STATE OF MARYLAND

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January 15, 2015

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chair
Health and Government Operations Committee
H-101 State House
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chair
Senate Finance Committee
H-107 State House
Annapolis, MD 21401-1991

RE: Chapter 537, 2010 Laws of Maryland- Health Insurance- Assignment of Benefits and Reimbursement of Nonpreferred Providers

Dear Governor O'Malley, and Chairs Middleton and Hammen:

The Maryland Health Care Commission (MHCC) is required to report to the House Health and Government Operations Committee and the Senate Finance Committee on the impact of the Assignment of Benefits (AOB) legislation, as required under Chapter 537, 2010 Laws of Maryland. An interim report was submitted in December 2012. We are pleased to submit this final report, which is based on information from two periods: (i) a period prior to implementation, primarily 2010, which provides a baseline by which to assess the impact of the legislation, and (ii) 2013, subsequent to implementation of the legislation.

The report concluded that the law, generally, achieved its intended purpose, which was to ease the financial burden on patients by discouraging non-participating physicians from balance billing patients. After its consideration of the impact of the legislation, MHCC recommends that the General Assembly remove the abrogation date but make no additional changes to the statute. The several disparities that were identified in our study can be corrected administratively. These changes are discussed at the conclusion of this letter.

The law applies to health insurance policies issued or renewed by Life and Health Insurers and Nonprofit Health Service Plans (insurance carriers) on or after July 1, 2011 and requires an insurance carrier to recognize a patient's assignment of benefits to a physician who does not participate in the carrier's provider network, if the physician agrees to accept the carrier's payment as full reimbursement for the service. The law establishes different payment formulas for hospital-based physicians, on-call physicians treating patients in hospitals, and certain other specialist physicians who agree to accept a patient's assignment of benefits as full payment for the service when the physician does not participate in a carrier's network.

The study analyzed privately insured medical claims for PPO and POS plans for 2010 and 2013 from the Commission's Medical Care Data Base. Results are presented from the perspective of the different stakeholders affected by the legislation; i.e., patients, payers, and providers.

Overall, this final report found that the legislation met its goal of reducing the burden on patients who used out-of-network providers, while protecting payment levels for non-participating physicians. Patients' financial burden became more predictable because balance billing was eliminated in most instances. The law protected payment levels for non-participating physicians. Non-participating physicians also benefited from increased predictability in payments. Overall, out-of-network services and the out-of-network reimbursements declined as a share of total services and reimbursements for most payers between 2010 and 2013.

It is important to note that certain incentives in the law could have discouraged network participation because a physician could potentially earn more by leaving a network. A major concern voiced by payers and some policymakers during the 2010 legislative debate was that the law would cause the unraveling of payers' networks. The report found no evidence of systematic deterioration in networks. The proportion of patients with at least one out-of-network service declined from one in five to one in ten from 2010 to 2013. From a payer perspective, the out-of-network share of total services and of total payments declined between 2010 and 2013, with variation by type of service and site of care. Some up and down fluctuations in network participation did occur by specialty; however, those changes were more significant for smaller carriers than for CareFirst.

Opponents of the original legislation insisted that the law would be administratively complex for patients and payers. The report documents that most hospital-based and on-call non-participating physicians opted to accept assignment of benefits approval from patients, although the potential to collect more via balance billing continued; the assignment of benefits option was chosen by the majority of non-participating physicians. Carriers were able to reimburse physicians based on whether the assignment of benefit indicator was checked.

MHCC staff identified dissatisfaction among carriers regarding the two-pronged payment formula that was established in the law. Under the AOB law, carriers are required to pay the greater of what was paid in 2009 adjusted to the current year by the Medicare Economic Index (MEI), or 140 percent of the average allowed charges for a similarly licensed in-network physician in the same Medicare geographic area. The first prong of the formula was established to maintain the level of physician reimbursement for carriers that had established payment policies for out-of-network services that physicians found acceptable. The second prong established a payment benchmark relative to in-network allowed charges for carriers that paid only in-network allowed charges for out-of-network services in 2009. The two-pronged test means that a carrier today pays according to either one or the other prong of the test based entirely on their behavior in 2009. Carriers subject to the first prong, i.e., paid billed charges in 2009, have argued that the law requires them to pay more than those carriers required to pay 140 percent of allowed charges.

Several carriers' implementation of the two-pronged test exacerbates the difference in payment levels. Two of the five carriers reported paying 2013 billed charges to both hospital-based and on-call physicians, even though the law requires current payments to be 2009 payments adjusted to the current year by the MEI. MHCC concludes that paying current billed charges would, in most cases, be higher than either of the two prongs of the payment formula under the law.

MHCC recommends that the General Assembly remove the abrogation date on the current AOB law without further modification to the statute. The report documents that the law has achieved most of its intended objectives. MHCC considered whether it would be appropriate to change the law to establish absolute parity in the payment formula under the AOB law. Changing the payment formula would likely

resurrect old tensions between carriers and physicians over reimbursement. Over the last several years such tensions have diminished as both carriers and physicians have focused on opportunities for collaboration in developing value-driven health care supported by new systems of reimbursement. Some inequalities in the implementation of the current law can be addressed through administrative actions by MHCC. The Commission acknowledges that carriers should have the opportunity to reimburse consistent with the AOB law, but also recognizes that some carriers may opt to pay more than the law requires for administrative convenience or for other reasons. The MHCC can simplify the process for payers that are subject to the first prong of the payment formula by taking two actions: (1) produce and distribute a 2009 fee schedule derived from the Medical Care Data Base that would be meet the requirements of the current law; and (2) provide consistent MEI annual inflators on an ongoing basis that can be used to adjust the 2009 payment levels to the current year.

The Commission looks forward to working with members of the General Assembly and stakeholders on cost and quality issues as Maryland continues to build a health system focused on value.

Please do not hesitate to contact me at (410) 764-3566 if you have any questions.

Sincerely,

Ben Steffen
Executive Director

cc: Laura Herrera Scott, Acting Secretary DHMH
Allison Taylor, DHMH
Linda L. Stahr
Patrick D. Carlson
Sarah Albert (5 copies)

FINAL REPORT

Impact of the Assignment of Benefits Legislation

January 15, 2015

Prepared for:

The Maryland Health Care Commission

Prepared by:

Social & Scientific Systems, Inc.

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EXECUTIVE SUMMARY

Background and Purpose

Effective July 1, 2011, the Assignment of Benefits and Reimbursement of Nonpreferred Providers (Chapter 537, 2010 Laws of Maryland) changed how non-participating, hospital-based or on-call physicians are reimbursed by non-HMO plans in Maryland. Under the law, insurance carriers in Maryland are required to recognize an Assignment of Benefits (AOB) and to send the insurance payment directly to the provider who accepts an AOB. Providers are not required to accept AOB, but if they do, the law establishes payment floors for three groups of providers: (1) hospital-based providers, (2) on-call providers and (3) all other providers.

The Maryland Health Care Commission (MHCC) is required to report to the House Health and Government Operations Committee and the Senate Finance Committee on the impact of the legislation. This report presents information based on information from two periods: (i) the period prior to implementation in order to have a baseline by which to assess the impact of the legislation, primarily 2010, and (ii) 2013, subsequent to implementation of the legislation.

The study analyzed privately insured medical claims for PPO and POS plans from the 2010 and the 2013 Medical Care Data Base. Data are presented from the perspective of the different stakeholders affected by the legislation—patients, payers, and providers.

Findings

- **Providers**

The provider analysis focuses on the physician specialties and the locations of care primarily affected by the law. For those physician groups affected by the legislation, the proportion of physicians participating in at least one private payer network showed no consistent pattern, with the participation rate increasing for some specialties, decreasing for some specialties, and staying unchanged for others. For these providers overall, the out-of-network share of total payments declined from just over one-fifth (20.8%) in 2010 to a little more than one-tenth of total payments (11.2%) in 2013. For non-participating providers affected by the legislation, assignment of benefits was chosen by the vast majority, accounting for between 65 and 82 percent of out-of-network (OON) spending for hospital-based and on-call specialists. There was a related decline in balance billing as a share of out-of-network payments, from 21 percent to less than 10 percent.

- **Patients**

The patient analysis focused on the impact on their share of and level of spending for out-of-network (OON) payments for professional services. Patients experienced an overall decline in financial burden, with the proportion of patients with at least one out-of-network service declining from one in five to one in ten. The percentage of users with more than half of all payments going toward OON services declined from 9 percent to 4 percent and the percentage with 100 percent of their services OON fell from 2 percent to 1 percent. Among those patients with at least some OON service use, the overall out-of-pocket share of total spending fell from 34 percent to 30 percent.

❖ **Payers**

The payer analysis examines payment liability by network status for private payers, with financial measures classified by service category and site of care. Overall, the out-of-network share of total services and of total payments declined between 2010 and 2013, with variation by type of service and site of care. For OON share of services, the smallest decline was 19 percent for critical care services and the largest was a 65 percent drop for anesthesia services. In terms of the OON share of total reimbursement, there were substantial declines for both emergency room and anesthesia. For 2013, the vast majority of hospital-based OON payments were AOB across all specialty/site of service categories. While network participation showed no evidence of decline overall, effects varied by payer with networks expanding for some and contracting for others.

Conclusions

Enactment of the Assignment of Benefits and Reimbursement of Nonpreferred Providers (Chapter 537, 2010 Laws of Maryland) was a response to reports of exceptionally high out-of-pocket expenses by patients for care rendered in hospital settings by out-of-network providers. The purpose of the legislation was to reduce the financial burden on patients by discouraging reliance on balance billing, without reducing payments to out-of-network physicians.

The analysis indicates that, overall, the legislation achieved its purpose. This report provides evidence that the financial burden on patients from out-of-network service use was lessened between 2010 and 2013. Assignment of benefits was chosen by the majority of providers who elected not to participate in private payer networks and income uncertainty for those providers affected by the legislation was likely reduced due to less reliance on balance billing for payments. Moreover, while impacts varied by payer, we found no evidence that provider participation rates in commercial networks systematically declined between 2010 and 2013.

INTRODUCTION

The Maryland Health Care Commission (MHCC) is required to report to the House Health and Government Operations Committee and the Senate Finance Committee on the impact of the Assignment of Benefits and Reimbursement of Nonpreferred Providers (Chapter 537, 2010 Laws of Maryland), which became effective July 1, 2011.

The law applies to health insurance policies issued or renewed by Life and Health Insurers and Nonprofit Health Service Plans (insurance carriers) on or after July 1, 2011. The law requires an insurance carrier to recognize an Assignment of Benefits (AOB) and to send the insurance payment directly to the provider who accepts an AOB. Providers are not required to accept AOB, but if they do, the law establishes payment floors for three groups of providers: (1) hospital-based providers, (2) on-call providers and (3) all other providers.

The law also establishes the following:[1]

- Hospital-based physicians who elect to receive an AOB may not "balance bill" the patient, but they will be paid by the insurance carrier the greater of:
    - 140% of the average rate the insurer paid for the 12–month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers, who are hospital–based physicians, under written contract with the insurer; or
    - the final allowed amount of the insurer for the same covered service for the 12–month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the hospital–based physician billing under the same federal tax identification number the hospital–based physician used in calendar year 2009.
- On-call providers who elect to receive an AOB may not "balance bill" the patient, but they will be paid by the insurance carrier the greater of:
    - 140% of the average rate the insurer paid for the 12–month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service, to similarly licensed providers under written contract with the insurer; or
    - the average rate the insurer paid for the 12–month period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider not under written contract with the insurer, inflated by the change in the Medicare Economic Index from 2010 to the current year.
- All other physicians (typically office-based providers) may elect to receive an AOB and will not be limited in the amount of their bill, but must provide a disclosure form (developed by the Maryland

[1] https://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/report-assignmentofbenefits12-15-10.pdf

Insurance Administration) to the patient giving an estimate of the costs of the services to be provided.

This report presents information based on information from two periods: (i) the period prior to implementation in order to have a baseline by which to assess the impact of the legislation, primarily 2010, and (ii) 2013, subsequent to implementation of the legislation. Data are presented from the perspective of the different stakeholders affected by the legislation—patients, payers, and providers.

STUDY DESIGN

This study analyzed privately insured medical claims from the 2010 and 2013 Medical Care Data Base. Claims were limited to fully insured claims for PPO and POS plans since other types of coverage are not covered by the law. Claims for plans covering federal government workers were excluded from the study, as were those for limited benefit plans. The claims analysis examines the relative volumes of out-of-network claims and their associated payments, including the payment shares contributed by payers and patients, for the three groups of stakeholders affected by the law: providers, patients, and payers. The analysis also relies on licensure data from the Board of Physicians and results of a limited survey of carriers.

FINDINGS

Provider Perspective

The provider analysis focuses on the physician specialties and the locations of care primarily affected by the law. Specialties were categorized based on provider specialty codes.[2] Hospital-based specialties include emergency room, anesthesia, neonatology, radiology, and pathology. Hospital on-call surgical specialties include general surgery, orthopedics, neurosurgery, urology, ENT, oral surgery, plastic surgery, ophthalmology, thoracic surgery, and vascular surgery. Hospital on-call medical specialties include cardiology, pulmonology, hematology, oncology, infectious diseases, nephrology, psychiatry, and neurology. We also examined services delivered by primary care physicians in a non-hospital setting. While not a comparison group per se, changes in primary care network participation over time allows observation of secular trends that may be relevant. Primary care specialties include internal medicine-general, family practice-general and adolescent, pediatrics-general and adolescent, and general medicine.

Network Participation

- **From 2010 to 2013, there was no clear pattern indicating a decline in provider participation. Changes in network participation were mixed, varying by specialty and across payers.**

We used the Maryland Board of Physicians (BOP) licensure survey data to measure participation by practicing physicians in at least one private payer network. The survey is part of the BOP application for license renewal. Participation rates were calculated among physicians with a Maryland license who reported providing patient care for a minimum of 8 hours per week.

Exhibit 1 shows the percent of physicians that participated in at least one private payer network, by physician specialty, for each of the study years. With the exception of psychiatry, all specialties reflect high participation rates of 81 percent or more in each of the study years. There was no clear pattern to

[2] As defined by the National Plan & Provider Enumeration System, based on the National Provider ID.

the changes between the baseline years (2009 -2010) and post-AOB implementation (2012-2013). Of the hospital-based specialties, participation rates for Radiology and Neonatal-Perinatal Medicine increased while those for Pathology and Emergency Medicine declined; the rate for Anesthesia was unchanged. Participation rates for on-call surgical specialists were essentially flat over this period. There were mixed results for on-call medical specialists, with the rate for other medical specialists rising, the rate for neurologists falling, and the rate for psychiatrists essentially flat.

Over this period, the percent of primary care physicians participating in at least one private insurer network remained at 87 percent.

Exhibit 1. Percent of Physicians Participating in Private Insurer Networks by Specialty, 2009-2010 and 2012-2013

Physician Specialty	2009-2010	2012-2013
Hospital Based		
Anesthesiology	91%	91%
Pathology	90%	82%
Radiology	81%	84%
Emergency Medicine	90%	85%
Neonatal-Perinatal Medicine	83%	87%
On-Call Surgical		
Surgery	87%	86%
Other specialties classified as surgical	91%	93%
On-Call Medical		
Neurology (including Neurosurgery)	94%	90%
Psychiatry	51%	50%
Other Medical Specialties	88%	92%
Primary Care Specialties		
	87%	87%

Source: Maryland Board of Physicians Licensure Data, 2009-2010 and 2012-2013

To supplement this information, we provide some more limited information gathered directly from the five largest commercial carriers operating in Maryland. These carriers were asked specifically about changes in their networks since implementation of the legislation. As shown in Exhibit 2, three of the five carriers experienced little to no change in their provider networks for hospital-based or on-call specialists, while one carrier reported increases for on-call specialists only. Substantial increases in network participation were noted by one of the five carriers; that carrier indicated that they had made significant efforts to increase their network in response to the AOB legislation. Four of the five carriers reported sizeable increases in their primary care provider networks.

Exhibit 2. Percentage Change in Network Size for Largest Commercial Carriers, 2013

Physician Specialty	Carrier 1	Carrier 2	Carrier 3	Carrier 4	Carrier 5
Hospital Based	0	Anesthesia only (+5%)	0	0	+11-29%, by specialty
On-Call Surgical	0	0	+9%	0	+9%
On-Call Medical	0	0	+7%	0	+10%
Primary Care	+24%	+17%	+16%	0	+15%

Source: Carrier survey conducted by MHCC, November 2014

Out-of-network versus In-network Payment for Hospital-based Services

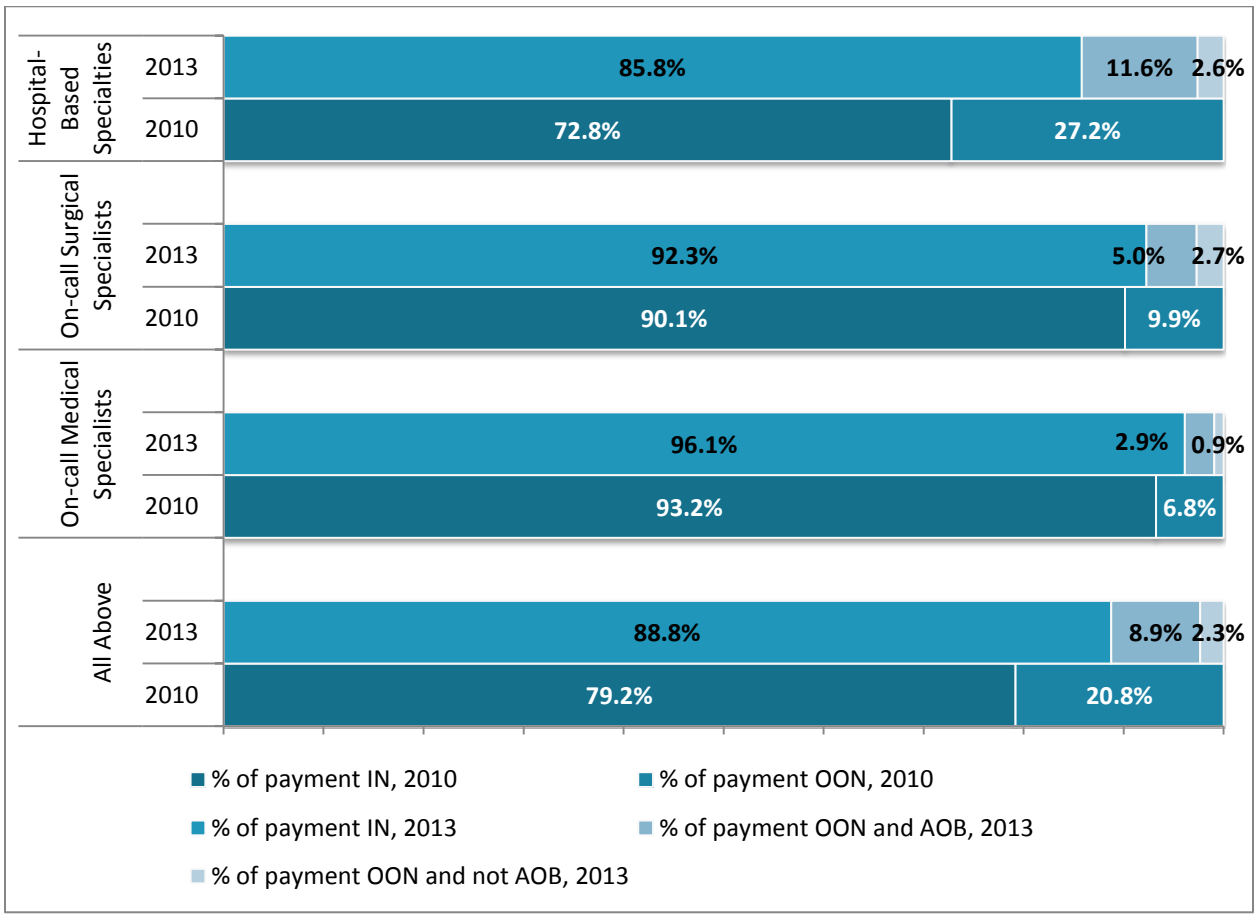
- **Across all specialties combined, the OON share of total payments for these services fell from 2010 to 2013. The vast majority of the OON payments in 2013 were subject to assignment of benefits with no balance billing of patients, which constrained the total payments for OON services.**

Exhibit 3 shows the aggregate payment shares for out-of-network (OON) versus in-network (IN) hospital-based services for the different provider groups affected by the legislation - hospital-based, on-call surgical, on-call medical - as well as for the three groups combined. Total payments include both patient and payer shares of payment and are limited to those for hospital-based inpatient, outpatient, and emergency room services. Aggregate payment shares are shown for 2010 and 2013; in 2013, OON payments are segmented into those where: 1) benefits were assigned to the provider (AOB) with no balance billing permitted, and 2) benefits were unassigned (not AOB) and the payment calculation included balancing billing of patients.

In 2010, aggregate OON payments for all affected specialties combined were just over one-fifth (20.8%) of overall total payments for hospital-based services. The OON share fell to a little more than one-tenth of total payments (11.2%) in 2013. Among hospital-based specialties, aggregate OON spending accounted for 27 percent of total spending in 2010 and 14 percent in 2013. Among the on-call specialties, aggregate OON spending accounted for smaller percentages of total spending in 2010, but also exhibited declines in 2013.

The vast majority of OON spending in 2013 was attributed to services where benefits were assigned to the physician and balance billing to the patient was prohibited. The prohibition against balance billing to a patient for AOB services in 2013 accounted for about 38 percent (3.7 percentage points) of the overall 9.6 percentage point decline in the total payments for OON services from 2010 to 2013 (no exhibit). Services where benefits were assigned accounted for 82 percent of OON payments to hospital-based providers, 65 percent of OON payments to on-call surgical specialists, and 76 percent of OON payments to on-call medical specialists.

Exhibit 3. Share of Aggregate Payment for Hospital-Based Services by Physician Specialty, Participation Status, and by Assignment Status, 2010 and 2013



Notes: Total payments for hospital-based inpatient, outpatient, and emergency room services include payer and patient payments; 'All' is hospital-based and on-call specialties combined.
Source: Maryland Medical Care Database, 2010 and 2013

Services delivered by primary care physicians in a non-hospital setting (Appendix Table 1) also exhibited a decline in the OON share of total payments for these services, from 6.5 percent in 2010 to 3.6 percent in 2013. Although these physicians are not directly affected by the AOB legislation, this information is presented to better understand general trends with respect to private payer network participation. This comparison indicates that a decline in the share of payments attributed to OON providers is not limited to just the providers and services covered by the AOB legislation.

Components of Out-of-Network Payments for Hospital-based Services

- **The composition of out-of-network payments for hospital-based and on-call specialists changed from 2010 to 2013, with the share accounted for by insurer reimbursement increasing and the patient portion falling.**

Exhibit 4 shows the decomposition of out-of-network payment shares by provider specialty for hospital-based and on-call specialists. Insurer reimbursement was calculated as the ratio of carrier reimbursement to the total payment. Total patient liability (out-of-pocket spending) was further decomposed into "other" patient liability and balance billing. "Other" patient liability is comprised of

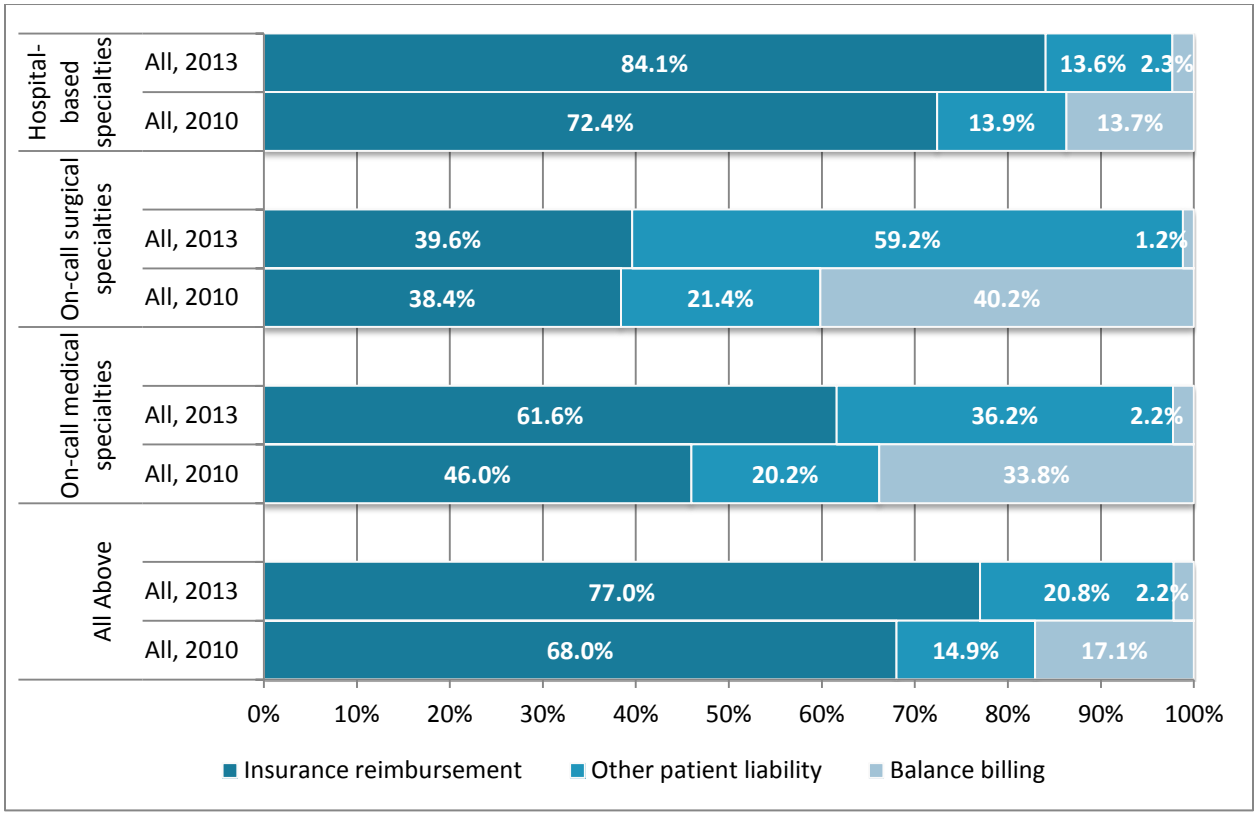
patient co-payment, patient deductible, and other patient obligations. Providers were able to balance bill in 2013 only if the patient did not assign benefits.

In 2010, insurer reimbursement accounted for 68 percent of the payments for OON hospital services delivered by hospital-based and on-call specialists. The patient share of payments was 32 percent, with patient balance billing and other patient liability accounting for 17.1 percent and 14.9 percent, respectively. In 2013, the insurer share for these services rose to 77 percent and the patient share declined to 23 percent, with patient balance billing and other patient liability accounting for 2.2 percent and 20.8 percent, respectively.

Compared to the overall averages, the insurer reimbursement share of payments for OON services to hospital-based specialists only was higher in 2010 (72.4 percent) and increased by more percentage points (to 84.1 percent) in 2013. The patient liability share of these payments fell from 27.6 percent to 15.9 percent.

On-call medical and surgical specialties received comparatively smaller proportions of their payments for OON hospital services from insurers and larger shares from patients. For on-call medical specialists, insurer reimbursements increased from 46 percent of payments in 2010 to 62 percent in 2013. For on-call surgical specialists, the increase in the insurer share was relatively small, from 38 percent in 2010 to 40 percent in 2013.

Exhibit 4. Decomposition of Out-of-Network Payments for Hospital-Based Services by Provider Specialty* and Assignment Status, 2010 and 2013



Notes: *Limited to inpatient, outpatient, and emergency room settings for hospital and on-call specialties. 'All' is hospital-based and on-call specialties combined.
Source: Maryland Medical Care Database, 2010 and 2013

Patient Perspective

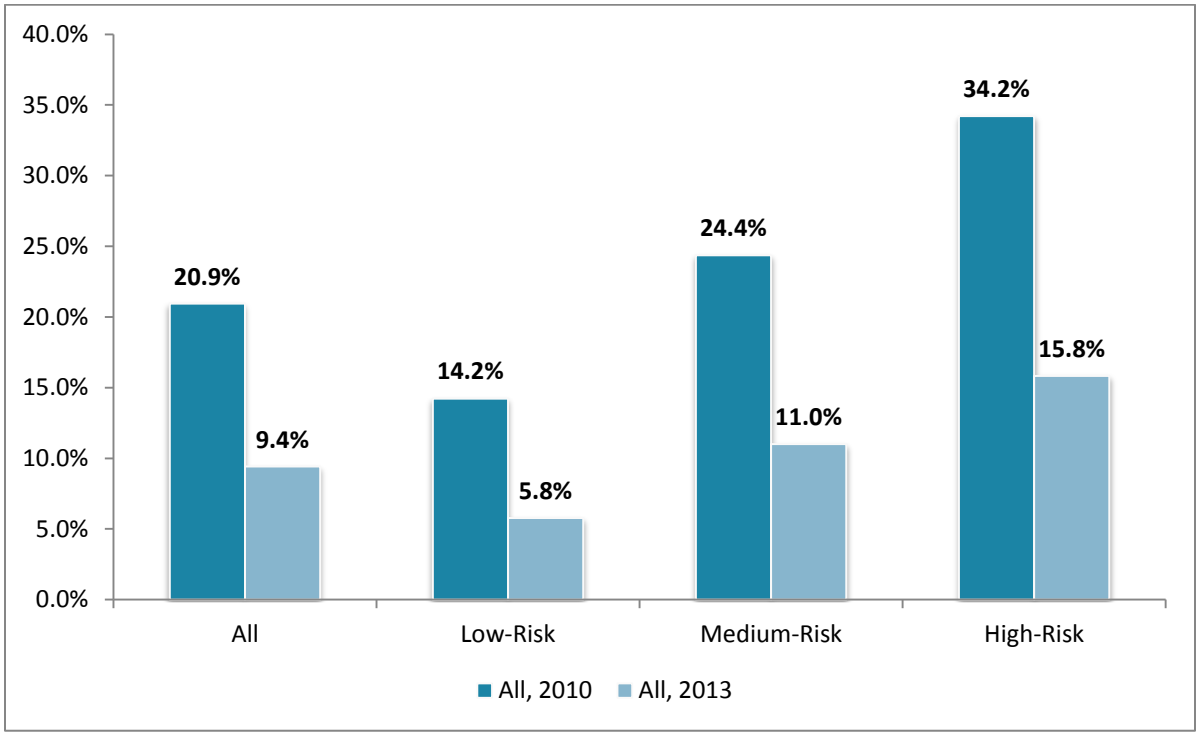
The patient analysis examines the impact of the AOB legislation on patients, particularly the impact on their share of spending for all out-of-network (OON) professional services. The patient analysis was limited to those individuals enrolled for all 12 months in 2010 and 2013, respectively, in order to ensure appropriate comparisons in terms of spending levels. The proportion of total payments for all professional services allocated to OON services was determined for each patient, and measures were constructed overall and by Maryland region of patient residence and patient risk category, where users are classified as low-, medium- or high-risk based on their risk for healthcare spending.

Use of Out-of-Network Professional Services by Patient Subgroups

- **Across all users, the proportion of users with at least one OON service declined substantially between 2010 and 2013. This decline was evident for all patient risk groups and across all Maryland regions, though the degree of decline varied.**

In Exhibit 5, we present the proportion of users who had any payments for OON professional services, overall and by user expenditure risk level. Across all users, the proportion of users with at least one OON service declined substantially, from one in five (20.9%) in 2010 to one in ten (9.4%) in 2013. As might be expected, use of OON services increases with risk category. This pattern exists in both years of analysis, with the OON share declining within each risk category from 2010 to 2013.

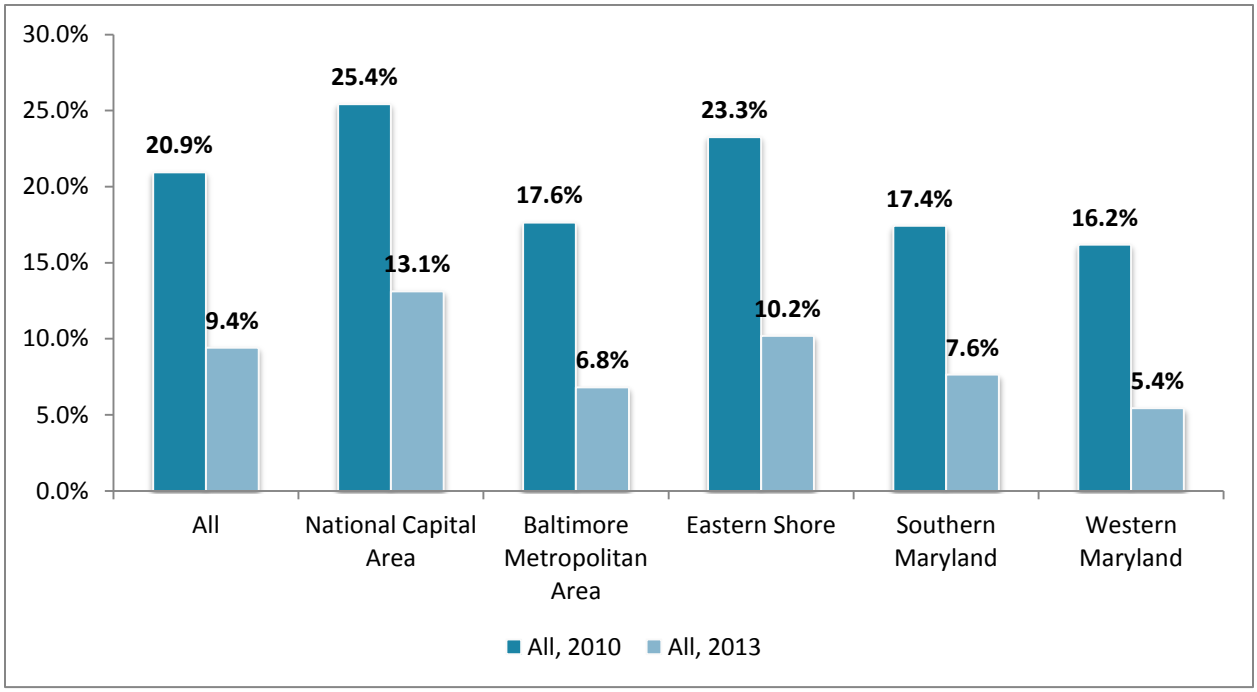
Exhibit 5. Proportion of Professional Service Users with Out-of-Network Services, Overall and by Expenditure Risk Category, 2010 and 2013



Notes: Limited to full-year enrollees with at least one professional services claim.
Source: Maryland Medical Care Database, 2010 and 2013

In Exhibit 6, we present the proportion of users who had any payments for OON professional services, overall and by patient region of residence. For 2013, the use of OON services varies by Maryland region: the lowest OON share is in Western Maryland (5.4%), and the highest OON share is in the National Capital Area (13.1%). This pattern was similar in 2010, and it is likely that this regional variation is driven, at least in part, by payer mix. Within each region, the OON share declined from 2010 to 2013.

Exhibit 6. Proportion of Professional Services Users with Out-of-Network Services, Overall and by Region of Residence, 2010 and 2013



Notes: Limited to full-year enrollees with at least one professional services claim.
Source: Maryland Medical Care Database, 2010 and 2013

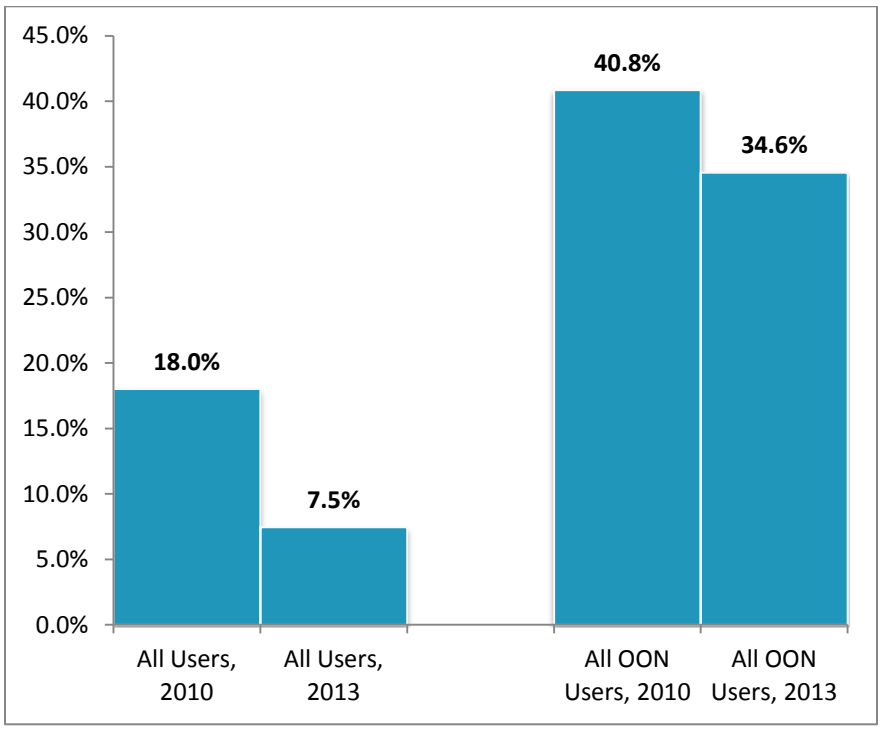
Out-of-Network Spending for Patient Subgroups

- **The average proportion of total payments spent on OON services fell between 2010 and 2013, for all users and for users with at least one OON service. While there was variation by risk category and region of residence, this proportion fell for all patient subgroups.**

Exhibit 7 shows the average out-of-network (OON) share of professional services payments for all users of professional services as well as among only those users who had one or more out-of-network services. Average OON share of payments is calculated as the ratio of payments for OON services to total payments for all professional services. Payments include insurer reimbursements as well as patient out-of-pocket spending.

Across all users of professional services, the average proportion of total payments spent on OON services fell markedly, from 18.0 percent in 2010 to 7.5 percent in 2013. Among users with at least one OON service, the average OON share of total payments is higher, as expected. This proportion also declined but fell by a smaller proportion: from 40.8 percent in 2010 to 34.6 percent in 2013.

Exhibit 7. Average User Out-of-Network Share of Total Payments for Professional Services, Overall and Among Users of Out-of-Network Services, 2010 and 2013

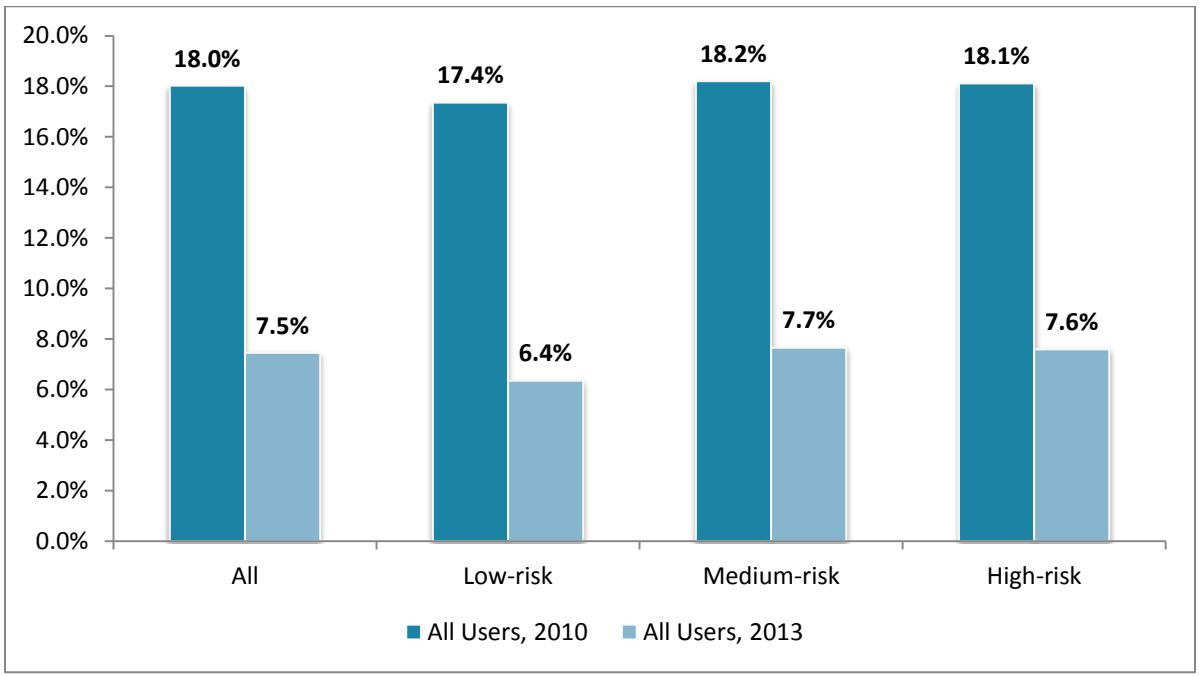


Notes: Limited to full-year enrollees with at least one professional services claim. Total payments for all services include payments made by payers as well as patients.
Source: Maryland Medical Care Database, 2010 and 2013

Exhibit 8 shows the average proportion of total payments spent on OON services by patient risk category. The OON share for all users was similar across risk categories and declined from 2010 to 2013 within each risk category by a similar amount. A similar pattern was seen among users who had at least one OON service (Appendix Table 2).

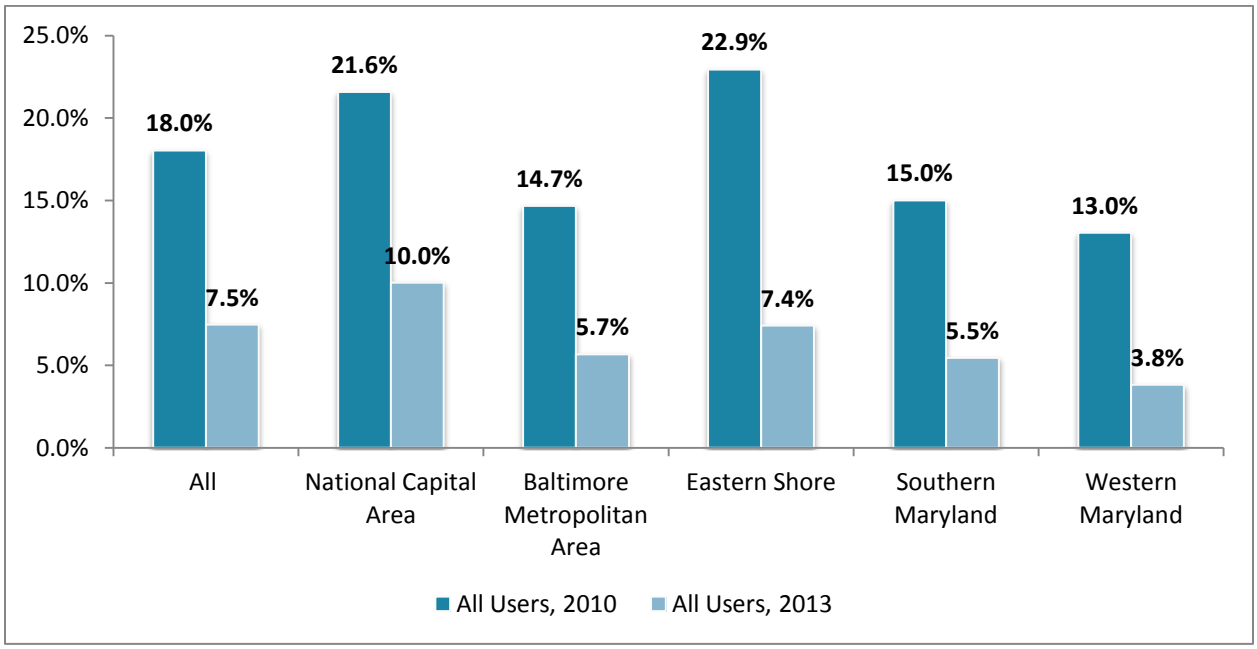
In Exhibit 9, we present the average OON share of total payments for users by patient region of residence. This share varied by patient region of residence for all users and declined from 2010 to 2013 within each region. In 2010, the OON share was lowest in Western Maryland (13%) and highest in the Eastern Shore (22.9%); with the largest decline by 2013 in the Eastern Shore and the smallest drop in the National Capital Area. In 2013, Western Maryland still has the lowest OON share (3.8%) while the highest OON share was in the National Capital Area (10%). A similar pattern was seen among users who had at least one OON service (Appendix Table 3).

Exhibit 8. Average User Out-of-Network Share of Total Payments for Professional Services, Overall and by Expenditure Risk Category, 2010 and 2013



Notes: Limited to full-year enrollees with at least one professional services claim. Total payments for all services include payments made by payers as well as patients.
Source: Maryland Medical Care Database, 2010 and 2013

Exhibit 9. Average User Out-of-Network Share of Professional Service Payments Overall and by Region of Residence, 2010 and 2013



Notes: Limited to full-year enrollees with at least one professional services claim. Total payments for all services include payments made by payers as well as by patients.
Source: Maryland Medical Care Database, 2010 and 2013

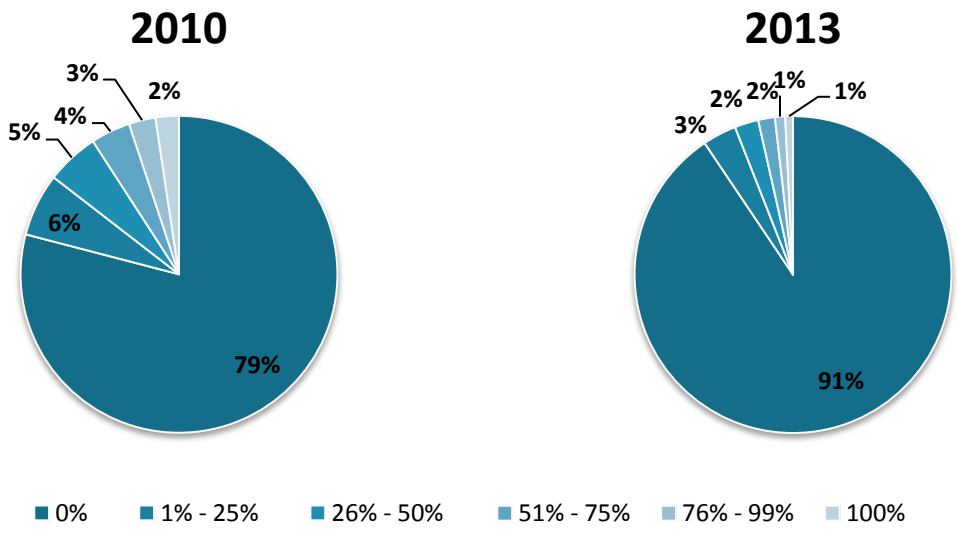
Variation in the Extent of Out-of-Network Spending

- **The percentage of users with more than half of all payments going toward OON services declined from 9 percent to 4 percent.**

Exhibit 10 shows the distribution of professional service users grouped according to the patient's OON share of total payments for professional services. There are six categories of OON share of payments, ranging from no OON payments to 100 percent of total professional payments allocated to OON services.

The vast majority (79%) of professional service users enrolled in private insurance plans throughout 2010 had no out-of-network payments; this proportion increased to 91 percent in 2013. Users with some OON payments accounted for 21 percent of all users in 2010 and only 9 percent in 2013. The percentage of users with more than half of all payments going toward OON services declined from 9 percent to 4 percent. Those with 100 percent of OON services fell from 2 percent to 1 percent.

Exhibit 10. Distribution of Users by Level of Out-of-Network Share of Professional Service Payments, 2010 and 2013



Notes: Limited to full-year enrollees with at least one professional services claim. Total payments for all services include payments made by payers as well as by patients. Percentages in 2010 do not add to 100% due to rounding.
Source: Maryland Medical Care Database, 2010 and 2013

Payer Perspective

The payer analysis examines the impact of the AOB legislation on private payers and how their payment liability has changed as a result of the legislation. We examined the impact on service networks as well as financial measures by service category and site of care. Service categories were defined using

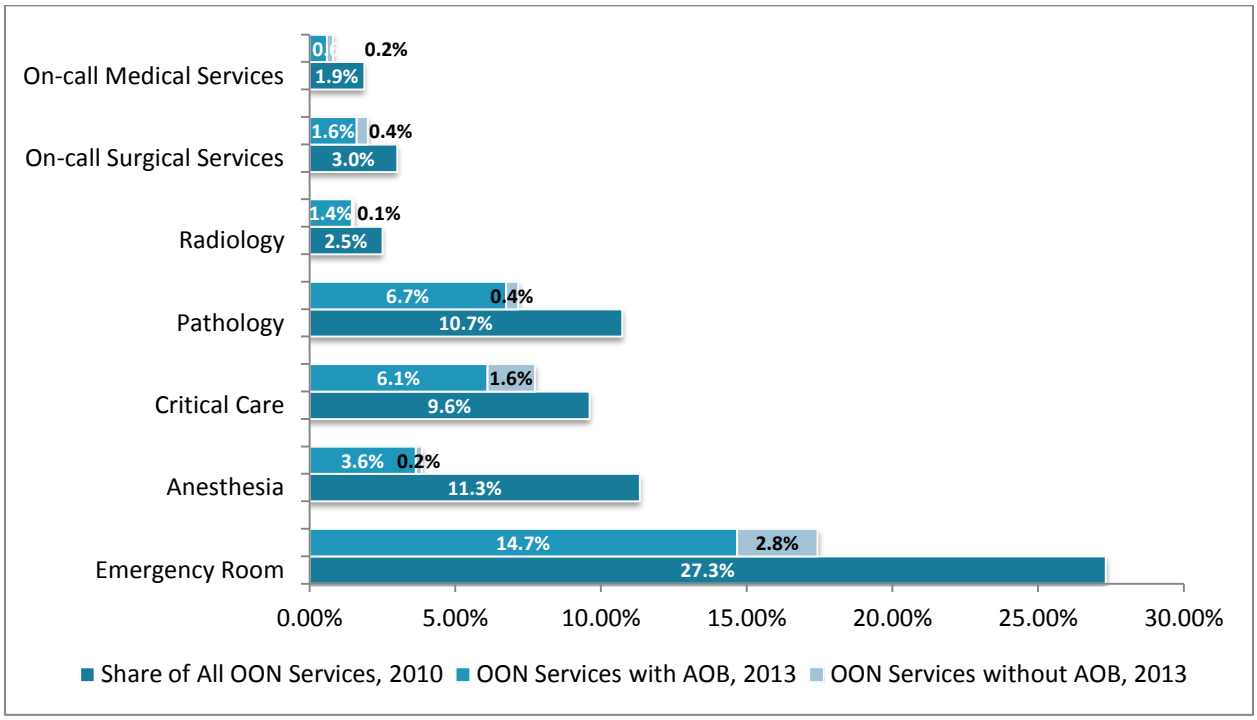
Berenson-Eggers Type of Service (BETOS) codes.[3] Site of care was categorized as hospital and non-hospital based services. Hospital-based services include emergency room, anesthesia, critical care, pathology, radiology, surgical specialists, and medical specialists. Non-hospital based services include anesthesia, pathology, radiology, surgical specialists, medical specialists, and primary care.

Out-of-Network Share of Services by Type of Service and Site of Care

- **The OON share of all hospital- and non-hospital based services declined from 2010 to 2013, with substantial variation by type of service in the hospital setting.**

Among hospital-based services, the OON share of services declined from 2010 to 2013 across all service categories (see Exhibit 11). The decline in OON share of services varied by type of service, from a 19 percent decline for critical care services to a 65 percent drop for anesthesia services. In 2013, the AOB share of hospital-based OON services varied by type of service, from 70 percent for on-call medical services to 93 percent for radiology services. The OON share of services for non-hospital-based services also fell from 2010 to 2013 for each of the service types listed in Exhibit 11 (Appendix Table 4).

Exhibit 11: Out-of-Network Share of Hospital-Based Services by Type of Service, 2010 and 2013



Notes: Hospital-based services included hospital inpatient, outpatient, and emergency room.
Source: Maryland Medical Care Database, 2010 and 2013

[3] Berenson-Eggers Type of Service (BETOS) codes are assigned for each Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure code. They are used to classify Medicare claims according to type of service (such as evaluation & management, procedure, imaging, test, etc.).

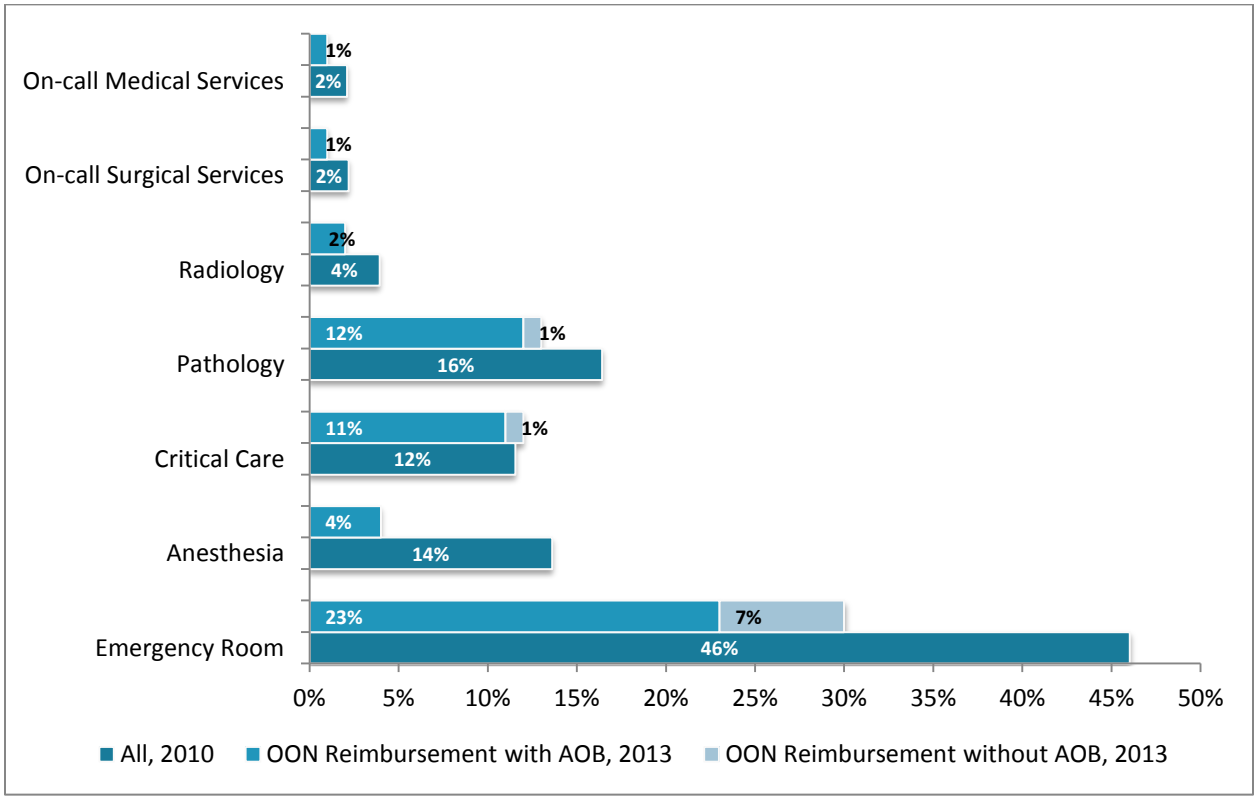
Out-of-Network Share of Insurer Reimbursement by Type of Service and Site of Care

- **The OON share of total insurer reimbursement for hospital and non-hospital services declined between 2010 and 2013. Changes varied by type of service and setting.**

Exhibit 12 shows the aggregate ratio of OON reimbursement to total reimbursement by service category for hospital-based services aggregated across all payers. From 2010 to 2013, there was a decline in the OON share of reimbursements for emergency room, anesthesia, radiology, and pathology services, but no change in the OON share of reimbursements for critical care services. While there was a decline in OON share for on-call medical services, there was no change in OON share for on-call surgical services.

Of all OON reimbursements for hospital-based services, the vast majority were AOB, ranging from 78 percent for on-call medical services and emergency room services to 94 percent for radiology. In general, the OON share for total reimbursements also declined among these services types in non-hospital settings (Appendix Table 5).

Exhibit 12: Aggregate Ratio of Out-of-Network Reimbursement to Total Reimbursement for Hospital-based Services, 2010 and 2013



Note: Site of care for hospital-based services included hospital inpatient, outpatient, and emergency room.
Source: Maryland Medical Care Database, 2010 and 2013

Payer Reimbursement Practices for Out-of-Network Services Covered by the AOB Legislation

- **Two of the five carriers surveyed about payment practices reported paying billed charges, which is higher than the rates they are required to pay under the law.**

To supplement the quantitative analysis for payers, we provide some more limited information gathered in November 2014 directly from the five largest commercial carriers operating in Maryland. These carriers were asked specifically about their reimbursement practices for services covered by the AOB legislation for hospital-based providers and for on-call providers prior to the passage of the legislation and now. Prior to the legislation, three carriers used comparable charges (within region), one used billed charges, and one used a combined approach. Currently, three carriers are reimbursing hospital-based providers using the 140% option (see page 1), and two are paying billed charges. With regard to on-call providers, two carriers are reimbursing providers using the 140% option, one is using the average rate option, and two are paying billed charges. Carriers currently paying billed charges are reimbursing providers more than is required by the law.

SUMMARY AND CONCLUSIONS

Enactment of the Assignment of Benefits and Reimbursement of Nonpreferred Providers (Chapter 537, 2010 Laws of Maryland) was a response to reports of exceptionally high out-of-pocket expenses by patients for care rendered in hospital settings by out-of-network providers. The purpose of the legislation was to eliminate the financial burden on patients by reducing reliance on balance billing, without reducing payments to out-of-network physicians.

This report provided the results of an analysis of the impact of the AOB legislation on the three different stakeholders that are affected by the law—providers, patients, and payers. For those physician groups affected by the legislation, the proportion of physicians participating in at least one private payer network showed no consistent pattern, with the participation rate increasing for some specialties, decreasing for some specialties, and staying unchanged for others. For these providers overall, the out-of-network share of total payments declined from 2010 to 2013. The vast majority of providers electing not to participate chose assignment of benefits and there was a related decline in balance billing as a share of out-of-network payments.

Patients experienced an overall decline in financial burden, with the proportion of patients with at least one out-of-network service declining over the period. The percentage of users with more than half of all payments going toward OON services also declined and, among those patients with at least some OON service use, the overall out-of-pocket share of total spending fell.

From the overall payer perspective, the out-of-network share of total services and of total payments declined between 2010 and 2013, with variation by type of service and site of care. For 2013, the vast majority of hospital-based OON payments were AOB across all specialty/site of service categories. While network participation showed no evidence of decline overall, effects varied by payer with networks expanding for some and contracting for others. Several of the large payers indicated concerns over paying higher rates to OON providers who elected AOB; however, carriers paying billed charges, are paying more than required by the law.

The analysis indicates that, overall, the legislation achieved its purpose. This report provides evidence that the financial burden on patients from out-of-network service use was lessened between 2010 and 2013. Assignment of benefits was chosen by the majority of providers who elected not to participate in private payer networks and that income uncertainty for those providers affected by the legislation was likely reduced due to less reliance on balance billing for payments. Moreover, while impacts varied by payer, we found no evidence that provider participation rates in commercial networks systematically declined between 2010 and 2013.