Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

House Bill 116 (Delegates Costa and Dwyer)
Health and Government Operations

Health Insurance - Small Group Market - Comprehensive Standard Health Benefit Plan

This bill requires the Comprehensive Standard Health Benefit Plan (CSHBP) offered to small businesses to include a pharmacy discount card option as well as specified copayments and deductibles for certain services.

Fiscal Summary

State Effect: Potential minimal general fund revenue increase from the 2% premium tax on for-profit insurers beginning FY 2005. Potential minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2005. The review of additional rate and form filings could be handled with existing MIA budgeted resources.

Local Effect: None.

Small Business Effect: Meaningful.

Analysis

Bill Summary: CSHBP's standard plan must include: (1) a $200 copayment for emergency room services; (2) a $50 copayment for primary and specialty care services for an HMO; and (3) copayments identical to specialty services copayments for: (a) outpatient laboratory and diagnostic services; (b) skilled nursing facility services; (c) outpatient rehabilitative and chiropractic services; and (d) outpatient services or surgery. In addition, the standard plan must include a $1,500 annual deductible for carriers that

provide indemnity, preferred provider option (PPO), or point of service (POS) delivery systems.

Current Law: 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 Maryland Health Care Commission (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 average premium will exceed the 10% affordability cap in calendar 2003 and 2004.

Exhibit 1 shows CSHBP's current copayments, coinsurance, deductibles, and prescription drug coverage.

Exhibit 1

Type of Coverage	Current CSHBP Cost-Sharing Feature	Bill's Proposed Changes
Prescription Drug	$250 deductible, then $15, $20, or $30 copayments per prescription drug	Offers a pharmacy discount card option
Indemnity Deductible	$1,250 for individual, $2,500 for family	$1,500
PPO Deductible	$1,000 for individual, $2,000 for family	$1,500
POS Deductible	$400 for individual, $800 for family	$1,500
HMO Deductible	None	
PPO/MSA Deductible	$2,250 for individual, $4,500 for family	$1,500
HMO Copayment	$20 Primary Care and In-patient Physician Care, $30 Specialty Care, $250 Inpatient Hospital Care	$50 copayment for primary and specialty care
Emergency Room	$35 copayment (waived if admitted) plus coinsurance amount	$200 copayment
Outpatient Lab and Diagnostic Services	$20 copayment or applicable coinsurance, whichever is greater under indemnity, PPO or POS plans; $20 copayment or 50% of the applicable cost, whichever is less for HMOs	$50 copayment
Skilled Nursing Facility Services	100 days as an alternative to otherwise covered care in a hospital or other related institution; $20 copayment or applicable coinsurance, whichever is greater	$50 copayment
Chiropractic Services	Carrier shall pay in-network provider 70% of allowable charges (50% out-of-network) up to 20 visits per condition, per year	$50 copayment
Outpatient Rehabilitative Services	Carrier pays 70% or may substitute a $20 copayment (except federally qualified HMOs may provide 60 consecutive days); for out-of-network services, carrier pays 50% of allowable charges	$50 copayment
Outpatient Services or Surgery	$20 copayment or applicable co-insurance, whichever is greater	$50 copayment

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.

Small Business Health Insurance Costs: The bill's higher deductibles and increased copayments could reduce the average premium rate in the small group market by a significant amount. While the exact savings created by these provisions cannot be determined at this time, similar cost-shifting proposals studied by MHCC would significantly reduce the average premium rate. For comparative purposes, increasing the PPO deductible from $1,000 to $2,500 would reduce the average premium by 9.4%, and increasing the POS deductible from $400 to $1,000 would reduce the average premium

0.6%. In addition, increasing copayments for specialty services from $30 to $40 would reduce the average premium by 2.1%. The bill's emergency room copayment increase from $35 to $200 was studied by MHCC, and this change would reduce the average premium by 2.5%.

The bill's uniform copayments for primary care providers and specialists could increase the average premium rate in the small group market. The uniformity of these premiums erodes the financial incentive for enrollees to use primary care, which generally costs less than specialty care, thus possibly increasing the average premium rate.

The bill's prescription drug card option would add minimal costs to carriers to pay for increased administrative costs. This provision is expected to have minimal impact on the average premium rate.

Small Business Pharmacies: There are approximately 1,100 pharmacies in Maryland, one-quarter of which are small businesses. Under the pharmacy discount card option, pharmacies could have to sell drugs to card holders at a loss. According to a Kaiser Family Foundation report, most discount drug card programs rely on discounts obtained from agreements with pharmacies rather than negotiated discounts or rebates with drug manufacturers.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): *Prescription Drug Discount Programs, Current Programs and Issues* (February 2002), Kaiser Family Foundation; Department of Health and Mental Hygiene (Medicaid, Maryland Health Care Commission, Maryland AIDS Administration); *Study of Issues Related to the Small Group Market* (2003), Maryland Health Care Commission; Maryland Insurance Administration, Department of Legislative Services

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