SB 117

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE
Revised

Senate Bill 117 (Senator Trotter, *et al.*)
Finance — Referred to Economic Matters

Health Benefit Plans - Minimum Inpatient Hospitalization Coverage - Treatments for Breast and Testicular Cancer

This amended bill requires health insurers, nonprofit health service plans, and HMOs (carriers) to provide a minimum of 48 hours of inpatient hospitalization after a mastectomy or the removal of a testicle due to testicular cancer and 24 hours of inpatient hospitalization after a lymph node dissection or lumpectomy, unless the patient decides, in consultation with the attending physician, on a shorter hospital stay or to receive treatment on an outpatient basis. If the patient's hospital stay is less than the required minimum, or the patient is treated on an outpatient basis, the health carrier must cover one home visit within a 24-hour period, and an additional home visit if prescribed by the patient's attending physician.

The bill takes effect July 1, 1997 and applies to all contracts issued on or after July 1, 1997. Any policy issued before July 1, 1997 must comply with the bill's requirements no later than July 1, 1998. The bill sunsets September 30, 2001.

Fiscal Summary

State Effect: If the State chooses to include the bill's mandated coverage for hospitalization and home visits after a mastectomy as part of the State employee health benefit plan, expenditures could increase by an estimated $10,300 in FY 1998. 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 Expenditures	10,300	$14,300	$15,000	$15,700	$16,400
Net Effect	($10,300)	($14,300)	($15,000)	($15,700)	($16,400)

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

Bill Summary: Carriers must provide notice of the mandated coverage to enrollees annually. In addition, health care providers must provide patients with appropriate training and educational materials which explain the procedure the patient is about to undergo and the necessary post-procedure care.

State Revenues: Exhibit 1 presents the inpatient hospital and ambulatory surgery data for mastectomies, lumpectomies, lymph node dissections, and the removal of a testicle due to testicular cancer. 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.

Exhibit 1: Inpatient Hospital and Ambulatory Surgery Data for Mastectomies, Lumpectomies, Lymph Node Dissections, and the Removal of a Testicle due to Testicular Cancer

Inpatient Hospital Data for Calender Year 1995			
Procedure	# of Cases	LOS	Avg. Charge
Mastectomy: DRG 257	1,097	2.76	$4,958.69
Mastectomy: DRG 258	815	1.96	$4,184.26
Mastectomy: DRG 259	257	2.26	$4,175.76
Mastectomy: DRG 260	338	1.32	$3,085.62
Mastectomy: other DRG	96	8.32	$11,982.18
Lumpectomy	429	2.98	$5,003.22
Lymph Node Dissections	739	1.95	$3,927.55
Removal of Testicle	31	3.45	$6,687.03
Ambulatory Surgery Data for Calender Year 1995			
Mastectomy	308	0	$1,855.19
Lumpectomy	1,898	0	$1,515.78
Lymph Node Dissection	235	0	$1,981.15
Removal of Testicle	77	0	$1,455.05

DRG 257: total mastectomy with complications; DRG 258: total mastectomy without complications;
DRG 259: subtotal mastectomy with complications; DRG 260: subtotal mastectomy without complications.

Given the data, the bill's requirements would increase medical care costs to carriers. 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. It is not possible to reliably estimate the number of insurers who will file new rates and forms 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 often included coverage for mandated benefits. Therefore, if the State chooses to include the bill's mandated coverage for hospitalization and home visits after a mastectomy, expenditures could increase by an estimated $10,260 (assumes a mix of 60% general funds, 20% special funds, and 20% federal funds) in fiscal 1998, which reflects an October 1, 1997 effective date. The State's medical care costs relating to the bill's mandated coverage for hospitalization and home visits after a lumpectomy and the removal of a testicle due to testicular cancer cannot be reliably estimated at this time. If the State employee health benefit plan includes the above coverage, medical care costs to the State would increase further.

The $10,260 relating to mastectomies includes $10,125 for nine additional days of hospital care and $135 for two home care visits in lieu of hospital care after a mastectomy. The estimate for hospital care assumes: (1) average hospital cost per day of $1,500; (2) patients currently receiving inpatient hospitalization for mastectomies stay at least 48 hours; (3) most patients would prefer inpatient hospitalization when given the option; and (4) 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. The estimate for home care assumes: (1) the cost per home visit is $90; (2) patients who currently elect an ambulatory procedure receive follow-up visits at a health care facility; and (3) there would be no change in medical care costs if home visits are substituted for follow-up visits at a health care facility.

Future year expenditures reflect medical cost inflation of 4.7% and annualization. Expenditures would increase further if some patients currently receiving inpatient hospitalization for mastectomies stay less than 48 hours and if the cost of home visits is higher than the cost of follow-up visits at a health facility. The extent of the increase,

however, cannot be reliably estimated at this time.

It is assumed that most lymph node dissections are performed in conjunction with a mastectomy and, hence, impose no additional cost to the State other than the cost of the mastectomy. However, there could be some instances when a lymph node dissection is performed without a mastectomy: as an ambulatory procedure. In that event, the cost of the mandate may increase State expenditures if it increases the direct medical costs to the State. This cost, however, cannot be reliably estimated at this time.

This bill would indirectly affect the Medicaid program 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 the minimum 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 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.

The cost to the Insurance Administration of monitoring the annual notice required of the carriers by the bill will be passed on to the industry and will not affect State expenditures.

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: Exhibit 1 presents the inpatient hospital and ambulatory data for the procedures identified in this bill. At 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, this bill would have a meaningful impact on the level of additional inpatient hospitalization after certain procedures, although some patients may elect a shorter hospital stay or an ambulatory procedure for a home visit option. In that event, the savings from choosing the home visit option in lieu of inpatient hospitalization would mitigate some of the increased medical care costs.

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 these benefits 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. To the extent that medical care costs increase as a

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

The bill may generate more business activity for small business nurse staffing agencies. It is assumed that carriers would most likely offer coverage for home visits by nurses. There are approximately 105 nurse staffing agencies licensed in Maryland. To the extent that some of these agencies could be considered a small business and if some home visits are provided by nurses employed by these small business agencies, it would minimally increase revenues for these agencies.

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

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