Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 79 (Chair, Finance Committee)(By Request - Departmental - Insurance Administration, Maryland)

Finance | Health and Government Operations

Health Insurance - Reform

This departmental bill (1) alters preexisting condition provisions for individual health insurance benefit plans; (2) requires carriers that sell health insurance under an out-of-state association contract to make certain disclosures to Maryland residents; (3) restricts the circumstances under which certain carriers are permitted to rescind a health insurance policy; and (4) requires the Maryland Insurance Administration (MIA) to study options to raise or define medical loss ratios in the individual, small group, and large group health insurance markets and report its findings by December 1, 2009.

The bill's main provisions take effect on and apply to all policies, contracts, certificates, and health benefit plans issued, delivered, or renewed on or after October 1, 2009. The loss ratio reporting study requirement takes effect July 1, 2009.

Fiscal Summary

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

Local Effect: None.

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

Analysis

Bill Summary:

Preexisting Condition Provisions: A health insurance application form or nonprofit health service plan application form for specified individual health benefit plans may not contain 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 obtains 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.

Association Health Plans: Carriers that require evidence of individual insurability for coverage under an out-of-state association contract must disclose certain information to applicants for coverage under an out-of-state association contract. A carrier must disclose (1) that coverage is conditioned on association membership; (2) all costs related to joining and maintaining membership in the association; (3) that membership fees or dues are in addition to the premium for coverage; (4) that the terms and conditions of coverage are determined by the association and carrier; (5) the health insurance benefits otherwise mandated in Maryland that are not included in the contract; (6) that the Maryland resident may purchase an individual health benefit plan that includes the mandated benefits that are not included in the contract; (7) that the contract is not regulated by the Insurance Commissioner; and (8) that the terms and conditions of coverage may be changed without the consent of a member. Carriers that collect membership fees or dues on behalf of an association must disclose this information on the enrollment application.

The Commissioner may require a carrier that offers coverage under an out-of-state association contract to report, by March 1 of each year, the number of Maryland residents covered by out-of-state association contracts.

Rescission: Carriers that condition coverage on evidence of individual insurability may not rescind coverage on the basis of written information submitted on or with or omitted from an application unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information before issuing the health benefit plan. A carrier must prove that any rescission of a health benefit plan complies with these provisions.

Current Law/Background:

Preexisting Condition Limitations: 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 (HIPAA).

Health maintenance organizations (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.

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 6 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 8 states and the District of Columbia have no limit on the maximum exclusion period.

Loss Ratios: Loss ratios are the ratio of incurred claims to premiums earned (the share of premium revenues spent on medical care). Carriers must include loss ratios for all health benefit plans specific to the State in their required annual reports to the Insurance Commissioner. The Commissioner may require an insurer, nonprofit health service plan, or HMO to file new rates if the loss ratio is less than 75% in the small group market and 60% in the individual market. The minimum acceptable loss ratio for Medicare supplement policies is 75% for group policies and 65% for individual policies. Medicaid managed care organizations (MCOs) must have loss ratios of at least 85% or are subject to adjustment of capitation rates. Minimum loss ratios are not required in the large group market.

Association Health Plans: Individuals may purchase health insurance through an association that has been issued a group contract for its members. Association health plans provide an alternative to individual policies for those who do not have access to employer-based group coverage; however, they are not group insurance plans and therefore are not subject to the same regulation. Generally, Maryland law does not apply to contracts through associations in other states, even when coverage is provided to residents of Maryland.

Twelve carriers offer nonemployment based health insurance coverage to individuals in Maryland on a medically underwritten basis. Of these, three require the individual to join an out-of-state association (GoldenRule/FACT, Mega Life Insurance Company/NASE, and Time Insurance/Health Advocate Alliance). Other carriers such as Aetna offer coverage both directly to an individual or through an association plan (such as AARP).

Rescission: After two years from the date of issue of a policy, no misstatements, except fraudulent misstatements, made by the applicant in the initial application for coverage can be used to void the policy or deny a claim for loss incurred or disability.

In 2008, the U.S. House of Representatives Committee on Oversight and Government Reform investigated rescission practices in the individual health insurance market after regulators in California and Connecticut uncovered evidence of improper rescissions. In response, MIA subjected consumer complaints about policy rescission to greater scrutiny.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Kaiser Family Foundation, 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
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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Health Insurance - Reform

BILL NUMBER: SB 79

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.