SB 953

Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 953 (Senator Middleton)(By Request)
Finance Health and Government Operations

Department of Health and Mental Hygiene - Maryland Medical Assistance Program - Information from and Liability of Health Insurance Carriers

This bill requires health insurance carriers, health maintenance organizations (HMOs), and certain third parties to provide the Department of Health and Mental Hygiene (DHMH) with information about individuals eligible for or enrolled in Medicaid so DHMH may determine whether an individual or the individual's spouse or dependent is receiving health care coverage from a carrier and the nature of that coverage. Carriers must accept Medicaid's right of recovery and the assignment to Medicaid of any right of an individual or other entity to payment from the carrier for an item or service for which payment has been made under Medicaid. As a condition of doing business in the State, a carrier must comply with certain requirements of federal law regarding third-party liability.

The bill takes effect June 1, 2007.

Fiscal Summary

State Effect: The bill would preserve federal funding for DHMH of $2.5 billion in FY 2008. DHMH Medicaid expenditures (50% general/50% federal) could decrease, perhaps significantly, from additional recoveries. Potential minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) from the $125 rate form and filing fee in FY 2008. The bill's requirements could be handled by DHMH with existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: Third parties subject to the bill include (1) self-insured plans; (2) pharmacy benefits managers; and (3) other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. Carriers must provide the required information in a manner prescribed by DHMH.

A carrier may not reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms or conditions of, or otherwise affect a health insurance policy or contract for a reason based wholly or partly on (1) the eligibility of the individual for receiving Medicaid benefits; or (2) the receipt by an individual of Medicaid benefits.

Current Law: Commercial insurers, nonprofit health service plans, HMOs, group health plans, and persons that offer a service benefit plan as defined in federal law may not consider whether an individual is eligible for or receives Medicaid when determining the eligibility of the individual for enrollment in health insurance coverage or calculating any payments for benefits for which the individual is eligible under the health insurance coverage.

Entities subject to this requirement must reimburse the State for expenses for health care services that are provided to an eligible individual under Medicaid if those health care services are included under the individual's health insurance coverage provided by the entity. If a State agency has been assigned the rights of an individual who is eligible for Medicaid and who has health insurance coverage provided by an entity subject to this section, the entity may not impose on the State agency requirements that are different from the requirements that apply to an insurance producer, assignee, or any other individual who has health insurance coverage provided by the entity.

Background: In February 2006, the federal Deficit Reduction Act of 2005 (DRA) made significant changes to the Medicaid program. DRA requires states, as a condition of federal financial participation, to enact legislation requiring health insurers to provide information to determine during what period Medicaid recipients may be or may have been covered by a health insurer and the nature of the coverage that is or was provided. States would use the information obtained to properly coordinate payments for services covered under the State Medicaid plan to ensure that correct payment is made and to recover mistaken payments. Maryland must adopt legislation to comply with these requirements by July 1, 2007.

The Governor's proposed fiscal 2008 allowance for Medicaid includes $2.5 billion in federal matching funds, which account for 47% of total Medicaid spending in Maryland.

State Fiscal Effect: DHMH would maintain $2.5 billion in federal Medicaid matching funds in fiscal 2008. The bill strengthens the ability of the department to obtain information on private health insurance coverage of applicants and enrollees and weakens the ability of carriers to deny claims from Medicaid. Accordingly, DHMH expenditures (50% general fund, 50% federal fund) could decrease beginning in fiscal 2008 due to additional recoveries from carriers. The amount of this increase cannot be reliably estimated at this time, but could be significant.

Potential minimal increase in special fund revenues for MIA in fiscal 2008 from the $125 rate form and filing fee. MIA will review policy forms to ensure compliance with the bill. The extent of the revenues will depend on the volume of forms submitted, which cannot be reliably estimated at this time.

Additional Information

Prior Introductions: None.

Cross File: HB 1313 (Delegate Hubbard) – Health and Government Operations.

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

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