Department of Legislative Services

Maryland General Assembly
1999 Session

FISCAL NOTE
Revised

Senate Bill 135 (The President, *et al.*) (Administration)
Finance

Patients' Bill of Rights Act of 1999

This Administration bill requires the Maryland Insurance Administration (MIA) to be the single point of entry for consumers to access any health insurance information and health care delivery information as it relates to health insurance. The cost of providing information will be paid through the Health Care Regulatory Fund. The bill also requires insurers, nonprofit health service plans, and HMOs (carriers) to establish and permit, in certain circumstances, a patient's direct access to specialists, including standing referrals to the specialists, and access to specialists outside the carrier's provider panel. The bill requires each carrier to file a copy of each of these procedures with the MIA. The bill also requires carriers with prescription drug coverage to cover, in certain circumstances, a prescription drug not on the carrier's formulary. In addition, the bill requires carriers to provide coverage for a set minimum length of hospitalization for mastectomy and testicle removal procedures, lymph node dissection, and lumpectomy. Under certain circumstances, carriers must also provide home visits.

The bill also requires the Secretary of the Department of Health and Mental Hygiene to review the extent to which Medicaid managed care organizations must meet the same or similar requirements and report the findings to the General Assembly by November 1, 1999.

This bill applies to all policies issued on or after October 1, 1999. Any policy in effect before October 1, 1999 must comply with the bill's requirements by October 1, 2000. The minimum length of stay provisions of this bill sunset on September 30, 2003.

Fiscal Summary

State Effect: Expenditures for the State Employee Health Benefits Plan could increase by at least $13,700 in FY 2000. Special fund expenditures and revenues for the Maryland Insurance Administration (MIA) could each increase by $74,900 for FY 2000. Out-year expenditures reflect inflation and the hospital length of stay provisions' sunset date of September 30, 2003. Expenditures for the Medicaid program will not be affected.

Special fund revenues for MIA may increase by an indeterminate amount for form and rate filings. General fund revenues as a result of the State's premium tax may increase by an indeterminate minimal amount.

(in dollars)	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
GF/FF/SF Revenues*	-	-	-	-	-
SF Revenues	$74,900	$96,400	$99,900	$103,600	$107,400
GF/FF/SF Expend.*	$13,700	$14,300	$14,900	$15,600	$4,000
SF Expenditures	$74,900	$96,400	$99,900	$103,600	$107,400
Net Effect	($13,700)	($14,300)	($14,900)	($15,600)	($4,000)

Note: ( ) = decrease; GF = general funds; FF = federal funds; SF = special funds; - =indeterminate effect
*State Employee Health Benefits Plan - assumes (1) a mix of 60% general funds, 20% special funds, and 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 minimal amount, depending upon the current type of health care coverage offered and number of enrollees. Revenues would not be affected.

Small Business Effect: A small business impact statement was not provided by the Administration in time for inclusion in this fiscal note. A revised fiscal note will be issued when the department's assessment becomes available.

Fiscal Analysis

Bill Summary: This bill requires or implements four separate patient rights to health insurance and health care access.

Single Point of Entry for Health Insurance Information: MIA shall serve as the single point of entry for consumers to access any information regarding health insurance and the delivery of health care as it relates to health insurance, including information prepared or collected by: (1) the Department of Health and Mental Hygiene; (2) the Health Care Access and Cost Commission; (3) the Health Services Cost Review Commission; (4) the Health Resources Planning Commission; (5) the Health Education and Advocacy Unit of the Attorney General's Office; and (6) the Department of Aging.
MIA will fund consumer access to information through the Health Care Regulatory Fund,

which is funded by an assessment imposed on health carriers.

Direct Access to Specialists: Carriers must permit direct access to a specialist in several circumstances. Each carrier must establish and implement a procedure by which: (1) a member may receive a standing referral to one of the carrier's specialists if the primary care provider determines, in consultation with the specialist, that the member needs continuing care from the specialist and the member has a condition or disease that is life-threatening, degenerative, chronic, or disabling and therefore requires specialized medical care; (2) one of the carrier's specialists may act as the primary care coordinator for a member if the member has a condition or a disease that is life-threatening, degenerative, chronic, or disabling and requires specialized medical care for at least one year; and (3) a member may request a referral to a specialist who is not part of the carrier's provider panel. Each carrier must file with MIA a copy of each of these procedures as required.

Coverage for Nonformulary Drugs: Carriers that limit their coverage of prescription drugs or devices to those on a formulary must establish and implement a procedure by which a member may receive a prescription drug or device that is not on the formulary if: (1) in the judgment of the prescribing physician, the drug or device not on the formulary is medically-necessary and there is no equivalent drug or device on the formulary; or (2) an equivalent prescription drug or device on the formulary has been ineffective in treating the member or has caused or is likely to cause an adverse reaction or other harm to the member. Carriers must also include certain consumer information about their formularies in their enrollment materials provided to members.

Minimum Hospitalization Requirements: Carriers must provide a minimum of 48 hours of inpatient hospitalization after a mastectomy or the removal of a testicle due to testicular cancer and to provide 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 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 also requires notice of this coverage to be provided to enrollees annually.

State Revenues: Special fund revenues could increase by an indeterminate amount in fiscal 2000 because carriers that do not already comply with the requirements of this bill would be subject to rate and form filings. Each affected carrier, including HMOs, that reviews its rates and amends its insurance policy must submit the proposed change(s) to the Maryland Insurance Administration (MIA) and pay a $125 rate and form filing fee. The number of carriers who will file new rates and forms as a result of the bill's requirements cannot be

reliably estimated at this time because carriers often combine several rate and policy amendments at one time when filing with MIA.

MIA's costs directly associated with consumer information will be funded through the Health Care Regulatory Fund, which is funded by an assessment imposed on health insurance carriers. MIA would increase the assessment in an amount to exactly offset expenditures.

In addition, if affected carriers increase premiums as a result of this bill, general fund revenues could increase by an indeterminate minimal amount as a result of the State's 2% insurance premium tax. The State's premium tax is applicable only to for-profit insurance carriers.

State Expenditures:

Single Point of Entry for Health Insurance Information: Expenditures for the Maryland Insurance Administration could increase by $74,921 in fiscal 2000, which accounts for the October 1, 1999 effective date. This estimate reflects the cost of two MIA technicians, one to handle an increased number of requests for information and one to process an increased number of rate and form filings resulting from direct access to specialists. It accounts for salaries, fringe benefits, one-time start-up costs, and ongoing operating costs. Out-year expenditures reflect (1) full salaries with 3.5% annual increases and 3% employee turnover; and (2) 1% annual increase in ongoing operating expenses. As the single point of entry for information, MIA will expect an increased number of telephone calls and written requests for information, as well as an increase in rate and form filings.

Direct Access to Specialists: The bill's requirement to provide direct access to specialists bypasses some managed care carriers' traditionally cost-saving gatekeeper function of routing patients through a primary care physician (PCP). It is possible that there may be some cost savings due to the elimination of the necessity for PCP visits. However, any savings will likely be more than offset by potential increases in utilization and the cost for increased specialty care, as specialty care is generally more expensive than primary care. Any increase in a carrier's medical costs because of this provision may be passed onto the State Employee Health Benefits Plan as increased premiums. However, any premium increase is expected to be minimal given the limited situations in which a member may bypass a PCP.

Coverage for Nonformulary Drugs: The State's prescription plan uses a restricted formulary. Generally, a restricted formulary enforces compliance with the formulary by charging members lower copays for formulary drugs than for nonformulary drugs. However, both formulary and nonformulary drugs are still covered under the State plan. The State plan

controls costs by imposing a $5 copay on formulary drugs and a $10 copay on nonformulary drugs. An open formulary, on the other hand, offers members coverage for all drugs. Publication of the formulary encourages use of listed drugs, but nonformulary drugs are still covered. A closed formulary provides coverage only for formulary drugs.

The State plan does not exclusively limit its coverage to formulary drugs. Because the bill does not prohibit the use of copays for nonformulary drugs there would be no fiscal impact on the State Employee Health Benefits Plan associated with the bill's coverage requirements.

Minimum Hospitalization Requirements: If the State chooses to include the bill's mandated coverage for hospitalization and home visits after treatment for breast cancer, expenditures could increase by an estimated $13,680 in fiscal 2000. The State Employee Health Benefits Plan has both self-insured and fully-insured health plans. The State does not have to include mandated benefits in its self-insured portions, but has traditionally done so in the past. Lymph node dissections generally are done when there is a mastectomy, and it is unlikely that there would be a separate procedure and thus, no additional increase in costs beyond that for mastectomies done on an inpatient basis. The medical care costs relating to the bill's mandated coverage for hospitalization and home visits after treatment for testicular cancer is expected to be minimal because the average length of stay after the procedure is currently higher than the 48 hours required by the bill. Data on the number or cost of lumpectomy were not readily available.

The $13,680 relating to mastectomies reflects an increase in medical care costs to the State of $13,500 for nine additional days of hospital care and $180 for two home care visits in lieu of hospital care after a mastectomy. The estimate for hospital care assumes: (1) an 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 old 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. Expenditures would increase further if some patients currently receiving inpatient hospitalization for mastectomies stay less than 48 hours. Any such impact cannot be reliably estimated at this time. Future year expenditures reflect medical cost inflation of 4.4%.

DHMH Study: The bill's requirement that the DHMH Secretary study the extent to which Medicaid managed care organizations must comply with the same or similar requirements can be handled with existing DHMH resources.

Information Source(s): Maryland Insurance Administration; Office of the Attorney General; Department of Health and Mental Hygiene; Department of Budget and Management (Employee Benefits Division); The Segal Company; U.S. Census Bureau; PCS HealthSystems, Inc.; CareFirst Blue Cross Blue Shield; Department of Legislative Services

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