# Department of Legislative Services

Maryland General Assembly
2009 Session

## FISCAL AND POLICY NOTE
**Revised**

House Bill 255 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations Finance

**Health Maintenance Organizations - Payments to Nonparticipating Providers**

This bill alters the rates that a health maintenance organization (HMO) must pay for a covered service rendered to an HMO enrollee by certain noncontracting health care providers. The Maryland Health Care Commission (MHCC) must annually review payment to health care providers to determine compliance with the bill and report its findings to the Maryland Insurance Administration (MIA).

The bill takes effect January 1, 2010, and terminates December 31, 2014.

## Fiscal Summary

**State Effect:** Any additional provider complaints can be handled by MIA with existing budgeted resources. No increase in expenditures is anticipated for the State Employee and Retiree Health and Welfare Benefits Program (State plan). No effect on revenues.

**Local Effect:** To the extent HMO premiums increase under the bill, health insurance expenditures for local jurisdictions may increase. No effect on revenues.

**Small Business Effect:** Potential meaningful. Certain physicians and physician group practices receive higher reimbursements for services provided.

## Analysis

**Bill Summary:** For a nonevaluation and management service, an HMO must pay noncontracting health care providers no less than 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, to a similarly licensed contracting provider for the same covered service.

In calculating the rate to be paid for an evaluation and management service, an HMO must calculate the average rate paid to similarly licensed providers under written contract with the HMO for the same covered service using a specified calculation (the sum of the contracted rate for all occurrences of the Current Procedural Terminology (CPT) code for that service divided by the total number of occurrences of the CPT code).

MIA is authorized to investigate and enforce a violation of the bill. MIA, in consultation with MHCC, must adopt regulations to implement the bill.

**Current Law:** Providers that participate in HMO networks must accept as payment in full the rate they negotiated with the HMO. Noncontracting (out-of-network) providers must accept the amount defined in statute. An HMO must pay claims for covered services rendered to an HMO enrollee by a noncontracting trauma physician for trauma care in a trauma center at the greater of:

- 140% of the Medicare rate for the same covered service, to a similarly licensed provider; or
- 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.

An HMO must pay any other noncontracting health care provider at the greater of:

- 125% of the rate the HMO pays in the same geographic area, for the same covered service, to a similarly licensed contracting provider; or
- 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 noncontracting provider.

An HMO may require noncontracting health care providers to submit adjunct claims documentation. Providers may not bill a patient for the balance remaining after an HMO pays a claim for a covered service. This prohibition on "balance billing" applies only to HMO plans. Patients enrolled in non-HMO health benefit plans are liable for paying the difference between the carrier's payment and a noncontracting provider's billed charge.

A health care provider may file an action against an HMO that violates these provisions with MIA or file a civil action. The Insurance Commissioner may impose a penalty up to $5,000 on any HMO that violates these provisions if the violation becomes a general business practice.

**Background:** This bill is based on one of eight recommendations of the Task Force on Health Care Access and Reimbursement, which issued its final report in December 2008.

The task force received testimony from providers that (1) fees paid to noncontracting providers are too low; (2) some HMOs do not pay what is required under law; (3) statutorily established fees serve as the ceiling on reimbursement rather than the floor; and (4) enforcement of existing statute is difficult due to lack of clarity. The task force found that the payment formula for noncontracting providers is susceptible to gaming by plans, not transparent to providers, and difficult to enforce. Current fee schedules were found to be particularly inadequate for evaluation and management services.

MHCC analysis for the task force's final report projected that enhancing reimbursement for noncontracting providers as specified in the bill would cost carriers $25 million to $30 million (in 2006 dollars), or less than a 2% increase in total payments, each year.

**Additional Comments:** To the extent HMO premiums increase under the bill, consumer health insurance expenditures may increase.

## Additional Information

**Prior Introductions:** None.

**Cross File:** SB 380 (Senator Garagiola, *et al.*) - Finance.

**Information Source(s):** Task Force on Health Care Access and Reimbursement *Final Report and Recommendations*, December 2008; Maryland Insurance Administration; Department of Budget and Management; Department of Health and Mental Hygiene; Department of Legislative Services

**Fiscal Note History:** First Reader - February 11, 2009
ncs/mwc Revised - House Third Reader - March 20, 2009

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510