Department of Legislative Services

Maryland General Assembly
2010 Session

FISCAL AND POLICY NOTE

Senate Bill 625 (Senator Frosh)
Finance

Health Insurance - Payment and Fee Disclosure

This bill requires, by July 1, 2012, insurers, nonprofit health service plans, and health maintenance organizations (HMOs) (carriers) to provide an enrollee or health care provider with a reasonably accurate estimate of the amount the carrier will pay for a covered service and the amount the enrollee will be required to pay for the covered service prior to the rendering of that covered service. The bill also requires carriers that use provider panels to provide further information, some only upon request, if the health care provider rendering a service does not participate in the carrier's provider panel. Finally, the bill requires health care providers to make a current schedule of fees for health care services rendered to patients by July 1, 2012.

Fiscal Summary

State Effect: Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State plan) may increase minimally beginning in FY 2015 due to additional administrative costs passed along to the plan after the current medical plan contract expires in July 2014. The development of regulations can be handled within the existing resources of the Maryland Insurance Administration (MIA). No effect on revenues.

Local Effect: Local government expenditures increase minimally beginning in FY 2013 to the extent that insurers pass additional administrative costs on to enrollees.

Small Business Effect: Expenditures for the Comprehensive Standard Health Benefit Plan may increase beginning in FY 2013 to the extent that insurers pass additional administrative costs on to enrollees.

Analysis

Bill Summary: A "provider panel" means an arrangement in which health care providers contract, either directly or through a subcontracting entity, with a carrier to provide health care services to the carrier's enrollees under a health insurance policy or contract.

The bill specifies information that a health care provider or enrollee requesting further information from a carrier must provide to the carrier to receive the information. A carrier must provide the information within five working days after the receipt of the request or as otherwise directed by the Insurance Commissioner.

A carrier must provide, on its web site, an explanation of the methodology used to calculate payments to health care providers who do not participate in the carrier's provider panel.

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. 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 carrier must provide a health care practitioner with a written copy of:

- a schedule of applicable fees for up to the 50 most common services billed by a health care practitioner in that specialty;
- a description of the coding guidelines used by the carrier that are applicable to the services billed by a practitioner in that specialty; and
- the information about the practitioner and the methodology used by the carrier to determine whether to increase or reduce the practitioner's level of reimbursement and provide a bonus or other incentive-based compensation.

This information must be provided at the time of contract execution, 30 days prior to a change, and upon request of the health care practitioner. These requirements do not apply to Medicaid managed care organizations.

Background: Oregon law requires health insurers to provide consumers with advance estimates of average costs for specified medical procedures and services. The estimate

for out-of-network costs must include the difference between the insurer's allowable charge and the billed charge for the procedure or service.

In addition, the New York State Office of the Attorney General issued a report in January 2009, *The Consumer Reimbursement System Is Code Blue*, which highlighted the lack of transparency in the out-of-network policies of insurers in the state.

MIA advises that, in Maryland, insurers promise to pay the allowed amount as determined by the insurer. There is no disclosure of how the determination is made or any promise that this will be the market rate. MIA recently looked at the benefit outlines of all insurers and HMOs offering preferred provider organizations or point of service policies in the small group market and found that some did not accurately describe the arrangement to potential policy holders. MIA fined those insurers accordingly.

MIA advises that it receives numerous complaints from insureds who receive care and are later surprised at their liability for rendered services. This is particularly common for out-of-network services. MIA advises that some insureds have requested advance estimates of the amounts payable out-of-network, which some carriers have refused to provide. According to MIA, the bill will result in a decrease in consumer complaints in this area.

State Expenditures: The Department of Budget and Management advises that administrative costs are included in contracts it negotiates with third-party medical plan administrators, and that its new contract was negotiated in July 2009 and extends for five years. Therefore, if the State plan followed the bill's mandate, its contract would not be adjusted for any additional administrative fees incurred by the medical plan under the current contract. However, costs could increase minimally for the State plan in fiscal 2015 when a new contract will be negotiated.

Local Expenditures: Local government expenditures (for those that purchase fully insured plans from an insurance company) increase minimally for some local governments beginning in fiscal 2013 to the extent that insurers pass additional administrative costs on to enrollees.

Additional Comments: CareFirst BlueCross/BlueShield advises that system enhancements may increase expenditures by approximately $1.5 million.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): CareFirst Blue Cross/Blue Shield, Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, New York Office of the Attorney General, Oregon Insurance Division, Department of Legislative Services

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