Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE
Revised

House Bill 32 (Delegate Kullen)
Health and Government Operations Finance

Health Insurance - Limitations on Preexisting Condition Provisions - Individual Health Benefit Plans

This bill alters preexisting condition provisions for individual health insurance benefit plans.

The bill takes effect October 1, 2009 and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed on or after October 1, 2009.

Fiscal Summary

State Effect: Minimal increase in special fund revenues for the Maryland Insurance Administration in FY 2010 from the $125 rate and form filing fee. Review and approval of forms and rate filings and enforcement of the bill's provisions can be handled with existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill prohibits a health insurance application form or a nonprofit health service plan application form for specified individual health benefit plans from containing inquiries about (1) a preexisting condition, illness, or disease for which the applicant has not received medical care or advice during the five years immediately before the date of application; or (2) medical screening, testing, monitoring, or any other similar medical procedure that the applicant received during the five years immediately before the date of application.

A carrier may not attach an exclusionary rider to an individual health benefit plan unless the carrier secures the prior written consent of the policyholder. A carrier may impose a preexisting condition exclusion or limitation on an individual for a condition that was not discovered during the underwriting process only if the exclusion or limitation (1) relates to a condition for which medical care was received during the 12-month period immediately preceding the effective date of the individual's coverage; (2) extends for a period of not more than 12 months after the effective date of the coverage; and (3) is reduced by the aggregate of any applicable periods of creditable coverage.

A preexisting condition exclusion or limitation may not be imposed on an individual who is covered under any creditable coverage as specified, but may be imposed on or after the end of the first 63-day period during which the individual was not covered for the entire period under any creditable coverage.

Current Law: In the individual market, carriers may medically underwrite policies. The carrier may inquire about conditions for which the applicant has received medical care or advice during the seven years immediately preceding the date of application. This is known as the "look back" period. An insurer or nonprofit health service plan must cover any condition revealed in the application or add an exclusionary rider for that particular condition. However, the insurer or nonprofit health service plan may exclude coverage for a preexisting condition identified in the look back period that is *not* revealed in the initial application for up to two years.

For group and blanket health insurance, the look back period is six months and carriers may limit coverage for a preexisting condition for up to one year or 18 months in the case of a late enrollee. The 12- or 18-month exclusion period is reduced by aggregate periods of creditable coverage (the amount of time a person was previously insured). The six-month look back period and 12-month exclusion period represent the maximum preexisting condition limitations allowable in the group health insurance market under the federal Health Insurance Portability and Accountability Act.

HMOs may not impose any preexisting condition limitations. There are no preexisting limitations in the small group market due to the requirement of guaranteed issue. There are also no preexisting limitations in the State Employee and Retiree Health and Welfare Benefits Program.

Background: The purpose of preexisting condition limitations is to discourage adverse selection that would result from applicants foregoing the purchase of health insurance coverage until medical services are necessary. Preexisting condition limitations lower insurers' losses on new applicants during the initial enrollment period when the exclusion is imposed.

All states allow preexisting condition limitations in the individual market. Sixteen states have a look back period of six months or less, and 28 states have a maximum exclusion period of 12 months or less (including Pennsylvania, Virginia, and West Virginia). Twelve states and the District of Columbia have no limit on the look back period, and eight states and the District of Columbia have no limit on the maximum exclusion period.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Kaiser Family Foundation State Health Facts; Kent, Montgomery, Washington, and Worcester counties; Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - February 10, 2009
ncs/mwc Revised - House Third Reader - March 25, 2009

Analysis by: Jennifer B. Chasse

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