Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 427 (Senators Middleton and Astle)
Finance Health and Government Operations

Health Insurance - Authorization of Additional Products and Small Group Administrative Discounts and Study

This bill authorizes insurers and nonprofit health service plans to: (1) offer certain preferred provider insurance policies; and (2) offer limited benefit plans to "special eligible employees." Small group carriers may offer an administrative discount to small employers that purchase for their employees other specified insurance sold by the carrier, provided that the discount is offered under the same terms and conditions for all qualifying small employers.

Uncodified language requires the Maryland Health Care Commission to conduct a study of the Comprehensive Standard Health Benefit Plan (CSHBP) and report by December 1, 2007 on options available to encourage more employers to enter the small group market.

Fiscal Summary

State Effect: Potential minimal special fund revenue increase for the Maryland Insurance Administration from the $125 rate and form filing fee in FY 2008. Potential minimal savings to the Medicaid program (50% general funds, 50% federal funds) to the extent that individuals currently ineligible for group health insurance elect new coverage available under the bill.

Local Effect: None.

Small Business Effect: To the extent carriers offer small businesses administrative discounts, health insurance expenditures for those businesses could decrease. Additional options for health insurance will be available in the small group market.

Analysis

Bill Summary:

Preferred Provider Insurance Policies: The Insurance Commissioner may authorize an insurer or nonprofit health service plan to offer a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers if the provider panel complies with specified regulations and the policy does not restrict payment for covered services provided by nonpreferred providers for emergency services; an unforeseen illness, injury, or condition requiring immediate care; or as otherwise specified under law. A preferred provider insurance policy must assure that all covered services are accessible to the enrollee with reasonable safeguards with respect to geographic locations.

If health benefits are provided to employees or individuals only through preferred providers, the insurer or nonprofit health service plan must provide an option to include preferred and nonpreferred providers as an optional benefit. Insurers and nonprofit health service plans must disclose the availability of this option and employers, associations, or other private group arrangements offering may require employees or individuals to pay a greater premium for this optional benefit.

Health Insurance Policies with Limited Benefits: Special eligible employees mean those who: ● are eligible for health coverage under an employer sponsored health plan; ● work on a temporary or substitute basis or less than 30 hours per week; and ● are not eligible for group coverage. An insurer or nonprofit health service plan that sells a limited benefit group health insurance contract may require an employer to collect premiums through payroll deduction, contribute to premium payments, and offer coverage to any dependent of a special eligible employee. An insurer or nonprofit health service plan must disclose that the limited group health insurance contract does not provide comprehensive coverage.

Current Law: CSHBP is a standard health benefit package that carriers must sell to small businesses (2 to 50 employees). Carriers must offer the standard plan to all small businesses, but may sell additional benefits or enhancements through riders. Riders must be offered and priced separately. CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and no 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: A preferred provider organization (PPO) is a health care organization that provides health care services at a reduced fee and is paid for services as they are received rather through advance capitation payments (as HMOs are paid). Exclusive provider organizations are similar to PPOs, but do not provide any benefit if the insured chooses a

nonpreferred provider, except in cases of emergencies. In a PPO, the insured pays a lower coinsurance amount by receiving care from a preferred provider. Nonpreferred providers can balance-bill the insured for the difference between the fee paid by the insurer and the providers charges.

Additional Comments: To the extent that individuals currently ineligible for group health insurance elect new coverage under the bill, the number of uninsured individuals and uncompensated care in Maryland could potentially decline.

Additional Information

Prior Introductions: None.

Cross File: HB 579 (Delegate Tarrant, *et al.*) – Health and Government Operations.

Information Source(s): *Annual Mandated Health Insurance Services Evaluation,* Maryland Health Care Commission (January 19, 2006); Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510