Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE

Senate Bill 636 (Senator Middleton)
Finance Health and Government Operations

Health Insurance - Required Report and Repeal of Obsolete Provisions

This bill repeals a provision of law that would apply the rules of the small group health insurance market to the entire commercial market if and when a certain trigger is reached. Instead, the Maryland Insurance Commissioner, by December 1 of each year, must report to the General Assembly on the estimated number of insured and self-insured contracts for health benefit plans in the State and the number of insured and self-insured lives younger than age 65 enrolled in health benefit plans in the State. An obsolete reporting requirement is also repealed.

Fiscal Summary

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

Local Effect: None.

Small Business Effect: None.

Analysis

Current Law: Chapter 9 of 1993 made significant health care reforms. Section 3 of Chapter 9 will apply the rules of the small group health insurance market, including guaranteed issuance, no preexisting condition limitations, and adjusted community rating, to the entire commercial market effective the second January after a certain trigger has been met. The trigger occurs when at least 60% of the total population younger than age 65 are covered under (1) an insured benefit plan; or (2) other employment-based self-insured/self-funded health benefits from an employer that registers with the Maryland Insurance Administration (MIA) and agrees to provide fully funded health

benefits for a three-year period. To assess whether the trigger has been met, the Insurance Commissioner must annually determine the number of individuals younger than age 65 who are covered under an insured health benefit plan or a prepaid health benefit package of a health maintenance organization.

Chapter 294 of 1997, the Maryland Health Insurance Portability and Accountability Act, established health insurance reform in the individual and group market consistent with the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). Chapter 294 requires the Insurance Commissioner to report annually to specified legislative committees regarding the effect of Chapter 294 on rates in the individual health insurance market and any proposed changes to existing law.

Background: Employees and government entities have two major options when providing health insurance benefits. They can purchase an insured plan from an insurance company or they can self-insure by assuming risk and paying all claims for services themselves, usually through a third-party administrator. The federal Employee Retirement Income Security Act (ERISA) limits states' ability to require employers to offer insurance coverage and exempts the coverage offered by self-insured entities from state insurance regulation.

According to MIA, at the time Chapter 9 of 1993 was enacted, the proportion of the population with insured health benefits (42.8%) slightly exceeded the proportion with other employment-based or self-insured benefits (37.9%). However, in 2008, less than one-quarter of the population has insured health benefits. Within the commercial market, which insures 72.5% of the population, only 34.9% of individuals are enrolled in an insured health benefit plan, while 65.1% have employment-based benefits (self-insured plans or the Federal Employees Health Benefit Plan). Based on this information, in its latest required report dated December 19, 2008, MIA requested that the trigger provisions be repealed, but that MIA continue to report annually on insured and employment-based health benefits in the commercial market.

The reporting requirement in Chapter 294 of 1997 was intended to monitor the impact of guaranteed issuance on the availability and affordability of policies in the nongroup market. Chapter 294 required carriers to offer a high and low policy option or its two most popular plans to applicants that failed medical underwriting. Carriers were required to renew the policies and charge no more than 200% of the rate for other individuals. MIA reports annually on the number of carriers offering high and low policies and the number of members covered by these policies. Chapter 60 of 2004 repealed the guaranteed issuance requirement, along with the high and low policy requirements. As of 2008, only four carriers offer a high and low policy option covering

2,346 members. As these products are no longer actively sold, the reporting requirements may be unnecessary. In its latest required report dated December 8, 2008, MIA requested that the reporting requirement be repealed.

Additional Information

Prior Introductions: None.

Cross File: None.

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

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