

ASSIGNMENT OF BENEFITS

Physicians are **not** required to accept AOB but, if they do, there are certain consequences under Senate Bill 314. For physicians who accept AOB, Senate Bill 314 identifies three groups of physicians: (1) hospital-based physicians, (2) on-call physicians and (3) all other physicians.

A) NPP- HOSPITAL BASED PHYSICIANS

- a) Hospital-Based Physicians** who accept an AOB under a preferred provider insurance policy shall:
- i) Accept the carrier's allowed amount as payment in full for the covered services provided
 - ii) Collect or attempt to collect from the insured only the monies for:
 - any deductible, copayment, or coinsurance amount owed by the insured for covered services rendered to the insured by hospital-based physician
 - if Medicare is the primary insurer and the insurer is the secondary insurer, any amount up to the Medicare approved or limiting amount, as specified under the federal Social Security Act, that is not owed to the hospital-based physician by Medicare or the insurer after coordination of benefits has been completed, for Medicare covered services rendered to the insured by the hospital-based physician
 - any payment or charges for services that are not covered services
 - iii) The hospital-based physician must submit to the carrier the uniform claim form HCFA Form 1500 (the form required by COMAR 31.10.11.03) and indicate acceptance of the AOB in box 27 of the uniform claims form to satisfy the notice requirements to notify the insurer of an insured in a manner specified by the Commissioner that the hospital-based physician has obtained and accepted the AOB from the insured.

b) NPP (hospital-based) Reimbursement

The insurer/agent shall pay the physician within 30 days after receipt of the claim that is submitted for a covered service no less than the greater of:

1. 140% of the average contract rate paid in the preceding calendar year in the same Medicare geographic area for the same covered services **or**,
2. The final allowed amount that the insured paid in 2010 to the hospital-based physician billing under the same 2009 federal tax identification number. This amount shall be inflated by the change in the Medicare Economic Index to the current year.

B) NPP – ON CALL PHYSICIANS

- a) On-call physician** are not required to accept AOB, but in case they do, the conditions from Section A(a)(i) and (ii) above apply in addition to the requirement to designate CPT code 99026, or its successor, on the uniform claims form.

b) NPP (on-call physician) Reimbursement

The insurer/agent shall pay the physician within 30 days after receipt of the claim that is submitted for a covered service no less than the greater of:

1. 140% of the average contract rate the insurer paid in the previous calendar year in the same Medicare geographic area for the same covered service or,
2. The average rate the insurer paid in 2010 for the same covered services to a physician who was not under written contract with the insurer. This amount shall be inflated by the change in the Medicare Economic Index from 2010 to the current year.

In the “all other physician or all other non-preferred physician” category are office based physicians who may elect to receive AOB and will not be limited in the amount of their bill but must provide a disclosure to the patient giving an estimate of the costs of the services to be provided. The disclosure will be on a form to be developed by the Maryland Insurance Administration (MIA).

The disclosure text required shall be printed in at least 12-point type and shall read as follows:

- Your doctor's charge may be higher than the amount your health insurer will pay and, if so, you may be required to pay the difference; and
- Your coinsurance, deductible and out-of-pocket maximum may be higher because your doctor is not in your health insurer's network.
- An estimate of the cost of the services;
- Any payment terms that apply; and
- Whether your doctor will charge you interest on any unpaid balance, and the amount of the interest, if any.

SENATE BILL 314

Maryland bars insurers from prohibiting assignment of benefits. Requires study of impact of direct reimbursement, the impact of not allowing insurers to refuse assignments and impact on networks.

Senate Bill 314 was enacted in Maryland in 2010, but implementation was delayed.

SB 314 prohibits insurers from barring assignment of benefits to a physician and prohibits insurers from refusing to directly reimbursing a non-preferred provider under an assignment of benefits arrangement.

The General Assembly delayed implementation until July 1, 2011 to address uncertainties on impact. Prior to the implementation of law, the Maryland Health Care Commission, in consultation with the Maryland Insurance Administration and the Office of the Attorney General, was tasked with a study to assess benefits and costs associated with direct reimbursement of NPP by health insurance carriers under a valid AOB, the impact of enacting a cap on balance billing for NPP, on call physicians and hospital based physicians, the impact on consumers prohibiting health insurance carriers from refusing to accept a valid AOB; and the impact of direct reimbursement of NPP by health insurance carriers to maintain an adequate number of primary and specialty providers in their networks, including impact on billed charges, allowed charges, and patient responsibility for remaining charges, by specialty. In addition to the study required under the bill, the Maryland governor requested additional information concerning 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).

STUDY/REPORT

The report may be found [here](#) (MIA Report on Assignment of Benefits) “...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.”

Notice required to be provided to patients by physicians seeking assignment of benefits who are classified as non-preferred providers by the patient's insurance company.

This notice must be printed in at least 12 point type with the following text:

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:

- Your doctor's charge may be higher than the amount your health insurer will pay and, if so, you may be required to pay the difference; and
- Your coinsurance, deductible and out-of-pocket maximum may be higher because your doctor is not in your health insurer's network.

Your doctor may charge you for services not covered under your health insurance contract.

Your doctor will provide you with the following information before performing the services for you:

- An estimate of the cost of the services;
- Any payment terms that apply; and
- Whether your doctor will charge you interest on any unpaid balance, and the amount of the interest, if any.

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]_____.