

Department of Fiscal Services
Maryland General Assembly

FISCAL NOTE
Revised

Senate Bill 465 (Senator Teitelbaum)
Finance

Referred to Economic Matters

Health Insurance - Reimbursement of Service Providers

This amended bill requires a health insurer, nonprofit health service plan, or health maintenance organization (carrier) to permit a provider at least six months from the date a covered service is rendered to submit a claim for the service.

If additional documentation is required by the carrier to adjudicate a claim, the carrier must reimburse the provider within 30 days after receipt of all reasonable and necessary documentation. The carrier must pay interest on claims not reimbursed within the specified payment time period.

Fiscal Summary

State Effect: General fund revenues and expenditures could increase by an indeterminate minimal amount in FY 1998.

Local Effect: Expenditures for local jurisdiction employee health benefits could increase by an indeterminate minimal amount. Revenues would not be affected.

Small Business Effect: Potential minimal effect on small businesses as discussed below.

Fiscal Analysis

State Revenues: Under this bill, health providers may have more time to submit claims information to health carriers. As a result, it is possible that some claims would be reimbursed where they previously would not have been because of untimely filing. This could increase medical care costs to carriers. Moreover, administrative costs could increase due to interest payments and if carriers have to establish a process for tracking claims. These carriers may raise premiums, meaning that general fund revenues could increase by an indeterminate minimal amount as a result of the State's 2% insurance premium tax. The State's premium tax is only applicable to "for-profit" insurance carriers.

In addition, general fund revenues could increase by an indeterminate minimal amount in fiscal 1998 since the bill's requirements could subject insurance companies to rate and form filings. Each insurer (except HMOs) that revises its rates and amends its insurance policy must submit the proposed change(s) to the Insurance Administration and pay a \$100 rate and form filing fee. The number of insurers who will file new forms and rates as a result of the bill's requirements cannot be reliably estimated at this time, since rate and form filings often combine several rate and policy amendments at one time.

State Expenditures: The State employee health benefit plan is self-insured for Preferred Provider Option plans (PPO) and Point of Service (POS) out-of-network services and pays an administrative fee to a third-party administrator (TPA); and is insured for health maintenance organization (HMO) plans and POS in-network services. Under this bill, administrative and medical care costs to the State employee health benefit plan could increase for the reasons discussed above. The extent of any increase in costs, however, is expected to be negligible.

This bill could indirectly affect the Medicaid program through the HMOs with which Medicaid contracts. HMOs may incur additional administrative and medical care costs due to this bill. In the long term, the bill could increase expenditures if HMOs with which Medicaid contracts persuade the State to increase the reimbursement rates to HMOs to accommodate the increase in costs as a result of the bill. The increase, however, is expected to be negligible.

Local Expenditures: Expenditures for local jurisdiction employee health benefits could increase by an indeterminate amount, depending upon the current type of health care coverage offered and number of enrollees.

Small Business Effect: This bill would benefit small business health providers by offering them more time to submit claims information to a health carrier. It is possible that some claims may now be reimbursed where they previously would not have been because of untimely filing. In addition, health care providers would be entitled, under the bill, to interest payments on any claim unpaid after 30 days in those cases where the carrier required additional documentation to adjudicate the claim. The 30-day time period would begin from the day the carrier received all reasonable and necessary documentation.

Information Source(s): Insurance Administration; Department of Budget and Management; Department of Health and Mental Hygiene (Medical Care Policy Administration, Health Care Access and Cost Commission); Department of Fiscal Services

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