SB 855

Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE
Revised

Senate Bill 855 (Senator Dyson, *et al.*)
Finance

Senior Assistance - Short-Term Prescription Drug Subsidy Plan

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This bill establishes a short-term prescription drug subsidy plan and fund. A health insurer, nonprofit health service plan, HMO, or dental plan organization (carrier) that offers a Substantial, Affordable, and Available Coverage (SAAC) product will not receive its SAAC differential unless the carrier contributes to the subsidy plan.

The bill takes effect July 1, 2000 and sunsets on the earlier of June 30, 2002 or when Medicare provides comparable prescription drug benefits.

Fiscal Summary

State Effect: Special fund revenues and expenditures for the short-term prescription drug subsidy plan fund could each increase by as much as $1,042,200 in both FY 2001 and FY 2002. Future year expenditures assume the bill will sunset June 30, 2002. Administrative costs associated with adopting regulations and preparing reports are assumed to be minimal, and could be handled with the existing budgeted resources of the Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA).

(in millions)	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
SF Revenues	$1.02	$1.02	$0.00	$0.00	$0.00
SF Expenditures	$1.02	$1.02	$0.0	$0.0	$0.0
Net Effect	$0.0	$0.0	$0.0	$0.0	$0.0

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

Local Effect: None.

Small Business Effect: Potential minimal. Pharmacists in medically under-served areas

may experience increased drug sales as a result of the subsidy plan.

Analysis

Bill Summary: The prescription drug subsidy plan provides prescription drug benefits to an individual who: (1) is 65 and over; (2) is eligible for Medicare Plus Choice; (3) resides in a medically under-served county; (4) pays the Medicare Part B premium; and (5) pays the premium, copayments, and deductibles required under the subsidy plan. Enrollment in the plan is limited to 15,000 participants.

The bill specifies that the subsidy plan must impose a $40 per month premium as well as a $50 deductible on each enrollee. The plan must also impose specified copayments for brand name and generic drugs, and sets a $1,000 annual benefit limit per individual. The plan may also include a restricted formulary of experimental drugs (not approved by the federal Food and Drug Administration) for which the plan will not reimburse enrollees.

Total contributions made to the subsidy plan fund by all carriers participating in the SAAC program are $5.4 million per year. An individual carrier's required contribution is based on the carrier's percentage of the total SAAC differential benefits paid to carriers on January 1, 2000.

The last carrier to provide Medicare Plus Choice coverage in medically under-served counties must administer the prescription drug subsidy plan. The Maryland Health Care Commission (MHCC) assesses each carrier for its contribution to the prescription drug subsidy plan fund, based on the carrier's percentage of the total SAAC differential. The carrier that administers the subsidy plan must use its assessment to fund the plan. The other carriers' assessments are deposited into the subsidy plan fund, and paid out to the carrier that administers the subsidy plan.

A carrier that offers a prescription drug subsidy program must contract with DHMH to: (1) provide prescription drug benefits to enrollees for at least two years; (2) not to alter the level or types of benefits provided under the plan; (3) hold enrollee premiums at the same level; (4) continue to serve at least the same medically under-served counties; and (5) make all performance review and financial records available for review by DHMH and the MIA.

MIA and DHMH must determine the maximum number of subsidy plan enrollees to be covered under each subsidy plan offered by carriers. If a carrier withdraws from the SAAC program, the MHCC must recalculate the subsidy plan contributions for the remaining carriers.
The Health Services Cost Review Commission (HSCRC) cannot take steps to eliminate or adjust the SAAC differential in hospital rates provided to carriers until the latter of the

termination of the short-term prescription drug subsidy plan or June 30, 2002. DHMH must adopt regulations to carry out the subsidy plan. In addition, DHMH, HSCRC, and MIA must submit a joint report to the Governor and the General Assembly that includes a summary of the program's activities for the year and any recommendations for consideration by the General Assembly. DHMH must also study the cost of providing access to managed care for Medicare Plus Choice-eligible individuals residing in urban, suburban, and rural areas throughout the State and must report the results to the Governor and the General Assembly by January 1, 2001.

The bill also specifies that a short-term prescription drug subsidy plan is not subject to the State's 2% premium tax imposed on insurers.

If DHMH is notified by the federal Health Care Financing Administration (HCFA) that any provision of the short-term prescription drug subsidy plan will invalidate the Maryland Medicare waiver or cause a reduction in the State's eligibility for federal funding of Medicaid, DHMH may suspend the subsidy plan provision or any other provision of the bill.

Current Law: There is no prescription drug subsidy program available to individuals eligible for Medicare Plus Choice coverage.

Background:

Medicare: Medicare is the nation's largest health insurance program, covering approximately 39 million Americans. Medicare provides health insurance to people aged 65 and over, those who have permanent kidney failure, and certain people with disabilities.
Medicare Part A covers hospitalization costs, while Part B covers supplemental medical services. Facing projected shortfalls in the Medicare Part A Trust Fund, Congress passed the Balanced Budget Act of 1997, part of which substantially restructured Medicare. The Act created Medicare Part C, the Medicare Plus Choice program.

Medicare Plus Choice offers beneficiaries a variety of health delivery models, including HMOs (with or without point-of-service options), preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and Medical Savings Accounts (MSAs).

HCFA pays Medicare Plus Choice programs a monthly capitation rate, which is adjusted for a beneficiary's age, disability status, gender, geographical location, and other factors. HCFA's reimbursement rate to Medicare Plus Choice became a source of controversy in 1999, with many carriers claiming reimbursement rates were too low. Medicare Plus Choice plans have pulled out or are pulling out of selected counties in 16 states, including Maryland.

SAAC Product: The SAAC product was established in 1974 as a means of encouraging

health insurance carriers to insure individuals with preexisting medical conditions. Insuring these individuals through the SAAC product reduces uncompensated care at hospitals and thus reduces the hospitals' costs for uncompensated care. Carriers who offer the SAAC product currently receive a 4% differential on regulated hospital charges. The SAAC product is budget-neutral for a hospital, because a carrier who offers the SAAC product is allowed to pay 2% less on its hospital charges for its entire enrolled population (i.e., not just on SAAC enrollees). Carriers who do not offer a SAAC product are charged 2% more for hospital charges.

Chapter 602 of 1999 established a task force to study the nongroup insurance market to examine how well the market is working in terms of access, availability, and quality of coverage. Part of the task force's study focused on the SAAC product health insurance carriers may offer to a medically uninsurable individual. In 1998, HSCRC raised serious concerns about whether the SAAC product's reduction of uncompensated hospital care was commensurate with the differential earned by carriers. For example, CareFirst saved $31 million in 1998 as a result of the 4% differential; however, HSCRC determined that CareFirst only averted $3.9 million in uncompensated hospital care costs.

State Fiscal Effect: Special fund expenditures and revenues each could increase by as much as $1,042,200 in fiscal 2001. Carriers that offer SAAC products will be assessed for their contribution to the prescription drug subsidy fund. These monies will be paid by the State directly to the carrier that administers the subsidy plan.

General fund revenues would not be affected by the subsidy plan's exemption from the State's 2% premium tax imposed on insurers.

Additional Comments: Currently three carriers, CareFirst Blue Cross Blue Shield of Maryland, Mid-Atlantic Medical Services, Inc. (MAMSI), and Aetna U.S. HealthCare, offer SAAC products. **Exhibit 1** illustrates each carrier's projected share of the $5.4 million to be used to fund the subsidy plan. CareFirst will administer the subsidy plan. MAMSI and Aetna are expected to pay their assessments to the plan fund as stated above.

Exhibit 1

Carrier	Total SAAC Differential - January 1, 2000	Total Differential Saved by Carrier	Carrier's Percentage of Total SAAC Differential	Projected FY 2001 Prescription Drug Subsidy Plan Assessment on Carriers
CareFirst	$40,300,000	$32,500,000	80.6%	$4,350,000

MAMSI	$40,300,000	$3,600,000	8.9%	$480,600
Aetna	$40,300,000	$4,200,000	10.4%	$561,600

Additional Information

Prior Introductions: None.

Cross File: HB 1350 (Delegate Guns, *et al.*) - Environmental Matters.

Information Source(s): CareFirst of Maryland; *A Summary of the New Medicare Plus Choice Program*, National Senior Citizens Law Center; *Medicare Managed Care*, Health Care Financing Administration; *Medicare Plus Choice - An Evaluation of the Program (August 4, 1999)*, Committee on Commerce, U.S. House of Representatives; CareFirst Blue Cross Blue Shield of Maryland; Department of Health and Mental Hygiene (Medicaid, Maryland Health Care Commission, Community Public Health Administration); Maryland Insurance Administration, Department of Aging; Department of Legislative Services

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Analysis by: Susan D. John

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 946-5510
(301) 970-5510