Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE

House Bill 116 (Delegate Benson)
Economic Matters

Health Care Provider Panels - Criteria and Procedures

This bill requires that a health care carrier (including an insurer, nonprofit health service plan, health maintenance organization, preferred provider organization, dental plan, or third party administrator) must provide health care services to enrollees in accordance with the preferred provider organization law governing payments to providers. The preferred provider law requires that carriers reimburse non-network providers at a rate of at least 80% of the level of in-network providers.

A carrier that makes use of a provider panel (group of providers under contract with a carrier) must: (1) establish reasonable criteria for membership on the carrier's provider panel; (2) establish and follow reasonable procedures for review of applications for membership on the provider panel; (3) make the criteria available to the public on request; and (4) supply a provider requesting an application for membership on the carrier's panel with the membership criteria and review procedures. A carrier is authorized to charge a reasonable fee for provider applications.

Fiscal Summary

State Effect: Expenditures could increase by $10.1 million in FY 1997, with the possibility of additional indeterminate but significant expenditure growth in Medicaid. Future year expenditures increase with annualization, inflation, and utilization. Revenues could increase by an indeterminate but significant amount.

($ in millions)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
GF Revenues	----	----	----	----	----
GF Expenditures*	$10.1	$14.8	$16.2	$17.9	$19.7
Net Effect*	($10.1)	($14.8)	($16.2)	($17.9)	($19.7)

Note: ( ) - decrease; GF - general funds; FF - federal funds; SF - special funds
**Assumes a mix of 60% GF, 20% SF and 20% FF.*

Local Effect: Expenditures could increase by an indeterminate but significant amount in FY 1997. Revenues would not be affected.

Fiscal Analysis

Bill Summary: The Insurance Administration and the Department of Health and Mental Hygiene must jointly develop regulations regarding: (1) the filing of membership criteria with the State and review by the public of the criteria; and (2) maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

The bill prohibits a carrier from terminating a provider without just cause and specifies procedures that a carrier must follow in notifying providers of termination.

A carrier may not limit a provider panel exclusively to physicians. A carrier must give priority when formulating a provider panel to providers who have provided services in the community for at least five years and to making the panel as ethnically representative of the community as possible.

This bill does not prohibit a carrier from requiring preauthorization or utilization review or establishing reasonable professional qualifications applicable to all providers of the same type, profession, and specialty.

State Revenues: General fund revenues could increase by an indeterminate but significant amount in fiscal 1997 as a result of the State's 2% insurance premium tax on increased health insurance premiums (for State employees and individuals not employed by the State). The State's premium tax is only applicable to "for-profit" insurance carriers. For illustrative purposes, general fund insurance tax revenues could increase by $2 million for every $100 million increase realized in premiums.

State Expenditures: General, special, and federal fund expenditures for State employee health benefit premiums could increase by $10.1 million in fiscal 1997 (or $13.4 million on an annualized basis). This estimate assumes: (1) an October 1, 1996 effective date; (2) an increase of 10% in HMO and POS premiums due to restrictions on managed care organizations' ability to manage care; and (3) a 10% increase in future year costs, reflecting a 5.5% increase in medical inflation and 4.5% increase in utilization. There may be cost savings to the State as a result of migration from the most expensive PPO plans to the less expensive HMO and POS plans, since State employees would have greater freedom of choice in physician selection at a lower cost than the PPO plan. It is not possible at this time to

accurately predict the extent of migration.

The bill affects a managed care organizations' (MCO) ability to manage care because it opens up the provider network, which means that MCOs are less able to ensure that the care received by patients is cost effective. In addition, MCOs are less able to negotiate discounts with providers because they can ensure a certain patient volume for their providers.

There is no direct impact to the Medical Assistance Program because the bill's requirements directly affect health insurers and not the program. However, the bill could indirectly affect Medicaid expenditures in the long-term if Medicaid rates set for MCOs increase due to higher costs incurred by MCOs. Currently 25% of Medicaid recipients are enrolled in managed health care plans. Under the Department of Health and Mental Hygiene's Medicaid reform proposal, most Medicaid recipients will be enrolled in managed care. It is not possible at this time to reliably estimate the magnitude of increase in Medicaid program expenditures resulting from the bill's requirements, although it could be significant.

There are two other indirect effects possible as a result of the bill: (1) if insurance premiums increase for HMO and POS plans and, as a result, some businesses are priced out of the market, the number of uninsured persons in Maryland could increase, thereby driving up uncompensated care and Medical Assistance Program costs; and (2) encouragement of the proliferation of health care specialists at a time when State policy seeks to increase the number of primary care providers, since enrollees in HMOs are more likely to go outside the network for specialists than for primary care providers.

General fund expenditures in the Insurance Administration could increase by an estimated $34,382 in fiscal 1997, which reflects the bill's October 1, 1996 effective date. This estimate reflects the cost of hiring a Technician position to review additional HMO contracts. Under the bill's requirements, HMOs would not be able to offer contracts which limit care to HMO providers. As a result, all HMOs would be required to refile their contracts with the Insurance Administration for re-approval. It includes salaries of $20,528, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$27,868
Office Equipment	5,215
Other Operating Expenses	1,299
FY 1997 State Administrative Expenditures	**$34,382**

Future year expenditures reflect (1) full salaries with 3.5% annual increases and 3% employee turnover; and (2) 2% annual increases in ongoing operating expenses.

Local Expenditures: Expenditures for local jurisdiction employee health benefits could increase by an indeterminate but significant amount, depending on the extent to which enrollees are in managed care health plans.

Information Source(s): Insurance Administration, Department of Fiscal Services, Department of Budget and Fiscal Planning, Health Care Access and Cost Commission, "Fifty State Profiles: Health Care Reform 1995" (Intergovernmental Health Policy Project at the George Washington University)

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