HB 1228

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE
Revised

House Bill 1228 (Delegate Taylor, *et al.*)
Economic Matters Finance

Health Insurance Safety Net Act of 2002

This bill establishes the Maryland Health Insurance Plan (MHIP) for medically uninsurable individuals and the Senior Prescription Drug Program for Medicare beneficiaries whose household income is at or below 300% of the federal poverty level (FPL) guidelines. In addition, the bill repeals the Substantial, Available, and Affordable Coverage (SAAC) product and the Short-Term Prescription Drug Subsidy Plan. The bill also requires a nonprofit health service plan that insures 10,000 covered lives or more to maintain its corporate headquarters in the State.

The provisions that establish the MHIP's funding mechanism take effect July 1, 2002. The bill's other provisions take effect July 1, 2003.

Fiscal Summary

State Effect: MHIP special fund expenditures would be $471,000 in FY 2003, which is included in the FY 2003 budget. Special fund revenues and expenditures would be at least $76 million in FY 2004 with the implementation of the two programs. Future year estimates reflect annualization and inflation.

($ in millions)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
SF Revenue	$0	$76.07	$82.34	$89.17	$96.60
SF Expenditure	.47	76.07	82.34	89.17	96.60
Net Effect	($.47)	$0	$0	$0	$0

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Maryland Health Insurance Plan: MHIP is an independent unit of the Maryland Insurance Administration (MIA), whose purpose is to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically-uninsurable residents by July 1, 2003.

The bill establishes a five-member board for MHIP. The board must appoint an executive director to act as MHIP's chief administrative officer and must adopt a plan of operation for MHIP and submit the plan to the Insurance Commissioner for approval. Premium rates must be from 110% to 200% of a standard risk rate. The board must adopt regulations necessary to operate and administer the plan.

The board must establish a standard benefit package to be offered by MHIP, and establish premium rates for MHIP, subject to review and approval by the Insurance Commissioner. The board must select a third party administrator (health insurance carrier) to administer MHIP that will perform such functions as: (1) eligibility determination; (2) data collection; (3) case management; (4) financial tracking and reporting; (5) claims payment; and (6) premium billing.

It is unlawful for a carrier, insurance producer, or third party administrator to refer an individual employee to MHIP, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from the group health insurance coverage provided through the employee's employer.

Senior Prescription Drug Program: The Senior Prescription Drug Program provides Medicare beneficiaries who lack prescription drug coverage with access to affordable, medically necessary prescription drugs until such time as an outpatient prescription drug benefit is provided through the federal Medicare program. The program must be administered by a nonprofit health service plan that issues comprehensive health care benefits in Maryland. An enrollee is subject to a $10 monthly premium, no deductible, and copayments ranging from $10 to $35 per prescription. A prescription drug formulary must be used in the program. The board may limit the total annual benefit to $1,000 per enrollee.

Maryland Health Insurance Plan Fund: The bill creates the Maryland Health Insurance Plan Fund, a special nonlapsing fund, which consists of: (1) premiums for coverage that MHIP issues; (2) premiums paid by enrollees of the Senior Prescription Drug Program; (3) assessment on the base hospital rate of each hospital in the State for which the Health Services Cost Review Commission (HSCRC) approves rates; (4) money deposited by a

carrier for the Senior Prescription Drug Program, (5) income from investments; (6) interest; (7) money collected by the board as a result of legal or other actions taken by the board on behalf of the fund; and (8) all funds from the Maryland Health Care Trust, not exceeding $471,728 in fiscal 2003. The fund is subject to an independent actuarial review at least once every three years. In addition to the operation and administration of MHIP, the fund must be used for the operation and administration of the Senior Prescription Drug Program.

Funds for the Senior Prescription Drug Plan must be kept in a segregated account and consist of: (1) premiums collected from the Senior Prescription Drug Program enrollees; and (2) the amount, in excess of premiums collected, that is necessary to operate and administer the program for the next 12 months deposited by the carrier that administers the program. The amount deposited by the carrier cannot exceed the value of the carrier's annual premium tax exemption. The board will reimburse the carrier on a quarterly basis for costs associated with prescription drug claims and administrative expenses.

For the final quarter of fiscal 2003, HSCRC must collect from each hospital for which rates are established by HSCRC an amount equal to the value of the SAAC purchaser differential and deposit that money in the MHIP fund. HSCRC must establish a methodology for reimbursing each carrier for losses incurred within the quarter that are attributable to SAAC enrollees and reimburse each carrier's losses incurred within the quarter and pay each carrier an administrative fee equal to 20% of the premiums collected for the quarter. HSCRC and MIA must terminate the SAAC program on July 1, 2003 and renew each SAAC policy as a policy under the MHIP.

If the State loses its Medicare Waiver that allows it to set hospital rates and maintain an all-payor system, MHIP must terminate at the end of the plan year during which the State loses the waiver, and the MHIP board must make recommendations to the General Assembly regarding the adoption of a new funding mechanism for the plan.

Current Law:

SAAC: Health insurance carriers may offer a SAAC product to individuals who are medically uninsurable because of their health status. Carriers that offer a SAAC product receive a 4% differential on hospital rates allowing them to pay less for hospital charges for certain enrollees than carriers that don't offer a SAAC product.

Short-Term Prescription Drug Subsidy Plan: This plan provides prescription drug coverage to Medicare-eligible individuals whose household income is at or below 300% of FPL. Enrollees pay a $10 monthly premium, have no deductible, pay $10 to $35 per prescription, and have an annual benefit limit of $1,000. The plan is funded by 37.5% of

the total SAAC differential earned by participating carriers as of January 1, 2001 ($17.6 million) and is administered by CareFirst BlueCross BlueShield. The plan terminates June 30, 2003.

Background:

State-Run High-Risk Pools: Approximately 30 states operate high-risk pools or other programs that grant medically uninsurable individuals access to health insurance coverage. Risk pool premiums are generally higher than comparable private insurance, but all pools have caps on premiums set by legislation to benefit consumers. Most risk pools are 125% to 150% of the average premium for comparable individual market coverage. The National Association of Insurance Commissioners' model risk pool legislation calls for an initial cap of 125% of the average premium, and not higher than 200% of the average. Because the people enrolled in risk pools tend to be less healthy and more likely to use health care services, the pool's costs always exceed the premiums that can be collected. As a result, premium revenue is generally supplemented with other funds. Some states choose to tax health insurers or health care providers to supplement the enrollees' premiums. Others fund high risk pool losses with general revenues or money from excise taxes on alcohol, cigarettes, and other items.

Nonprofit Health Service Plans: In 2001 nine nonprofit health service plans were registered with MIA, eight of which wrote premiums in Maryland. Only two nonprofit health service plans, CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., would be subject to the bill's requirement to administer the Senior Prescription Drug Program. Both of these plans are wholly-owned subsidiaries of CareFirst, Inc. According to MIA, CareFirst, Inc. received a premium tax exemption of $16,597,709 for calendar 2000. Information regarding CareFirst's premium tax exemption for calendar 2001 will not be available to MIA until CareFirst files its 2001 annual statement on March 1, 2002. CareFirst advises that its premium tax exemption was approximately $19 million for calendar 2001.

The Maryland Health Care Foundation was established in 1997 (Chapter 180) as a charitable, nonprofit organization to support efforts to increase and improve access to quality health care for the uninsured, underinsured, and medically underserved residents of Maryland. The foundation awards grants to help fund programs that expand access to health care for Marylanders without health insurance.

Chapter 701 of 2001 established the Maryland Health Care Trust to accept and retain funds for future initiatives aimed at improving the health status of Maryland residents. Trust assets may only be expended to implement acts of the General Assembly that specifically direct the use of the assets. The Maryland Health Care Foundation functions as the trustee, and the trust consists of public and charitable assets received by the

foundation as a result of the acquisition, on or after June 1, 2001, of a nonprofit health service plan or a nonprofit HMO.

State Fiscal Effect: The Maryland Health Care Foundation's fiscal 2003 budget includes $1 million from the Cigarette Restitution Fund, of which, $471,000 must be transferred to the Maryland Health Care Trust on July 1, 2003 for use by MHIP. It is assumed these funds will be used in fiscal 2003 to cover MHIP start-up costs, including salaries and operating expenses for at least six new positions.

MHIP special fund revenues could increase by $76,065,028 in fiscal 2004, which includes approximately $57 million from the new base hospital rate assessment and approximately $19 million from a distribution made by CareFirst to the fund in an amount that does not exceed CareFirst's premium tax exemption.

The base hospital rate is based on the value of the SAAC purchase differential as determined by HSCRC for calendar 2002. In calendar 2001, the SAAC differential totaled approximately $53 million. Future year increases assume 7% medical care inflation. The distribution by CareFirst is based on CareFirst's projected $19 million value of its premium tax exemption in calendar 2001, and assumes the exemption will meet or exceed this amount by fiscal 2004. Future year increases in CareFirst's distributions to the fund assume 12% inflation in health insurance costs.

It is assumed annual MHIP special fund expenditures for MHIP and the Senior Prescription Drug Program will closely match annual revenues to provide health insurance and prescription drug coverage to enrollees.

Additional Comments:

2002 Federal Poverty Level Guidelines* for One Person	
100% FPL	$8,860
200% FPL	$17,720
300% FPL	$26,580

*Federal Register, Vol. 67, No. 31, February 14, 2002, pp. 6931-6933.

Additional Information

Prior Introductions: HB 1042 of 2001, as introduced, created a similar program. The bill was reported favorably with amendments by the House Economic Matters Committee, but was materially changed by the Senate Finance Committee before passing both houses and enacted as Chapter 701 of 2001. A similar bill, HB 3 of 2000, also

created a similar program. It passed the House, but was not reported by the Senate Finance Committee.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene (Medicaid, Health Services Cost Review Commission, Maryland Health Care Commission, Boards and Commissions, AIDS Administration); Maryland Insurance Administration; State Coverage Initiatives (Robert Wood Johnson Foundation); CareFirst, Inc.; Oregon Medical Insurance Pool; Institute for Health Care Research and Policy (Georgetown University); Department of Legislative Services

Fiscal Note History: First Reader - February 13, 2002
ncs/jr Revised - House Third Reader - April 1, 2002
Revised - Enrolled Bill - May 7, 2002

Analysis by: Susan D. John

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 946-5510
(301) 970-5510