HB 200

Department of Legislative Services

Maryland General Assembly
2006 Session

FISCAL AND POLICY NOTE

House Bill 200 (Delegates Benson and Nathan-Pulliam)
Health and Government Operations

Health Insurance - Coverage for Hospitalization After Mastectomy

This bill requires a health insurer, nonprofit health service plan, or HMO (carrier) that provides inpatient hospitalization coverage to provide inpatient hospitalization coverage for an overnight stay following a mastectomy that is performed for the treatment of breast cancer.

Fiscal Summary

State Effect: State Employee and Retiree Health and Welfare Benefits Plan (State plan) expenditures could increase by $580,900 in FY 2007, with the potential for off-setting savings. Future year estimates reflect annualization and inflation. No effect on revenues.

(in dollars)	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Revenues	$0	$0	$0	$0	$0
GF Expenditure	348,500	515,800	572,500	635,500	705,400
SF Expenditure	116,200	171,900	190,800	211,800	235,100
FF Expenditure	116,200	171,900	190,800	211,800	235,100
Net Effect	($580,900)	($859,600)	($954,100)	($1,059,100)	($1,175,600)

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

Local Effect: To the extent carriers increase premiums as a result of the bill's requirements, expenditures for local government employee health benefits could increase. Any increase is expected to be negligible. No effect on revenues

Small Business Effect: Potential minimal.

Analysis

Bill Summary: If a physical complication related to the mastectomy occurs, a carrier must provide coverage for inpatient hospitalization beyond an overnight stay. A carrier is not required to cover the cost of overnight hospitalization if the patient, in consultation with the health care provider, determines that a shorter period of hospitalization is appropriate for recovery.

A carrier may not deny, limit, or otherwise impair the participation of an attending health care provider under contract with the carrier due to the provider's advocating: (1) the interest of a mastectomy patient through the carrier's utilization review or appeals system; (2) for an overnight stay following a mastectomy; or (3) for additional inpatient hospitalization if there are any physical complications related to a mastectomy.

A carrier must provide annual notice to its enrollees about the required coverage.

Current Law: There are 40 mandated health insurance benefits that certain carriers must provide to their enrollees. There is no provision requiring overnight hospitalization for mastectomy patients.

For a patient who receives less than 48 hours of hospitalization following a mastectomy, a carrier must provide coverage for: (1) one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and (2) an additional home visit if prescribed by the patient's attending physician. This mandated benefit terminates September 30, 2006.

Background: The number of outpatient mastectomies has been increasing in recent years. Several factors have contributed to this trend, including advances in medical surgical techniques. One significant factor, however, is the type of health insurance coverage a patient has. A 2001 study noted that while clinical factors were important, insurance coverage influenced whether a complete mastectomy was followed by a hospital stay. Among Medicaid patients, 97% were kept in the hospital after surgery, while 94% of Medicare patients stayed in the hospital. By comparison, 89% of HMO patients were kept in the hospital.

Several studies have examined the quality of outcomes for outpatient vs. inpatient mastectomies. While most studies found no difference in outcomes, one conducted in 2000 found that breast cancer patients who undergo outpatient surgery report faster recovery and better psychological adjustment than those who undergo inpatient surgery. Patients who spent the first night in the hospital reported it took an average of 27 days to feel they had recovered from surgery, about 10 days longer than the outpatient group.

Returning to usual activities took about 6 weeks for inpatients, about 11 days longer than for outpatients.

While outpatient outcomes tend to be quite favorable, many HMOs and other types of managed care plans used these outcomes to justify covering only outpatient surgery, regardless of clinical factors. Some carriers that mandate outpatient surgery have used savings to provide more extended care at home.

The Maryland Health Care Commission (MHCC) conducts an annual study of mandated health benefits. According to its January 15, 2004 report, there are 40 required health insurance benefits for services that carriers must include. On average, these mandated health benefits account for 15% of a health insurance policy premium's total cost.

State Fiscal Effect: If the State plan chooses to cover this mandated health benefit, expenditures could increase by $580,838 in fiscal 2007, which reflects the bill's October 1, 2006 effective date. The State has both self-insured and fully-insured health plans. The State is not required to cover mandated benefits under its self-insured plans, but it has generally done so in the past. The information and assumptions used in calculating the estimate are stated below:

- 150 people receive mastectomies annually*;*
- the State plan covers 1.5 days' inpatient hospitalization per patient*;* and
- the average impatient cost for a neoplasm (cancer) case is $3,442 per day.

State plan expenditures would be offset if inpatient hospitalization reduced the need for aftercare visits at the patient's home. There are insufficient data at this time to reliably estimate any savings.

State plan expenditures assume a fund mix of 60% general funds, 20% federal funds, and 20% special funds; 20% of expenditures are reimbursable through employee contributions. Future year estimates reflect annualization and 11% annual inflation.

Small Business Effect: Small businesses (2-50 employees) purchase the Comprehensive Standard Health Benefit Plan (CSHBP), which is exempt from including mandated benefits in its coverage. All carriers participating in the small business market must sell CSHBP to any small business that applies for it. A small business may purchase riders to expand the covered services. In addition, MHCC takes mandated benefits into consideration when reevaluating the CSHBP benefit package. Small business health

insurance costs may increase if carriers increase their premiums as a result of this bill. Any increase is expected to be negligible.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Budget and Management (Employee Benefits Division), Department of Legislative Services

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