MARYLAND
INSURANCE
ADMINISTRATION

Assignment of Benefits

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Executive Summary

Beginning July 1, 2011, Chapter 537 of the Acts of 2010 requires carriers to accept an assignment of benefits from a nonpreferred physician under certain circumstances. Prior to the implementation of Chapter 537, Governor O'Malley and the General Assembly asked the Maryland Insurance Administration ("MIA") to assess the impact of Chapter 537 on provider networks and fee schedules. Chapter 537 also requires the MIA promulgate certain regulations prior to July 1, 2011.

During the legislative debate on Chapter 537, proponents and opponents of assignment of benefits and limitations on balance billing predicted significant changes in provider networks and fee schedules. There is no definitive data to confirm or dismiss the predictions of proponents or opponents.

Introduction

Generally, preferred provider insurance policies ("PPO policies") offered by insurers or nonprofit health service plans (hereinafter "carriers") allow insureds to receive covered health care services from preferred providers or nonpreferred providers.[1] The out-of-pocket costs for an insured can be quite different for preferred and nonpreferred providers.

Each provider establishes a charge for the health care services the provider renders to patients. Carriers develop fee schedules establishing the "allowed amount", the amount the carrier believes is appropriate for each covered health care service. The difference between the provider's charge and the carrier's allowed amount is known as the balance bill.

Preferred providers are a part of the carrier's provider network. They have entered into a contract with the carrier establishing a common determination of the value of the health care services. The allowed amount contractually agreed to for each health care service is specified in the preferred provider's fee schedule, a part of the contract between the insurer and the preferred provider. If there is a difference between the preferred provider's charge and the carrier's allowed amount, the contractual agreement between the preferred provider and the carrier prohibits the preferred provider from collecting the balance bill from the carrier's insured.

By contrast, nonpreferred providers are not a part of the carrier's provider network. If there is a difference between the nonpreferred provider's charge and the carrier's allowed amount, the insured typically is responsible for paying the balance bill.

When a patient obtains health care services from a provider, the provider asks the patient to "assign benefits" to the provider. When the patient gives a preferred provider an assignment of benefits, the carrier sends payment for the allowed amount for the covered service, less any applicable copayment, coinsurance or deductible amounts, directly to the preferred provider.

Some carriers will not accept an assignment of benefits provided by the patient/insured to a nonpreferred provider. In this case, the carrier sends a check for the allowed amount, less any applicable copayment, coinsurance or deductible amounts, to the insured. The insured is responsible for paying the nonpreferred provider all amounts due, including the allowed amount and the balance bill, if any.

The acceptance of assignment of benefits by carriers for nonpreferred providers has been the subject of great debate. Physicians, particularly hospital-based physicians, maintain that when a carrier does not accept an assignment of benefits it is difficult to collect the allowed amount from the patient, thus increasing administrative costs and the charge for the health care services rendered by the physician. Carriers respond that without the ability to reject an assignment of benefits for nonpreferred providers, particularly hospital-based physicians, physicians will not have an incentive to join the carrier's provider network and costs for all insureds will increase. Others note that balance billing unfairly increases cost for insureds and maintain nonpreferred

[1] Carriers may offer a PPO policy that requires insureds to receive most covered health care services only from preferred providers. See *Ins.* § 14-205.1

providers should only be afforded the convenience of assignment of benefits if the nonpreferred provider agrees not to balance bill the insured.

Chapter 537 of the Acts of 2010 ("Chapter 537") addresses this issue in two ways. It requires carriers to accept an assignment of benefits from a nonpreferred hospital-based physician or on-call physician providing covered health care services to an insured if the nonpreferred hospital-based physician or on-call physician agrees to accept the carrier's allowed amount as payment in full and forego collecting the balance bill from the insured. To encourage nonpreferred hospital-based physicians and on-call physicians to accept assignment of benefits, Chapter 537 specifies how a carrier must determine the allowed amount.

Chapter 537 also requires the carrier to accept an assignment of benefits from other physicians who are nonpreferred physicians if they provide greater disclosure to the patient/insured to be sure the insured understands the amount that he or she will owe to the nonpreferred physician. In these cases, the insured remains responsible for the balance bill.

Because of the uncertain impact of Chapter 537 on the cost of health care services, the General Assembly delayed its implementation until July 1, 2011. Prior to the implementation of Chapter 537, the Maryland Insurance Administration ("MIA") was directed to study the:

- benefits, including payments, provided by carriers before July 1, 2011 under PPO policies for covered services rendered by nonpreferred providers at hospitals that are preferred providers during emergencies and elective admissions; and
- impact of these benefits on complaints filed by insureds with insurers and the Administration regarding balance billing.

The General Assembly also directed the MIA to make any recommendations about the final methodology carriers should use to determine the allowed amount for nonpreferred providers who are hospital-based physicians or on-call physicians and agree to accept assignment of benefits.

In addition, Governor Martin O'Malley requested that the MIA review and report to the Governor and the General Assembly information about the impact of assignment of benefits on provider networks and fee schedules, taking into account information from other states and Maryland's experience with health maintenance organizations (HMOs).

This report summarizes the MIA's findings in these areas as well as the next steps the MIA will take to implement Chapter 537.

Payment for benefits provided by nonpreferred providers

How carriers reimburse physicians who are nonpreferred providers varies by carrier, policy and type of nonpreferred provider. To obtain more complete information about this, the MIA's Compliance and Enforcement unit surveyed the largest carriers offering PPO policies in the State. This section summarizes the survey's findings.

Carriers look to one or more of the following to determine the allowed amount for a health care service provided by a nonpreferred provider:

- Billed charges;
- Comparable charges in the geographic region; and/or
- Amount paid to preferred providers.

Carriers cited the following cost-sharing arrangements for their insureds in PPO policies:

- Same cost-sharing for preferred and nonpreferred providers if the covered service was authorized by the carrier or if a hospital-based physician provided the covered services; or
- Different cost-sharing for preferred and nonpreferred providers for all covered services even if the covered service was provided by a hospital-based physician who is a nonpreferred provider in a hospital that is a preferred provider.

In all cases, carriers responded that the insured is responsible for the balance bill, if any, if the health care service was received from a nonpreferred provider.

The particular combination in a PPO policy of how the carrier determines the allowed amount and the insured's cost-sharing impacts the total amount the insured must contribute to cover the cost of the health care service. The table below illustrates the variation in the insured's contribution based on the carrier's method for determining the allowed amount and the coinsurance specified in the PPO policy based on hypothetical scenarios varies assuming the billed charge for a health care service provided by a nonpreferred provider who is a hospital-based physician at a hospital that is a preferred provider is $1,000.

Examples of insured's out-of-pocket costs			
	Insured co-insurance	Insured balance bill	Insured total
Scenario 1: Carrier determines allowed amount based on billed charges. The carrier pays 80 percent of the allowed amount, the insured 20 percent.	$200	$0	$200
Scenario 2: Carrier determines allowed amount based on comparable charges; this is determined to be $900. The carrier pays 80 percent of the allowed amount, the insured 20 percent.	$180	$100	$280
Scenario 3: Carrier determines allowed amount based on fee schedule for preferred providers; this is determined to be $800. The carrier pays 80 percent of the allowed amount, the insured 20 percent.	$160	$200	$360
Scenario 4: Carrier determines allowed amount based on billed charges. The PPO policy specifies a higher coinsurance amount for nonpreferred providers so now carrier pays 70 percent of the allowed amount, the insured 30 percent.	$300	$0	$300
Scenario 5: Carrier determines allowed amount based on comparable charges; this is determined to be $900. The PPO policy specifies a higher coinsurance amount for nonpreferred providers so now carrier pays 70 percent of the allowed amount, the insured 30 percent.	$270	$100	$370
Scenario 6: Carrier determines allowed amount based on the fee schedule for preferred providers; this is determined to be $800. The PPO policy specifies a higher coinsurance amount for nonpreferred providers so now carrier pays 70 percent of the allowed amount, the insured 30 percent.	$240	$200	$440

For the above scenarios, the insured's out-of-pocket costs are lowest when the carrier bases the allowed amount on the nonpreferred provider's billed charge and the highest when the allowed amount is based on the fee schedule for preferred providers. However, the insured's out-of-pocket costs will always be the lowest for a preferred provider because there is no balance bill and the insured is only responsible for 20 percent of the allowed amount.

Consumer complaints

In order to ascertain the impact of these benefit variations on consumer complaints, the MIA reviewed complaints filed between January 2008 and August 2010 where the MIA staff coded one of the reasons as "balance billing" and requested complaint information from the largest carriers for calendar year 2009.[2]

Between January 2008 and August 2010, the MIA received a total of 40 complaints regarding balance billing or out-of-network benefits more generally. Detailed information about these complaints is found in Appendix A. Most of these (25) pertained to services received in a hospital, including the emergency department.

[2] When the MIA receives a complaint, it is coded in accordance with standards developed by the National Association of Insurance Commissioners. Staff may code up to three reasons for the complaint. One possible reason is "out-of-network benefits." While the MIA believes most of these complaints involve balance billing, only those complaints that the staff coded as "balance billing" were analyzed here.

When the MIA investigated the cases in which it had jurisdiction, no violations were found. In each case, the carrier had properly calculated the allowed amount and applied the correct coinsurance amount. The insureds were responsible for the balance bill.

In the three cases where the MIA recorded the balance bill, the sum demonstrates the potential impact on consumers. In these three cases, the balance bill was $631, $1,209 and $5,290 respectively.

Carriers report an insignificant number of complaints about balance billing. One carrier reported receiving eight (8) complaints and another one (1) during calendar year 2009.

Although a small number of consumers appear to be impacted by balance billing, the MIA complaint staff notes that the balance bill can place an economic hardship on an individual consumer.

Provider Networks

Carriers that offer PPO policies must maintain a provider network that meets the requirements of § 15-112 of the Insurance Article. The MIA adopted regulations (see COMAR 31.10.34.05) requiring carriers to annually evaluate their provider networks to be sure there are sufficient providers to meet the health care needs of their enrollees in the following areas:

- general and internal medicine providers;
- family practitioners;
- pediatricians;
- obstetricians and gynecologists;
- high-volume specialty behavioral health care providers, including psychiatrists, psychologists, clinical social workers, and any other behavioral health care providers identified by the carrier; and
- high-volume specialty health care providers, identified by the carrier.

Prominent carriers (defined as a carrier reporting at least $90,000,000 in written premium for medical benefits in Maryland in the most recent annual statement) are required to submit to the MIA their availability plan and performance assessment. The information submitted by the prominent carriers demonstrates that each has an adequate provider network to meet the needs of their enrollees in the aforementioned areas and that this has not materially changed between 2008 and 2010.

In addition, the prominent carriers are required to file with the MIA a list noting whether specific hospital-based physician specialties participate in the carrier's provider panel for each hospital in Maryland. The table below shows the number of Maryland hospitals where the specific type of hospital-based physician is a part of the carrier's network, a preferred provider.

Hospital-based physicians by number of hospitals								
	Anesthesiologist		**Emergency Physician**		**Pathologist**		**Radiologist**	
	2009	2010	2009	2010	2009	2010	2009	2010
Carrier A	28	30	23	23	28	28	36	38
Carrier B	30	32	16	17	28	26	41	39
Carrier C	26	26	28	26	22	24	22	26
Carrier D	39	46	33	46	35	46	27	47

The data indicates that insureds can expect to receive services from a nonpreferred provider at a preferred hospital. Overall, the number of hospital-based physicians participating in carriers' network for PPO policies has improved.

Although carriers are not required to report whether hospital-based physicians participate in the provider network of one or more HMOs under the same insurance holding company, the MIA contacted these companies to ask if there are any material differences between the network for the HMOs and the carriers offering PPO policies. The companies reported no material differences.

The Colorado Insurance Commissioner issued a report earlier this year about the impact of Colorado's law that requires carriers to hold insureds harmless from being balanced billed by nonpreferred hospital-based physicians in preferred hospitals. To assess the impact on provider networks, the Colorado Insurance Commissioner compared the number of in-network and out-of-network claims submitted by providers. The Colorado Insurance Commissioner reported that the ratio of claims between in-network and out-of-network providers held steady between 2007 and 2009, suggesting no material change in the number of hospital-based physicians who are preferred and nonpreferred providers over this three year period.

Fee Schedules

Carriers are not required to file their fee schedules with the MIA for PPO policies. Carriers frequently change fee schedules to add and delete services or to reflect changes in the value of a service. In addition, a preferred provider's fee schedule may change through contract negotiations with a carrier.

The MIA asked the largest insurance holding companies with a carrier and an HMO if Maryland's prohibition on balance billing of HMO members had impacted the HMO's fee schedules. These companies responded that the prohibition on balance billing had been in effect for so many years that it was impossible to ascertain whether it had or continues to have an effect on the HMO's fee schedule.

The Colorado Insurance Commissioner reported that the total allowable charges for in-network providers fell by one percent and rose by nine percent for out-of-network providers in 2008. During the first six months of 2009, this pattern reversed.

Methodology for determining allowed amount

Chapter 537 asks the MIA to recommend a methodology for determining the final allowed amount to be paid to an on-call or hospital-based physician who is a nonpreferred provider and accepts an assignment of benefits.

The statute requires a carrier to reimburse an on-call physician who is a nonpreferred provider the greater of:

- 140 percent of the average rate paid to preferred providers; or
- the average rate paid to nonpreferred providers.[3]

For hospital-based physicians who are nonpreferred providers, the statute requires the carrier to pay the greater of:

- 140 percent of the average rate paid to hospital-based physicians who are preferred providers; or
- the final allowed amount the carrier paid to the nonpreferred provider inflated by the change in the Medicare Economic Index.

Although the specifics are different, these benchmarks are similar to what health maintenance organizations (HMOs) are required to use to determine the allowed amount for non-participating providers.

Every methodology used to determine the allowed amount has its strengths and weaknesses. The MIA has not identified an alternative methodology that would more adequately balance the interests of consumers, physicians and carriers.

Next Steps

Chapter 537 requires the MIA to promulgate regulations to provide directions to physicians and carriers as to how a physician must effectuate an assignment of benefits. In addition, the MIA must develop a disclosure for physicians, who are non-hospital-based nonpreferred providers, to use. The MIA's proposed draft regulations are shown in Appendix B for public review and comment prior to publication.

[3] The carrier must base its calculation on the amount paid to preferred and nonpreferred providers who are similarly licensed providers to the on-call physician.

Conclusion

During the legislative debate on Chapter 537, proponents and opponents of assignment of benefits and limitations on balance billing predicted significant changes in provider networks and fee schedules. There is no definitive data to confirm the predictions of proponents or opponents. However, the reported similarity in provider networks for HMOs and carriers under the same holding company suggests that policy provisions on assignment of benefits and balance billing are not in and of themselves predictive of the size of a network for hospital-based physicians. This is confirmed by the experience noted in Colorado regarding the impact on provider networks following that state's prohibition on balance billing.

Attachment A – Complaints Submitted to MIA re: Balance Billing

Case Number	Year	Complaint	Outcome
79736	2008	After sudden illness member went to long-time doctor. Member did not realize doctor was out of network until after 4 months of treatment. Member was balance billed.	MIA found no violation. Member went to nonparticipating doctor. Doctor can bill member for balance above the allowed benefit.
80150	2008	Member's husband drove her to hospital close to home. ER diagnosed heart attack and called helicopter to take member to other hospital. Carrier paid only $2845, leaving member responsible for $5290 balance. Helicopter was nonpar company.	No MIA jurisdiction. Member was covered by self-funded plan.
80214	2008	Member had blood work done in doctor's office. Lab billed member for $32.87. Carrier said no contract with lab.	Issue resolved prior to MIA investigation. Doctor contacted lab and said an error made in the billing procedure. Bill corrected and member owed nothing.
80215	2008	Member's daughter sustained head injury. Emergency center referred daughter to hospital to see on-call surgeon. Surgeon received $454.46 from carrier and billed member for remaining $1209.54	No MIA jurisdiction. Situs of contract is Virginia. Member told to notify Virginia Dept of Ins.
80221	2008	Member was billed for dental x-rays because he exceeded his limit of x-rays per visit. Carrier paid per contract and member was balance billed by non-participating dentist.	MIA found no violation. However, carrier made one-time exception and agreed to pay claim in full so member did not owe balance.
80286	2008	Member had ear pain and had to fly the next day. Member called carrier to find out options and who was in-network. Carrier said one hospital was near and total member payment would be $35 copay. Upon arrival at hospital member called carrier again and was again told $35 copay. After visit, member was charged deductible plus copay.	MIA found no violation. Carrier paid in accordance with member's policy. Carrier charged co-pay only as one-time exception.

Case Number	Year	Complaint	Outcome
80721	2008	Member's daughter was admitted to in-patient rehab facility for substance abuse. Facility billed member instead of filing claim with carrier. Facility then submitted claim to carrier with incomplete and erroneous information.	No MIA jurisdiction. Member was covered by a self-funded plan. MIA referred member to her employer and provided Board of Physicians and HEAU contact information.
80899	2008	Member received bills in 2008 for hospital visits in 2003 and 2005.	No MIA jurisdiction. Complainant referred to D.C.
80996	2008	Member had cataract surgery by in network provider then received letter from provider saying he no longer participated and member would be liable for uncovered charges.	Carrier advised provider that balance billing was prohibited since provider was in network at time of service.
80997	2008	Member hospitalized for heart failure in participating hospital. Dermatological consultation was requested. Dermatologist was a "participating provider" but not a "preferred provider." Member balance billed.	No MIA jurisdiction. Complainant referred to Virginia DOI
81213	2008	Member received services from non-participating ambulance provider and was balance billed by ambulance company.	MIA found no violation. Member's contract says carrier will pay 100% of the in-network allowed amount for emergency ambulance services and carrier did. Since ambulance provider is not in-network they do not have to accept allowed amount as payment in full and are permitted to balance bill the member for the difference.
81634	2008	Member's son was hospitalized and member disputed the bill received for anesthesia services provided by non-participating provider.	MIA found no violation. Anesthesia claim was paid at the in-network allowed amount because a preferred provider was not reasonably available. Non-participating providers (anesthesiologist) can balance bill.

Case Number	Year	Complaint	Outcome
83651	2008	Member received bill for lab work because carrier paid claim as if lab was out-of-network. After member complained to carrier, then carrier realized lab was part of Shared Savings Plan and therefore a participating provider.	Carrier re-processed claim correctly prior to MIA investigation.
83892	2009	Member received bill from non-participating provider for treatment during hospital admission. Hospital itself was preferred provider so member assumed all physicians in hospital were too.	No MIA jurisdiction. Member covered by an employer-sponsored self-funded plan.
83894	2009	Member's daughter received services in a participating hospital by a non-participating anesthesiologist and was balance billed.	MIA found no violation. Carrier processed claim at the in-network level even though provider was out of network. Provider does not have to accept that as payment in full and may bill member for balance.
84189	2009	Member was transferred by ambulance from hospital near home to U of MD and was rushed into operating room. Surgeon was not in-network and member was balance billed. Surgeon appealed on basis that service was life-threatening emergency. Carrier denied appeal and paid as out of network.	Carrier overturned original determination after member's appeal, and allowed reimbursement at the participating provider level. Carrier paid full allowable amount. Member may still be responsible for any additional amount billed by surgeon.
84670	2009	Member's son had surgery and claim was reimbursed at preferred benefit level. Member appealed, requesting claim be reimbursed at non-preferred level.	No MIA jurisdiction. Complainant referred to DC DOI.
85230	2009	Member had colonoscopy performed by in-network doctor but anesthesiologist was out-of-network. Carrier paid $534.98 of $1800 bill. Member was responsible for $500 deductible, $133.34 copay (20%) and $631.28 (amount that exceeded the customary charges).	No MIA jurisdiction. Complainant referred to DC DOI.

Case Number	Year	Complaint	Outcome
85652	2009	Member went to emergency room, was admitted and had gallbladder removed. Surgeons were non-participating providers. Carrier paid 100% of the allowable amount for an in-network because of the emergency. Member appealed because he was balance billed.	MIA found no violation. Carrier paid allowable amount but nonparticipating doctor can balance bill member.
85749	2009	Member had wart removal in doctor's office. Member was balance billed because doctor was non-preferred.	No MIA jurisdiction. Complainant covered by Federal Employees Health Benefit Program.
85763	2009	Member went to nonparticipant medical center and received bill for services.	No MIA jurisdiction. Member was covered by employer-sponsored self funded plan.
85957	2009	Member balance billed by lab because lab did not participate with her carrier.	No MIA jurisdiction. Member was covered by employer-sponsored self funded plan.
86313	2009	Carrier erroneously processed claim for emergency services at out-of-network rate but policy states hospital based emergency room physicians are paid at the in-network benefit level.	Carrier corrected the claim processing error prior to any MIA action. Additional monies were sent to provider. Member still responsible for difference ($79.00).
86599	2009	Member was balance billed for ambulance services provided by non-participating provider. Since it was an emergency situation carrier paid 100% of allowed benefit.	MIA found no violation. Since non-participating provider, ambulance company may bill member for difference between billed amount and allowed amount paid by carrier.
86674	2009	Member was admitted to emergency department of participating hospital but treated by an out-of-network physician and out-of-network surgeon. Member was balance billed for the difference.	No MIA jurisdiction. The policy was issued in Indiana.
87024	2009	Member was transported by an ambulance service that is not an in-network provider. Member was balance billed by out-of-network ambulance service.	MIA found no violation. Carrier paid the in-network benefit which is 90% of the allowed amount. Since ambulance provider was out-of-network they can bill member for difference.

Case Number	Year	Complaint	Outcome
87295	2009	Member's daughter had outpatient surgery and surgeon was not a preferred provider. Carrier pays 80% of allowable charges after member meets deductible. Member had not met deductible and was balance billed by surgeon.	MIA found no violation. Surgeon was paid and member was billed pursuant to policy terms. Surgeon may balance bill since he was not a participating provider.
87768	2009	Member was balance billed by 2 anesthesiologists. Carrier paid 1 anesthesiologist 100% of allowable amount. Other doctor's claim was submitted too late.	No MIA jurisdiction. Member was covered by an employer-sponsored self-funded ERISA plan.
88241	2010	Member had emergency surgery for appendix removal. Surgeon was out of network. Carrier paid claim at PPO out-of network rate 60% of allowed amount. After reviewing more info, carrier adjusted claim due to emergency and paid at the in-network level of 80%.	MIA found no violation. Since surgeon was out of network member can be billed for difference.
88738	2010	Member was balance billed by provider for services in emergency room. Carrier paid the allowed amount minus member copay.	MIA found no violation. Carrier paid provider correctly and out-of-network provider balance billed. However, member was misinformed by Carrier and believed provider was in-network so Carrier made member whole as one-time exception based on their erroneous information.
88880	2010	Member was balance billed by out of network provider who treated uterine cancer.	MIA found no violation. Provider was paid 80% of allowed amount and can bill member for balance owed.
89137	2010	Member was balance billed by out of network provider for treatment in hospital.	No MIA jurisdiction. Member was covered by employer-sponsored self-funded plan.
89138	2010	Member was balance billed by out of network provider for treatment in hospital.	No MIA jurisdiction. Member was covered by employer-sponsored self-funded plan.
89256	2010	Member was balance billed by out of network provider for emergency care at an in-network hospital.	Carrier made an exception based on emergency situation and paid additional amount prior to MIA action.
89469	2010	Member was balance billed by out of network provider for emergency care at an in-network hospital.	No MIA jurisdiction. Policy was issued to employer in DC

Case Number	Year	Complaint	Outcome
89877	2010	Member was balance billed by out of network anesthesiologist for service at in-network facility with in-network surgeon.	No MIA jurisdiction. Member was covered by an employer-sponsored self-funded plan.
90060	2010	Provider requested investigation. Member had emergency surgery by provider who was out-of-network.	MIA found no violation. Carrier paid as stated in policy - emergency services as in-network 80% of allowable amount. Provider can balance bill for the difference.
90471	2010	Member was balance billed by a non-participating provider.	MIA found no violation. Claims were processed per policy (100% of allowable charge). Provider can balance bill for the difference.
90913	2010	Member was balance billed by attending physician from the emergency room of a participating facility.	MIA found no violation. Claim was processed per policy and non-participating provider can balance bill for the difference.
90954	2010	Member was charged by non-participating cardiologist. Member alleges that carrier said prior authorization was not necessary and that provider was a participating provider.	No MIA jurisdiction. Member was covered by an employer-sponsored self-funded plan.

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH GENERAL

Chapter 41 Assignment of Benefits to Nonpreferred Providers

Authority: Insurance Article, §§2-109, 14-205.2 and 14-205.3, Annotated Code of Maryland

.01 Applicability.

This chapter applies to preferred provider insurance policies offered by carriers under insured policies or contracts that are issued, renewed or delivered in the State on or after July 1, 2011.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Allowed amount" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(2) "Assignment of benefits" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(3) "Carrier" means an insurer or nonprofit health service plan.

(4) "Covered service" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(5) "Hospital-based physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(6) "Insured" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(7) "Insurer" has the meaning stated in Insurance Article, §1-101, Annotated Code of Maryland.

(8) "Nonpreferred provider" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(9) "Nonprofit health service plan" means a person who has a certificate of authority to operate as a nonprofit health service plan in Maryland.

(10) "On-call physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(11) "Preferential basis" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(12) "Preferred provider" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

(13) "Preferred provider insurance policy" means a contract issued or delivered in the State under which health care services furnished by a preferred provider are paid on a preferential basis.

(14) "Provider" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

.03 Assignment of Benefits--On-Call Physicians.

A. A nonpreferred provider who is an on-call physician may accept an assignment of benefits under a preferred provider insurance policy.

B. A nonpreferred provider who is an on-call physician and accepts an assignment of benefits under a preferred provider insurance policy shall:

(1) Accept the carrier's allowed amount as payment in full; and
(2) Collect or attempt to collect from the insured only the monies for the items identified in Insurance Article, §14-205.2 (b), Annotated Code of Maryland.

C. A nonpreferred provider who is an on-call physician and who accepts assignment of benefits shall submit the uniform claim form required by COMAR 31.10.11.03 and indicate acceptance of assignment of benefits in box 27 of the CMS 1500 form, or its successor.

D. A carrier shall:

(1) Accept as evidence that the nonpreferred provider who is an on-call physician obtained an assignment of benefits from an insured if the nonpreferred provider submits the uniform claim form required by COMAR 31.10.11.03 and indicates acceptance of assignment of benefits in box 27 of the CMS 1500 form, or its successor; and
(2) Reimburse a nonpreferred provider who is an on-call physician who has accepted an assignment of benefits in accordance with the provisions in Insurance Article, §14-205.2 (c), Annotated Code of Maryland.

.04 Assignment of Benefits--Hospital-Based Physicians.

A. A nonpreferred provider who is a hospital-based physician may accept an assignment of benefits under a preferred provider insurance policy.

B. A nonpreferred provider who is a hospital-based physician and accepts an assignment of benefits under a preferred provider insurance policy shall:

(1) Accept the carrier's allowed amount as payment in full; and
(2) Collect or attempt to collect from the insured only the monies for the items identified in Insurance Article, §14-205.2 (b), Annotated Code of Maryland.

C. A nonpreferred provider who is a hospital-based physician shall submit the uniform claim form required by COMAR 31.10.11.03 and indicate acceptance of assignment of benefits in box 27 of the CMS 1500 form.

D. A carrier shall:

(1) Accept as evidence that the nonpreferred provider who is a hospital-based physician obtained an assignment of benefits from an insured if the nonpreferred provider submits the

uniform claim form required by COMAR 31.10.11.03 and indicates acceptance of assignment of benefits in box 27 of the CMS 1500 form, or its successor; and

(2) Reimburse a nonpreferred provider who is a hospital-based physician who has accepted an assignment of benefits in accordance with the provisions in Insurance Article, §14-205.2 (c), Annotated Code of Maryland.

.05 Assignment of Benefits--Nonpreferred Providers.

A. This regulation applies to carriers who receive claims for services provided by physicians who are nonpreferred providers but are not on-call physicians or hospital-based physicians.

B. A carrier shall permit a nonpreferred provider to accept an assignment of benefits under a preferred provider insurance policy offered by the carrier.

C. A carrier who receives a claim for services provided by a nonpreferred provider who accepts an assignment of benefits under a preferred provider insurance policy shall pay the provider directly if the provider:

(1) Provides a copy of the disclosure set forth in Regulation .06 of this chapter to the insured prior to performing a health care service; and

(2) Submits a copy of the signed disclosure set forth in Regulation .06 of this chapter to the carrier as an attachment to the uniform claims form adopted by the Commissioner under COMAR 31.10.11.03.

D. If the nonpreferred provider elects not to accept an assignment of benefits under a preferred provider insurance policy, the carrier shall provide the nonpreferred provider with the information specified in Insurance Article, §14-205.3 (c), Annotated Code of Maryland.

.06 Required Disclosure for Nonpreferred Providers Seeking Assignment of Benefits.

A. A nonpreferred provider shall provide a printed copy of the disclosure found in §B of this regulation to each patient on each date of service in order to qualify for an assignment of benefits under a preferred provider insurance policy as required under Regulation .05 of this chapter.

B. The disclosure text required by §A of this regulation shall be printed in at least 12 point type and shall read as follows:

“IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE

Your doctor is not a part of your health insurer’s network. You may pay more for the services provided by your doctor because:

1. Your doctor’s charge may be higher than the amount your health insurer will pay and, if so, you must pay the difference; and

2. Your coinsurance, deductible and out-of-pocket maximum may be higher because your doctor is not in your health insurer's network.

Your doctor will provide you with the following information to help you understand what you will have to pay for the services you will receive from you doctor:

1. An estimate of the cost of the services;
2. Any payment terms your doctor offers to help you pay for these services; and
3. Whether your doctor will charge you interest on any unpaid balance.

I, [patient's name] _____ received the information above and authorize my health insurer to reimburse my doctor directly for the services provided [today's date]_____."