

HOUSE BILL 669

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C3

2004 Regular Session
(4lr0123)

ENROLLED BILL

-- Health and Government Operations/Finance --

Introduced by **Chairman, Health and Government Operations Committee (By
Request - Departmental - Insurance Administration, Maryland)**

Read and Examined by Proofreaders:

Proofreader.

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this
____ day of _____ at _____ o'clock, ____ M.

Speaker.

CHAPTER 60

1 AN ACT concerning

2 **Health Insurance - HIPAA - Maryland Health Insurance Plan - Alternative**
3 **Mechanism**

4 FOR the purpose of making the Maryland Health Insurance Plan the alternative to
5 the standard coverage for eligible individuals under the federal Health
6 Insurance Portability and Accountability Act (HIPAA) as required by certain
7 provisions of law; defining certain terms; *repealing certain definitions*; deleting
8 certain provisions made unnecessary under the alternative mechanism;
9 clarifying certain continuation of coverage provisions applying to certain
10 individuals; making certain stylistic changes; and generally relating to the
11 Maryland Health Insurance Plan as an alternative to the standard coverage
12 required under the federal Health Insurance Portability and Accountability Act.

13 BY repealing and reenacting, with amendments,
14 Article - Insurance
15 Section 14-501, 15-508(a), 15-1301, 15-1308, and 15-1312

1 Annotated Code of Maryland
2 (2002 Replacement Volume and 2003 Supplement)

3 BY adding to
4 Article - Insurance
5 Section 14-508
6 Annotated Code of Maryland
7 (2002 Replacement Volume and 2003 Supplement)

8 BY repealing
9 Article - Insurance
10 Section 15-1304, 15-1305, and 15-1306
11 Annotated Code of Maryland
12 (2002 Replacement Volume and 2003 Supplement)

13 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
14 MARYLAND, That the Laws of Maryland read as follows:

15 **Article - Insurance**

16 14-501.

17 (a) In this subtitle the following words have the meanings indicated.

18 (b) "Administrator" means:

19 (1) a person that is registered as an administrator under Title 8, Subtitle
20 3 of this article; or

21 (2) a carrier as defined under subsection (d) of this section.

22 (c) "Board" means the Board of Directors for the Maryland Health Insurance
23 Plan.

24 (d) "Carrier" means:

25 (1) an authorized insurer that provides health insurance in the State;

26 (2) a nonprofit health service plan that is licensed to operate in the
27 State; or

28 (3) a health maintenance organization that is licensed to operate in the
29 State.

30 (E) "CREDITABLE COVERAGE" HAS THE MEANING STATED IN § 15-1301 OF THIS
31 ~~TITLE~~ ARTICLE.

32 (F) "ELIGIBLE INDIVIDUAL" HAS THE MEANING STATED IN § 15-1301 OF THIS
33 ~~TITLE~~ ARTICLE.

1 [(e)] (G) "Fund" means the Maryland Health Insurance Plan Fund.

2 [(f)] (H) (1) "Medically uninsurable individual" means an individual who is
3 a resident of the State and who:

4 (i) provides evidence that, for health reasons, a carrier has refused
5 to issue substantially similar coverage to the individual;

6 (ii) provides evidence that, for health reasons, a carrier has refused
7 to issue substantially similar coverage to the individual, except at a rate that exceeds
8 the Plan rate;

9 (iii) satisfies the definition of "eligible individual" under § 15-1301
10 of this article;

11 (iv) has a history of or suffers from a medical or health condition
12 that is included on a list promulgated in regulation by the Board;

13 (v) is eligible for the tax credit for health insurance costs under § 35
14 of the Internal Revenue Code; or

15 (vi) is a dependent of an individual who is eligible for coverage
16 under this subsection.

17 (2) "Medically uninsurable individual" does not include an individual
18 who is eligible for coverage under:

19 (i) the federal Medicare program;

20 (ii) the Maryland Medical Assistance Program;

21 (iii) the Maryland Children's Health Program; or

22 (iv) an employer-sponsored group health insurance plan that
23 includes benefits comparable to Plan benefits, unless the individual is eligible for the
24 tax credit for health insurance costs under [Section] § 35 of the Internal Revenue
25 Code.

26 [(g)] (I) "Plan" means the Maryland Health Insurance Plan.

27 [(h)] (J) "Plan of operation" means the articles, bylaws, and operating rules
28 and procedures adopted by the Board in accordance with § 14-503 of this subtitle.

29 14-508.

30 (A) THE PLAN SHALL BE THE ALTERNATIVE MECHANISM FOR ELIGIBLE
31 INDIVIDUALS UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND
32 ACCOUNTABILITY ACT IN ACCORDANCE WITH 45 CFR 148.128.

1 (B) THE PLAN MAY NOT APPLY A PREEXISTING CONDITION EXCLUSION TO AN
2 ELIGIBLE INDIVIDUAL WHO APPLIES FOR COVERAGE UNDER THE PLAN WITHIN 63
3 DAYS OF TERMINATING PRIOR CREDITABLE COVERAGE.

4 (C) IF THE BOARD IMPOSES A LIMIT ON THE NUMBER OF INDIVIDUALS WHO
5 CAN PARTICIPATE IN THE PLAN, THE LIMIT MAY NOT BE APPLIED TO HIPAA ELIGIBLE
6 INDIVIDUALS.

7 15-508.

8 (a) (1) In this section the following words have the meanings indicated.

9 (2) "Carrier" has the meaning stated in § 15-1301 of this title.

10 (3) "ENROLLMENT DATE" HAS THE MEANING STATED IN § 15-1301 OF
11 THIS TITLE.

12 [(3)] (4) "Policy or certificate" means any group or blanket health
13 insurance contract or policy that is issued or delivered in the State by an insurer or
14 nonprofit health service plan that provides hospital, medical, or surgical benefits on
15 an expense-incurred basis.

16 [(4)] (5) "Preexisting condition provision" has the meaning stated in §
17 15-1301 of this title.

18 [(5)] (6) "Late enrollee" has the meaning stated in § 15-1401 of this title.
19 15-1301.

20 (a) In this subtitle the following words have the meanings indicated.

21 [(b) "Actuarial certification" means a written statement in a form approved by
22 the Commissioner, signed by a member of the American Academy of Actuaries or
23 other individual acceptable to the Commissioner that a carrier is in compliance with
24 the provisions of this subtitle.]

25 [(c)] (B) "Affiliation period" means a period of time beginning on the date of
26 enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee,
27 during which a health maintenance organization does not collect premium, and
28 coverage issued does not become effective.

29 [(d)] (C) "Association" or "bona fide association" means[,] an association that:

30 (1) has been actively in existence for at least 5 years;

31 (2) has been formed and maintained in good faith for purposes other
32 than obtaining insurance and does not condition membership on the purchase of
33 association-sponsored insurance;

1 (3) does not condition membership in the association on any health
2 status-related factor relating to an individual, and states so clearly in all
3 membership and application materials;

4 (4) makes health insurance coverage offered through the association
5 available to all members regardless of any health status-related factor relating to the
6 members or individuals eligible for coverage and states so clearly in all membership
7 and application materials;

8 (5) does not make health insurance coverage offered through the
9 association available other than in connection with membership in the association,
10 and states so clearly in all marketing and application materials; and

11 (6) provides and annually updates information necessary for the
12 Commissioner to determine whether or not the association meets the definition of
13 bona fide association before qualifying as an association under this subtitle.

14 [(e)] (D) "Carrier" means a person that is:

15 (1) an insurer that holds a certificate of authority in the State and
16 provides health insurance in the State;

17 (2) a health maintenance organization that is licensed to operate in the
18 State;

19 (3) a nonprofit health service plan that is licensed to operate in the
20 State; or

21 (4) any other person or organization that provides health benefit plans
22 subject to State insurance regulation.

23 [(f)] (E) "Church plan" means a plan as defined under § 3(33) of the Employee
24 Retirement Income Security Act of 1974.

25 [(g)] (F) (1) "Creditable coverage" means coverage of an individual under:

26 (i) an employer sponsored plan;

27 (ii) a health benefit plan;

28 (iii) Part A or Part B of Title XVIII of the Social Security Act;

29 (iv) Title XIX of the Social Security Act, other than coverage
30 consisting solely of benefits under § 1928 of that Act;

31 (v) Chapter 55 of Title 10 of the United States Code;

32 (vi) a medical care program of the Indian Health Service or of a
33 tribal organization;

34 (vii) a State health benefits risk pool;

1 (viii) a health plan offered under the Federal Employees Health
2 Benefits Program (FEHBP), Title 5, Chapter 89 of the United States Code;

3 (ix) a public health plan as defined by federal regulations
4 authorized by the Public Health Service Act, § 2701(c)(1)(i), as amended by P.L.
5 104-191; or

6 (x) a health benefit plan under § 5(e) of the Peace Corps Act, 22
7 U.S.C. 2504(e).

8 (2) A period of creditable coverage shall not be counted, with respect to
9 enrollment of an individual under a health benefit plan or an employer sponsored
10 plan, if, after such period and before the enrollment date, there was a 63-day period
11 during all of which the individual was not covered under any creditable coverage.

12 [(h)] (G) "Eligible individual" means an individual:

13 (1) (i) for whom, as of the date on which the individual seeks coverage
14 under this subtitle, the aggregate of the periods of creditable coverage is 18 or more
15 months; and

16 (ii) whose most recent prior creditable coverage was under an
17 employer sponsored plan, governmental plan, church plan, or health benefit plan
18 offered in connection with any of these plans;

19 (2) who is not eligible for coverage under:

20 (i) an employer sponsored plan;

21 (ii) Part A or Part B of Title XVIII of the Social Security Act; or

22 (iii) a State plan under Title XIX of the Social Security Act;

23 (3) who does not have coverage under a health benefit plan;

24 (4) who has not had the most recent prior creditable coverage described
25 in paragraph (1)(ii) of this subsection terminated for nonpayment of premiums or
26 fraud by the individual; and

27 (5) who, if the individual has been offered the option of continuation
28 coverage under a State or federal continuation provision:

29 (i) has elected that coverage; and

30 (ii) has exhausted that coverage.

31 [(i)] (H) "Enrollment date" means the date on which:

32 (1) an individual enrolls in a health benefit plan; or

1 (2) the first day of the waiting period before which the individual may
2 enroll.

3 [(j)] (I) "Governmental plan" means a plan as defined in § 3(32) of the
4 Employee Retirement Income Security Act of 1974 and any federal governmental
5 plan.

6 [(k)] (J) "Employer sponsored plan" means an employee welfare benefit plan
7 that provides medical care to employees or their dependents, and is not subject to
8 State regulation in accordance with the federal Employee Retirement Income
9 Security Act of 1974.

10 [(l)] (K) (1) "Health benefit plan" means a:

11 (i) hospital or medical policy or certificate, including those issued
12 under multiple employer trusts or associations located in Maryland or any other state
13 covering Maryland residents;

14 (ii) policy, contract, or certificate issued by a nonprofit health
15 service plan that covers Maryland residents; or

16 (iii) health maintenance organization subscriber or group master
17 contract.

18 (2) "Health benefit plan" does not include:

19 (i) one or more, or any combination of the following:

20 1. coverage only for accident or disability income insurance;

21 2. coverage issued as a supplement to liability insurance;

22 3. liability insurance, including general liability insurance
23 and automobile liability insurance;

24 4. workers' compensation or similar insurance;

25 5. automobile medical payment insurance;

26 6. credit-only insurance;

27 7. coverage for on-site medical clinics; and

28 8. other similar insurance coverage, specified in federal
29 regulations issued pursuant to P.L. 104-191, under which benefits for medical care
30 are secondary or incidental to other insurance benefits;

31 (ii) the following benefits if they are provided under a separate
32 policy, certificate, or contract of insurance or are otherwise not an integral part of a
33 plan:

1. limited scope dental or vision benefits;
 2. benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; and
 3. such other similar, limited benefits as are specified in federal regulations issued pursuant to P.L. 104-191;
- (iii) the following benefits if offered as independent, noncoordinated benefits:
1. coverage only for a specified disease or illness; and
 2. hospital indemnity or other fixed indemnity insurance; or
- (iv) the following benefits if offered as a separate insurance policy:
1. Medicare supplemental health insurance (as defined under § 1882(g)(1) of the Social Security Act);
 2. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
 3. similar supplemental coverage provided to coverage under an employer sponsored plan.

[m] (L) "Health status-related factor" means a factor related to:

- (1) health status;
- (2) medical condition;
- (3) claims experience;
- (4) receipt of health care;
- (5) medical history;
- (6) genetic information;
- (7) evidence of insurability including conditions arising out of acts of domestic violence; or
- (8) disability.

[n] (M) "High level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is:

- (1) at least 15% greater than the actuarial value of the low level policy form coverage offered by the carrier in this State; and

1 (2) at least 100% but not greater than 120% of the weighted average.

2 [(o)] (N) (1) "Individual health benefit plan" means:

3 (i) a health benefit plan other than a converted policy or a
4 professional association plan for eligible individuals and their dependents; and

5 (ii) a certificate issued to an eligible individual that evidences
6 coverage under a policy or contract issued to a trust or association or other similar
7 group of individuals, regardless of the situs of delivery of the policy or contract, if the
8 eligible individual pays the premium and is not being covered under the policy or
9 contract under either federal or State continuation of benefits provisions.

10 (2) "Individual health benefit plan" does not include short-term limited
11 duration insurance.

12 [(p)] (O) "Low level policy form" means a policy or plan under which the
13 actuarial value of the benefit under the coverage is at least 85% but not greater than
14 100% of the weighted average.

15 [(q)] (P) "Preexisting condition" means a condition that was present before the
16 date of enrollment for coverage, whether or not any medical advice, diagnosis, care, or
17 treatment was recommended or received before that date.

18 [(r)] "Preexisting condition provision" means a provision in a health benefit
19 plan that denies, excludes, or limits benefits for an enrollee for expenses or services
20 related to a preexisting condition.]

21 [(s)] (Q) "Waiting period" means the period of time that must pass before an
22 individual is eligible to be covered for benefits under the terms of a group health
23 benefit plan.

24 [(t)] (R) (1) "Weighted average" means the average actuarial value of the
25 benefits provided by:

26 (i) all the health insurance coverages issued by the carrier in this
27 State in the individual market during the previous calendar year, weighted by
28 enrollment for the different coverages; or

29 (ii) all the health insurance coverages issued by all carriers in this
30 State in the individual market, if the data are available, during the previous calendar
31 year, weighted by enrollment for the different coverages.

32 (2) "Weighted average" does not include coverages issued under this
33 subtitle.

34 [15-1304.

35 A carrier may not offer any individual health benefit plans in this State unless
36 the carrier offers, and actively markets, the policies required by this subtitle.]

1 [15-1305.

2 (a) Unless a carrier makes an election under § 15-1306 of this subtitle, the
3 carrier may not:

4 (1) decline to offer coverage to, or deny enrollment of an eligible
5 individual; or

6 (2) impose any preexisting condition provision on an eligible individual.

7 (b) (1) A carrier that makes an election under § 15-1306 of this subtitle may
8 choose to offer at least two different policy forms, both of which are designed for, made
9 generally available to, actively marketed to, and enroll, both eligible individuals and
10 other individuals.

11 (2) Policy forms that have different cost-sharing arrangements or
12 different riders shall be considered to be different policy forms.

13 (c) Policy forms shall comply with the requirements of this subtitle.]

14 [15-1306.

15 (a) A carrier that intends to offer two policy forms shall submit in writing to
16 the Commissioner both:

17 (1) an election whether to offer:

18 (i) a high level and low level policy form, each of which includes
19 benefits substantially similar to other individual health insurance coverage offered by
20 the carrier in this State; or

21 (ii) policy forms with the largest and next to largest premium
22 volume of all policy forms offered by the carrier in this State; and

23 (2) an election whether to use the weighted average valuation described
24 in § 15-1301(t)(1)(i) or (ii) of this subtitle.

25 (b) (1) An election made under this section shall be binding for a 2-year
26 period.

27 (2) After the initial 2-year period, and for each subsequent 2-year
28 period, carriers shall again make the elections required by this section.

29 (3) An election shall be made on a form and in a manner required by the
30 Commissioner.]

31 15-1308.

32 (a) In this section, "affiliate" means a person that directly or indirectly,
33 through one or more intermediaries, controls, is controlled by, or is under common
34 control with another person.

1 [(b) Subject to subsections (d) and (k) of this section, a carrier shall issue the
2 individual health benefit plan elected under § 15-1305 or § 15-1306(a)(1) of this
3 subtitle to any eligible individual.

4 (c) (1) A carrier may not limit coverage under any individual health benefit
5 plan issued to an eligible individual under a preexisting condition provision.

6 (2) A carrier may impose a preexisting condition provision on an
7 individual who has had a period of at least 63 days during all of which the individual
8 was not covered under any creditable coverage and who would otherwise have been
9 an eligible individual.

10 (d) A carrier may refuse to issue an individual health benefit plan to an
11 eligible individual, if the carrier demonstrates to the satisfaction of the Commissioner
12 that:

13 (1) it does not have the policyholder surplus necessary to underwrite
14 additional coverage; and

15 (2) it is applying this section uniformly to all individuals in the
16 individual market in this State without regard to:

17 (i) any health status-related factor; and

18 (ii) whether the individuals are eligible individuals.

19 (e) A carrier that denies individual health insurance coverage under
20 subsection (d) of this section may not offer coverage in the individual market until the
21 later of:

22 (1) a period of 180 days after the date the coverage is denied; or

23 (2) until the carrier has demonstrated, to the Commissioner's
24 satisfaction that the carrier has sufficient policyholder surplus to underwrite
25 additional coverage.]

26 [(f) (B) A carrier may elect not to renew all individual health benefit plans in
27 the State.

28 [(g) (C) When a carrier elects not to renew all individual health benefit plans
29 in the State, the carrier:

30 (1) shall give notice of its decision to the affected individuals at least 180
31 days before the effective date of nonrenewal;

32 (2) at least 30 working days before that notice, shall give notice to the
33 Commissioner;

34 (3) if the carrier has an affiliate in the individual market, shall give
35 notice to each affected individual at least 180 days before the effective date of

1 nonrenewal of the individual's option to purchase all other individual health benefit
2 plans currently offered by the affiliate of the carrier; and

3 (4) may not write new business for individuals in the State for a 5-year
4 period beginning on the date of notice to the Commissioner.

5 [(h)] (D) A carrier that offers an individual health benefit plan shall offer an
6 individual health benefit plan to an individual who is nonrenewed by an affiliate of
7 the carrier under subsection [(g)] (C) of this section on a guarantee issue basis, if the
8 individual applies for coverage no later than 63 days after the effective date of
9 nonrenewal.

10 [(i)] (E) A carrier that issues coverage under subsection [(h)] (D) of this
11 section may not rate the coverage on a substandard basis unless the individual was
12 rated on a substandard basis under the prior coverage provided to the individual by
13 the affiliate of the carrier.

14 [(j)] (F) (1) Subject to paragraph (2) of this subsection, a carrier that issues
15 coverage under subsection [(h)] (D) of this section shall waive the waiting period for
16 coverage of a preexisting condition to the extent that the individual has satisfied a
17 waiting period under the individual's prior contract or policy.

18 (2) The carrier that issues coverage under subsection [(h)] (D) of this
19 section may require the individual to satisfy the remaining part of the waiting period
20 if any part of the waiting period under the individual's prior contract or policy has not
21 been satisfied, unless the coverage issued under subsection [(h)] (D) of this section
22 has a shorter waiting period.

23 [(k)] (G) A health maintenance organization need not offer coverage to an
24 individual who does not live, reside, or work within the health maintenance
25 organization's approved service areas.

26 15-1312.

27 A carrier that [elects to offer] ISSUED a high level [and] OR low level policy
28 form[, under § 15-1306 of this subtitle] PRIOR TO JULY 1, 2004, may not charge a rate
29 to eligible individuals UNDER THE HIGH LEVEL OR LOW LEVEL POLICY FORM that is
30 greater than 200% of the rate the carrier normally would charge for the same or
31 similar policy forms to other individuals.

32 SECTION 2. AND BE IT FURTHER ENACTED, That a carrier may not
33 terminate a health benefit plan that was issued to an eligible individual prior to July
34 1, 2004, unless the carrier complies with the terms of §§ 15-1308 and 15-1309 of the
35 Insurance Article.

36 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take
37 effect July 1, 2004.

