HB 795

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE

House Bill 795 (Delegate Love, *et al*.)
Economic Matters

Health Insurance - Private Review Agents - Adverse Decisions

This bill increases the time period, from 24 to 72 hours after admission, during which a private review agent is prohibited from making an adverse decision for a patient admission.

Fiscal Summary

State Effect: Expenditures for the State Employee Health Benefits Plan may increase by a minimal amount. Minimal general fund revenues increase from the State's 2% insurance premium tax on for-profit carriers. Minimal special fund revenue increase for the Maryland Insurance Administration from the $125 rate and form filing fee.

Local Effect: Expenditures for local jurisdiction employee health benefits could increase if carriers increase their premiums as a result of this bill. Any increase is assumed to be minimal.

Small Business Effect: Potential minimal. Health insurance costs for small businesses may increase if carriers raise premiums as a result of this bill.

Analysis

Current Law: A private review agent cannot render an adverse decision as to a patient admission during the first 24 hours after admission when: (1) the admission is based on a determination that the patient is in imminent danger to self or others; (2) the determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and (3) the hospital immediately notifies the private review agent of the admission and the reasons for the admission.

An adverse decision is a utilization review determination made by a private review agent that a proposed or delivered health care service is or was not medically necessary, appropriate, or efficient, and may result in noncoverage of the health care service.

Background: Chapter 112 of 1998 requires a health insurer, nonprofit health service plan, or HMO (carrier) to establish an internal grievance procedure so that enrollees may address complaints regarding an adverse decision made by the carrier resulting from utilization review. The appeals and grievance process permits an enrollee to seek both internal and external review where care is denied on the grounds it is not "medically necessary." The Maryland Insurance Administration (MIA) may investigate and make a final determination on all complaints filed with the Insurance Commissioner about a carrier's adverse decision. Chapter 112 of 1998 also gave MIA regulatory authority over private review agents and established a new statutory process to certify medical directors of HMOs.

State Fiscal Effect: The bill limits the situations in which a carrier may deny payment to a health care provider, thus increasing carrier costs. To the extent that carrier expenditures increase for claims it could formerly deny, a carrier may pass the increased costs on to the State Employee Health Benefits Plan as increased premiums. Any increase is expected to be minimal. 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. Revenues would not be affected.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Budget and Management, Department of Legislative Services

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