SB 107

Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 107 (The President, *et al.*) (By Request – Administration)
Finance Health and Government Operations

Task Force on Health Care Access and Reimbursement

This Administration bill establishes a Task Force on Health Care Access and Reimbursement staffed by the Department of Health and Mental Hygiene (DHMH). A report of findings and recommendations is due by December 31, 2007. If the task force does not complete its work by this date, an interim report is required by December 1, 2007 and a final report by June 30, 2008. A report on the need to prohibit health insurance carriers from requiring providers to serve on certain provider panels must be submitted by December 1, 2007.

The bill takes effect July 1, 2007 and terminates June 30, 2008.

Fiscal Summary

State Effect: The bill's requirements could be handled with existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The task force must examine:

- reimbursement rates and total payments to health care providers by specialty and geographic area and trends in such reimbursement rates and total payments;

- the impact of changes in reimbursement on access to health care, health care disparities, volume of services, and quality of care;
- the effect of competition on payments to health care providers;
- trends for health care provider shortages by specialty and geographic area and any impact on access and quality cause by such shortages;
- the amount of uncompensated care being provided by health care providers and trends in uncompensated care;
- the extent to which current reimbursement methods recognize and reward higher quality of care;
- methods used by large purchasers of health care to evaluate adequacy and cost of provider networks; and
- the practice by certain carriers of requiring providers who join a provider network of a carrier to also serve on a provider network of a different carrier and the effect of this practice.

The task force must develop recommendations regarding: (1) specific options available to change physician and other health care provider reimbursements, if needed; (2) the sufficiency of present statutory formulas for the reimbursement of noncontracting physicians and other health care providers by health maintenance organizations; (3) whether the Maryland Insurance Administration and the Attorney General have sufficient authority to regulate rate setting and market-related practices of health insurance carriers; (4) whether there is a need to enhance the ability of physicians and other health care providers to negotiate reimbursement rates with health insurance carriers; (5) whether there is a need to establish a rate-setting system for health care providers; (6) the advisability of the use of payment methods linked to quality of care or outcomes; and (7) the need to prohibit carriers from requiring health care providers who join a provider network of the carrier to also serve on a provider network of a different carrier.

A task force member may not receive compensation but is entitled to reimbursement for expenses under the standard State travel regulations.

Current Law: The Maryland Health Care Provider Rate Stabilization Fund, financed by a 2% premium tax on managed care organizations (MCOs) and health maintenance organizations (HMOs), dedicates an increasing proportion of revenues each year to higher Medicaid provider reimbursement rates.

In fiscal 2006, $15.0 million was used to increase rates for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency

medicine physicians. In fiscal 2007, $25.2 million was targeted to anesthesia, general surgery, radiation oncology, gastroenterology, otorhinolaryngology, dermatology, and allergen immunology – specialties with particularly low fees. Fees in these areas have been raised to 80% to 100% of Medicare levels (a common benchmark for both private payers and Medicaid). Additional funds will be allocated in fiscal 2008, 2009, and 2010 with the goal of attaining parity with Medicare fees.

Background:

Provider Reimbursement in Maryland: According to the Maryland Health Care Commission (MHCC), in 2004 fees for physician services paid by HMOs averaged about 3.0% below the Medicare level, while fees paid by non-HMO plans were about 2.6% above the Medicare level. Although services provided in a hospital setting commanded rates exceeding Medicare, services provided in an office-based setting, accounting for 70% of all practitioner payments, were paid at below-Medicare rates.

In May 2006, the Maryland Medical Society requested the Attorney General to investigate whether monopolistic pricing practices exist in the Maryland health insurance market, citing that the market is dominated by two insurers and that reimbursement ranks in the bottom twenty-fifth percentile for all states for commercial reimbursement of physicians.

Pay-for-performance Activities: CareFirst has provided financial support for the Bridges to Excellence program, with a goal of reducing waste and inefficiency in the provision of health care, reengineering processes to reduce mistakes, and increasing accountability and quality by providing comparative provider performance data to consumers. UnitedHealthcare is implementing its Premium Designation Program, designating with one or two stars in its provider directory those physicians who reach quality and efficiency standards. Under the Maryland HealthChoice program, Medicaid MCOs receive monetary rewards and penalties for performance on specified quality measures such as timely immunizations of children.

Past Studies of Physician Uncompensated and Under-compensated Care: Chapter 250 of 2002 required MHCC and the Health Services Cost Review Commission (HSCRC) to study the reimbursement of health care providers, including the feasibility of an uncompensated care fund for hospital physicians. A report was issued in January 2004. The report noted that for health care providers the cumulative impact of declining real payments and increasing operational costs, particularly malpractice expenses, could pose serious consequences for the availability of services and patient access to care. The report concluded that an expansion of commercial insurance coverage coupled with

increased levels of public funding for Medicaid and Medicare would ease the need for providers to count on a cross-subsidy from private insurance.

Chapter 280 of 2005 required MHCC and HSCRC to conduct a study of uncompensated charity and under-compensated care for physicians who provide at least 25% of care in hospital settings and recommend options for financing this care. The study, released in February 2006, estimated that Maryland physicians provided about $115 million in uncompensated care in 2004 and provided $305 million in Medicaid services at or below costs. The study projected the cost of funding physician uncompensated charity care and under-compensated Medicaid care at between $67.9 million (increasing rates to 50% of Medicare) and $181.1 million (increasing rates to 100% of Medicare).

Additional Information

Prior Introductions: None.

Cross File: HB 138 (The Speaker, *et al.*) (By Request – Administration) – Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene, *Uncompensated Charity and Under-Compensated Care Provided in Maryland: What We Know and Estimates of the Cost of Subsidizing This Care*, Maryland Health Care Commission and Health Services Cost Review Commission (February 2006), *Study of Reimbursement of Health Care Providers*, Maryland Health Care Commission (January 2004); Maryland Insurance Administration; Department of Legislative Services.

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