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December 20, 2007

The Honorable Thomas McClain Middleton
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair, House Health and Government Operations Committee
Lowe House Office Building, Room 161
84 College Avenue
Annapolis, MD 21401-1991

Dear Chairman Middleton and Chairman Hammen:

HB 1003, "Health Insurance – Carrier Provider Panels – Participation by Providers" enacted in 2006 by the General Assembly directed the Maryland Insurance Administration (MIA) to study the feasibility and desirability of setting access and availability standards for hospital-based physician services and report its findings and recommendations to you by January 1, 2008.

In conducting this study, the MIA considered: (1) the unique characteristics of hospital-based physicians; (2) the access and availability standards now applicable in Maryland and other states as well as the access and availability standards recommended by the National Association of Insurance Commissioners (NAIC) and the National Committee for Quality Assurance (NCQA), an independent accreditation organization for health care organizations including HMOs and PPOs. The MIA also considered the impact of the contractual status of hospital-based physicians on a member's out-of-pocket payment obligation in assessing the desirability of setting access and availability standards for hospital-based physicians.

Because of the unique status of hospital-based physicians, their services are available to all Marylanders with health care coverage. The member's payment obligation to non-contracting hospital-based physicians depends upon the member's specific policy. Some policies specify higher copayments, coinsurance and deductibles for covered services rendered by non-contracting hospital-based physicians. In addition, for the non-contracting hospital-based physician, the members covered under policies issued by insurers or nonprofit health service plans may be responsible for the difference between the insurer's or the nonprofit health service plan's allowed amount and the non-contracting hospital-based physician's charges (known as the balance bill). By contrast, non-contracting hospital-based physicians are prohibited by law from balance billing HMO members.

Our review found no state or accreditation organization with an access and availability standard for hospital-based physicians. For this reason, it is not feasible at this time to impose access and availability standards for hospital-based physicians.

Establishing an access and availability standard alone does not guarantee a member will have a lower out-of-pocket payment obligation because non-contracting providers may balance bill patients covered by insurers or nonprofit health service plans. Moreover, imposing an access and availability standard on all insurers and nonprofit health service plans may have the unintended consequence of raising health care costs and thus premiums for insurers with a small market share, further diminishing competition in the health insurance market.

For these reasons, the MIA does not recommend establishing an access and availability standard for carriers. The MIA will continue to monitor the access and availability standards adopted by other states and the NCQA to determine if standards are developed for hospital-based physicians.

Enclosed is the MIA's report on the access and availability standards for hospital-based physicians. Should you have any further questions concerning this matter, please do not hesitate to contact me.

Sincerely,

Beth Sammis
Deputy Commissioner

BS:kc

Enclosure

Access and Availability Standards: Hospital-Based Physicians

Introduction

In 2006, the General Assembly enacted HB 1003, "Health Insurance – Carrier Provider Panels – Participation by Providers." This bill strengthened the tools available to the Insurance Commissioner ("Commissioner") to ensure access to health care services on an in-network basis for individuals enrolled in benefit plans requiring the use of contracting providers (e.g., health maintenance organization) or providing financial incentives to use contracting providers (e.g., preferred provider organizations). These include: (1) access and availability standards for insurers, nonprofit health service plans and dental plan organizations; (2) new requirements for provider directories; and (3) new requirements for accessing certain non-contracting providers.

Prior to the passage of HB 1003, health maintenance organizations (HMOs) were required to have access and availability standards for health care providers to meet their members' health care needs.[1] No such access and availability standards existed for health insurers, nonprofit health service plans or dental plan organizations. HB 1003 directed the Commissioner, in consultation with the Department of Health and Mental Hygiene's Office of Health Care Quality and other interested parties, to adopt regulations specifying the access and availability standards for health insurers, nonprofit health services plans and dental plan organizations by January 1, 2007.[2]

It is through a carrier's provider directory – available in print or electronically on the carrier's website – that consumers obtain information about contracting providers. HB 1003 included new requirements for carriers to help ensure that the most accurate and up-to-date information is available to consumers about contracting providers. At the time of credentialing and recredentialing, carriers must ask if a provider is accepting new patients and disclose this in all applicable provider directories.[3] When a provider sends new information to a carrier (e.g., change of address), the carrier must update its directory within 15 working days after receipt of written notification from the provider of the change.

Carriers do not always have a particular specialist a member needs to treat a particular health condition. Recognizing this, the General Assembly previously enacted §15-830 of the Insurance Article requiring carriers to allow a member to be treated by a non-contracting specialist if the member is diagnosed with a condition or disease that requires specialized medical care and the

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[1] HMOs must adhere to the standards developed by the Department of Health and Mental Hygiene through regulations previously adopted under §19-705.1 (B) (1) (ii) of the Health General Article.

[2] The Commissioner published proposed regulations specifying access and availability standards for health insurers, nonprofit health service plans and dental plan organizations in December 2006.

[3] HB 1003 also specified that this provision may not be construed to require a carrier to allow a provider to refuse to accept new patients covered by the carrier. Typically, carriers allow Primary Care Physicians to close their panel to new patients when a Primary Care Physician cannot accommodate more patients. Specialists, on the other hand, are usually not allowed to close their practice to new patients.

carrier does not have a specialist on its panel to treat the condition or disease as long as the non-contracting provider agreed to accept the same reimbursement as a specialist in the carrier's network.

HB 1003 strengthened this requirement by allowing a member diagnosed with a condition or disease that requires specialized medical care to be treated by a non-contracting specialist if the carrier cannot provide reasonable access to a specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel. Moreover, the bill removed the requirement that the non-contracting provider accept the same reimbursement as a contracting specialist. Carriers must calculate the member's payment obligation (e.g., deductibles, copayments and coinsurance) under these circumstances as if the service was provided in-network.

Proponents of HB 1003 believed these new provisions would: (1) increase a member's access to covered health care services on an in-network basis; and (2) minimize a member's out-of-pocket obligation for covered services provided by non-contracting providers. However, because HB 1003 does not apply to hospital-based physicians, the General Assembly directed the Maryland Insurance Administration (MIA) to study the feasibility and desirability of setting access and availability standards for hospital-based physician services and report its findings and recommendations in accordance with §2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee by January 1, 2008.

In conducting this study, the MIA considered: (1) the unique characteristics of hospital-based physicians; (2) the access and availability standards now applicable in Maryland and other states as well as the access and availability standards recommended by the National Association of Insurance Commissioners (NAIC) and the National Committee for Quality Assurance (NCQA), an independent accreditation organization for health care organizations including HMOs and PPOs. The remainder of this report describes hospital-based physicians, access and availability standards and the MIA's conclusions and recommendations.

Hospital-Based Physicians

Hospital-based physicians provide ancillary medical services in hospitals and generally do not maintain offices separate from these facilities. Hospital-based physicians include anesthesiologists, pathologists, radiologists and emergency medicine physicians.

Typically, hospital-based physicians are not hospital employees. Rather, the hospital contracts with one or more groups to provide anesthesiology, pathology, radiology and emergency medicine services to its patients. Only anesthesiologists, pathologists, radiologists or emergency medicine physicians under contract with the hospital may provide services to patients admitted to the hospital. Hospital-based physicians must treat any patient admitted to the hospital, irrespective of the patient's ability to pay or, for those patients with health care coverage, the contractual status of the hospital-based physician with the carrier or other payor.

Some maintain it is difficult for carriers to contract with hospital-based physicians because the patient volume for these physicians depends solely upon hospital admissions. According to a recent study by the Maryland Health Care Commission (MHCC), emergency medicine physicians and pathologists are less likely to participate with carriers than Primary Care Physicians, Physician Medical Specialists or Physician Surgical.[4]

The MIA asked selected carriers to provide information on the contractual status of hospital-based physicians. Three provided information, one with a large market share in Maryland and two with a small market share. For the large carrier, virtually all hospital-based physicians in all Maryland hospitals contracted with the large carrier. For the two with a small market share, the contracting status of hospital-based physicians varied. For one small carrier about one-third of the Maryland hospitals had more than one type of hospital-based physician contracting with the carrier; for the other small carrier, over half the hospitals had contracting anesthesiologists and radiologists and over one-third of the hospitals had contracting pathologists and emergency medicine physicians.

The member's payment obligation to non-contracting hospital-based physicians depends upon the member's specific policy. Some policies specify higher copayments, coinsurance and deductibles for covered services rendered by non-contracting hospital-based physicians. In addition, for the non-contracting hospital-based physician, the members covered under policies issued by insurers or nonprofit health service plans may be responsible for the difference between the insurer's or the nonprofit health service plan's allowed amount and the non-contracting hospital-based physician's charges (known as the balance bill). By contrast, non-contracting hospital-based physicians are prohibited by law from balance billing HMO members.

The MIA reviewed other state laws regarding a member's payment obligation to non-contracting providers. While other states limit an HMO member's payment obligation to non-contracting providers, no other state appears to limit a member's payment obligation to non-contracting providers for members covered by health insurers.[5]

Access and Availability Standards

Sixteen states (including Maryland) require carriers to have access and availability standards. Most follow the provisions set forth in the NAIC's "Managed Care Plan Access and availability Model Act" (Model Act).

The Model Act requires insurers to maintain a sufficient network "to assure that all services to covered persons will be accessible without unreasonable delay."[6] Insurers may demonstrate sufficiency through any reasonable criteria, including provider-covered person ratios, geographic accessibility, or waiting times for appointments. Each insurer must file with the commissioner

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[4] See "Practitioner Utilization: Trends Among Privately Insured Patients, 2004-2005" (2007). The study shows "Other Physicians" as having the highest non-participation rate.

[5] Nebraska requires a carrier to pay a non-contracting provider at the carrier's usual and customary rate or at the agreed upon rate but it is not clear if the non-contracting provider may balance bill the member.

[6] See Section 5 of the Model Act.

an access plan. If the insurer has an insufficient number or type of contracting provider to provide a covered benefit, the Model Act requires the insurer to ensure that the covered person obtains the covered benefit from a non-contracting provider at no greater cost to the covered person than if the benefit were obtained from a contracting provider.

NCQA's accreditation program requires HMOs and PPOs to meet certain access and availability standards. HMOs and PPOs are required to administer a standard survey with questions included on the survey instrument designed to ascertain the availability of care. In addition, HMOs and PPOs are required to have quantifiable and measurable standards for the number and geographic distribution of: general and internal medicine, family practice, pediatrics, obstetrics/gynecology, a high volume behavioral health care specialty, and two other high volume specialties.

Maryland's HMOs are required to adhere to access and availability standards in accordance with regulations adopted under §19-705.1 (B) (1) (ii) of the Health General Article. Insurers, nonprofit health service plans and dental plan organizations are required to adhere to access and availability standards in accordance with regulations adopted by the Commissioner.

Insurers and nonprofit health service plans must maintain a provider panel that is sufficient in numbers and types of available providers to meet the health care needs of enrollees. The availability plan for these carriers must describe the quantifiable and measurable standards for the number and geographic distribution of general and internal medicine, family practice, obstetrics and gynecology, a high volume behavioral health care provider and high volume specialty health care providers.

The MIA reviewed other state access and availability standards. The MIA found no other state with access and availability standards for hospital-based physicians.

Conclusions and Recommendations

The services provided by hospital-based physicians are available and accessible to all Marylanders with health care coverage issued by an HMO, insurer or nonprofit health service plan. The MIA's review found no state or accreditation organization with an access and availability standard for hospital-based physicians. *For this reason, it is not feasible at this time to impose access and availability standards for hospital-based physicians.*

Although an HMO member's out-of-pocket payment obligation is the same for covered services provided by contracting and non-contracting hospital-based physicians, insurer and nonprofit health service plan members are more likely to have a higher out-of-pocket payment obligation for non-contracting hospital-based physicians. No state appears to have resolved how to limit a member's payment obligation for non-contracting hospital-based physicians specified under an insurance contract. *Establishing an access and availability standard alone does not guarantee a member will have a lower out-of-pocket payment obligation because non-contracting providers may balance bill patients covered by insurers or nonprofit health service plans.*

The information from the MHCC and the three carriers suggests it may be difficult for some carriers to contract with hospital-based physicians. Carriers with a smaller market share appear to be less able to contract with hospital-based physicians than their larger counterparts. *Imposing an access and availability standard on all insurers and nonprofit health service plans may have the unintended consequence of raising health care costs and thus premiums for insurers with a small market share, further diminishing competition in the health insurance market.*

For these reasons, the MIA does not recommend establishing an access and adequacy standard for carriers. The MIA will continue to monitor the access and availability standards adopted by other states and the NCQA to determine if standards are developed for hospital-based physicians.