HB 669

Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

House Bill 669 (Chairman, Health and Government Operations Committee)
(By Request − Departmental − Insurance Administration, Maryland)

Health and Government Operations — Finance

Health Insurance - HIPAA - Maryland Health Insurance Plan - Alternative Mechanism

This departmental bill specifies that the Maryland Health Insurance Plan (MHIP) is the alternative mechanism for eligible individuals under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The bill takes effect July 1, 2004.

Fiscal Summary

State Effect: The bill would not substantively change State activities or operations.

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). Legislative Services concurs with this assessment.

Analysis

Bill Summary: MHIP may not apply a preexisting condition exclusion to an eligible individual who applies for coverage within 63 days of terminating prior creditable coverage. If the MHIP board imposes a limit on the number of individuals who can enroll in the plan, the limit may not be applied to HIPAA eligible individuals. A carrier that issued a high level or low level policy form prior to July 1, 2004 may not charge a

rate to eligible individuals under either policy form that is greater than 200% the carrier normally would charge for the same or similar policy forms to other individuals. A carrier may not terminate a health benefit plan that was issued to an eligible individual prior to July 1, 2004 unless the carrier gives sufficient notice as required by law. The bill repeals other current law provisions that would become obsolete if MHIP is considered a HIPAA alternative mechanism.

Current Law: HIPAA is intended to improve access, portability, and renewal of health insurance policies. Under HIPAA, a state may choose to implement an "alternative mechanism" to ensure that eligible individuals have access to the individual health insurance market or comparable coverage. States that choose this option must submit timely notice to the federal Centers for Medicare and Medicaid Services (CMS) with sufficient documentation. Chapter 2 of 2003 required MIA to submit a request to CMS to deem MHIP an alternative mechanism under federal law.

MHIP is a high-risk pool and an independent unit of MIA whose purpose is to decrease uncompensated care by providing affordable access to comprehensive health benefits for medically uninsurable residents.

Background: One of HIPAA's provisions guarantees the availability of individual health insurance coverage to certain individuals with prior group coverage. HIPAA's portability requirements apply to individuals who had, at a minimum, an aggregate of 18 months of group health coverage, with no break exceeding 62 days between periods of coverage, immediately preceding the individual coverage.

States have two options for enforcing HIPAA's individual health insurance provisions. First, states can require all insurers that offer coverage in the individual market to make all their individual policies available to all eligible individuals on a guaranteed basis, without preexisting condition exclusions (referred to as the "federal default" provisions). In states that implement the federal default provisions, health insurers may limit the individual coverage offered as long as there are two different policy forms of coverage offered that meet specified requirements. Each of these policy forms must include benefits substantially similar to other individual health insurance coverage offered by the insurer in the state.

Second, states can elect to implement an "alternative mechanism." States that choose this option must submit to CMS a notice with sufficient documentation to enable the agency to determine whether the alternative mechanism is acceptable. Examples of an acceptable alternative mechanism may include a health insurance coverage pool or program, a mandatory group conversion policy, guaranteed issue of one or more individual health insurance plans, open enrollment by one or more health insurance

issuers, or a combination of these mechanisms. States with an approved alternative mechanism also may request approval of subsequent revisions, and states that initially elected the federal default provisions may later switch to an alternative mechanism with the requisite approval.

An alternative mechanism must meet a number of requirements for all eligible individuals. These requirements include that the mechanism: (1) provide a choice of health insurance coverage; (2) not impose any preexisting condition exclusions; and (3) include at least one policy form of coverage that is comparable to either (a) comprehensive health insurance coverage offered in the individual market in the state; or (b) a standard option of coverage available under the group or individual health insurance laws in the state.

Additional Information

Prior Introductions: None.

Cross File: None.

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

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