Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE
Revised

Senate Bill 567 (Senator Exum *et al.*)
Finance

Health Insurance - Access to Obstetric and Gynecological Services

This bill requires a health insurer, nonprofit health service plan, or HMO (carrier) to allow an enrollee direct access to primary and preventive obstetric and gynecological services from an in-network certified nurse midwife or any other in-network provider authorized under the Health Occupations Article to provide obstetric and gynecological services. A certified nurse midwife or any other nonphysician provider must consult with an obstetrician/gynecologist with whom the certified nurse midwife or other provider has a collaborative agreement regarding any care rendered to the enrollee.

The bill's requirements apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2000.

Fiscal Summary

State Effect: Minimal general fund revenue increase from the State's 2% insurance premium tax on for-profit carriers. Minimal special fund revenue increase for the Maryland Insurance Administration from the $125 rate and form filing fee. No effect on the State Employee Health Benefits Plan or Medicaid.

Local Effect: None.

Small Business Effect: Potential minimal. Certified nurse midwives and nurse practitioners may gain increased business under the bill's requirements.

Analysis

Current Law: Carriers must provide an enrollee with direct access to an obstetrician or a gynecologist. Carriers are not required to provide this direct access to other types of providers who render obstetric and gynecological services.

Background: According to the Maryland Health Care Commission's (MHCC) annual report on mandated benefits (December 1, 1999), requiring direct access to other obstetric and gynecological (ob/gyn) providers would increase group policy costs by approximately $0.01 per enrollee. The average cost of a yearly check-up performed by a certified nurse midwife (CNM) or a nurse practitioner is approximately $95, compared to $150 - $200 for routine care provided by a physician. MHCC reports that about 60% of nurse practitioner services and 80% of CNM services are covered by health benefit plans, which would reduce the marginal cost per enrollee to less than $0.01 per enrollee per year.

MHCC estimates that there are approximately 2.67 visits per 1,000 enrollees in any given plan for ob/gyn services. Approximately 19.1% of these visits are to a CNM or a nurse practitioner.

Thirty-one states require carriers to provide coverage for CNM services; however, these states do not necessarily require direct access to the provider.

State Fiscal Effect: Allowing direct access to ob/gyn service providers would not have any fiscal effect on the State Employee Health Benefits Plan. According to MHCC's annual report on mandated benefits, requiring carriers to provide direct access to providers who render ob/gyn services would increase plan costs by less than $0.01 per member. With approximately 250,000 individuals covered by the State plan, the increased cost to the State would be somewhat less than $2,500. This additional expenditure is absorbable with existing budgeted resources.

Additional Information

Prior Introductions: Similar bills, HB 279 and SB 358, were introduced in 1999. HB 279 received an unfavorable report from the House Economic Matters Committee. SB 358 was not reported from the Senate Finance Committee.

Cross File: HB 669 (Delegate Goldwater, *et al.*) - Economic Matters.

Information Source(s): Department of Health and Mental Hygiene (Maryland Health Care Commission, Office of Health Care Quality), Department of Legislative Services

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