Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE
Revised

House Bill 1082 (Delegate Hubbard)
Health and Government Operations Finance

Managed Care Organizations - Retroactive Denial of Claims and Applicability of State Laws

This bill provides that Medicaid managed care organizations (MCOs) are subject to restrictions on retroactive denial of claims and clarifies the applicability of State insurance laws on MCOs.

The bill takes effect July 1, 2007 and applies to claims paid by Medicaid MCOs on or after that date.

Fiscal Summary

State Effect: None. According to the Maryland Insurance Administration, the bill clarifies current law.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill provides that MCOs are not subject to the insurance laws of the State or to the provisions of Title 19 of the Health-General Article, with the exception of • appropriate risk-based capital standards; • payment of hospital rates with Medicaid prepaid capitation payments; • annual financial reporting and submission of business plans; • medical loss ratios; and • retroactive denial of claims.

The bill permits an MCO to retroactively deny a claim submitted for services provided to a Medicaid enrollee during a time period for which Medicaid has permanently retracted the capitation payment for the recipient from the MCO.

Current Law: Generally, carriers may only retroactively deny reimbursement for services provided within six months of payment to a health care provider. Retroactive denial may occur within 18 months of payment for services subject to coordination of benefits with another carrier, Medicaid, or Medicare. Carriers are otherwise prohibited from retroactively denying reimbursement, with the exception of cases in which the information submitted to the carrier was fraudulent, improperly coded, or duplicative.

Carriers that retroactively deny reimbursement must provide the health care provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial results from coordination of benefits, the written statement must provide the name and address of the entity acknowledging responsibility for payment of the denied claim. If a carrier retroactively denies reimbursement for services as a result of coordination of benefits, the health care provider has at least six months from the date of denial to submit a claim for reimbursement for the service to the carrier, Medicaid, or Medicare.

The Insurance Commissioner must adopt regulations that apply appropriate risk based capital standards to MCOs. Each MCO authorized to receive Medicaid prepaid capitation payments must pay hospitals for hospital services at the rates approved by the Health Services Cost Review Commission.

By March 1 of each year, each MCO must submit an annual report to the Commissioner that includes information on premiums written and earned, the total amount of incurred claims and expenses, loss and expense ratios, and a consolidated financial statement. Data must be reported in the aggregate. The Commissioner may conduct an examination to ensure that an annual report is accurate.

Before an MCO may enroll a Medicaid recipient, the MCO must provide a business plan to the Commissioner.

The Secretary of Health and Mental Hygiene, in consultation with the Commissioner, may adjust capitation payments for an MCO if the MCO's loss ratio is less than 85%. An MCO may appeal a decision of the Secretary to adjust capitation payments on this basis.

Background: Concerns have been raised about whether certain insurance provisions, particularly restrictions regarding retroactive denial of claims, apply to Medicaid MCOs.

Additional Information

Prior Introductions: None.

Cross File: None.

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

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