HB 488

Department of Legislative Services

Maryland General Assembly
2001 Session

FISCAL NOTE

House Bill 488 (Delegate McHale)
Economic Matters

Health Insurance - Patient Rights - The No More Runaround Act of 2001

This bill provides that a health insurer, nonprofit health service plan, HMO, or dental plan organization (carrier) may not prohibit a health care provider on the carrier's provider panel from rendering, to an enrollee, a covered health care service that is within the provider's lawful scope of practice. In addition, the carrier cannot refuse to reimburse the health care provider for rendering, to an enrollee, a covered health care service that is within the provider's lawful scope of practice.

Fiscal Summary

State Effect: Potentially significant expenditure increase for the State Employee Health Benefits Plan. Any revised carrier-provider contracts filed with the Maryland Insurance Administration could be handled with existing budgeted resources. No effect on revenues.

Local Effect: Expenditures for local jurisdiction employee health benefits could increase if carriers increase their premiums as a result of the bill's requirements. No effect on revenues.

Small Business Effect: Potentially meaningful.

Analysis

Current Law: A carrier is not required to reimburse a health care provider on its provider panel for services rendered to an enrollee, unless the carrier and the provider have contracted to do so.

Background: An HMO or any type of traditional managed care organization contains costs by: (1) requiring enrollees to initially go to their primary care providers (PCPs) for diagnosis and referral (gatekeeper function); (2) preauthorizing certain services; (3) conducting utilization review; and (4) making determinations of medical necessity. In theory, an HMO manages health care services in this manner to provide comprehensive, yet cost-effective, health care to an enrollee. Enrollees may believe, however, that they cannot get the appropriate care from the provider that they want. Providers also may believe that they are prohibited from giving an enrollee the best course of treatment.

The bill's provisions allow an HMO enrollee to receive treatment from any provider on the HMO's provider panel, giving the enrollee much greater choice in choosing a physician. In addition, a provider on the HMO's provider panel may treat the enrollee in any way the provider sees fit without consulting with an enrollee's PCP or the HMO, and without fear of being denied payment from the HMO. These provisions, however, also effectively eliminate an HMO's ability to manage health care for its enrollees. An HMO would, in effect, become a preferred provider organization (PPO), which is a minimally-managed network of participating physicians. In addition, the bill's prohibition against denying any reimbursement to a provider for services rendered also erodes a carrier's ability to contain costs in minimally-managed networks like PPOs.

State Fiscal Effect: Expenditures for the State Employee Health Benefits Plan could increase significantly. The bill's requirements eliminate an HMO's ability to manage health care for its enrollees and would establish a minimally-managed network of participating providers, similar to a PPO. While there are insufficient data at this time to quantify the fiscal impact on the program, the premium rate difference between a PPO and an HMO is significant, and may be illustrative of the type of impact on the State plan. The total monthly PPO premium for a State employee (one individual) is $257. The total monthly HMO premium for a State employee is $189 (based on an average of the four available HMOs). Revenues would not be affected.

Additional Information

Prior Introductions: An identical bill, SB 485, was introduced in the 2000 session. It was reported unfavorably from the Senate Finance Committee.

Cross File: SB 269 (Senator Della) – Finance.

Information Source(s): Department of Health and Mental Hygiene (Boards and Commissions, Board of Physician Quality Assurance, Health Care Commission), Maryland Insurance Administration, Department of Budget and Management (Employee Benefits Division), CareFirst of Maryland, Department of Legislative Services

Fiscal Note History: First Reader – February 13, 2001
cm/jr

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 946-5510
(301) 970-5510