SB 717

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE

Senate Bill 717 (Senator Young, et al.)
Rules

Health - Benefit and Evaluation Requirements

This bill requires health insurers and health maintenance organizations (HMO) to provide a minimum number of hours of inpatient hospitalization care following childbirth, authorizes the Secretary of Health and Mental Hygiene (DHMH) to waive the requirements for an external review of the quality of health services of an HMO, requires DHMH to establish a unified credentialing information system by January 1, 1997, and establishes a committee to evaluate the effectiveness of current law regarding HMO patient and provider grievance appeal mechanisms.

Fiscal Summary

State Effect: If the State chooses to include the bill's mandated benefit in the State employee health benefit plan, expenditures could increase by an estimated $428,900 in FY 1997. Future year expenditures increase with annualization and inflation. General fund revenues could increase by an indeterminate amount.

(in dollars)	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
GF Revenues	----	----	----	----	----
GF Expenditures	$428,900	$905,000	$954,800	$1,007,300	$1,062,700
Net Effect	($428,900)	($905,000)	($954,800)	($1,007,300)	($1,062,700)

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

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

Fiscal Analysis

Bill Summary: The bill requires health insurers and health maintenance organizations (HMO) to provide a minimum of 48 hours of inpatient hospitalization care following a vaginal delivery and 96 hours following a cesarean section. A carrier that provides postdelivery coverage for a mother and newborn child in the home is not required to provide the minimum length of hospital stay, unless the attending physician determines that inpatient hospitalization is necessary.

The Secretary of Health and Mental Hygiene is authorized to waive the requirements for an external review of the quality of health services of an HMO if the HMO has been accredited by a nationally recognized accrediting entity and the Secretary determines that the accrediting entity's standards are equivalent to the State's requirements. The Secretary is authorized to inspect an HMO to investigate complaints or serious problems identified in the accreditation report. In addition, the Secretary is to establish a unified credentialing information system available for all health practitioners licensed under the Health Occupations Article by January 1, 1997. The system is to be administered by one or more professional organizations approved by the Secretary through regulation.

Finally, the bill establishes a 10-member committee to evaluate the effectiveness of current law regarding patient and provider grievance appeal mechanisms for the appeal of HMO decisions. The committee is to be staffed by the Departments of Legislative Reference and Fiscal Services and must report to the Senate Finance Committee and the House Economic Matters Committee by October 15, 1996.

State Revenues: General fund revenues could increase by an indeterminate 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 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:

Hospitalization Coverage for Childbirth

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 an estimated $428,920 (assumes a mix of 60% general funds, 20% special funds and 20% federal funds) in fiscal 1997. The estimate is based on fiscal 1995 utilization rates and hospital expenses for employees in the Blue Cross and Blue Shield (BCBS) preferred provider organization and assumes: (1) utilization rates and hospital expenses for different lengths of stay for the BCBS population are equivalent to the entire State active employee enrolled population; (2) the number of State employees enrolled in the health plan stays constant; and (3) 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.

Although the number of State employees has remained relatively constant in recent years, the fiscal 1997 budget allowance reflects a net decrease of 851 permanent positions. Any decrease in the number of covered lives would serve to mitigate the projected expenditure growth, but it is not possible to reliably estimate the extent at this time.

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. Fifty percent of Medicaid expenditures are reimbursable by federal funds, to the extent that such funds are available in the future given pending congressional restructuring of the Medicaid program.

External Review of Quality

Of the 21 currently licensed HMOs, two have full accreditation and three have one-year accreditation status. Assuming that the Secretary of Health and Mental Hygiene will consider only fully accredited HMOs as equivalent to the department's own standards, 19 HMOs would continue to require an external review by the department. Although future year general fund expenditures could theoretically decrease to the extent that a greater number of HMOs receive full accreditation and the department conducts fewer HMO survey reviews, it

is more likely that staff resources no longer needed to conduct HMO surveys will be reassigned to other licensure functions.

Credentialing System

DHMH's Office of Licensing and Certification (OLC) advises that general fund expenditures could increase $545,700 in fiscal 1997 as a result of hiring 20 new positions. Of the 20 new positions, one is a Program Administrator, 14 are Administrative Specialists, and five are Office Secretaries. The estimate reflects the bill's October 1, 1996 effective date and includes salaries of $312,365, fringe benefits of $129,100, equipment purchases of $64,800, and ongoing operating expenses of $39,435.

The Department of Fiscal Services advises, however, that the estimate is a worst case scenario that assumes that the office will perform credentialing rather than relying on a professional organization to administer a credentialing system. Since the bill's intent seems to be that DHMH adopt regulations and monitor other organizations performing credentialing and not for DHMH to do the credentialing in-house, Fiscal Services assumes that DHMH could handle any additional workload with existing budgeted resources. OLC is already authorized under current law to adopt regulations and monitor hospitals' physician credentialing procedures as part of its hospital licensure and certification review.

Study of HMO Patient and Provider Grievance Appeal Mechanisms

Travel and staffing expenditures for the study committee are assumed to be minimal and absorbable within the executive and legislative branch departments.

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

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