SB 416

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 416 (Senator Lam)
Finance

Health Maintenance Organizations - Payments to Nonparticipating Providers - Reimbursement Rate

This bill alters the reimbursement rate that a health maintenance organization (HMO) must pay a nonparticipating provider. Specifically, if an HMO pays a nonparticipating provider 125% of the average rate the HMO paid, reimbursement must be based on the rate paid as of January 31, 2019, indexed for inflation as specified.

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) in FY 2027 only from the $125 rate and form filing fee. Any additional workload for MIA can be absorbed within existing resources. Expenditures for the State Employee and Retiree Health and Welfare Benefits Program (State plan) increase by *at least* $112,500 in FY 2027 and *more than* $150,000 annually thereafter, as discussed below.

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
SF Revenue	-	$0	$0	$0	$0
GF/SF/FF Exp.	$112,500	-	-	-	-
Net Effect	($112,500)	($-)	($-)	($-)	($-)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Current Law/Bill Summary: Section 19-710.1 of the Health-General Article specifies how much an HMO must pay for a covered service rendered to an enrollee by a noncontracting provider.

- For an evaluation and management (E&M) service, an HMO must pay the greater of (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 the same covered service, to a similarly licensed provider, in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year.
- For a service that is not an E&M service, an HMO must pay at least 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.
- An HMO must pay a noncontracting trauma physician the greater of (1) 140% of the Medicare rate or (2) the rate the HMO paid, as of January 1, 2001, in the same geographic area, for the same covered service, to a similarly licensed provider.

Under the bill, for an E&M service, an HMO must pay the greater of (1) 125% of the average rate the HMO paid *as of January 31, 2019*, in the same geographic area, for the same covered service, to similarly licensed contracting providers, *inflated by the change in the Medicare Economic Index from 2019 to the current year* or (2) 140% of the Medicare rate for the same covered service, to similarly licensed contracting providers.

Under the bill, for a service that is not an E&M service, an HMO must pay at least 125% of the average rate the HMO paid *as of January 31, 2019*, in the same geographic area, to a similarly licensed contracting provider for the same covered service, *inflated by the change in the Medicare Economic Index from 2019 to the current year*.

The bill does not alter the rate that an HMO must pay a noncontracting trauma physician.

Federal No Suprises Act

The federal No Surprises Act, which took effect January 1, 2022, requires health plans to cover surprise bills for emergency services, as well as out-of-network (OON) provider bills rendered at in-network hospitals and facilities. Balance billing is prohibited, with specified exceptions, and OON providers may not send patients bills for excess charges.

State Expenditures: The State plan 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 advises that, under the bill, Kaiser's costs increase to provide additional reimbursement to nonparticipating providers by an estimated $150,000 in the first full year. Given the bill's October 1, 2026 effective date, this analysis assumes the requirement for payment applies for three quarters of fiscal 2027. Thus, costs for the State plan increase by *at least* $112,500 in fiscal 2027. Annually thereafter, expenditures increase by *more than* $150,000 as the estimate must be adjusted to reflect inflation.

Additional Comments: MIA advises that consumers may see an increase in the amount of reimbursement for services received from noncontracting providers, but given existing balance billing protections for HMO members there should be no direct impact on consumer out-of-pocket costs.

According to a January 2025 report from the Maryland Health Care Commission, adopting preferred provider organization (PPO) payment rules for HMO OON services would result in higher reimbursements across most specialties, particularly for hospital-based services. The report concludes that, while a single OON formula might simplify administration for payers, higher OON payments could incentivize providers to leave networks, creating a cyclic effect as OON payments are derived from in-network rates. MIA notes that adopting PPO payment rules for HMO OON services would increase average reimbursement for OON providers by 50%, impacting approximately 0.6% of claims on average, and increasing premiums by about 0.3%.

Additional Information

Recent Prior Introductions: Similar legislation has been introduced within the last three years. See SB 437 and HB 418 of 2025, and SB 487 and HB 570 of 2024.

Designated Cross File: HB 737 (Delegate Hill, *et al.*) - Health.

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

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