HB 364

Department of Legislative Services

Maryland General Assembly
2003 Session

FISCAL AND POLICY NOTE

House Bill 364 (Delegate Rosenberg)
Health and Government Operations

Health Insurance - Noncontracting Providers - Reimbursement Rate Disclosure

This bill requires an HMO, nonprofit health service plan, or fraternal benefit society (carrier) to submit to the Insurance Commissioner a schedule of the actual dollar amount of each Current Procedural Terminology (CPT) code rate payment for any out-of-network services for each health care benefit plan offered by a carrier. The schedule must be submitted by December 31 annually.

The bill takes effect July 1, 2003.

Fiscal Summary

State Effect: Maryland Insurance Administration (MIA) special fund expenditures could increase by an estimated $216,000 in FY 2004. Future year estimates reflect annualization and inflation. No effect on revenues.

(in dollars)	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Revenues	$0	$0	$0	$0	$0
SF Expenditure	216,000	207,400	219,200	232,000	245,723`
Net Effect	($216,000)	($207,400)	($219,200)	($232,000)	$0

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The carrier must update the schedule information within 30 days after any CPT code rate payment change and submit the updated information to the

Commissioner. A carrier must also provide this information to: (1) each prospective enrollee; (2) each current enrollee; and (3) each provider who is not under contract with the carrier.

By February 1 of each year, the Commissioner must compile the required schedules and issue an annual report to the Governor and the General Assembly. Any carrier that is providing or has offered or provided enrollee coverage for any out-of-network services at any time up to one year prior to the enactment of this bill may not: (1) file an application for a proposed rate increase based on any cost resulting from compliance with the bill's requirements; or (2) alter the dollar amount of the CPT code rate payment for any offered out-of-network service coverage without prior approval of the Commissioner. The Commissioner may not approve an alternation in the CPT code dollar amount if the alternation is based on any cost to the carrier resulting from compliance with the bill's provisions.

Current Law: An HMO must disclose, upon request of a health care provider not under written contract with the HMO, the HMO's reimbursement rate required for trauma physicians. An HMO must pay a claim for a covered service rendered to an enrollee by a noncontracting trauma physician for trauma care at the greater of: (1) 140% of the rate paid by the Medicare program; or (2) the rate as of January 1, 2001 that the HMO paid in the same geographic area, for the same covered service, to a similarly licensed provider.

A health care provider may not balance bill an HMO enrollee for any portion of services provided that were not covered by the HMO. If an HMO determines an enrollee is responsible for a portion of the payment, the HMO may seek reimbursement from the enrollee.

Background: Carrier reimbursement to out-of-network health care providers has been at issue for several years. Prior to October 1, 2000, State law required HMOs to reimburse noncontracting providers at the rate billed or at the usual, customary, and reasonable (UCR) rate. Since there was no standard definition of what constituted UCR rates, Chapter 275 of 2000 changed the reimbursement methodology and required HMOs to reimburse noncontracting providers at the greater of: (1) 125% of the rate the HMO pays in the same geographic area for the same covered service to a similarly licensed provider under written contract; or (2) the rate as of January 1, 2000 that the HMO paid in the same geographic area, for the same covered service, to a similarly licensed provider not under written contract with the HMO. Chapter 423 of 2001 provided an exception to the reimbursement methodology adopted in Chapter 275 of 2000, requiring HMOs to reimburse trauma care providers at a higher rate.

The HMO reimbursement rate to out-of-network providers is at issue because State law does not permit health care providers to balance bill patients for the cost of services rendered that are covered by a carrier.

State Fiscal Effect: MIA special fund expenditures could increase by an estimated $215,979 in fiscal 2004, which accounts for a 90-day start-up delay. This estimate reflects the cost of hiring two MIA associate clerical positions and one MIA executive position to: (1) develop a form for carriers to use when submitting CPT code rate payment information; (2) compile the CPT code rate payment information and issue a report to the Governor and the General Assembly; and (3) review and approve or disapprove each request to alter the dollar amount of the CPT code rate payment for, or the CPT code procedures included in, any offered out-of-network service coverage. There are over 7,000 CPT codes for which carriers could be billed by health care providers. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$199,971
Operating Expenses	16,008
Total FY 2004 State Expenditures	**$215,979**

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.

Additional Information

Prior Introductions: None.

Cross File: None.

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

Fiscal Note History: First Reader - February 23, 2003
ncs/jr

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