HB 1563

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1563 (The Speaker and Delegate Bhandari)
Health

Emergency Room Services and Post-Acute Care - Coverage and Facility Studies

This bill prohibits certain policies and contracts issued by an insurer, nonprofit health service plan, or health maintenance organization (collectively carriers) from denying a covered emergency room service solely on the basis that the insured or enrollee did not experience an "emergency medical condition." The Insurance Commissioner must include specified data on post-acute services in the annual summary report on carrier appeals and grievances. By January 1, 2027, the Maryland Health Care Commission (MHCC), in conjunction with the Health Services Cost Review Commission (HSCRC), must conduct two studies to (1) quantify bed capacity in hospitals and post-acute settings and recommend a collection and auditing process for bed reporting and (2) analyze options to facilitate clinically appropriate transitions from acute to post-acute care settings. **The bill generally takes effect June 1, 2026, while the insurance prohibition takes effect January 1, 2027, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.**

Fiscal Summary

State Effect: Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) in FY 2027 from the $125 rate and form filing fee; any additional MIA workload can be handled with existing resources. MHCC and HSCRC can conduct the required studies using existing resources. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program increase significantly beginning in FY 2027, as discussed below.

Local Effect: To the extent the bill increases the cost of health insurance, expenditures for local governments that purchase fully insured plans increase. Revenues are not affected.

Small Business Effect: Minimal.

Analysis

Bill Summary:

Appeals and Grievance Summary Report

In the annual summary report of carrier appeals and grievance reports, the Commissioner must include data on adverse decisions and grievances related to post-acute services, including adverse decisions and grievances relating to admissions to skilled nursing facilities and inpatient rehabilitation facilities.

Study to Quantify Bed Capacity in Post-acute Care Settings

MHCC, in conjunction with HSCRC, must conduct a study to quantify bed capacity in post-acute care settings and hospitals in the State and make recommendations regarding a collection and auditing process by which hospital and post-acute beds will be reported to MHCC or HSCRC each year. The study must include:

- a count of the number of physical beds within each post-acute care facility;
- the use of a standardized definition for each inpatient and outpatient bed type, as specified;
- a count of the number of physical beds, using the standardized definition, within each hospital, by bed type;
- a count of the number of staffed beds, using the standardized definition, within each post-acute care facility;
- a count of the number of staffed beds, using the standardized definition, within each hospital, by bed type;
- a count of the number of licensed beds within each post-acute care facility;
- a count of the number of licensed beds within each hospital, by bed type;
- a count of the number of other types of beds as determined appropriate; and
- any other information necessary for MHCC and HSCRC to quantify bed capacity.

By January 1, 2027, MHCC, in conjunction with HSCRC, must report to the Governor, the Senate Finance Committee, and the House Health Committee on the findings of the study and its recommendation regarding a collection and auditing process.

Study on Options to Facilitate Clinically Appropriate Transitions from Acute to Post-acute Care Settings

MHCC, in consultation with HSCRC, must conduct a study analyzing options to facilitate clinically appropriate transitions from acute to post-acute care settings. The study must

include (1) an analysis of the factors affecting efficiency of clinically appropriate transitions from acute to post-acute care settings; (2) identification of potential solutions that can address such factors; and (3) any other information necessary for MHCC and HSCRC to analyze options for clinically appropriate transitions from acute to post-acute care settings.

By January 1, 2027, MHCC, in conjunction with HSCRC, must report its findings and recommendations to the Governor, the Senate Finance Committee, and the House Health Committee.

Current Law:

Definition of Emergency Medical Condition

"Emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in a condition described in § 1867(e)(1) of the Social Security Act, part of the Emergency Medical Treatment and Labor Act (EMTALA).

EMTALA specifies that an "emergency medical condition" means a condition for which the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, it means that either there is inadequate time to effect a safe transfer to another hospital before delivery or such a transfer may pose a threat to the health or safety of the woman or the unborn child.

Federal No Surprises Act

The federal No Surprises Act (NSA), enacted as part of the Consolidated Appropriations Act, 2021, requires health plans to cover surprise bills for emergency services, as well as out-of-network provider bills rendered at in-network hospitals and facilities. Balance billing is prohibited, with specified exceptions, and out-of-network providers may not send patients bills for excess charges. NSA permits access to an independent dispute resolution process for any surprise medical bill following a 30-day period when the plan and provider try to negotiate a payment amount.

Coverage of Emergency Services in Maryland

Under Maryland law, if a carrier provides or covers any benefits for emergency services in an emergency department (ED) or freestanding medical facility, the carrier:

- may not require prior authorization for the emergency services;
- must provide coverage for the emergency services regardless of whether the health care provider providing the emergency services has a contractual relationship with the carrier to furnish emergency services;
- may not limit what constitutes an emergency medical condition solely on the basis of diagnosis codes; and
- may not impose any other term or condition on the coverage for emergency services, except for the exclusion or coordination of benefits, a waiting period, and applicable cost sharing.

If a health care provider does not have a contractual relationship with the carrier to provide emergency services, the carrier:

- may not impose any administrative requirement or limitation on coverage that would be more restrictive than that imposed on coverage for emergency services furnished by a health care provider with a contractual relationship with the carrier;
- may not impose any cost-sharing amount greater than the amount imposed for emergency services furnished by a health care provider with a contractual relationship with the carrier;
- must calculate and apply the cost-sharing amounts in accordance with specified federal requirements; and
- with specified exception, must reimburse the health care provider in accordance with specified federal requirements.

State Expenditures: The State Employee and Retiree Health and Welfare Benefits Program is largely self-insured for its medical contracts, except for the one fully insured integrated health model medical plan (Kaiser).

The Department of Budget and Management (DBM) advises that the program applies the definition of "emergency medical condition" to all ED claims. If an ED claim is received and the definition is not met, the program applies a "non-emergency use of the ED" penalty, which reduces reimbursement to 50% of the allowed benefit after any applicable copayment. This financial deterrent is designed to drive members toward more appropriate, lower-cost care settings for non-urgent issues. The plan's carrier partners also share "site of care" information to encourage members to seek appropriate care.

DBM advises that the bill's prohibition against denying a covered service if an enrollee did not experience an emergency medical condition could increase program costs by approximately $3.8 million annually. Accordingly, program expenditures (general, special, and federal funds) could increase by $1.9 million in fiscal 2027 (to reflect the bill's January 1, 2027 effective date) and by $3.8 million annually thereafter.

DBM further notes that mandating coverage regardless of the severity of the condition inadvertently encourages use of the ED for non-emergent issues.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: None.

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

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