HB 951

Department of Legislative Services

Maryland General Assembly
2001 Session

FISCAL NOTE

House Bill 951 (Delegate Pendergrass, *et al.*)
Economic Matters

Health Insurance - Requirements for Provider Panels

This bill requires a primary care provider (PCP) who refers an enrollee to a specialist to indicate on the referral form the maximum acceptable waiting period for a referral visit. Each insurer, nonprofit health service plan, or HMO (carrier) must ensure that its provider panel has sufficient providers to allow an enrollee to be seen by a specialist in the time set by the PCP. If an enrollee cannot see a specialist in the time specified, the enrollee must be allowed to see an out-of-network provider and the carrier must pay any additional costs incurred.

Fiscal Summary

State Effect: Potential minimal increase in State Employee Health Benefits Plan expenditures as a result of the bill's requirement relating to non-contracting providers. Potential minimal general fund revenue increase from the State's 2% insurance premium tax on for-profit carriers.

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

Small Business Effect: Potential minimal. Small business out-of-network specialists may receive more referrals from carriers that cannot accommodate their enrollees' specialist care needs with existing in-network providers. Expenditures for small business employee health benefits could increase if carriers raise their premiums as a result of the bill's requirements. Any increase is expected to be minimal.

Analysis

Current Law: There is no time limitation imposed on primary care provider referrals to specialists. An HMO that reimburses an out-of-network provider for services rendered to the HMO's enrollee must pay the greater of: (1) 125% of the rate the HMO pays in the same geographic region, for the same covered service, to a similarly licensed provider under written contract with the HMO; or (2) the rate as of January 1, 2000 that the HMO paid in the same geographic region, for the same covered service, to a similarly licensed provider not under written contract with the HMO.

State Fiscal Effect: State Employee Health Benefits Plan expenditures could increase to the extent that the bill's requirements erode a carrier's ability to control provider costs and the carrier passes the increased costs on to the State plan. Any increase is expected to be minimal.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): CareFirst BlueCross BlueShield of Maryland, Maryland Insurance Administration, Department of Legislative Services

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