Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE
Revised

House Bill 360 (Chair, Health and Government Operations Committee)(By Request - Departmental - Insurance Administration, Maryland)

Health and Government Operations | Finance

Health Insurance - Repeal of Obsolete Provisions of Law

This departmental bill repeals provisions of insurance law that are obsolete under the federal Patient Protection and Affordable Care Act (ACA) or other federal or State law.

The bill takes effect January 1, 2014.

Fiscal Summary

State Effect: The bill does not materially affect State operations or finances.

Local Effect: None.

Small Business Effect: The Maryland Insurance Administration (MIA) has determined that this bill has minimal or no impact on small business (attached). The Department of Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary: The bill repeals as obsolete:

- the authority of health maintenance organizations (HMOs) to offer limited benefit plans;
- the authority for a group health insurance policy to continue benefits for family members due to the death of the individual in the insured group;

- the requirement that specified group policies must provide that an insured individual whose coverage under the group policy is terminated is entitled to an individual policy of hospital and medical insurance from the same insurer and related provisions regarding such conversion policies;
- the requirement that a succeeding insurer to a group contract provide an employer with information regarding waiting periods for preexisting conditions, exclusions, or similar policy provisions that exclude coverage for members of the group;
- the prohibition against an insurer or nonprofit health service plan denying coverage or not renewing individual, group, or blanket coverage because an individual has had a breast implant;
- subject to certain conditions and exclusions, the requirement that an insurer or nonprofit health service plan provide coverage to an individual regardless of preexisting conditions if an individual had coverage under a prior contract issued by the insurer or nonprofit health service plan within the past 30 days; and
- the requirement that nonprofit health service plans offer catastrophic health insurance policies.

Current Law/Background: An HMO may offer a benefit package that provides, at a minimum, specified benefits for a limited benefits policy. A limited benefits policy must be subject to the approval of the Insurance Commissioner and satisfy specified requirements. This provision is repealed as, according to MIA, limited benefits policies have not been permitted in Maryland since 1994.

A group health insurance policy that provides benefits for family members or dependents may provide for the continuation of all or part of the benefit provisions after the death of the individual in the insured group. These provisions are obsolete as § 15-407 of the Insurance Article provides the requirements and procedures for continuation of coverage to a qualified secondary beneficiary after the death of an insured in the small group market, while the federal Consolidated Omnibus Reconciliation Act (COBRA) applies for continuation of coverage requirements for groups of 20 or more.

Before entering into a group contract, a succeeding insurer must provide the employer with a written statement that (1) describes any waiting periods for preexisting conditions, exclusions, or similar policy provisions in the succeeding policy that limit or exclude coverage and (2) identifies each individual who is covered under the replaced or succeeded group contract but who is ineligible for full coverage under the succeeding policy. The statement must be sufficiently clear and specific so that an individual of average intelligence can understand the statement without making further inquiry to the succeeding insurer. These provisions are repealed as ACA does not allow waiting periods or exclusions.

Each group insurance policy must allow an insured individual whose coverage under the group policy is terminated (for any reason other than failure to pay a required premium or contribution) to obtain an individual policy (known as a conversion policy) from the insurer or nonprofit health service plan.

The Commissioner may exempt certain types of group policies or certain coverage under group policies from this requirement and establish conditions under which the conversion privilege does not apply. The Commissioner may establish different requirements and levels of benefits for various types of group policies and coverage, including exclusions and benefit limitations.

A conversion policy must (1) cover the insured individual whose coverage is terminated under the group policy and any eligible dependents; (2) take effect immediately after the termination of coverage under the group policy; and (3) provide the benefits the Commissioner requires. Premiums for a conversion policy must be determined in accordance with the insurer's or nonprofit health service plan's table of premium rates. The Commissioner must establish requirements that govern notification by the insurer or nonprofit health service plan to the insured individual whose coverage under the group policy is being terminated of the right of conversion to an individual policy and the timely election of the conversion privilege. Generally, continuation of group coverage at the expense of the insured individual may be required for a period of up to six months.

These provisions are repealed because under ACA an individual who loses group coverage at any time during the year has 60 days to enroll in a qualified health plan (QHP) offered through the individual exchange. According to CareFirst, after 2014, insurers and members will not receive any benefit from maintaining a separate conversion policy distinct from QHPs offered in the exchange.

An individual, group, or blanket health insurance policy (1) may not be denied by an insurer or nonprofit health service plan solely because the insured has had a breast implant and (2) on renewal, may not impose a waiting period or exclusion for a preexisting condition that limits or excludes coverage solely because the insured has had a breast implant. This provision is repealed as ACA does not allow waiting periods or exclusions.

An insurer or nonprofit health service plan must provide coverage to an individual regardless of the health of the individual if the individual had prior coverage and, within 30 days of the prior coverage terminating, the individual becomes eligible for and accepts coverage from the insurer or nonprofit health service plan. An insurer or nonprofit health service plan may exclude coverage for a medical condition if the contract is a group contract and the exclusion applies to all individuals under the contract. The insurer or nonprofit health service plan must waive a waiting period for coverage of a preexisting

condition if the individual has already satisfied a waiting period under his or her former coverage. These provisions are repealed as the federal Health Insurance Portability and Accountability Act (better known as HIPAA) is applicable in these circumstances.

Each nonprofit health service plan must offer a catastrophic health insurance policy with full coverage of up to $1.0 million. The policy may provide a deductible for each benefit period. The deductible may be satisfied by the insured's basic health insurance coverage or major medical insurance coverage. This provision is repealed as ACA does not permit annual or lifetime limits after January 1, 2014.

ACA Insurance Provisions: Among other provisions, ACA includes a number of patient protection provisions that took effect on September 23, 2010, for new policies upon issuance and for existing policies upon renewal, including coverage for children up to age 26 on a parent's policy, a ban on lifetime limits and on preexisting condition limitations on children, a restriction on annual limits, and coverage of certain preventive services without cost sharing. Additional insurance reforms will take effect January 1, 2014, including (1) policies that prohibit most insurance plans from excluding people for preexisting conditions, discriminating based on health status, and imposing annual monetary caps on coverage and (2) reforms to require guaranteed issue and renewal of policies, premium rating rules, nondiscrimination in benefits, and mental health and substance abuse parity.

Additional Information

Prior Introductions: None.

Cross File: None.

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

Fiscal Note History: First Reader - February 11, 2013
ncs/ljm Revised - House Third Reader - March 25, 2013

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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Health Insurance – Repeal of Obsolete Provisions of Law

BILL NUMBER: HB 360

PREPARED BY: Maryland Insurance Administration

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

__X__ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

___ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

The proposed legislation will have no impact on small business in Maryland.