HB 1304

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE

House Bill 1304 (Delegate Busch)
Economic Matters

Health and Disability Insurance - Appeals and Grievance Process - Modifications

This bill amends the health insurance appeals and grievance process that a health insurer, nonprofit health service plan, or HMO (carrier) must provide to its members.

The bill takes effect July 1, 2002.

Fiscal Summary

State Effect: General fund expenditures for the Office of the Attorney General could increase by $72,600 in FY 2003. State Employee Health Benefits Plan expenditures could increase by a minimal amount. Minimal special fund revenue increase from the Maryland Insurance Administration's $125 rate and form filing fee. Future year expenditures reflect annualization and inflation.

(in dollars)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
SF Revenue	-	$0	$0	$0	$0
GF Expenditure	72,600	90,200	94,400	98,900	103,800
GF/SF/FF Exp.	-	-	-	-	-
Net Effect	($72,600)	($90,200)	($94,400)	($98,900)	($103,800)

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

Local Effect: Local jurisdiction health and disability benefit expenditures could increase by a minimal amount if carriers pass on additional administrative costs to local governments.

Small Business Effect: Potential minimal. Small business health and disability benefit expenditures could increase by a minimal amount if carriers pass on additional administrative costs to small businesses.

Analysis

Bill Summary: The bill expands the definition of "health benefit plan" to include disability insurance, thereby requiring carriers offering disability insurance to provide the same appeals and grievance process available for health insurance disputes to members who dispute coverage decisions made under their disability policies.

The bill specifies timeframes in an emergency case, non-emergency case, or retrospective denial in which a carrier may request additional information from the member or member's health care provider in order to make a determination about coverage. If the carrier requires additional information before rendering an adverse decision or coverage determination, the carrier must provide a description of any additional information required from the member or health care provider, and an explanation of why the information is necessary.

The bill modifies certain notification requirements, changing the number of days a carrier has to render adverse decisions or coverage determinations and notify members. A carrier's notice of a coverage determination must include a description of the carrier's appeal procedures and the applicable time limits.

The bill provides that a grievance decision cannot be made by a physician or other health care service reviewer who was consulted in connection with the adverse decision under review, or who is a subordinate of the physician or other health care service reviewer who made the adverse decision. The bill requires a carrier to provide, upon the request of the Insurance Commissioner, the names of the reviewing physicians or other health care service reviewers who made a particular adverse decision or grievance decision.

Current Law: The appeals and grievance process establishes various mechanisms for a member to appeal health benefit plan coverage and utilization review determinations made by a carrier or the carrier's private review agent (PRA). An "adverse decision" is a utilization review determination made by a carrier that a particular health care service proposed or rendered to a member is not medically necessary, and therefore not covered by the member's insurance policy or contract. A "coverage decision" is an initial determination made by a carrier that a member or a particular health care service is not covered by the member's insurance policy or contract. A member may appeal these determinations through a carrier's internal appeals process, and may further appeal the carrier's final determination, or "grievance decision," to the Insurance Commissioner.

The Health Care Advocacy Unit of the Office of the Attorney General may also assist members in the appeals process.

A carrier or PRA is required to render certain decisions and give proper notice to a member or the member's health care provider within established timeframes. In general, carriers have 30 working days for a grievance involving pending care and 45 working days for a grievance involving care that has already been rendered. A member may appeal the grievance decision to the Insurance Commissioner for an external review of the carrier's decision. In most cases, members must exhaust the carrier's internal grievance process prior to filing a complaint with the Commissioner. However, members may file a complaint with the Commissioner without exhausting the internal grievance process when there is a compelling reason not to go through the internal grievance process.

State Fiscal Effect:

Office of the Attorney General (OAG): OAG general fund expenditures could increase by an estimated $72,616 in fiscal 2003, which accounts for a 90-day start-up delay. The Health Care Advocacy Unit within OAG is responsible for assisting consumers with their appeals against carriers. Expanding the definition of health benefit plan to include disability benefits is expected to generate about 600 new cases annually. This estimate reflects the cost of hiring one administrative officer and one legal secretary to assist consumers with their appeals and grievances against disability insurance carriers. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$63,725
Operating Expenses	8,891
Total FY 2003 State Expenditures	**$72,616**

Future year expenditures reflect: (1) full salaries with 3.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses. Revenues would not be affected.

State Employee Health Benefits Plan: To the extent carriers' administrative costs increase due to the bill's provisions and carriers pass these increases on to the State plan, State plan expenditures could increase by a minimal amount. State plan expenditures assume a fund mix of 60% general funds, 20% federal funds, and 20% special funds; 20% of expenditures are reimbursable through employee contributions.

Additional Information

Prior Introductions: None.

Cross File: SB 842 (Senator Bromwell) – Finance.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Office of the Attorney General, Department of Budget and Management (Employee Benefits Division), Department of Legislative Services

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