SB 570

Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 570 (Senator Teitelbaum, *et al.*)

Finance Health and Government Operations

Health Insurance - Small Group Market - Limited Health Benefit Plan

This bill establishes a limited health benefit plan that may be sold in the small group health insurance market.

The bill takes effect July 1, 2004 and terminates June 30, 2008.

Fiscal Summary

State Effect: The Maryland Health Care Commission (MHCC) special fund expenditures and revenues could each increase by $50,000 in FY 2005. Potential minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2006. Future year estimates reflect inflation.

(in dollars)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
SF Revenue	$50,000	$50,500	$51,000	$51,500	$52,000
SF Expenditure	50,000	50,500	51,000	51,500	52,000
Net Effect	$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 meaningful.

Analysis

Bill Summary: MHCC must specify the benefits to be included in the limited benefit plan (LBP). A health insurer, nonprofit health service plan, or HMO (carrier) that insures

at least 10% of the total lives insured in the small group market must offer, and any other carrier may offer, the LBP to a small employer if the small employer meets certain requirements. The small employer must not have provided the Comprehensive Standard Health Benefit Plan (CSHBP) Standard plan during the last 12 months, or if the small employer has existed less than 12 months, from the date the small employer commenced business. In addition, the small employer's average annual wage paid to employees cannot exceed 75% of the average annual wage in the State. This wage limit does not apply to renewed LBP policies. The carrier must offer coverage for all eligible employees and dependents and may not offer the Standard plan for any members of the group.

A carrier may not offer a benefit in addition to the LBP other than one that reduces cost-sharing for the employee. The Insurance Commissioner may prohibit a carrier from offering an additional benefit if the Commissioner finds the benefit would be sold in conjunction with the limited benefit plan in a manner designed to promote risk selection or underwriting practices.

MHCC must ensure the actuarial value of the limited benefit plan does not exceed 70% of the actuarial value of CSHBP as of January 1, 2004 and consider including the in LBP the benefits required in the limited benefits policy authorized by Chapter 434 of 1991.

The Maryland Insurance Administration (MIA) must adopt regulations by July 1, 2005 that specify a disclosure statement notifying a small employer that the LBP provides only basic benefits and that more comprehensive benefits are available under CSHBP. The regulations must also require a carrier that offers the LBP to obtain a signed disclosure statement at the time of initial purchase and at renewal. MIA must also develop a uniform form for carriers to determine if an employer meets the eligibility criteria for LBP.

MHCC and the Maryland Insurance Commissioner must take all other actions necessary to ensure LBP is available to be offered by July 1, 2005. MHCC must report by January 1, 2008 to the Governor, the Senate Finance Committee, and the House Health and Government Operations Committee on: (1) the number of carriers offering LBP policies; (2) the number of LBP policies sold; (3) the number of eligible employees; (4) the average age, geographic area, and average age of eligible employees; (5) the impact of LBP on the small group market and the uninsured population in the State; and (6) any recommendations on continuing or expanding the availability of LHBP in the small group market.

Current Law: The Comprehensive Standard Health Benefit Plan (CSHBP) is a standard health benefit package (standard plan) that carriers must sell to small businesses (50 or

fewer employees). Carriers must offer the standard plan to all small businesses, but may sell additional benefits or enhancements through riders. Any riders must be offered and priced separately. CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and the elimination of preexisting condition limitations. In order to maintain affordability, the average CSHBP premium rate per employee must remain below 10% of Maryland's average annual wage.

Background: CSHBP was established in 1994 as a result of health care reforms adopted by the General Assembly to provide better access to coverage in the small group market. MIA and MHCC have joint responsibility for administering CSHBP. MIA must approve contracts, rates, and forms, as well as monitor carrier marketing. MHCC is responsible for the design and annual review of CSHBP.

MHCC's annual review of CSHBP includes determining the affordability of CSHBP in the small group market. If MHCC finds the average rate for the standard plan across all carriers and delivery systems exceeds 10% of Maryland's average annual wage, MHCC must modify CSHBP by increasing the cost-sharing arrangements or decreasing required benefits.

CSHBP has continued to stay under the affordability cap. At the end of 2002, Maryland's average annual wage was $39,360, the 10% cap was $3,960, and the average premium rate was $3,813. However, MHCC predicts that the average premium will exceed the 10% affordability cap in calendar 2003 and 2004.

Options for Covering the Uninsured: In January 2004, MHCC reported to the General Assembly on a variety of options for covering the uninsured. One proposal included a limited benefit plan to be offered in the small group market. The primary advantage of this type of plan is its affordability. Employees who currently cannot afford to obtain and maintain health insurance coverage through CSHBP may be able to purchase a basic benefit plan. The increased access to health care could, in turn, help to improve the quality of health of these individuals. Conversely, such a plan also could be problematic. The availability of a basic benefit plan in the small group market could encourage risk segmentation. Such a plan is likely to be marketed to and chosen primarily by employers who have relatively healthy or young employees. Less healthy or older employees would need and choose CSHBP. As a result of this market segmentation, the healthier employees would no longer be part of the shared-risk pool and would no longer help subsidize the costs of less healthy or older employees. MHCC found that a basic benefit plan would need to offer substantially fewer benefits than CSHBP to discourage this type of adverse selection.

State Fiscal Effect: MHCC special fund expenditures and revenues could each increase by $50,000 in fiscal 2005. MHCC must contract with an actuarial consultant to examine the mandated benefits in LHBP to comply with the bill's report requirements.

MHCC is specially funded through fees imposed on payors and providers. As a result of the increase in expenditures, MHCC would raise provider fees by an amount to exactly offset the increase in expenditures. Future year estimates reflect inflation.

Small Business Effect: In 2002, approximately 53,000 small businesses provided health insurance coverage to 448,000 covered lives in the small group market. Each policy carried an average 1.835 covered lives.

LHBP could provide limited health coverage to employees, reducing the number of uninsured in the State. If used properly to access preventive care, LHBP coverage could result in a healthier population.

On the other hand, if risk segmentation occurs because employers with healthy, young employees choose LHBP, CSHBP premiums could increase. There are several provisions in the bill that discourage risk segmentation, including a crowd-out provision and income limitations. There are insufficient data at this time to reliably project the amount of risk segmentation, if any, that could occur in the small group market.

Additional Information

Prior Introductions: None.

Cross File: None.

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

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