMO member from being balanced billed.⁶⁵ One state (Wisconsin) indicated in the survey that non-participating emergency room physicians may not bill the patient under a prudent layperson standard so long as the insured complies with the terms of the insurer when emergency services are received from a non-participating provider.⁶⁶

See Appendix B for the state survey questions and a table documenting the states’ responses.

Issues Specific to Maryland

The following issues were considered by staff when developing recommendations and options for the continuation of Maryland’s prohibition on balance billing HMO members for covered services. **Note that providers, both contracting and non-contracting, may bill an HMO**

⁶⁰ General Laws of Massachusetts, c. 176G, sec. 5(f).

⁶¹ General Laws of Massachusetts, c. 176I, sec. 3(b).

⁶² Ohio Revised Code, § 1751.13 (A)(2)

⁶³ Ohio Revised Code, § 1751.01 (H)

⁶⁴ Personal communication with the Texas Department of Insurance

⁶⁵ Personal communication with a representative of the Pennsylvania Insurance Department.

⁶⁶ Personal communication with a representative of the Wisconsin Office of the Commissioner of Insurance.

member in full for services not included in the HMO (or POS) contract. The chart below presents the various scenarios for which providers may or may not balance bill HMO members.

Maryland HMO Policies*	Covered Service, In–Network	Covered Service, Out-of-Network	Non-covered service
Traditional HMO	Cannot balance bill (must have referral or preauthorization for specialty care)	Cannot balance bill (must have referral or preauthorization for specialty care) NOTE: Emergency care and out-of-network urgent care is considered a covered service. Emergency providers cannot balance bill. Non-participating providers are reimbursed according to the methodology in Health-General Article, §19-710.1 of the Maryland Annotated Code.	Providers may enter into private contracts with HMO members for services that are not covered by the member’s HMO (or POS) plan
HMO-POS	Cannot balance bill	Cannot balance bill UNLESS contract specifies that the member is responsible for the difference between the amount charged by the non-participating provider and the amount reimbursed to the provider by the HMO/POS plan. NOTE: Emergency care and out-of-network urgent care is considered a covered service. Non-participating providers are reimbursed according to the methodology in Health-General Article, §19-710.1 of the Maryland Annotated Code.	Providers may enter into private contracts with HMO members for services that are not covered by the member’s HMO (or POS) plan

* **NOTE:** Providers cannot balance bill for covered services obtained in accordance with the terms of the benefit contract, such as emergency care, out-of-area urgent care, and all POS benefits (unless defined in contract).

1. Covered services provided by a health care provider participating in an insurer's network

In Maryland, an HMO member receiving covered services within the plan's network cannot be balance billed. Most states that responded to the survey have either a 'hold harmless' provision and/or a balance billing prohibition in statute. HMOs generally include the hold harmless language in their contracts with providers regardless of a state requirement. An example is an HMO member being treated by a provider participating in the HMO member's plan for a service covered under the contract between the HMO and the HMO member. The HMO member cannot be balance billed by the contracting health care provider.

Recommendation: No action.

2. Covered services provided by a non-participating health care provider in an emergency situation (ER care)

An HMO or HMO-POS member who receives services provided by a non-participating provider in an emergency situation, whether the hospital is within network or not, cannot be balance billed by the facility nor by emergency room physicians. Most emergency room physicians, radiologists, and anesthesiologists contract with the hospital to provide specialized services. These providers are not employees of the hospital, but rather have negotiated reimbursement rates with the HMOs. If the practice does not have a contract with the HMO, then they are considered non-contracting physicians and bill separately from the hospital for services provided. The HMO reimburses the hospital at the rate set by the Health Services Cost Review Commission (if the service is covered) and reimburses the non-contracting provider based upon the state-mandated reimbursement formula.

An example is an HMO member seeking treatment for an emergency medical condition within a hospital participating in the HMO member's plan (emergency care is a covered service in the HMO member's plan). While in the emergency room, the HMO member is treated by several physicians who do not participate in the HMO member's plan (non-participating providers). Current Maryland law prohibits non-participating providers from balance billing an HMO member for a covered service.

The Maryland General Assembly recognized that in an emergency situation, because of the federal EMTALA regulations, the provider has no choice about whether to treat the patient regardless of the patient's insurance status. However, the patient has no choice concerning where to seek treatment and whether the physician treating the patient is under contract with the HMO. Therefore, the legislature enacted legislation that sought to balance those interests by recognizing that non-participating providers should be reimbursed at a rate defined in statute. At the same time, the legislature did not want to hold the HMO member responsible for the monetary balance between the non-participating provider's bill and the amount reimbursed by the HMO.

Recommendation: The Commission could not reach consensus on whether the balance billing prohibition should be maintained. The balance billing prohibition is not the central

reason providers are experiencing financial stress. Commissioners were sympathetic to both provider and consumer concerns.

Currently approximately about 2 percent of all privately insured services are provided by non-participating providers.⁶⁷ That share increases to 15 percent of all emergency room visits by privately insured patients. However, MHCC analysis of Maryland emergency department (ED) data reveals that all forms of private health insurance were the primary source of payment for about 46 percent of all patients treated in emergency department.⁶⁸ MHCC estimates that about 34 percent of HMO enrollees treated in Maryland EDs are affected by the balance billing prohibition; however this translates into only about 7 percent of all patients treated in Maryland EDs in 2002.

Reimbursement levels for services paid to non-contracting providers are quite favorable, relative to the rates paid by HMOs to contracting physicians. Overall, the MHCC estimates that on average, non-contracting physicians are paid \$61 per relative value unit (RVU) compared to an average of \$48 for contracting physicians performing the same service.⁶⁹

Although balance billing would not affect the majority of HMO enrollees, for those affected, the consequences could be significant. If balance billing was allowed, HMO members being treated by non-contracting providers for covered services could be faced with large bills on top of the premium that they had already paid in the belief that they had purchased coverage for emergency services or, in order to avoid these additional charges, could be placed in the position of requesting a delay in critical care in order to receive services from a contracting provider.

A primary reason for the financial stress to hospital-based physicians is the lack of reimbursement for uninsured patients and under-compensation for Medicaid patients. MHCC estimates about 40 percent of patients treated in hospital outpatient departments and clinics are either uninsured or covered by Medicaid. The lack of compensation and under-compensation, in the case of Medicaid, are much larger sources of financial stress than losses that may occur due to the balance bill prohibition. The Commission concluded these larger problems needed to be addressed, but the repeal of the balance billing prohibition would have little impact. **A clear consensus emerged among MHCC Commissioners that more progress could be made if attention is directed toward addressing the issues of uncompensated care funding through a pooling mechanism or, indirectly, through insurance coverage expansions.**

3. Covered non-emergency services provided by a non-contracting provider

Reimbursement by HMOs for non-emergency care that is considered a covered service provided by a non-contracting provider, such as specialist physician office visits with a referral, is based upon the statutory formula. The recently revised definition of a ‘covered service’ in Maryland

⁶⁷ MHCC, *Adequacy of Payments to Relative to Costs and Implications for Maryland Health Care Providers*, Baltimore, MD December 2003, p 32

⁶⁸ MHCC analysis of HSCRC’s 2002 Emergency Room data file.

⁶⁹ A relative value unit is a standardized unit of health care service used by CMS and other payers to equitably reimburse physicians for the resources provided.

statute clarifies for both providers and HMO members what is considered ‘covered’ by the HMO (HB 656, Health Maintenance Organizations – Definition of Covered Service, 2003). In addition, information supplied by the HMO, broker, and/or employer before and at the time a person is enrolled in an HMO describes the organization of the HMO’s network of providers and stipulates that care received by the HMO member must be within the network (out-of-network care would require a referral or preauthorization with the exception of emergencies and out-of-area urgent care). However, in emergency situations, an in-network hospital is not always available (see issue number 2).

An example is an HMO (not POS) member seeking care from a specialist outside of the HMO’s network. If the HMO member receives a referral from a primary care physician or the HMO, or the specialist care is preauthorized by the HMO, the service is consider ‘covered’ and therefore, if the non-participating provider agrees to treat the HMO member, the provider cannot balance bill the HMO member. However, an HMO member may enter into a private contract with the non-participating provider for services that are not covered. A service is considered not covered for an HMO member (not POS) if the service is not included in the HMO member’s benefit plan, or if the member does not have a referral or preauthorization for a service by a referring provider or the HMO.

In the case of an HMO policy with a POS option (HMO-POS), POS members may seek care from a provider out-of-network without a referral or preauthorization. If the service is included in the POS member’s benefit plan, the POS member cannot be balance billed by the provider unless the ability to balance bill is specified in the POS member’s contract. Most POS plans include a deductible and coinsurance amount (e.g., 20%) that the POS member is responsible for paying. The POS member’s plan may also require the POS member to pay the difference between the amount reimbursed by the POS plan (allowable charge) and the amount billed by the non-participating provider.

Recommendation: The Commission could not reach a consensus on whether the prohibition on balance billing should be maintained for the reasons previously discussed.

4. Non-covered services provided by a non-participating provider

As specified in Maryland statute, all providers (both participating and non-participating) may collect from an HMO member “any payment or charges for services that are not covered services.”⁷² No state that responded to the MHCC’s survey indicated that it prohibits balance billing for non-covered services.

An example is an HMO member who seeks treatment for a medical service not included in the contract with the HMO from either a participating or non-participating provider. Since the medical service is not covered under the member’s HMO plan, all providers may bill the member directly.

⁷² Maryland Annotated Code, Health-General Article, § 19-710(p)(3)

Recommendation: No action.

Conclusions

Balance billing HMO members for the difference between a provider's charges and the amount reimbursed by the HMO is currently not permitted in Maryland for covered services. This prohibition includes covered services (with referral and/or preauthorization) rendered by non-participating providers. Services that are not included in an HMO enrollee's contract (non-covered), however, are not reimbursable by an HMO and may be billed in full by the physician. Some states responding to the MHCC/MIA survey require HMOs to include in contracts with providers a hold harmless clause that does not permit participating providers to seek payment from an enrollee for a covered service in any event (other than coinsurance, deductibles, or copayments). In addition, The National Association of Insurance Commissioners developed model 'enrollee hold harmless' language for states to adopt.

HMO plans are designed to provide care to their enrollees in a cost effective manner, with the member or enrollee contributing a monthly premium in exchange for a set of covered benefits. Many people choose an HMO plan over other types of managed care arrangements (such as a PPO) in order to receive first dollar coverage at a reasonable cost. Services are generally provided by a primary care 'gatekeeper' who authorizes specialty care and services. Emergency services are considered an essential service for a federally-qualified health plan and an HMO operating in Maryland,⁷³ and HMO enrollees expect this type of service to be covered regardless of whether it is within the plan's network. In Maryland, emergency services are covered based upon the 'prudent layperson' standard, and are considered covered services.

Federal law requires hospitals to screen patients who seek emergency care,⁷⁴ regardless of their ability to pay. While many states require HMO contracts to contain language barring the participating provider from seeking payment from HMO enrollees for anything other than deductibles, copayments, and coinsurance, some states have language in statute specifying how non-contracting providers are to be reimbursed.

Maryland is not the only state with balance billing prohibitions extending to HMO non-contracting providers. There are currently three states that responded to our survey that have language in their statutes (FL, RI, WV) prohibiting balance billing by all providers for covered services, while other states are enacting additional consumer protections in a piecemeal fashion (CA).

The Commission could not reach consensus on whether the balance billing prohibition should be maintained. The balance billing prohibition is not the central reason providers are experiencing financial stress. The Commission considered other corrective actions.

⁷³ Maryland Annotated Code, Health General Article, § 19-701 (f) (2)

⁷⁴ EMTALA "requires a hospital to provide an appropriate medical screening examination to any person who comes to the hospital emergency department and requests treatment or an examination for a medical condition." CMS News, "Medicare Announces Final Rule on Hospital Responsibilities to Patients Seeking Treatment for Emergency Conditions," August 29, 2003, <http://www.cms.gov>

- **The MHCC, considered but rejected, the proposal of changing the reimbursement formula for balance billing.** As previously stated, a sizeable portion of non-contracting bills are paid at less than 125 percent of the average reimbursement paid to a similarly licensed contracting provider. Substituting a reimbursement methodology for non-participating providers for emergency services that is based on Medicare rates (similar to the methodology for trauma physicians) would offer more clarity to providers on what the rate must be. By requiring carriers to reimburse non-participating providers for emergency room services delivered to an HMO member at a benchmark using the standardized Medicare rate, providers will know and expect to be reimbursed at a rate that is widely understood by the provider community. However, the MHCC felt that the Medicare fee schedule was sufficiently flawed that no improvement would result for most providers. Therefore, the MHCC does not recommend this approach.
- **Hospitals should consider requiring providers with whom the hospital contracts to contract with the same health insurance carriers as hospitals.** Currently, Maryland hospitals request that hospital-based physicians' contract with those same large carriers as the hospital; however, there may be some smaller carriers with which the hospital may contract and the hospital-based physicians do not contract. In these scenarios, emergency room providers are required to treat HMO members since emergency care and out-of-area urgent care is considered a covered service in Maryland statute. Many consumers are not aware of the discrepancy in participation in an HMO between hospitals and non-participating hospital-based physicians.
- **MedChi, in consultation with the MIA, should disseminate to providers a list and description of those insurance carriers with HMO-POS delivery systems that have contracts that contain a cost sharing provision which requires the member to pay the difference between the amount reimbursed under the plan and the amount billed by the non-participating provider.** Many physicians who do not contract with HMOs are not aware of those HMO-POS plans which allow the provider to balance bill the POS member for non-emergency and urgent care received out-of-network.⁷⁵ An advisory opinion issued by the Office of the Attorney General in 1998 specifies that members of an HMO-POS policy may be balance billed by a non-contracting provider for non-emergency care if the member's contract contains a cost sharing provision authorizing balance billing of the member.⁷⁶

⁷⁵ In Maryland, providers cannot balance bill HMO members for emergency care and out-of-area urgent care. These services are considered 'covered services' under Maryland Code, Health-General Article § 19-701(d).

⁷⁶ 83 Opinions of the Attorney General ____ (1998) [Opinion No. 98-018 (September 28, 1998)]

APPENDIX A

Maryland Code
Health-General Article § 19-701.

(a) In this subtitle the following words have the meanings indicated.

(b) "Benefit package" means a set of health care services to be provided to a member or subscriber of a health maintenance organization under a contract that entitles the member to the health care services, whether the services are provided:

- (1) Directly by a health maintenance organization; or
- (2) Through a contract or arrangement with another person.

(c) "Commissioner" means the State Insurance Commissioner.

(d) "Covered service" means a health care service included in the benefit package of the health maintenance organization and rendered to a member or subscriber of the health maintenance organization by:

(1) A provider under contract with the health maintenance organization, when the service is obtained in accordance with the terms of the benefit contract of the member; or

(2) A noncontracting provider under § 19-710.1 of this subtitle, when the service is:

(i) Obtained in accordance with the terms of the benefit contract of the member or subscriber;

(ii) Obtained pursuant to a verbal or written referral by:

1. The health maintenance organization of the member or subscriber; or
2. A provider under written contract with the health maintenance organization of the member or subscriber; or

(iii) Preauthorized or otherwise approved either verbally or in writing by:

1. The health maintenance organization of the member or subscriber; or
2. A provider under written contract with the health maintenance organization of the member or subscriber.

(e) "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

(f) (1) "Health care services" means services, medical equipment, and supplies that are provided by a provider.

- (2) "Health care services" includes:
 - (i) Ambulance services;
 - (ii) Appliances, drugs, medicines, and supplies;
 - (iii) Chiropractic care and services;
 - (iv) Convalescent institutional care;
 - (v) Dental care and services;
 - (vi) Extended care;
 - (vii) Family planning or infertility services;
 - (viii) Health education services;
 - (ix) Home health care or medical social services;
 - (x) Inpatient hospital services;
 - (xi) Laboratory, radiological, or other diagnostic services;
 - (xii) Medical care and services;
 - (xiii) Mental health services;
 - (xiv) Nursing care and services;
 - (xv) Nursing home care;
 - (xvi) Optical care and services;
 - (xvii) Optometric care and services;
 - (xviii) Osteopathic care and services;

- (xix) Outpatient services;
- (xx) Pharmaceutical services;
- (xxi) Physical therapy care and services;
- (xxii) Podiatric care and services;
- (xxiii) Preventive medical services;
- (xxiv) Psychological care and services;
- (xxv) Rehabilitative services;
- (xxvi) Surgical care and services;
- (xxvii) Treatment for alcoholism or drug abuse; and
- (xxviii) Any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

(g) "Health maintenance organization" means any person, including a profit or nonprofit corporation organized under the laws of any state or country, that:

- (1) Operates or proposes to operate in this State;
- (2) Except as provided in § 19-703(b) and (f) of this subtitle, provides or otherwise makes available to its members health care services that include at least physician, hospitalization, laboratory, X-ray, emergency, and preventive services, out-of-area coverage, and any other health care services that the Commissioner determines to be available generally on an insured or prepaid basis in the area serviced by the health maintenance organization, and, at the option of the health maintenance organization, may provide additional coverage;
- (3) Except for any copayment or deductible arrangement, is compensated only on a predetermined periodic rate basis for providing to members the minimum services that are specified in item (2) of this subsection;
- (4) Assures its subscribers and members, the Commissioner, and the Department that one clearly specified legal and administrative focal point or element of the health maintenance organization has the responsibility of providing the availability, accessibility, quality, and effective use of comprehensive health care services; and
- (5) Primarily provides services of physicians:
 - (i) Directly through physicians who are either employees or partners of the health maintenance organization; or

(ii) Under arrangements with one or more groups of physicians, who are organized on a group practice or individual practice basis, under which each group:

1. Is compensated for its services primarily on the basis of an aggregate fixed sum or on a per capita basis; and

2. Is provided with an effective incentive to avoid unnecessary inpatient use, whether the individual physician members of the group are paid on a fee-for-service or other basis.

(h) "Member" means a person who makes a contract or on whose behalf a contract is made with a health maintenance organization for health care services.

(i) "Provider" means any person, including a physician or hospital, who is licensed or otherwise authorized in this State to provide health care services.

(j) "Subscriber" means a person who makes a contract with a health maintenance organization, either directly or through an insurer or marketing organization, under which the person or other designated persons are entitled to the health care services.

Maryland Code

Health-General Article § 19-710.

(i) (1) The terms of the agreements between a health maintenance organization and providers of health services shall contain a "hold harmless" clause.

(2) The hold harmless clause shall provide that the provider may not, under any circumstances, including nonpayment of moneys due the providers by the health maintenance organization, insolvency of the health maintenance organization, or breach of the provider contract, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, member, enrollee, patient, or any persons other than the health maintenance organization acting on their behalf, for services provided in accordance with the provider contract.

(3) Collection from the subscriber or member of copayments or supplemental charges in accordance with the terms of the subscriber's contract with the health maintenance organization, or charges for services not covered under the subscriber's contract, may be excluded from the hold harmless clause.

(4) Each provider contract shall state that the hold harmless clause will survive the termination of the provider contract, regardless of the cause of termination.

(p) (1) Except as provided in paragraph (3) of this subsection, individual enrollees and subscribers of health maintenance organizations issued certificates of authority to operate in this State shall not be liable to any health care provider for any covered services provided to the enrollee or subscriber.

(2) (i) A health care provider or any representative of a health care provider may not collect or attempt to collect from any subscriber or enrollee any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(ii) A health care provider or any representative of a health care provider may not maintain any action against any subscriber or enrollee to collect or attempt to collect any money owed to the health care provider by a health maintenance organization issued a certificate of authority to operate in this State.

(3) Notwithstanding any other provision of this subsection, a health care provider or representative of a health care provider may collect or attempt to collect from a subscriber or enrollee:

(i) Any copayment or coinsurance sums owed by the subscriber or enrollee to a health maintenance organization issued a certificate of authority to operate in this State for covered services provided by the health care provider; or

(ii) Any payment or charges for services that are not covered services.

Maryland Code

Health-General Article § 19-710.1.

CAUTION: READ FULL TEXT OF SECTION FOR SPECIAL NOTE

(a) (1) In this section the following words have the meanings indicated.

(2) "Enrollee" means a subscriber or member of the health maintenance organization.

(3) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee, including, in the case of trauma rendered in a trauma center, an operative report, a discharge summary, a Maryland Ambulance Information Systems form, or a medical record.

(4) "Institute" means the Maryland Institute for Emergency Medical Services Systems.

(5) (i) "Trauma center" means a primary adult resource center, level I trauma center, level II trauma center, level III trauma center, or pediatric trauma center that has been designated by the institute to provide care to trauma patients.

(ii) "Trauma center" includes an out-of-state pediatric facility that has entered into an agreement with the institute to provide care to trauma patients.

(6) "Trauma patient" means a patient that is evaluated or treated in a trauma center and is entered into the State trauma registry as a trauma patient.

(7) "Trauma physician" means a licensed physician who has been credentialed or designated by a trauma center to provide care to a trauma patient at a trauma center.

(b) (1) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(i) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(ii) Shall pay the claim submitted by:

1. A hospital at the rate approved by the Health Services Cost Review Commission;

2. A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:

A. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; or

B. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider; and

3. Any other health care provider at the greater of:

A. 125% of the rate the health maintenance organization pays in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider under written contract with the health maintenance organization; or

B. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.

(2) A health maintenance organization shall disclose, on request of a health care provider not under written contract with the health maintenance organization, the reimbursement rate required under paragraph (1)(ii)2 and 3 of this subsection.

(3) (i) Subject to subparagraph (ii) of this paragraph, a health maintenance organization may require a trauma physician not under contract with the health maintenance organization to submit appropriate adjunct claims documentation and to include on the uniform claim form a provider number assigned to the trauma physician by the health maintenance organization.

(ii) If a health maintenance organization requires a trauma physician to include a provider number on the uniform claim form in accordance with subparagraph (i) of this paragraph, the health maintenance organization shall assign a provider number to a trauma physician not under contract with the health maintenance organization at the request of the physician.

(4) A trauma center, on request from a health maintenance organization, shall verify that a licensed physician is credentialed or otherwise designated by the trauma center to provide trauma care.

(5) Notwithstanding the provisions of § 19-701(d) of this subtitle, for trauma care rendered to a trauma patient in a trauma center by a trauma physician, a health maintenance organization may not require a referral or preauthorization for a service to be covered.

(c) (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted

by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

(d) (1) A health care provider may enforce the provisions of this section by filing a complaint against a health maintenance organization with the Maryland Insurance Administration or by filing a civil action in a court of competent jurisdiction under § 1-501 or § 4-201 of the Courts Article.

(2) The Maryland Insurance Administration or a court shall award reasonable attorney fees if the complaint of the health care provider is sustained.

(e) In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed \$5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization.

// SPECIAL NOTE: THE ABOVE SECTION WAS CHANGED BY CHAPTER 250 OF 2002 AND CHAPTER 423 OF 2001 AND WILL REMAIN IN EFFECT UNTIL JUNE 30, 2005 //

(a) (1) In this section the following words have the meanings indicated.

(2) "Enrollee" means a subscriber or member of the health maintenance organization.

(3) "Adjunct claims documentation" means an abstract of an enrollee's medical record which describes and summarizes the diagnosis and treatment of, and services rendered to, the enrollee.

(b) (1) In addition to any other provisions of this subtitle, for a covered service rendered to an enrollee of a health maintenance organization by a health care provider not under written contract with the health maintenance organization, the health maintenance organization or its agent:

(i) Shall pay the health care provider within 30 days after the receipt of a claim in accordance with the applicable provisions of this subtitle; and

(ii) Shall pay the claim submitted by:

1. A hospital at the rate approved by the Health Services Cost Review Commission; and

2. Any other health care provider at the rate billed or at the usual, customary, and reasonable rate.

(2) A health maintenance organization that pays a health care provider at the usual, customary, and reasonable rate:

(i) Except for services rendered to medical assistance recipients or for services rendered under a contract entered into under § 1876(g) of the federal Social Security Act (42 U.S.C. § 1395mm), may not use Medicare, Medicaid, or workers' compensation payments as part of any methodology used to determine a payment at the usual, customary, and reasonable rate; and

(ii) On request of the health care provider, shall disclose the methodology used to determine the amount of payment.

(c) (1) A health maintenance organization may seek reimbursement from an enrollee for any payment under subsection (b) of this section for a claim or portion of a claim submitted by a health care provider and paid by the health maintenance organization that the health maintenance organization determines is the responsibility of the enrollee.

(2) The health maintenance organization may request and the health care provider shall provide adjunct claims documentation to assist in making the determination under paragraph (1) of this subsection or under subsection (b) of this section.

(d) In addition to any other penalties under this subtitle, the Commissioner may impose a penalty not to exceed \$5,000 on any health maintenance organization which violates the provisions of this section if the violation is committed with such frequency as to indicate a general business practice of the health maintenance organization.

APPENDIX B

Last year, the Maryland General Assembly enacted legislation that requires the Maryland Health Care Commission to develop recommendations on whether the State should maintain a prohibition against the balance billing of HMO subscribers for covered services (some states refer to this as 'enrollee hold harmless'). The Maryland Insurance Administration is assisting the Maryland Health Care Commission by gathering information on balance billing.

As part of our study, we would like to understand other states' laws/regulations regarding this issue. Please help us to better understand your state's position on balance billing by answering the questions listed below by August 1, 2003. In your responses, please reference supporting legislation or regulations.

1a. Does your state have a prohibition against balance billing for HMO subscribers/enrollees for covered services?

1b. If yes, does it apply to participating providers (contracting with HMOs) AND/OR non-participating providers?

1c. What is the definition of 'covered service'?

1d. Does your state's balance billing prohibitions apply to all services and settings or only those where choice of provider is not discretionary, such as emergency department care?

2. Does your state have a prohibition against balance billing for non-covered services (or language that states that all providers can balance bill for non-covered services)?

3. Does your state have language in statute that specifies a payment formula for non-contracting providers? (Note: Maryland statute specifies the rate non-contracting physicians will be reimbursed for covered services).

4. Other comments -

5. Please provide your contact information -

Name:

Title:

State Insurance Department:

Email address:

Telephone number:

Thank you assisting us with this study. Responses should be directed to Brenda Wilson at bwilson@mdinsurance.state.md.us. If you have any questions, please contact Kristin Helfer Koester at (410) 764-3575.

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	STATE	Q 1a.	Prohibition against balance billing for covered services?	Q 1b.	Par vs. Non-Par?	Q 1c.	Definition of covered service?	Q 1d.	All services and settings?	Q 2.	Prohibition/non-covered services	Q 3.	Payment formula/non-contracting MDs
1	CT		Yes, requires HMOs to include hold harmless language in provider contracts		Par Only		"Contractual Service"		All contractual services.		No		No
2	DC		Yes, requires HMOs to include hold harmless language in provider contracts		Par Only		"Covered service" means health care services included in the HMO's evidence of coverage in accordance with the terms of the HMO's group or individual market.		All services & setting in-network		No		No
3	DE		Yes		Par Only		None		All services		No		None
4	FL		Yes (Section 641.3154, Florida Statutes)		All providers		Refers to the agreed upon set of comprehensive health care services as stated in Section 641.31(1), Florida Statutes.		All services		Florida has conditional language that addresses all providers balance billing for non-covered services, Section 641.3154(4), Florida Statutes		Sections 641.513(5)(6), Florida Statutes, Emergency Services and Care, have formulae for non-contracting providers.
5	GA		Yes (administrative prohibition)		Par Only		"Basic health care services" (33-21-1) and "Health care services" (33-21-1)		For emergency services, HMO law and Patient Protection Act would apply an emergency provision to have true emergencies covered as an in-network benefit (33-21-10(a)(2), 33-21-13(c), 33-21-18.1		No		No – HMO contracting language generally includes UCR or similar limiting language.
6	HI		Yes (requires HMOs to include hold harmless language in provider contracts) (Section 432D-8(d) HI Revised Statutes)		Par Only		No – "health care services"		All services		No		No
7	IL		Hospital provider contracts must have a hold harmless clause. There is no such requirement for other providers; however, most provider contracts contain similar clauses.		Par Only (contract providers)		No -however, there are specific services that are considered basic health care services that must be covered by an HMO		Applies to all hospital services, including emergency care.		No		No
8	KS		Yes		Par Only		No		Applies services and settings in-network, including emergency care.		No		No - HMOs compensate non-participating emergency care providers per a negotiated rate.

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	STATE	Q 1a.	Prohibition against balance billing for covered services?	Q 1b.	Par vs. Non-Par?	Q 1c.	Definition of covered service?	Q 1d.	All services and settings?	Q 2.	Prohibition/non-covered services	Q 3.	Payment formula/non-contracting MDs
9	KY	Yes		Par Only		Services that are covered under an individual's policy or certificate.		Applies to all covered services under a policy or certificate provided by <u>in-network</u> providers.		No		No	
10	MA	Yes (M.G.L. c. 176G. secs 21 (hold harmless provision) & 22 (insolvency))		Par only (M.G.L c 176G sec 21 and 211 CMR 52.12(8) & (9)) (M.G.L. c. 176G sec 22 (HMO insolvency) applies to par and non-par)		'Health service' - at least reasonably comprehensive physician services on a nondiscriminatory basis, inpatient & outpatient services, emergency health services, and may include chiro., optometry, and podiatric services (M.G.L. c. 176G sec.1); 'Covered benefit(s)' health care services to which an insured is entitled under the terms of the health benefit plan (211 CMR 52.01)		All services & settings (CMR 52.12(8)), including emergency care.		No		Yes; depends on plan offered by HMO (211 CMR 41.06(2)(i) and CMR 51.01(2)(c). Non-contracting emergency care providers subject to M.G.L. c. 176G, s 5(f) and M.G.L. c. 176I, s. 3(b).	
11	MI	Yes, (MCL 500.3529(3) – hold harmless language)		Par Only		Health maintenance services' (covered service) – services provided to enrollees of a HMO under their HMO contract (MCL 500.3501(g).		All services & settings provided by an affiliated provider.		No		No, however, if non-contracting emergency provider, HMO shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case MCL 500.3517)	
12	MN	Yes, (MN statute 62C.02, subd.8 and 62C.14, subd.8.)		Par Only		Any service or class of services, supply, drug, or equipment provided to an individual for diagnosis, relief, or treatment on an injury, ailment, or bodily condition.		All covered services & settings		No		No, however, nonparticipating providers may bill for the usual and customary (MN statute 62A.61)	
13	NJ	Yes		Par Only		Not defined in statutes or regulations		All services, including emergency care.		No		No, however, if non-participating ER provider, enrollee is responsible for in-network cost sharing.	
14	OH	Yes, (Ohio Revised Code § 1751.60)		Par Only		All basic health care services in addition to any other benefits the plan covers.		All services		No (plan must state that a member is responsible for non-covered services)		Yes; for 'out-of-area' emergency health services, HMO must compensate providers through indemnity payments or service agreements (Ohio Revised Code § 1751.01 (H).	
15	PA	Yes, (PA Code 154.15(g)(1))		Par Only (except for continuity of care providers)		As defined by contract		All covered services, including emergency care.		No		No	
16	RI	Yes, (RI Code 27-41-26)		All providers		"Covered health services" means the services that a HMO contracts with enrollees and enrolled		All services by participating and non-participating providers		No		No	

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	STATE	Q 1a.	Prohibition against balance billing for covered services?	Q 1b.	Par vs. Non-Par?	Q 1c.	Definition of covered service?	Q 1d.	All services and settings?	Q 2.	Prohibition/non-covered services	Q 3.	Payment formula/non-contracting MDs
							groups to provide or make available to an enrolled participant. (27-41-2(a))						
17	SD	Yes (58-17c-14(2))		Par Only (HMOs, PPOs, and other network plans)		No statutory definition		All services by participating providers		No		No	
18	TX	Yes (network provider contracts must contain a 'hold harmless' clause that prohibits balance billing of HMO enrollees)		Par Only		No definition		All services & settings in-network, including emergency care.		No		No, however, HMOs are required to reimburse non-network providers at a usual and customary charge or an agreed rate for emergency services or approved out-of-network referrals.	
19	VA	Yes		Par Only		Services that are covered in accordance with the terms of the policy.		All services & settings in-network(non-participating providers may balance bill)		No		No ('non-participating referral providers' are reimbursed according to Virginia Code §38.2-4300)	
20	WV	Yes (WV Code 33-25A-71)		All providers		A covered service is a service authorized by the HMO.		All services		No		No - however considered it and no decision made (controversial).(NOTE: ER care, WV Code 33-25A-7a says that a non-contracting provider must be reimbursed his/her "normal" charges, which is not defined.	
21	WI	Yes, s.609.91 et.seq., Wis. Stat., and s. Ins 9.09, Wis. Adm. Code		Par Only, however, s.609.925, Wis. Stat., allows for non-participating providers to "elect" to be subject to S.609.91, Wis. Stat.		No global definition, rather the state and in turn the Commissioner have proscribed that specific services be covered by mandate. The insurers define "covered services" within policies that are reviewed by the office.		Applies to par providers inc. hospitals, and does cover emergency situations utilizing a prudent person standard (so long as the insured complies with the terms of the insurer when emergency services are received from a non-participating provider.		No		No	
22	WY	No (have hold harmless provision regarding an insolvent HMO)		NA		NA		NA		NA		NA	