HB 322

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE

House Bill 322 (Delegate Donoghue)
Economic Matters

Health Benefits Coverage - Inpatient Hospitalization for Mastectomy

This bill requires health insurers, nonprofit health service plans, and health maintenance organizations (carriers) to provide coverage for inpatient hospitalization after a mastectomy for a period of time determined by the attending physician in consultation with the patient. In addition, a carrier may not prevent a physician from advocating inpatient hospitalization after a mastectomy.

Fiscal Summary

State Effect: If the State chooses to include the bill's mandated benefit as part of the State employee health benefit plan, expenditures could increase by an estimated $12,400 in FY 1998, which reflects the bill's October 1, 1997 effective date. Future year expenditures reflect annualization and inflation. General fund revenues could increase by an indeterminate amount.

(in dollars)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
GF Revenues	---	---	---	---	---
GF/SF/FF	$12,400	$17,300	$18,100	$18,900	$19,800
Net Effect	($12,400)	($17,300)	($18,100)	($18,900)	($19,800)

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: Meaningful effect on small businesses as discussed below.

Fiscal Analysis

State Revenues: In Maryland, the average hospital length of stay for a mastectomy in 1995 ranged from 1.22 days (subtotal mastectomy without complications by HMOs) to 2.76 days (total mastectomy with complications by all health facilities). These figures, however, do not include ambulatory (outpatient) mastectomy procedures. At the Johns Hopkins Hospital System (JHHS), approximately 60% (160) of all mastectomies are performed on an outpatient basis. JHHS performs over 250 mastectomies annually. Nationally, 8,360 mastectomies were performed on an outpatient basis in 1995. Given the data, mandating coverage for inpatient hospitalization would increase medical care costs to carriers because the level of hospitalization after a mastectomy will likely increase. These carriers would raise premiums on their health plans, meaning that general fund revenues could increase by an indeterminate amount in fiscal 1998 as a result of the State's 2% insurance premium tax. The State's premium tax is only applicable to "for-profit" insurance carriers.

In addition, general fund revenues could increase by an indeterminate 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: 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 $12,400 (assumes a mix of 60% general funds, 20% special funds, and 20% federal funds) in fiscal 1998.

The $12,400 estimate assumes: (1) some patients would continue to elect the ambulatory procedure; (2) there are currently 150,000 State employees, retirees, and dependents under 65 years enrolled in a health plan and this number will remain constant over time; (3) increased inpatient utilization rate of 0.0037%; (4) the average length of inpatient hospitalization is 48 hours; (5) average hospital cost per day of $1,500; and (6) an effective date of October 1, 1997. Future year expenditures reflect medical cost inflation of 4.7% and annualization. Expenditures would increase further if some patients choose to remain in the hospital for more than 48 hours after a mastectomy as a result of this bill. The extent of the increase, however, cannot be reliably estimated at this time.

This bill would not directly affect the Medicaid program, but would indirectly affect it

through the HMOs with which Medicaid contracts. The Medicaid program reimburses providers only for medically necessary inpatient hospitalization. Under this bill, HMOs would be required to provide coverage for inpatient hospitalization; however, the Medicaid program may not reimburse providers for all the costs if the program decides that the hospitalization was not medically necessary. In the short term, this bill would not affect the Medicaid program. However, in the long term the bill could increase expenditures minimally if HMOs with which Medicaid contracts persuade the State to increase the reimbursement rates to HMOs to accommodate the increase in costs as a result of the bill.

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 Maryland hospital diagnosis-related group (DRG) codes compiled by the Health Services Cost Review Commission (HSCRC), the 1995 average length of stay for total and subtotal mastectomies with complications were 2.76 and 2.26 days, respectively; and total and subtotal mastectomies without complications were 1.92 and 1.32 days, respectively. This corresponds to average total costs for inpatient mastectomies ranging from $3,008 (subtotal mastectomy without complications by HMOs) to $5,334 (total mastectomy with complications by HMOs). The inpatient hospitalization data, however, do not include data on ambulatory procedures. At the Johns Hopkins Hospital System (JHHS), approximately 60% (160) of all mastectomies are performed on an outpatient basis. JHHS performs over 250 mastectomies annually. Nationally, 8,360 mastectomies were performed on an outpatient basis in 1995. If ambulatory data were combined with inpatient hospitalization data, the average hospital length of stay would be lower, and consequently, this bill would have a meaningful impact on the level of additional inpatient hospitalization after a mastectomy.

The expected increase in medical care costs to small businesses as a result of this bill cannot be reliably estimated at this time, but it is expected to be meaningful. In 1995, 40% of small businesses were covered under the Comprehensive Standard Health Benefit Plan (CSHBP), which is exempt from State mandated benefits. If the CSHBP adds this benefit as a covered service, the insurance cost for participating small businesses would increase. For the remaining 60% of small businesses, health insurance costs would increase if they offer health insurance and their health plan is subject to mandated benefits. Alternatively, small business could pass an increase in health insurance premium costs onto their employees.

Additional Comments: Less than 36% of insured Maryland residents will be affected by this bill because State mandated benefits do not apply to self-insured health plans (including the State health benefit plan), the Comprehensive Standard Health Benefit Plan (CSHBP),

and federal programs such as FEHBP, CHAMPUS, Medicaid and Medicare (with the exception of enrollees who receive care through an HMO).

According to 1995 national hospital DRG codes, total and subtotal mastectomies without complications were, respectively, 2.7 and 1.8 days; and total and subtotal mastectomies with complications were, respectively, 3.6 and 3.3 days.

Information Source(s): Insurance Administration; Department of Health and Mental Hygiene (Health Care Access and Cost Commission, Medical Care Policy Administration, Health Services Cost Review Commission); Department of Budget and Management; Department of Fiscal Services; Foster Higgins; John Hopkins Hospital System

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