HB 1271

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE
Revised

House Bill 1271 (Delegate Donoghue, et al.)
Economic Matters — Referred to Finance

**Health Insurance - Mothers and Newborns -
Minimum Length of Stay and Utilization Review**

This enrolled bill requires health insurers and health maintenance organizations (HMO) to provide a minimum of: (1) 48 hours of inpatient hospitalization following an uncomplicated vaginal delivery; and (2) 96 hours of inpatient hospitalization following an uncomplicated cesarean section, unless a mother requests a shorter length of stay. The health insurer or HMO must provide: (1) one home visit for mothers who request a hospital stay shorter than the required minimum and an additional home visit as prescribed by the attending provider; and (2) a home visit as prescribed by the attending provider for all other mothers. It further requires insurers and HMOs to pay the additional cost of hospitalization for up to four days for a newborn if a mother is required to remain in the hospital after childbirth and requests that the newborn remain in the hospital.

The bill takes effect on July 1, 1996. Health insurers and HMOs must make the benefits required by the bill available by July 1, 1996, notwithstanding any policy or benefit statement to the contrary.

Fiscal Summary

State Effect: If the State elects to include these mandated benefits in the State employee health benefit plan, expenditures could increase by $963,800 in FY 1997, exclusive of home visit costs. Future year expenditures increase with inflation. General fund revenues could increase by an indeterminate minimal amount.

(in dollars)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
GF Revenues	----	----	----	----	----
GF/SF/FF	$963,800	$1,016,800	$1,072,700	$1,131,700	$1,194,000
Net Effect*	($963,800)	($1,016,800)	($1,072,700)	($1,131,700)	($1,194,000)

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

Local Effect: Expenditures could increase by an indeterminate amount. Revenues would not be affected.

Fiscal Analysis

Bill Summary: A health insurer or HMO is prohibited from: (1) charging a copayment, coinsurance requirement, or imposing a deductible for home visits; or (2) impairing the participation of an attending provider under contract with the insurer or HMO in providing health care services to enrollees for advocating the interest of a mother and newborn child or prescribing home visits. A private review agent or HMO may not provide financial disincentives for an attending provider who orders care consistent with the sections of this bill requiring up to four days of additional hospitalization for a newborn to remain with its mother. A health insurer or HMO must provide notice to enrollees regarding maternity and newborn care hospital lengths of stay and home visit coverage by January 1, 1997 and on an annual basis thereafter.

State Revenues: General fund revenues could increase by an indeterminate minimal amount as a result of the State's 2% insurance premium tax that would apply to any increased health insurance premiums resulting from the bill's requirements. The State's premium tax is only applicable to "for-profit" insurance carriers.

In addition, general fund revenues could increase by an indeterminate minimal amount in fiscal 1997 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 (with the exception of health maintenance organizations) that amends its insurance policy must submit the proposed change to the Insurance Administration and pay a $100 form filing fee. Further, each insurer (with the exception of health maintenance organizations) that revises its rates must submit the proposed rate change to the Insurance Administration and pay a $100 rate filing fee. It is not possible to reliably estimate the number of insurers who will file new forms and rates as a result of the bill's requirements, since rate and form filings often combine several rate and policy amendments at one time.

State Expenditures: 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 health benefits. Therefore, if the State chooses to include the bill's mandated benefits, expenditures could increase by an estimated $963,800 (assumes a mix of 60% general funds, 20% special funds, and 20% federal funds) in fiscal 1997. The $963,800 estimate reflects: (1) a cost of $857,800 for the 846 women whose hospital stay was shorter than the minimum required by the bill; and (2) a cost of $106,000 for newborns to stay in the hospital for up to four days with their mothers.

The estimate is based on fiscal 1995 utilization rates and hospital expenditures for State employees enrolled in the Blue Cross/Blue Shield (BCBS) preferred provider organization (PPO) plan and assumes: (1) that utilization rates and hospital expenses for the BCBS population are equivalent for the entire State active employee enrolled population; (2) the number of State employees enrolled in the health plan remains constant; and (3) an effective date of July 1, 1996. This estimate does not address the cost of home visits because it is not possible at this time to reliably estimate the number of mothers who would choose the less expensive home visit option ($90 per visit) rather than an additional day of hospital care or the number of home visits which might be prescribed by attending providers. Future year expenditures reflect medical cost inflation of 5.5%.

There is no direct impact to the Medical Assistance Program because the bill's requirements directly affect health insurers and not the program. However, the bill could indirectly affect Medicaid expenditures in the long-term if Medicaid rates set for health maintenance organizations (HMOs) increase due to higher costs incurred by HMOs. Currently, 25% of Medicaid recipients are enrolled in HMOs. Under the Department of Health and Mental Hygiene's Medicaid reform proposal, most Medicaid recipients will be enrolled in managed care. In addition, under current federal law, 50% of any additional Medicaid expenditures are reimbursable by federal funds. However, Congress is considering legislation that may cap the amount of funds that states receive under Medicaid. As a result, it's possible that any additional Medicaid expenditures will be funded entirely with general funds. It is not possible at this time to reliably estimate the magnitude of any increase in Medicaid program expenditures resulting from the bill's requirements.

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 enrollees.

Information Source(s): Department of Budget and Fiscal Planning, Department of Health and Mental Hygiene (Health Care Access and Cost Commission), Department of Fiscal Services, Insurance Administration

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Analysis by: Sue Friedlander
Reviewed by: John Rixey

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 841-3710
(301) 858-3710