SB 654

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE

Senate Bill 654 (Senator Pinsky)
Finance

Health Insurance - Quality of Care - Requirements

This bill requires a health insurer, nonprofit health service plan, and HMO (carrier) to maintain a provider panel that is sufficient to provide timely access to health care services for the number of enrollees covered by the carrier. Unless otherwise provided, a carrier must comply with the maximum primary care provider-to-enrollee ratio established by the Insurance Commissioner. In addition, the carrier must comply with specified time frames within which an appointment with a physician must be scheduled. This bill prohibits carriers from paying bonuses, incentives, or other financial compensation to a practitioner that would induce the practitioner to withhold or delay the provision of appropriate care to an enrollee. A carrier may not take adverse action against any individual for (1) reporting to State or federal authorities any action by the carrier that jeopardizes a patient's health; and (2) notifying the carrier, health care provider, patients, or other individuals of conditions that may be dangerous or potentially dangerous to enrollees or employees.

Fiscal Summary

State Effect: General fund expenditures for the Insurance Administration could increase by $29,900 in FY 1998, which accounts for the bill's October 1, 1997 effective date; out-year expenditures reflect annualization and inflation. Indeterminate effect on general fund revenues.

(in dollars)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
GF Revenues	---	---	---	---	---
GF Expenditures	$29,900	$33,900	$35,200	$36,400	$37,800
Net Effect	($29,900)	($33,900)	($35,200)	($36,400)	($37,800)

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.

Small Business Effect: Potential meaningful effect on small businesses as discussed below.

Fiscal Analysis

Bill Summary: Carriers must report annually to the Insurance Commission: (1) the number of enrollees of the carrier; (2) the number of primary care providers (PCP) under contract with the carrier; (3) the location of the PCP practice, if applicable; (4) the staffing at each PCP practice; (5) office and telephone waiting time; (6) time between a request for an appointment and the actual appointment; and (7) any other information necessary to assess if the provider panel is sufficient.

A carrier may have a higher primary care provider-to-enrollee ratio than that established by the Commissioner if it can demonstrate the ability to provide timely access to health care services for the number of enrollees covered by the carrier.

Appointments for (1) routine primary preventive care must be scheduled within 30 days of a request for an appointment; (2) routine specialist follow-up care must be scheduled within 30 days of the initial authorization; and (3) newborns must be scheduled within 14 days after discharge from the hospital if no home visit has occurred, or within 30 days if a home visit was provided.

State Revenues: The Department of Fiscal Services (DFS) has not received any information relating to existing primary care provider-to-enrollee ratios for carriers and the occurrence of and frequency with which carriers provide financial incentives to physicians to restrict utilization of health care services.

The bill provides that primary care provider-to-enrollee ratios cannot exceed (1) 2,000 to 1, for physicians with respect to adult enrollees; (2) 1,500 to 1, for physicians with respect to enrollees under 21 years; and (3) 1,000 to 1, for advanced practice nurses. Under these guidelines, for instance, there must be 2,000 physicians serving every adult enrollee. DFS assumes that the intent of the bill is to limit primary care provider-to-enrollee ratios to (1) 1 to 2,000, for physicians with respect to adult enrollees; (2) 1 to 1,500, for physicians with respect to enrollees under 21 years; and (3) 1 to 1,000, for advanced practice nurses with respect to enrollees.

Establishing maximum primary care provider-to-enrollee ratios and time limits within which appointments have to be scheduled may increase costs to carriers if they have to expand their provider panel to comply with the requirements. For some carriers, their current provider panel may already satisfy the requirements of the bill, in which case, it would impose no additional cost to them. The effect of this provision would vary among carriers.

In addition, the effect of this bill on utilization controls in managed care plans would depend on the extent to which financial incentives are currently employed to restrict utilization of

health care services. If this practice is limited in scope, the bill would have a negligible effect on premiums of health carriers. If, however, the practice is widespread among managed care plans to restrict utilization, the bill could potentially increase medical care costs to health carriers, and consequently, premiums could rise.

If costs increase as a result of this bill and carriers raise premiums, general fund revenues could increase by an indeterminate amount in fiscal 1998 due to 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 if carriers have to file new rates and forms to the Insurance Administration and pay a $100 rate and/or form filing fee.

State Expenditures: The State employee health benefit plan is self-insured for Preferred Provider Option plans (PPO) and Point of Service (POS) out-of-network services and pays an administrative fee to a third-party administrator (TPA); and is insured for HMO plans and POS in-network services. As enunciated above, if costs to carriers increase, carriers may pass the increased costs onto the State employee health benefit plan. The extent of the increase in premiums cannot be reliably estimated at this time.

General fund expenditures for the Insurance Administration could increase by an estimated $29,873 in fiscal 1998, which accounts for the bill's October 1, 1997 effective date. This estimate reflects the cost of hiring a Market Conduct Examiner to monitor compliance with the bill's requirements. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses

Salaries and Fringe Benefits	$24,853
Operating Expenses	5,020
Total FY 1998 State Expenditures	**$29,873**

Future year expenditures reflect (1) a full salary with 3.5% annual increases and 3% employee turnover; and (2) 2% annual increases in ongoing operating expenses.

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: To the extent that current financial incentive programs would be prohibited under this bill, some health care practitioners may experience a reduction in their compensation package from health carriers as a result of this bill. With the exception of some nonprofit vision and dental plans, health insurers, nonprofit health service plans, and

HMOs are not small businesses. For the small business nonprofit vision and dental plans, it is assumed the effect of prohibiting certain financial incentives would be negligible for the reason specified above.

To the extent that costs increase as a result of this bill and health carriers raise premiums to cover that increase, self-employed persons and small businesses that offer health insurance could face higher health care costs. Alternatively, small businesses could pass an increase in health insurance premium costs onto their employees.

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

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