HB 1505

Department of Legislative Services

Maryland General Assembly
2008 Session

FISCAL AND POLICY NOTE

House Bill 1505 (Delegate Oaks, *et al.*)
Health and Government Operations

Health Insurance - Reimbursement for Preauthorized or Approved Health Care Services

This bill • requires a carrier to establish a mechanism for a health care provider to submit to the carrier the provider's fee for a proposed health care service; • requires a carrier or a carrier's private review agent to notify a provider or patient about the amount of reimbursement the carrier will pay for a preauthorized or approved health care service at the time of preauthorization or approval; and • prohibits a carrier from altering the amount of reimbursement to a provider for a preauthorized or approved health care service except under specified circumstances.

Fiscal Summary

State Effect: To the extent payments for medical claims increase under the bill, expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State plan) could increase beginning in FY 2009. To the extent the Maryland Insurance Administration receives additional complaints from providers, MIA special fund expenditures could increase beginning in FY 2009. No effect on revenues.

Local Effect: To the extent payments for medical claims increase under the bill, health care expenditures for local jurisdictions could increase.

Small Business Effect: Health care providers could receive additional reimbursement for preauthorized or approved services under the bill.

Analysis

Current Law: Carrier means an insurer, nonprofit health service plan, HMO, dental plan organization, or any other person that provides regulated health benefit plans. The section of law amended by the bill does not apply to Medicaid managed care organizations.

If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny reimbursement for the service unless • the information submitted to the carrier was fraudulent or intentionally misrepresentative; • critical information requested by the carrier was omitted such that the carrier's determination would have been different; • an approved planned course of treatment for the patient was not substantially followed by the provider; or • on the date the preauthorized or approved service was delivered the patient was not covered by the carrier. A carrier has to pay a claim for a preauthorized or approved covered health care service in accordance with clean claims and retroactive denial of claims requirements.

Background: Currently, a carrier and its private review agent review only the medical necessity of a proposed service and not the potential payment for that service. The amount of reimbursement for preauthorized or approved services is subject to change based on claims and medical records review.

State Expenditures: State plan expenditures (60% general funds, 20% federal funds, and 20% special funds) could increase beginning in fiscal 2009 to the extent medical claims costs increase under the bill. This amount cannot be reliably estimated but could be significant.

MIA special fund expenditures could increase beginning in fiscal 2009 to the extent additional complaints are received from providers. This amount cannot be reliably estimated but is not expected to be significant.

Additional Comments: MIA indicates that the bill could be costly to implement for carriers as it would significantly alter the current preauthorization and preapproval process for health care services.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Budget and Management, Department of Legislative Services

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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510