Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE
Revised

House Bill 5 (Delegate Taylor, *et al.*)
Economic Matters

Health Maintenance Organizations - Responsibility for and Regulation of Downstream Risk

This bill authorizes the Insurance Commissioner to regulate downstream risk assumption contracts between HMOs and contracting providers. The bill's requirements also apply to Medicaid managed care organizations (MCOs).

The bill takes effect June 1, 2000 and applies to all administrative service provider contracts entered into on or after June 1, 2000. An administrative service provider contract in effect before June 1, 2000 must comply with the bill's requirements by January 1, 2001.

Fiscal Summary

State Effect: Special fund expenditures increase by $161,400 for the Maryland Insurance Administration (MIA) in FY 2001. Future year estimates reflect annualization and inflation. Special fund revenues increase by $363,900 in FY 2001 as a result of the registration fees. Future year estimates reflect biennial registration renewal and assume that registration fees will be adjusted to generate revenue that closely matches projected expenditures. Potential minimal expenditure increase for the State Employee Health Benefits Plan. Minimal general fund revenue increase as a result of the penalty provisions. No effect on Medicaid.

(in dollars)	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
GF Revenues	-	-	-	-	-
SF Revenues	$363,900	0	$434,300	0	$479,600
SF Expenditures	$161,400	$202,500	$212,100	$222,200	$232,800
Net Effect	$202,500	($202,500)	$222,200	($222,200)	$246,800

Note: ( ) = decrease; GF = general funds; FF = federal funds; SF = special funds; - =indeterminate effect

Local Effect: Expenditures for local jurisdiction employee health benefits could increase if carriers increase their premiums as a result of the bill's requirements. Revenues would not be affected.

Small Business Effect: Potential minimal.

Analysis

Background: The Insurance Commissioner, the Health Services Cost Review Commission, and the Health Care Access and Cost Commission (now the Maryland Health Care Commission) studied the issue of downstream risk arrangements between licensed carriers and subcontracting provider entities. The Insurance Administration submitted a report on this issue in January 2000. This bill incorporates several of the report's recommendations, including direct regulation and licensure of health services contractors and strengthening current law as it relates to administrative service provider contracts.

This bill attempts to reduce or eliminate unpaid claims to providers as a result of downstream risk. Many HMOs contract with other provider organizations to provide benefits to the HMO's members. HMOs pay capitated fees to these provider organizations, who then manage a member's health care. In effect, the HMO has shifted its financial risk for the member to the provider organization. Provider organizations, in turn, often contract with other specialists or carve-out plans for such things as mental health care. If a provider organization becomes insolvent and cannot pay its external providers, claims often go unpaid. Even though a provider organization may assume administrative and financial risk for an HMO's members, it is not subject to insurance laws and is not effectively regulated.

Bill Summary: This bill authorizes the Commissioner to register contracting providers. The bill requires the Commissioner to adopt by regulation the procedure and fees associated with registration. Registration is on a biennial basis.

The bill prohibits an HMO or MCO (carrier) from entering into an administrative service provider contract with an entity unless the entity is a registered contracting provider. An administrative service provider contract is any contract or capitation agreement between a carrier and a contracting provider which includes requirements that: (1) the contracting provider accept payments from a carrier for health care services rendered to the carrier's enrollees that the contracting provider arranges to be provided by external providers; and (2) the contracting provider administer payments pursuant to the contract with the carrier for the health care services to the external providers. The bill's requirements do not apply to a contract between a carrier and a contracting provider that is affiliated with the carrier through common ownership if the carrier files consolidated financial statements with the Commissioner and records a reserve for the contracting provider's liabilities.

A carrier that enters into an administrative service provider contract with a contracting

provider must establish and maintain a segregated fund in a form and amount approved by the Commissioner. This fund cannot be considered an asset of a contracting provider for the purpose of determining the assets of a contracting provider. If a contracting provider fails to comply with the administrative service provider contract or if the contract is terminated, the carrier must notify the Insurance Commissioner and must assume the administration of any payments due from the contracting provider to external providers.

The bill also establishes certain financial reporting requirements that a carrier must submit to the Insurance Commissioner. A carrier must review the contracting provider's books, records, and operations at least quarterly. The carrier must submit the quarterly reviews to the Commissioner. The carrier must also file a copy of the administrative service provider contract as well as other documentation with the Commissioner. In addition, the contracting provider must submit monthly reports to the carrier on the status of the payments made and owed to external providers and the compliance by the contracting provider with State law regarding the prompt payment of claims.

If a person violates any administrative service contract provisions, the Commissioner may impose a penalty of not more than $125,000 for each violation. In addition, the Commissioner may order a carrier to pay restitution to any person who has suffered financial injury because of a violation.

The Insurance Commissioner, after reviewing the information obtained from registered contracting providers, must submit a report to the Governor and the General Assembly with recommendations as to whether, and to what extent, contracting providers should be subject to additional regulation for the protection of health care providers and consumers. The report must include recommendations relating to licensing standards, solvency requirements, and the application of State receivership laws. The report must be submitted on or before January 1, 2002.

Current Law: Title 19 of the Health - General Article requires HMOs that enter into administrative service provider contracts with contracting providers to file a plan with the Insurance Commissioner, subject to the Commissioner's approval. The contracting provider must also establish a segregated fund sufficient to pay external contractors for services rendered to the HMO's members. If a contracting provider fails to comply with the plan's requirements or if the administrative service contract is terminated, the HMO must assume the administration of any payments due from the provider to external providers. An HMO is subject to a fine of not more than $5,000 for each violation of these requirements. MCOs are not required to file an administrative service contract plan with the Insurance Commissioner.

State Revenues: Special fund revenues from registration fees must be sufficient to cover the costs of the registration program and any other costs associated with the bill's requirements. It is unknown at this time how many contracting providers will apply for registration. Current MIA licensure fees range from $1,000 - $11,000 and are often tied to premium revenue amounts. MIA will set the registration fee to meet expenditures. It is assumed that registration fees will generate $363,900 in special fund revenues for fiscal 2001 to cover associated expenditures for fiscal 2001 and 2002. Future year estimates reflect biennial registration renewals and assume that MIA will adjust registration fees to closely match projected expenditures. Any general fund revenues that result from the penalty provisions are expected to be minimal.

State Expenditures:

Maryland Insurance Administration:

MIA special fund expenditures could increase by an estimated $161,436 for fiscal 2001, which accounts for a 90-day start-up delay. This estimate reflects the cost of four positions to monitor carrier compliance to administrative service provider contract requirements, analyze the quarterly and annual reports, process registrations of contracting providers, review the administrative service provider contracts, and conduct market conduct examinations to ensure that contracting providers are registered and the carriers are operating in accordance with the bill's requirements. These positions include two MIA technician IIIs, one MIA technician I, and one MIA technician IV. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$148,761
Operating Expenses	12,675
Total FY 2001 Expenditures	**$161,436**

Future year expenditures reflect: (1) full salaries with 4.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

State Employee Health Benefits Plan:

To the extent carriers increase their premiums as a result of the bill's requirements, expenditures for the State Employee Health Benefits Plan may increase. Any increase is expected to be minimal.

Medicaid:

Medicaid MCOs are subject to the bill's requirements; however, these administrative costs are born by the MCOs and have no fiscal impact on the Medicaid program.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): "Report on Downstream Risk," January 2000, Maryland Insurance Administration; Department of Health and Mental Hygiene (Boards and Commissions); "Regulation of Downstream and Direct Risk Contracting by Health Care Providers," American Journal of Law & Medicine; CareFirst Blue Cross Blue Shield; Department of Legislative Services

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