SB 149

Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 149 (The President, *et al.*) (By Request – Administration)
Finance Health and Government Operations

Maryland Health Care Access Act of 2007

This Administration bill, among other things, expands access to the Maryland Children's Health Program (MCHP) to all children under age 19; requires insurers, nonprofit health service plans, and HMOs (carriers) to allow a child dependent to remain on a parent's plan until age 25; and requires the Secretary of Health and Mental Hygiene to establish a Maryland Health Care Quality Coordinating Council.

The bill takes effect July 1, 2007 and applies to all policies and contracts issued, delivered, or renewed in the State on or after January 1, 2008.

Fiscal Summary

State Effect: Expenditures for the State employee and retiree health insurance program (State plan) could increase by $4.3 million in FY 2009 (60% general funds, 20% federal funds, 20% special funds) to extend coverage for child dependents. Maryland Health Care Commission (MHCC) special fund revenues and expenditures could increase by $350,000 in FY 2008, of which $150,000 is budgeted, to conduct a study and seek proposals to implement a regional health information exchange. Any effect on MCHP cannot be reliably estimated at this time. Potential minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2008. Future years reflect inflation.

(in dollars)	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
SF Revenue	$350,000	-	-	-	-
GF Expenditure	-	2,575,800	2,807,600	3,060,300	3,335,800
SF Expenditure	350,000	858,600	935,900	1,020,100	1,111,900
FF Expenditure	0	858,600	935,900	1,020,100	1,111,900
Net Effect	$0	($4,293,000)	($4,679,400)	($5,100,500)	($5,559,600)

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

Local Effect: Potentially significant increase in local government health insurance expenditures to cover child dependents beyond the limiting age of their plans.

Small Business Effect: A small business impact statement was not provided by the Administration in time for inclusion in this fiscal note. A revised fiscal note will be issued when the Administration's assessment becomes available.

Analysis

Bill Summary:

Maryland Children's Health Program: The bill establishes an MCHP buy-in option for children under age 19 with household incomes above 300% of federal poverty guidelines (FPG). Enrollees must pay an annual family contribution based on the full cost of coverage, including the cost of specialty mental health services.

The bill removes the current requirement that families in the MCHP Premium Plan contribute an annual premium of 2% of annual income and requires the Department of Health and Mental Hygiene (DHMH) to establish an annual family contribution that is reasonable, according to family income, and encourages enrollment of all eligible individuals. DHMH is authorized to provide incentives to families of eligible children to enroll the child in available employer-sponsored health insurance.

Uncodified language provides that it is the intent of the General Assembly that DHMH, subject to the State budget, provide for increased education and outreach for all children who are eligible for MCHP.

Continuation of Coverage for Child Dependents: A "child dependent" means an unmarried child, stepchild, adopted child, grandchild, child placed for legal adoption, or other child entitled to dependent coverage who is under the age of 25, unmarried, and meets the definition of a dependent under federal law and regulation. Each health insurance policy or contract issued in Maryland that provides coverage for dependents must (1) include coverage for a child dependent; (2) provide the same benefits to a child dependent that are available to any other covered dependent; and (3) provide benefits to a child dependent at the same rate or premium applicable to any other covered dependent. The bill does not limit or alter any right to dependent coverage or continuation of coverage otherwise provided under law.

Carriers must notify a parent, at least 60 days before a child covered under the parent's policy turns 18 years of age, of the criteria under which a child may remain eligible for

coverage as a child dependent. The Insurance Commissioner must establish and publish by bulletin the notice to be given.

Maryland Health Care Quality Coordinating Council: The council is established to coordinate, evaluate, and prioritize health care quality initiatives in the State. The council will • coordinate and facilitate collaboration on health care quality improvement initiatives; • conduct strategic planning and prioritization of health care quality initiatives; • participate in health care quality discussions and make recommendations; • evaluate the impact of health information technology products and systems and facilitate their integration in health care systems; and • avoid duplication of existing health care quality improvement efforts. Members may not receive compensation but are entitled to reimbursement for expenses. Staff for the council will be designated by the Secretary of Health and Mental Hygiene. By December 1 of each year, the council must report on its activities and make recommendations for improving health care quality in the State.

Task Force on Expanding Access to Affordable Health Care: Uncodified language establishes a Task Force on Expanding Access to Affordable Health Care to study and make recommendations regarding expanding access to health insurance and reducing the amount of uncompensated care in the State. Staff will be provided by MHCC, MIA, and the Health Services Cost Review Commission (HSCRC). A report with findings and recommendations is due by December 31, 2007.

Hospital Pay-for-performance: The bill requires HSCRC, by July 1, 2008, to adopt regulations that provide incentives within hospital payment standards for adherence to quality standards and achievement of performance benchmarks. HSCRC also must report to specified legislative committees on a plan to analyze data collected under the commission's quality-based reimbursement project that indicates whether there are racial and ethnic disparities in adherence to quality standards and performance benchmarks. HSCRC has to establish quality standards and performance benchmarks in conjunction with the Maryland Health Care Commission (MHCC), the Office of Health Care Quality, and the Health Care Quality Coordinating Council.

Wellness Promotion: The bill authorizes health insurance carriers, after applying risk adjustment factors for age and geography, to offer a discounted rate of up to 20% to a small employer for participation in a "wellness program." Discounts must be • applied to reduce the rate otherwise payable by the small employer; • actuarially adjusted; • offered uniformly to all small employers; and • approved by the Insurance Commissioner.

Wellness programs include programs and activities for smoking cessation, reduction of alcohol misuse, weight reduction, nutrition education, and automobile and motorcycle safety. Eligible wellness programs have to comply with guidelines adopted by MHCC.

Uncodified language requires the Department of Budget and Management and DHMH, within currently budgeted resources, to develop a wellness incentive pilot for State employees to provide incentives for employees and their dependents to maintain their health and prevent chronic illness. The departments are required to report on the components of and implementation plans for the program by January 1, 2008. The plan must be implemented beginning July 1, 2008.

Chronic Care Management: Uncodified language, effective July 1, 2008, requires the Secretary of Health and Mental Hygiene to develop a statewide plan to improve the quality and cost-effectiveness of care for individuals with, and at risk for, chronic health care conditions. The Secretary is required to report on the plan by January 1, 2008.

Health Insurance Exchange Study: Uncodified language requires MHCC, in consultation with MIA, to conduct a study of the feasibility and desirability of establishing a health insurance exchange to promote expansion of affordable health care coverage in the State. In conducting the study, MHCC must solicit oral and written comments, data, and other information from all interested parties. By October 1, 2007, MHCC must submit an interim report on the results of the study to the Task Force on Expanding Access to Affordable Health Care. By January 1, 2008, MHCC must report on the results of the study to specified legislative committees.

Regional Health Information Exchange: Uncodified language requires MHCC and HSCRC to collaborate in seeking a proposal or proposals leading to the establishment of a regional health information exchange and a method of unambiguously linking an individual's health information from different sources, while protecting privacy.

Uncodified Medicaid Reporting Requirements: DHMH is required to submit a report by December 1, 2007 on the progress made in updating the Medicaid computer eligibility system, including securing funding from the Centers for Medicare and Medicaid Services (CMS) and issuing a request for proposals to purchase and implement the system.

DHMH and the Department of Human Resources (DHR) are required to conduct a needs assessment to determine the number of additional caseworkers needed to enroll current applicants into Medicaid in a timely manner and the number of caseworkers needed if Medicaid is expanded. DHMH must report on the needs assessment by December 1, 2007, including the protocol for training all caseworkers on the eligibility process and new federal and State rules.

Joint Committee on Health Care Delivery and Financing: Uncodified language directs the joint committee during the 2007 interim to study • the interaction of Medicaid policy and State budget issues; • potential policy and budget issues that will need to be addressed if Medicaid is expanded; and • policy and State budget issues affecting access

to public mental health services. The joint committee must include a summary of its findings in its annual report, due by January 1, 2008.

Current Law:

Maryland Children's Health Program: Eligibility for MCHP currently extends to individuals under age 19 with family incomes up to 300% FPG. Children in families with incomes above 200% but at or below 300% FPG are enrolled in the MCHP Premium Plan. These families pay a family contribution toward the cost of the program equal to 2% of the annual income for: (1) a family of 2 at 200% FPG (about $548 per year), for families earning up to 250% FPG; or (2) a family of 2 at 250% FPG (about $685 per year), for families earning up to 300% FPG. In 2006, the cost per family for the MCHP Premium Plan was $44 to $55 per month. Individuals who have been eligible for employer-sponsored health insurance in the previous six months are ineligible for MCHP.

Coverage for Dependent Children: Notwithstanding any limiting age stated in a health benefit policy, a child, grandchild, or individual for whom guardianship is granted must continue to be covered under the policy as a dependent of a covered individual if the child, grandchild, or individual under guardianship is unmarried, chiefly dependent for support on the covered individual, and is incapable of self-support because of a mental or physical incapacity. Generally, children are allowed to remain on the policy of a parent until age 19 or until age 23 if the child is a full-time student.

The Secretary of Budget and Management administers the State employee and retiree health insurance plan and specifies the types of benefits as well as the types or categories of State employees and retirees who may participate. The enrollment of dependent children is limited by specified factors including age and marital status of the child, legal guardianship, college enrollment status, or disability. State regulations cover dependent children through the end of the year in which they turn age 19. Thereafter, the dependent child may continue coverage through age 23 as long as they are a full-time student, or continue coverage indefinitely if they are certified as disabled.

Background:

MCHP Buy-in Option: According to MHCC, in 2004-2005, of the 790,00 Maryland children with family incomes over 300% FPG, 40,000 (5%) were uninsured.

Continuation of Coverage for Dependent Children: Young adults, ages 19 to 29, have one of the highest risks of being uninsured in Maryland, in part because they are the least likely to have access to employer sponsored health insurance. In 2004-2005, 28% of individuals in this age group (about 110,000 individuals) did not have health insurance coverage.

Task Force on Expanding Access to Affordable Health Care: Chapter 290 of 2005, as amended by Chapter 21 of 2006 established the Joint Legislative Task Force on Universal Access to Quality and Affordable Health Care. The task force is scheduled to terminate effective June 30, 2007.

Health Care Quality Initiatives: In 2004, MHCC designated the Maryland Patient Safety Center to bring together health care providers to study the causes of unsafe practices and put practical improvements in place to prevent errors in hospitals and nursing homes.

Wellness Promotion: In an effort to stem increasing health insurance and medical costs, many employers offer health insurance premium discounts to enrollees who participate in wellness programs. In 1998, the U.S. Department of Labor estimated that premium discounts associated with wellness programs ranged from $60 to $500 and averaged $240 per participant. Wellness programs include such things as smoking cessation, weight management, stress management, nutrition education, and prenatal education.

Other states have enacted legislation to provide wellness incentives. In 2006, Michigan enacted legislation requiring health insurance carriers to provide premium rebates to group health plans in which a majority of employees or members enroll and maintain participation in group wellness programs. The rebates apply to the individual policies of those who participate in the wellness programs. In 2004, New Hampshire authorized insurers in the small group and individual market to use a rating factor to discount premium rates for plans, giving monetary incentives for participants in wellness or disease management programs.

Health Insurance Exchanges: Legislation enacted in Massachusetts in April 2006 established the Commonwealth Health Insurance Connector to facilitate health coverage to small businesses and individuals. Eligible workers will be able to buy coverage with pre-tax dollars and multiple employers may contribute to an employee's premium through the Connector. The Connector program is expected to facilitate portability of coverage, permit multiple source payments for premiums, and make premiums pre-tax.

State Fiscal Effect:

Coverage for Dependent Children: Expenditures for the State plan could increase by as much as $4.3 million in fiscal 2009 (60% general funds, 20% federal funds, 20% special funds) to extend coverage to child dependents beyond the current limiting age of the State plan (age 19 or age 23 if a full-time student), which accounts for the January 1, 2008 effective date of this provision. Policies under the State plan are written on a fiscal year basis meaning that the bill will not affect the State plan until July 1, 2008 (fiscal 2009). The information and assumptions used in calculating the estimate are stated below:

- DBM estimates that 9,966 child dependents would be eligible to remain on the plan in fiscal 2008;
- approximately 75% of eligible child dependents (7,475) will gain coverage elsewhere (i.e., marriage or employment);
- 2,492 eligible child dependents will remain on the plan at a total annual cost of $2,154 per individual; and
- the State will pay 80% of the cost ($1,723) for each child dependent, while employees will pay 20% of the cost ($431).

Future year expenditures reflect 9% inflation.

Potential minimal special fund revenue increase for MIA from the $125 rate and form filing fee in fiscal 2008. Additional resources may be required to review forms and ensure compliance with the mandate, depending on the volume of forms received for review.

Maryland Children's Health Program: To the extent that DHMH alters the current annual family contribution for children enrolled in the MCHP Premium Plan, DHMH expenditures could increase or decrease beginning in fiscal 2008. If the family contribution were reduced, the cost per child paid by the State (and federal matching funds) would increase. The amount of this increase cannot be reliably estimated at this time. Although Maryland typically receives a 65% federal match for MCHP expenditures, the State has spent its federal allotment, after which time the match drops to 50% federal funds.

The cost of the MCHP buy-in option would be paid by enrollees, as specified under the bill. DHMH indicates that any administrative expenses incurred for enrollment and premium collection would be passed on to enrollees through the annual family contribution. No federal matching funds would be available for this population.

The Governor's proposed Supplemental Budget No. 2 includes $6.0 million (65% federal funds, 35% general funds) to expand the MCHP Premium Plan to children with household incomes between 300% and 400% FPG. This funding is contingent upon the enactment of SB 149 or HB 132 of 2007 pertaining to MCHP expansion.

Experience with the MCHP Premium Plan for families with incomes between 200% and 300% FPG suggests that enrollment in the buy-in option, which requires an annual family contribution equal to the full cost of the program, may be minimal. The premium plan has been available since 2000 and current enrollment is only 11,000.

Health Care Coordinating Council: DHMH general fund expenditures would increase beginning in fiscal 2008 to provide staff to the council and reimburse members for

expenses. The amount of this increase cannot be reliably estimated at this time, but is expected to be minimal and absorbable within existing resources.

Hospital Pay-for-performance: HSCRC indicates that the commission could adopt hospital pay-for-performance regulations, establish quality standards and benchmarks, submit a report on a plan to identify whether there are racial and ethnic disparities in quality standards and performance benchmarks, and collaborate in seeking a proposal or proposals leading to the establishment of a regional health information exchange using existing resources.

Wellness Promotion: To the extent carriers provide incentives for participation in wellness programs and members subsequently participate, health care-related expenditures in the State could decrease. DBM indicates that it could develop and implement a wellness incentive pilot for State employees within existing budgeted resources.

Health Insurance Exchange Study: MHCC special fund revenues and expenditures would increase by approximately $200,000 in fiscal 2008 to hire a contractor for the data collection and analysis required for the study.

Regional Health Information Exchange: The Governor's proposed fiscal 2008 budget for MHCC includes $150,000 for MHCC and HSCRC to seek a proposal leading to the establishment of a regional health information exchange.

Task Force on Expanding Access to Affordable Health Care: DHMH could handle the requirements for staffing the task force with existing budgeted resources.

Additional Uncodified Language: Legislative Services estimates that all additional uncodified language included in the bill could be handled with existing budgeted resources.

Additional Comments: HSCRC indicates that enrollment of previously uninsured children in the MCHP buy-in option could result in reduced hospital uncompensated care by fiscal 2010. This savings could be used to fund expansion of health insurance coverage or reduce hospital rates, which in turn reduces the cost of health insurance for all payors. The magnitude of these savings cannot be reliably estimated at this time and will depend on enrollment in MCHP under the bill.

To the extent child dependents remain covered under their parents' health insurance policies and avoid becoming uninsured, uncompensated care costs to hospitals and other health care providers could decrease.

Exhibit 1 displays the 2007 federal poverty guidelines by family size for 300% FPG.

Exhibit 1
2007 Federal Poverty Guidelines

Family Size	300% FPG
1	$30,630
2	$41,070
3	$51,510
4	$61,950

Additional Information

Prior Introductions: HB 882 of 2006, which was withdrawn, would have required insurers to permit a child to continue to be covered under a parent's policy after the child meets the limiting age specified in the contract up to the age of 30, if the child has had continuous coverage for at least two years prior to reaching the limiting age. SB 530 of 2006 would have created the Maryland Health Insurance Exchange within MHCC to provide a choice of health insurance plans to participating individuals and employer groups. SB 530 received an unfavorable report from the Senate Finance Committee.

Cross File: HB 132 (The Speaker, *et al.*) (By Request – Administration) – Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Budget and Management; *Health Insurance Coverage in Maryland Through 2005,* Maryland Health Care Commission, January 2007; Department of Legislative Services.

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