SB 392

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE
Revised

Senate Bill 392 (Senator Trotter, et al.)
Finance — Referred to Economic Matters

Health Insurance - Gynecological Care

This enrolled bill alters the circumstances under which health insurers and health maintenance organizations (HMOs) must permit a woman to receive gynecological care from an obstetrician/gynecologist (OB/GYN) who is not her primary care provider. Specifically, it provides that if an OB/GYN chooses not to be a primary care physician, a woman can receive gynecological care from an in-network OB/GYN without requiring that the woman first visit a primary care provider if (1) the care is medically necessary, including routine care; (2) following each visit, the OB/GYN communicates with the woman's primary care physician regarding any diagnosis or treatment rendered; and (3) the OB/GYN confers with the primary care physician before performing any non-routine diagnostic procedure.

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 up to an estimated $406,500 in FY 1997. Future year expenditures grow with annualization and inflation. General fund revenues could increase by a moderate amount.

(in dollars)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
GF Revenues	-----	-----	----	-----	-----
GF/SF/FF Expenditures	$406,500	$857,600	$904,800	$954,500	$1,007,000
Net Effect*	($406,500)	($857,600)	($904,800)	($954,500)	($1,007,000)

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

* assumes (1) a mix of 60% general funds, 20% special funds, 20% federal funds; and (2) 20% of expenditures are reimbursable through employee contributions

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

Fiscal Analysis

State Revenues: General fund revenues could increase by an indeterminate moderate 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: The effect of the bill is to allow women in Point-of-Service (POS) and HMO plans to self-refer to an in-network OB/GYN more than the once a year allowed under current law for routine gynecological care. Under current law, a woman who wishes to see her OB/GYN in addition to the one routine visit must be seen by a primary care physician who acts as a "gatekeeper". The primary care physician will either provide treatment for the woman's symptoms or refer her to an OB/GYN. As compared to current law, the bill's requirements could result in either:

- *Additional OB/GYN visits that would have been prevented under current law by a primary care visit.* As a result, expenditures could increase by the difference between the OB/GYN's reimbursement rate and the primary care physician's reimbursement rate. It is difficult to compare the two rates, however, because they depend on the rates each HMO or POS plan negotiates with its providers. For example, an HMO that can promise a high volume of patient business has the potential for negotiating a lower fee-for-service arrangement with an OB/GYN than an HMO with a lower volume of business. In addition, an OB/GYN's negotiated fee can be either a capitated rate or a fee-for-service rate, while a primary care physician's negotiated fee is most likely to be a capitated rate. It is difficult to compare a capitated rate (based on the number of plan enrollees) with a fee-for-service rate (based on the number of office visits); or

- *Additional OB/GYN visits that would not have been prevented under current*

law by a primary care visit because the primary care physician would have referred the patient to an OB/GYN. As a result, expenditures could decrease due to averting a primary care physician visit. However, the growing managed care industry is based on the premise that it is cost-effective to use primary care physicians as "gatekeepers" who can handle the more routine care and decide when referrals to specialists are needed. So, although in some cases there will be a visit to two doctors (the primary care physician and the OB/GYN) when the primary care physician makes a referral, it is assumed that any additional expense of a "gatekeeper" is more than offset by savings from averting unnecessary referrals to a specialist. The bill's requirements will affect the "gatekeeper" system of managed care, since there are no limits on the number of times a woman can self-refer, except that the care be deemed "medically necessary" by the OB/GYN.

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 benefit, expenditures could increase by up to an estimated $406,500 (assumes a mix of 60% general funds, 20% special funds, and 20% federal funds) in fiscal 1997. The estimate assumes: (1) 230,000 covered lives; (2) 29% of covered lives are females who would require OB/GYN services; (3) 65% of the females are in an HMO or POS plan; (4) 25% of the females will incur an average of one additional annual visit; (5) an average cost for an OB/GYN visit of $75; and (6) an effective date of January 1, 1997, the start date of the annual State employee health benefit plan contract. Future year expenditures reflect medical cost inflation of 5.5% and annualization in fiscal 1998 from fiscal 1997.

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

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