

Department of Fiscal Services  
Maryland General Assembly

FISCAL NOTE

House Bill 313 (Delegates Goldwater and Barve)  
Economic Matters

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**Benefits for Routine Gynecological Care - Coverage Requirements**

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This bill allows a woman to self-refer to an in-network obstetrician/gynecologist (OB/GYN) for gynecological care without obtaining a referral or prior approval from the insurer, nonprofit health service plan, or HMO (carrier) if (1) the care is necessary, including routine care; (2) following each visit, the OB/GYN communicates with the woman’s primary care provider (PCP) regarding any diagnosis or treatment rendered; and (3) the OB/GYN confers with the PCP before performing any non-routine diagnostic procedure. This bill applies to health insurance contracts issued and delivered in the State, as well as contracts issued out-of-state. The bill also applies to contracts sold to small businesses covered under the Maryland Health Insurance Reform Act. Carriers are required to provide notice of this coverage to enrollees.

The bill will take effect June 1, 1997.

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**Fiscal Summary**

**State Effect:** If the State chooses to include the bill’s mandated benefit as part of the employee health benefit plan, expenditures could increase by an estimated \$87,000 in FY 1997, which reflects the June 1, 1997 effective date. Future year expenditures reflect annualization and inflation. General fund revenues could increase by an indeterminate minimal amount.

(in thousands)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
GF Revenues	---	---	---	---	---
GF/SF/FF	\$87	\$1,049	\$1,098	\$1,150	\$1,204
Net Effect	\$87	\$1,049	\$1,098	\$1,150	\$1,204

Note: ( ) - decrease; GF - general funds; FF - federal funds; SF - special funds  
\*assumes a mix of 60% general funds, 20% special funds, and 20% federal funds.

**Local Effect:** Expenditures for local jurisdiction employee health benefits could increase by an indeterminate amount. Revenues would not be affected.

**Small Business Effect:** Potential minimal effect on small businesses as discussed below.

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## Fiscal Analysis

**State Revenues:** Chapters 579 and 580 of the Acts of 1996 allows a woman to obtain gynecological care from an in-network OB/GYN without first visiting her PCP under certain circumstances. This bill makes the Act applicable to (1) contracts issued outside Maryland to individuals who reside and work in Maryland; (2) policies sold to small businesses; and (3) policies subject to this mandate regardless of the contract date. The bill also clarifies the self-referral provision and prevents a carrier from requiring that the woman obtain prior approval from the carrier before visiting an OB/GYN.

According to a Foster Higgins analysis, if a woman can self-refer to an OB/GYN without utilization controls (i.e., limits on the number of self-referrals a year), premiums for the Comprehensive Standard Health Benefit Plan (CSHBP) will increase by about 0.1% (approximately \$2.88 on average). This estimate is based on a survey of plans in the Maryland small group market which revealed that all participating HMO and PPO plans allow self-referral to an OB/GYN and one out of four limit self-referrals to one per year. The increase in cost is a result of the loss in utilization control for 25% of the participating plans.

Although the CSHBP is applicable only to small businesses, it is assumed that the additional cost of covering the mandated benefit to other health carriers would be approximately the same as the additional cost to the CSHBP, and insurance premiums for the other health plans would increase by approximately the same magnitude. Therefore, based on an estimate of \$1.25 billion in premiums collected by health insurers in the State in 1995 (excluding HMOs), general fund revenues could increase by about \$25,000 in fiscal 1998 as a result of the State's 2% insurance premium tax. The premium tax is only applicable to "for-profit" insurance carriers.

In addition, general fund revenues could increase by an indeterminate minimal amount since insurance companies that do not already provide the coverage mandated by the bill's requirements will be subject to rate and form filing fees. Each insurer (except HMOs) that revises its rates and amends its insurance policy must submit the proposed change(s) to the Insurance Administration and pay a \$100 rate and/or form filing fee. The number of insurers who will file new rates and forms as a result of the bill's requirements cannot be reliably estimated at this time, since rate and form filings often combine several rate and policy amendments at one time.

**State Expenditures:** Under the current POS and HMO plans offered by the State employee health benefit plan, a woman can self-refer to a gynecologist for one routine annual visit. The plan requires a woman to obtain a referral or prior approval from the PCP for additional visits. Although the State is self-insured and not required to cover mandated health benefits, in the past the State employee health benefit plan has always included coverage for mandated benefits. Therefore, if the State chooses to include the bill's mandated benefit, expenditures could increase by an estimated \$87,000 (assumes a mix of 60% general funds, 20% special funds, and 20% federal funds) in fiscal 1997, which reflects the cost of covering the mandated benefit for a month in fiscal 1997, and \$1,049,000 on an annual basis in fiscal 1998. This estimate is based on an increase of 0.25% in annualized program cost for the State employee health benefit plan.

This \$1,049,000 estimate assumes (1) the affected population consists of women age 13 to 55, which is about 29% of the covered population; (2) 65% of the affected population are in POS and HMO plans; (3) 25% of the affected population will incur, on average, an additional visit to an OB/GYN a year; (4) the average cost of the visit is \$100; (5) women who are no longer of child-bearing age would not use an OB/GYN for primary health care; and (6) the program cost in fiscal 1998 to be approximately \$419,469,540. The estimated average cost per visit of \$100 reflects the mean payment for all services among OB/GYNs in Maryland. Future year expenditures reflect annualization and medical cost inflation of 4.7%.

Fiscal Services notes that the State employee health benefit plan did not include the mandated coverage required by Chapters 579 and 580 of the Acts of 1996. The gynecological care coverage currently offered by the State employee health benefit plan has not changed from the previous year.

**Local Expenditures:** Expenditures for local jurisdiction employee health benefits could increase by an indeterminate amount, depending upon the current type of health care coverage offered and number of employees.

**Small Business Effect:** According to a Foster Higgins analysis, if women can self-refer to an OB/GYN without utilization controls (i.e., limits on the number of self-referrals a year), premiums for the CSHBP will increase by about 0.1% (approximately \$2.88 on average). Currently, the average cost of the CSHBP is \$2,879. This estimate is based on a survey of plans in the Maryland small group market which revealed that all participating HMO and PPO plans allow self-referral to an OB/GYN and one out of four limit self-referrals to one per year. The increase in cost is a result of the loss in utilization control for 25% of the participating plans. Approximately 40% of small businesses are covered by the CSHBP.

For the remaining 60% of small businesses, health insurance costs would increase if they offer health insurance and they are required to cover additional OB/GYN visits.

Alternatively, small business could pass an increase in health insurance premium costs onto their employees.

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**Information Source(s):** Insurance Administration; Department of Health and Mental Hygiene (Community and Public Health Administration, Health Care Access and Cost Commission); Department of Budget and Management; Department of Fiscal Services

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