HB 437

Department of Legislative Services

Maryland General Assembly
2014 Session

FISCAL AND POLICY NOTE

House Bill 437 (Delegate Pena-Melnyk, *et al.*)
Health and Government Operations Finance

Health Maintenance Organizations - Payments to Nonparticipating Providers - Repeal of Termination Date

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This bill repeals the termination date on provisions of law that require health maintenance organizations (HMOs) to pay specified rates for a covered service rendered to an HMO enrollee by noncontracting health care providers.

Fiscal Summary

State Effect: Any enforcement can continue to be handled by the Maryland Insurance Administration (MIA) with existing budgeted resources. No increase in expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State plan). The Maryland Health Care Commission (MHCC) can continue to review payments and report its finding. 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 will continue to receive higher reimbursements for services provided. To the extent HMO premiums increase under the bill, health insurance expenditures for small businesses may increase.

Analysis

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. Through December 31, 2014, other than

trauma physicians for trauma care, an HMO must pay a noncontracting provider no less than the greater of the following rates for an evaluation and management service: (1) 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, for the same covered service, to similarly licensed contracting providers or (2) 140% of the Medicare rate. For other services, an HMO must pay 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).

MHCC must annually review payment to health care providers to determine compliance and report its findings to MIA. MIA is authorized to take any action to investigate and enforce a violation of these provisions. The Insurance Commissioner may impose a penalty of up to $5,000 on any HMO that violates the provisions if the violation is committed with such frequency as to indicate a general business practice.

Background: Chapter 664 of 2009 altered the rates that an HMO must pay to noncontracting providers as described above. Chapter 664 was 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 fees paid to noncontracting providers were too low and found that the payment formula for noncontracting providers was susceptible to gaming by plans, not transparent to providers, and difficult to enforce. Chapter 664 included a five-year termination provision, which is repealed by this bill.

MHCC analysis for the task force's final report projected that enhancing reimbursement for noncontracting providers as specified in Chapter 664 would cost HMOs $25 million to $30 million, or less than a 2% increase in total payments, each year. According to MHCC, applying the cumulative Medicare Economic Index to that original estimate, Chapter 664 cost HMOs an estimated $28.4 million to $34.0 million in 2014. MHCC reports that, although carriers contended that Chapter 664 would encourage providers to drop network participation, the commission has not seen evidence of this – with the exception of primary care as "concierge medicine" has become more prevalent in some areas of the State.

Additional Information

Prior Introductions: None.

Cross File: SB 416 (Senator Astle) - Finance.

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

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