

CF 7r2466

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**By: Delegates Busch, Gordon, Donoghue, Love, Kach, V. Mitchell, McClenahan, Eckardt, Goldwater, Boston, Barve, Krysiak, Exum, Kirk, Walkup, La Vay, Crumlin, Frank, Pendergrass, Fulton, and Harrison**

Introduced and read first time: February 21, 1997

Assigned to: Economic Matters

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Committee Report: Favorable with amendments

House action: Adopted

Read second time: March 20, 1997

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CHAPTER \_\_\_\_\_

1 AN ACT concerning

2 **Maryland Health Insurance Portability and Accountability Act**

3 FOR the purpose of establishing certain market reforms in the individual and group  
 4 market consistent with the provisions of the federal Health Insurance Portability  
 5 and Accountability Act; prohibiting certain preexisting condition provisions under  
 6 certain circumstances; requiring certain carriers that sell certain policies to  
 7 individuals to make certain elections under certain circumstances; requiring certain  
 8 carriers to submit certain information to the Insurance Commissioner under certain  
 9 circumstances and to file certain documents; establishing eligibility for certain  
 10 individuals and groups to benefit from certain provisions of this Act; requiring  
 11 certain carriers to issue and renew certain health benefit plans under certain  
 12 circumstances; requiring certain certification of coverage to be given by certain  
 13 carriers to certain persons under certain circumstances; prohibiting certain carriers  
 14 under certain circumstances from establishing rules for eligibility for coverage;  
 15 making provisions of this Act applicable to health maintenance organizations;  
 16 defining certain terms; authorizing the Insurance Commissioner to adopt certain  
 17 regulations; requiring the Insurance Commissioner to report to certain committees  
 18 of the General Assembly at certain times; providing for the effective ~~date~~ dates of  
 19 this Act; providing for the effective date of certain requirements of this Act;  
 20 providing that certain requirements of this Act shall be implemented no later than  
 21 a certain date; providing for the future codification of this Act; and generally  
 22 relating to health insurance and health benefits coverage.

23 BY renumbering

24 Article - Insurance

25 Section 15-1301 through 15-1307, respectively, and the subtitle "Subtitle 13.

2

1 Interdepartmental Committee on Mandated Health Insurance Benefits"  
 2 to be Section 15-1501 through 15-1507, respectively and the subtitle "Subtitle 15.  
 3 Interdepartmental Committee on Mandated Health Insurance Benefits"  
 4 Annotated Code of Maryland  
 5 (1995 Volume and 1996 Supplement)  
 6 (As enacted by Chapter \_\_\_\_\_ (H.B. 11) of the Acts of the General Assembly of  
 7 1997)

8 BY repealing and reenacting, with amendments,  
 9 Article 48A - Insurance Code  
 10 Section 490Y  
 11 Annotated Code of Maryland  
 12 (1994 Replacement Volume and 1996 Supplement)

13 BY adding to  
 14 Article 48A - Insurance Code  
 15 Section 703(h); 752 through 763, inclusive, and the new subtitle "59. Maryland  
 16 Health Insurance Portability and Accountability Act -- Individual Market  
 17 Reforms"; and 764 through 772, inclusive, and the new subtitle "60. Maryland  
 18 Health Insurance Portability and Accountability Act -- Large Group Market  
 19 Reforms"  
 20 Annotated Code of Maryland  
 21 (1994 Replacement Volume and 1996 Supplement)

22 BY adding to  
 23 Article - Health - General  
 24 Section 19-706(n)  
 25 Annotated Code of Maryland  
 26 (1996 Replacement Volume and 1996 Supplement)

27 BY repealing and reenacting, with amendments,  
 28 Article - Insurance  
 29 Section 15-1202  
 30 Annotated Code of Maryland  
 31 (1995 Volume and 1996 Supplement)  
 32 (As enacted by Chapter \_\_\_\_\_ (H.B. 11) of the Acts of the General Assembly of  
 33 1997)

34 BY adding to  
 35 Article - Insurance  
 36 Section 15-508; 15-1301 through 15-1312, inclusive, and the new subtitle "Subtitle  
 37 13. Maryland Health Insurance Portability and Accountability Act --  
 38 Individual Market Reforms"; and 15-1401 through 15-1409, inclusive, and the  
 39 new subtitle "Subtitle 14. Maryland Health Insurance Portability and  
 40 Accountability Act -- Large Group Market Reforms"

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1 Annotated Code of Maryland  
2 (1995 Volume and 1996 Supplement)  
3 (As enacted by Chapter\_\_\_\_\_ (H.B. 11) of the Acts of the General Assembly of  
4 1997)

5 BY repealing and reenacting, with amendments,

6 Article - Health - General  
7 Section 19-706(n)  
8 Annotated Code of Maryland  
9 (1996 Replacement Volume and 1996 Supplement)  
10 (As enacted by Section 2 of this Act)

11 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF  
12 MARYLAND, That Section(s) 15-1301 through 15-1307, respectively, and the subtitle  
13 "Subtitle 13. Interdepartmental Committee on Mandated Health Insurance Benefits" of  
14 Article - Insurance of the Annotated Code of Maryland (as enacted by  
15 Chapter\_\_\_\_\_ (H.B. 11) of the Acts of the General Assembly of 1997) be renumbered to  
16 be Section(s) 15-1501 through 15-1507, respectively, and the subtitle "Subtitle 15.  
17 Interdepartmental Committee on Mandated Health Insurance Benefits".

18 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland  
19 read as follows:

20 **Article 48A - Insurance Code**

21 490Y.

22 (a) In this section[,] THE FOLLOWING WORDS HAVE THE MEANINGS  
23 INDICATED.

24 (B) "CARRIER" HAS THE MEANING STATED IN § 752(E) OF THIS ARTICLE.

25 (C) "[policy] POLICY or certificate" means any health insurance contract or  
26 policy that is issued or delivered in the State [to an employer] by an insurer or nonprofit  
27 health service plan that provides hospital, medical, or surgical benefits on an  
28 expense-incurred basis.

29 (D) "PREEXISTING CONDITION PROVISION" HAS THE MEANING STATED IN §  
30 752(R) OF THIS ARTICLE.

31 (E) "LATE ENROLLEE" HAS THE MEANING STATED IN § 764(L) OF THIS  
32 ARTICLE.

33 [(b)] (F) This section does not apply to a policy or certificate issued to a small  
34 employer in accordance with [Title 55 of this article] SUBTITLE 55 OF THIS ARTICLE OR  
35 TO AN INDIVIDUAL IN ACCORDANCE WITH SUBTITLE 59 OF THIS ARTICLE.

36 [(c)] (G) (1) Subject to the provisions of paragraphs (2) and (3) of this  
37 [section] SUBSECTION, an insurer or nonprofit health service plan shall provide  
38 coverage to an individual under a policy or certificate regardless of the health of the  
39 individual if:

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1 (i) The individual had coverage under a prior policy or certificate  
2 issued by that insurer or nonprofit health service plan; and

3 (ii) Within 30 days after the coverage under the prior policy or  
4 certificate terminates, the individual becomes eligible for and accepts coverage under the  
5 subsequent policy or certificate.

6 (2) An insurer or nonprofit health service plan may exclude coverage under  
7 a policy or certificate for a medical condition of an individual who obtains coverage under  
8 paragraph (1)(ii) of this subsection to the extent that:

9 (i) The policy or certificate is issued as a part of a group contract; and

10 (ii) The exclusion is applicable to all individuals insured under the  
11 group contract.

12 (3) (i) Subject to the provisions of subparagraph (ii) of this paragraph, an  
13 insurer or nonprofit health service plan shall waive a waiting period for coverage of a  
14 preexisting condition under a subsequent policy or certificate issued to an individual in  
15 accordance with paragraph (1)(ii) of this subsection to the extent that the individual has  
16 satisfied a waiting period under the individual's prior policy or certificate.

17 (ii) If any portion of a waiting period has not been satisfied under the  
18 individual's prior policy or certificate, the insurer or nonprofit health service plan may  
19 require the individual to satisfy the remaining portion of the waiting period under the  
20 subsequent policy unless the subsequent policy has a shorter waiting period.

21 [(d)] (H) This section does not prohibit an insurer or nonprofit health service plan  
22 from requiring a previously insured individual to complete an application for coverage  
23 that includes information regarding the health of the previously insured individual.

24 (I) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (J) OF THIS SECTION, A  
25 CARRIER MAY IMPOSE A PREEXISTING CONDITION PROVISION ONLY IF IT:

26 (1) RELATES TO A CONDITION, REGARDLESS OF THE CAUSE OF THE  
27 CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS  
28 RECOMMENDED OR RECEIVED WITHIN THE 6-MONTH PERIOD ENDING ON THE  
29 ENROLLMENT DATE;

30 (2) EXTENDS FOR A PERIOD OF NOT MORE THAN 12 MONTHS AFTER  
31 THE ENROLLMENT DATE OR 18 MONTHS IN THE CASE OF A LATE ENROLLEE; AND

32 (3) IS REDUCED BY THE AGGREGATE OF THE PERIODS OF CREDITABLE  
33 COVERAGE, AS DEFINED IN SUBTITLE 60 OF THIS ARTICLE.

34 (J) (1) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, A CARRIER MAY  
35 NOT IMPOSE ANY PREEXISTING CONDITION PROVISION ON AN INDIVIDUAL WHO, AS  
36 OF THE LAST DAY OF THE 30-DAY PERIOD BEGINNING WITH THE DATE OF BIRTH, IS  
37 COVERED UNDER CREDITABLE COVERAGE.

38 (2) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, A CARRIER MAY  
39 NOT IMPOSE ANY PREEXISTING CONDITION PROVISIONS ON A CHILD WHO:

5

1 (I) IS ADOPTED OR PLACED FOR ADOPTION BEFORE ATTAINING  
2 18 YEARS OF AGE; AND

3 (II) AS OF THE LAST DAY OF THE 30-DAY PERIOD BEGINNING ON  
4 THE DATE OF ADOPTION OR PLACEMENT FOR ADOPTION, IS COVERED UNDER  
5 CREDITABLE COVERAGE.

6 (3) A CARRIER MAY NOT IMPOSE ANY PREEXISTING CONDITION  
7 PROVISION RELATING TO PREGNANCY.

8 (4) PARAGRAPHS (1) AND (2) OF THIS SUBSECTION DO NOT APPLY TO AN  
9 INDIVIDUAL AFTER THE END OF THE FIRST 63-DAY PERIOD DURING ALL OF WHICH  
10 THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE.

11 703.

12 (H) A CARRIER IS SUBJECT TO THE REQUIREMENTS OF § 766 OF THIS ARTICLE  
13 IN CONNECTION WITH HEALTH BENEFIT PLANS ISSUED UNDER THIS SUBTITLE.

14 59. MARYLAND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT --  
15 INDIVIDUAL MARKET REFORMS

16 752.

17 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS  
18 INDICATED.

19 (B) "ACTUARIAL CERTIFICATION" MEANS A WRITTEN STATEMENT IN A FORM  
20 APPROVED BY THE COMMISSIONER, SIGNED BY A MEMBER OF THE AMERICAN  
21 ACADEMY OF ACTUARIES OR OTHER INDIVIDUAL ACCEPTABLE TO THE  
22 COMMISSIONER THAT A CARRIER IS IN COMPLIANCE WITH THE PROVISIONS OF THIS  
23 SUBTITLE.

24 (C) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME BEGINNING ON THE  
25 DATE OF ENROLLMENT AND NOT TO EXCEED 2 MONTHS, OR 3 MONTHS IN THE CASE  
26 OF A LATE ENROLLEE, DURING WHICH A HEALTH MAINTENANCE ORGANIZATION  
27 DOES NOT COLLECT PREMIUM, AND COVERAGE ISSUED DOES NOT BECOME  
28 EFFECTIVE.

29 (D) "ASSOCIATION" OR "BONA FIDE ASSOCIATION" MEANS, AN ASSOCIATION  
30 THAT:

31 (1) HAS BEEN ACTIVELY IN EXISTENCE FOR AT LEAST 5 YEARS;

32 (2) HAS BEEN FORMED AND MAINTAINED IN GOOD FAITH FOR  
33 PURPOSES OTHER THAN OBTAINING INSURANCE AND DOES NOT CONDITION  
34 MEMBERSHIP ON THE PURCHASE OF ASSOCIATION-SPONSORED INSURANCE;

35 (3) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON ANY  
36 HEALTH STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL, AND STATES SO  
37 CLEARLY IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

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1 (4) MAKES HEALTH INSURANCE COVERAGE OFFERED THROUGH THE  
2 ASSOCIATION AVAILABLE TO ALL MEMBERS REGARDLESS OF ANY HEALTH  
3 STATUS-RELATED FACTOR RELATING TO THE MEMBERS OR INDIVIDUALS ELIGIBLE  
4 FOR COVERAGE AND STATES SO CLEARLY IN ALL MEMBERSHIP AND APPLICATION  
5 MATERIALS;

6 (5) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED  
7 THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH  
8 MEMBERSHIP IN THE ASSOCIATION, AND STATES SO CLEARLY IN ALL MARKETING  
9 AND APPLICATION MATERIALS; AND

10 (6) PROVIDES AND ANNUALLY UPDATES INFORMATION NECESSARY  
11 FOR THE COMMISSIONER TO DETERMINE WHETHER OR NOT THE ASSOCIATION  
12 MEETS THE DEFINITION OF BONA FIDE ASSOCIATION BEFORE QUALIFYING AS AN  
13 ASSOCIATION UNDER THIS SUBTITLE.

14 (E) "CARRIER" MEANS A PERSON THAT IS:

15 (1) AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE  
16 STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

17 (2) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO  
18 OPERATE IN THE STATE;

19 (3) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO  
20 OPERATE IN THE STATE; OR

21 (4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH  
22 BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

23 (F) "CHURCH PLAN" MEANS A PLAN AS DEFINED UNDER SECTION 3(33) OF  
24 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

25 (G) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL  
26 UNDER:

27 (I) AN EMPLOYER SPONSORED PLAN;

28 (II) A HEALTH BENEFIT PLAN;

29 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY  
30 ACT;

31 (IV) TITLE XIX OF THE SOCIAL SECURITY ACT, OTHER THAN  
32 COVERAGE CONSISTING SOLELY OF BENEFITS UNDER SECTION 1928 OF THAT ACT;

33 (V) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE;

34 (VI) A MEDICAL CARE PROGRAM OF THE INDIAN HEALTH SERVICE  
35 OR OF A TRIBAL ORGANIZATION;

36 (VII) A STATE HEALTH BENEFITS RISK POOL;

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1 (VIII) A HEALTH PLAN OFFERED UNDER THE FEDERAL EMPLOYEES  
2 HEALTH BENEFITS PROGRAM (FEHBP), TITLE 5, CHAPTER 89 OF THE UNITED STATES  
3 CODE;

4 (IX) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL  
5 REGULATIONS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT, SECTION  
6 2701(C)(1)(I), AS AMENDED BY P.L. 104-191; OR

7 (X) A HEALTH BENEFIT PLAN UNDER SECTION 5(E) OF THE PEACE  
8 CORPS ACT, 22 U.S.C. 2504(E).

9 (2) A PERIOD OF CREDITABLE COVERAGE SHALL NOT BE COUNTED,  
10 WITH RESPECT TO ENROLLMENT OF AN INDIVIDUAL UNDER A HEALTH BENEFIT  
11 PLAN OR AN EMPLOYER SPONSORED PLAN, IF, AFTER SUCH PERIOD AND BEFORE  
12 THE ENROLLMENT DATE, THERE WAS A 63-DAY PERIOD DURING ALL OF WHICH THE  
13 INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE.

14 (H) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL:

15 (1) (I) FOR WHOM, AS OF THE DATE ON WHICH THE INDIVIDUAL  
16 SEEKS COVERAGE UNDER THIS SUBTITLE, THE AGGREGATE OF THE PERIODS OF  
17 CREDITABLE COVERAGE IS 18 OR MORE MONTHS; AND

18 (II) WHOSE MOST RECENT PRIOR CREDITABLE COVERAGE WAS  
19 UNDER AN EMPLOYER SPONSORED PLAN, GOVERNMENTAL PLAN, CHURCH PLAN,  
20 OR HEALTH BENEFIT PLAN OFFERED IN CONNECTION WITH ANY OF THESE PLANS;

21 (2) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER:

22 (I) AN EMPLOYER SPONSORED PLAN;

23 (II) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY  
24 ACT;

25 (III) A STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY  
26 ACT; OR

27 (IV) A HEALTH BENEFIT PLAN;

28 (3) WHO HAS NOT HAD THE MOST RECENT PRIOR CREDITABLE  
29 COVERAGE DESCRIBED IN PARAGRAPH (1)(II) OF THIS SUBSECTION TERMINATED  
30 FOR NONPAYMENT OF PREMIUMS OR FRAUD BY THE INDIVIDUAL; AND

31 (4) WHO, IF THE INDIVIDUAL HAS BEEN OFFERED THE OPTION OF  
32 CONTINUATION COVERAGE UNDER A STATE OR FEDERAL CONTINUATION  
33 PROVISION:

34 (I) HAS ELECTED THAT COVERAGE; AND

35 (II) HAS EXHAUSTED THAT COVERAGE.

36 (I) "ENROLLMENT DATE" MEANS THE DATE ON WHICH:

37 (1) AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN; OR

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1 (2) THE FIRST DAY OF THE WAITING PERIOD BEFORE WHICH THE  
2 INDIVIDUAL MAY ENROLL.

3 (J) "GOVERNMENTAL PLAN" MEANS A PLAN AS DEFINED IN SECTION 3(32) OF  
4 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 AND ANY FEDERAL  
5 GOVERNMENTAL PLAN.

6 (K) "EMPLOYER SPONSORED PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT  
7 PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THEIR DEPENDENTS, AND  
8 IS NOT SUBJECT TO STATE REGULATION IN ACCORDANCE WITH THE FEDERAL  
9 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

10 (L) (1) "HEALTH BENEFIT PLAN" MEANS A:

11 (I) HOSPITAL OR MEDICAL POLICY OR CERTIFICATE, INCLUDING  
12 THOSE ISSUED UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS LOCATED  
13 IN MARYLAND OR ANY OTHER STATE COVERING MARYLAND RESIDENTS;

14 (II) POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A NONPROFIT  
15 HEALTH SERVICE PLAN THAT COVERS MARYLAND RESIDENTS; OR

16 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR  
17 GROUP MASTER 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  
21 INSURANCE;

22 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY  
23 INSURANCE;

24 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY  
25 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

26 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

27 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

28 6. CREDIT-ONLY INSURANCE;

29 7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

30 8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN  
31 FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191, UNDER WHICH BENEFITS  
32 FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE  
33 BENEFITS; ~~OR~~

34 (II) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A  
35 SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE  
36 OTHERWISE NOT AN INTEGRAL PART OF A PLAN:

37 1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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1                                   2. BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE,  
2 HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF THESE  
3 BENEFITS; AND

4                                   3. SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE  
5 SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191;

6                                   (III) THE FOLLOWING BENEFITS IF OFFERED AS INDEPENDENT,  
7 NONCOORDINATED BENEFITS:

8                                   1. COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS;  
9 AND

10                                  2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY  
11 INSURANCE; OR

12                                  (IV) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE  
13 INSURANCE POLICY:

14                                  1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE (AS  
15 DEFINED UNDER § 1882(G)(1) OF THE SOCIAL SECURITY ACT);

16                                  2. COVERAGE SUPPLEMENTAL TO THE COVERAGE  
17 PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE; AND

18                                  3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO  
19 COVERAGE UNDER AN EMPLOYER SPONSORED PLAN.

20                   (M) "HEALTH STATUS-RELATED FACTOR" MEANS A FACTOR RELATED TO:

21                           (1) HEALTH STATUS;

22                           (2) MEDICAL CONDITION;

23                           (3) CLAIMS EXPERIENCE;

24                           (4) RECEIPT OF HEALTH CARE;

25                           (5) MEDICAL HISTORY;

26                           (6) GENETIC INFORMATION;

27                           (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT  
28 OF ACTS OF DOMESTIC VIOLENCE; OR

29                           (8) DISABILITY.

30                   (N) "HIGH LEVEL POLICY FORM" MEANS A POLICY OR PLAN UNDER WHICH  
31 THE ACTUARIAL VALUE OF THE BENEFIT UNDER THE COVERAGE IS:

32                           (1) AT LEAST 15% GREATER THAN THE ACTUARIAL VALUE OF THE LOW  
33 LEVEL POLICY FORM COVERAGE OFFERED BY THE CARRIER IN THIS STATE; AND

34                           (2) AT LEAST 100% BUT NOT GREATER THAN 120% OF THE WEIGHTED  
35 AVERAGE.

10

1 (O) (1) "INDIVIDUAL HEALTH BENEFIT PLAN" MEANS:

2 ~~(1)~~ (I) A HEALTH BENEFIT PLAN OTHER THAN A CONVERTED POLICY  
3 OR A PROFESSIONAL ASSOCIATION PLAN FOR ELIGIBLE INDIVIDUALS AND THEIR  
4 DEPENDENTS; AND

5 ~~(2)~~ (II) A CERTIFICATE ISSUED TO AN ELIGIBLE INDIVIDUAL THAT  
6 EVIDENCES COVERAGE UNDER A POLICY OR CONTRACT ISSUED TO A TRUST OR  
7 ASSOCIATION OR OTHER SIMILAR GROUP OF INDIVIDUALS, REGARDLESS OF THE  
8 SITUS OF DELIVERY OF THE POLICY OR CONTRACT, IF THE ELIGIBLE INDIVIDUAL  
9 PAYS THE PREMIUM AND IS NOT BEING COVERED UNDER THE POLICY OR  
10 CONTRACT UNDER EITHER FEDERAL OR STATE CONTINUATION OF BENEFITS  
11 PROVISIONS.

12 (2) "INDIVIDUAL HEALTH BENEFIT PLAN" DOES NOT INCLUDE  
13 SHORT-TERM LIMITED DURATION INSURANCE.

14 (P) "LOW LEVEL POLICY FORM" MEANS A POLICY OR PLAN UNDER WHICH  
15 THE ACTUARIAL VALUE OF THE BENEFIT UNDER THE COVERAGE IS AT LEAST 85%  
16 BUT NOT GREATER THAN 100% OF THE WEIGHTED AVERAGE.

17 (Q) "PREEXISTING CONDITION" MEANS:

18 ~~(1) A CONDITION EXISTING DURING A SPECIFIED PERIOD~~  
19 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE THAT WOULD~~  
20 ~~HAVE CAUSED AN ORDINARILY PRUDENT PERSON TO SEEK MEDICAL ADVICE,~~  
21 ~~DIAGNOSIS, CARE, OR TREATMENT; OR~~

22 ~~(2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR~~  
23 ~~TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD~~  
24 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE~~ A CONDITION  
25 THAT WAS PRESENT BEFORE THE DATE OF ENROLLMENT FOR COVERAGE,  
26 WHETHER OR NOT ANY MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS  
27 RECOMMENDED OR RECEIVED BEFORE THAT DATE.

28 (R) "PREEXISTING CONDITION PROVISION" MEANS A PROVISION IN A  
29 HEALTH BENEFIT PLAN THAT DENIES, EXCLUDES, OR LIMITS BENEFITS FOR AN  
30 ENROLLEE FOR EXPENSES OR SERVICES RELATED TO A PREEXISTING CONDITION.

31 (S) "WAITING PERIOD" MEANS THE PERIOD OF TIME THAT MUST PASS  
32 BEFORE AN INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE  
33 TERMS OF A GROUP HEALTH BENEFIT PLAN.

34 (T) (1) "WEIGHTED AVERAGE" MEANS THE AVERAGE ACTUARIAL VALUE  
35 OF THE BENEFITS PROVIDED BY:

36 (I) ALL THE HEALTH INSURANCE COVERAGES ISSUED BY THE  
37 CARRIER IN THIS STATE IN THE INDIVIDUAL MARKET DURING THE PREVIOUS  
38 CALENDAR YEAR, WEIGHTED BY ENROLLMENT FOR THE DIFFERENT COVERAGES;  
39 OR

40 (II) ALL THE HEALTH INSURANCE COVERAGES ISSUED BY ALL  
41 CARRIERS IN THIS STATE IN THE INDIVIDUAL MARKET, IF THE DATA ARE

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1 AVAILABLE, DURING THE PREVIOUS CALENDAR YEAR, WEIGHTED BY ENROLLMENT  
2 FOR THE DIFFERENT COVERAGES.

3 (2) "WEIGHTED AVERAGE" DOES NOT INCLUDE COVERAGES ISSUED  
4 UNDER THIS SUBTITLE.

5 753.

6 (A) THIS SUBTITLE APPLIES TO ALL CARRIERS THAT OFFER HEALTH BENEFIT  
7 PLANS TO INDIVIDUALS IN THE STATE.

8 (B) THIS SUBTITLE DOES NOT APPLY TO A CARRIER THAT OFFERS ONLY  
9 CONVERSION POLICIES AS REQUIRED BY LAW.

10 (C) THIS SUBTITLE DOES NOT APPLY TO A CARRIER THAT OFFERS HEALTH  
11 INSURANCE COVERAGE ONLY IN CONNECTION WITH GROUP HEALTH PLANS OR  
12 THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, OR BOTH.

13 754.

14 IN ADDITION TO ANY OTHER REQUIREMENTS UNDER THIS ARTICLE, A  
15 CARRIER THAT OFFERS INDIVIDUAL HEALTH BENEFIT PLANS IN THIS STATE SHALL:

16 (1) HAVE DEMONSTRATED THE CAPACITY TO ADMINISTER THE  
17 INDIVIDUAL HEALTH BENEFIT PLANS, INCLUDING ADEQUATE NUMBERS AND TYPES  
18 OF ADMINISTRATIVE STAFF;

19 (2) HAVE A SATISFACTORY GRIEVANCE PROCEDURE AND ABILITY TO  
20 RESPOND TO CALLS, QUESTIONS, AND COMPLAINTS FROM ENROLLEES OR  
21 INSUREDS; AND

22 (3) DESIGN POLICIES TO HELP ENSURE THAT ENROLLEES OR INSUREDS  
23 HAVE ADEQUATE ACCESS TO PROVIDERS OF HEALTH CARE.

24 755.

25 A CARRIER MAY NOT OFFER ANY INDIVIDUAL HEALTH BENEFIT PLANS IN THIS  
26 STATE UNLESS THE CARRIER OFFERS, AND ACTIVELY MARKETS, THE POLICIES  
27 REQUIRED BY THIS SUBTITLE.

28 756.

29 (A) UNLESS A CARRIER MAKES AN ELECTION UNDER § 757 OF THIS SUBTITLE,  
30 THE CARRIER MAY NOT:

31 (1) DECLINE TO OFFER COVERAGE TO, OR DENY ENROLLMENT OF AN  
32 ELIGIBLE INDIVIDUAL; OR

33 (2) IMPOSE ANY PREEXISTING CONDITION PROVISION ON AN ELIGIBLE  
34 INDIVIDUAL.

35 (B) (1) A CARRIER THAT MAKES AN ELECTION UNDER § 757 OF THIS  
36 SUBTITLE MAY CHOOSE TO OFFER AT LEAST TWO DIFFERENT POLICY FORMS, BOTH  
37 OF WHICH ARE DESIGNED FOR, MADE GENERALLY AVAILABLE TO, ACTIVELY

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1 MARKETED TO, AND ENROLL, BOTH ELIGIBLE INDIVIDUALS AND OTHER  
2 INDIVIDUALS.

3 (2) POLICY FORMS THAT HAVE DIFFERENT COST-SHARING  
4 ARRANGEMENTS OR DIFFERENT RIDERS SHALL BE CONSIDERED TO BE DIFFERENT  
5 POLICY FORMS.

6 (C) POLICY FORMS SHALL COMPLY WITH THE REQUIREMENTS OF THIS  
7 SUBTITLE.

8 757.

9 (A) NO LATER THAN JULY 1, 1997, A CARRIER THAT INTENDS TO OFFER TWO  
10 POLICY FORMS SHALL SUBMIT IN WRITING TO THE COMMISSIONER BOTH:

11 (1) AN ELECTION WHETHER TO OFFER:

12 (I) A HIGH LEVEL AND LOW LEVEL POLICY FORM, EACH OF  
13 WHICH INCLUDES BENEFITS SUBSTANTIALLY SIMILAR TO OTHER INDIVIDUAL  
14 HEALTH INSURANCE COVERAGE OFFERED BY THE CARRIER IN THIS STATE; OR

15 (II) POLICY FORMS WITH THE LARGEST AND NEXT TO LARGEST  
16 PREMIUM VOLUME OF ALL POLICY FORMS OFFERED BY THE CARRIER IN THIS  
17 STATE; AND

18 (2) AN ELECTION WHETHER TO USE THE WEIGHTED AVERAGE  
19 VALUATION DESCRIBED IN § 752(T)(1)(I) OR (II) OF THIS SUBTITLE.

20 (B) (1) AN ELECTION MADE UNDER THIS SECTION SHALL BE BINDING FOR  
21 A 2-YEAR PERIOD.

22 (2) AFTER THE INITIAL 2-YEAR PERIOD, AND FOR EACH SUBSEQUENT  
23 2-YEAR PERIOD, CARRIERS SHALL AGAIN MAKE THE ELECTIONS REQUIRED BY THIS  
24 SECTION.

25 (3) AN ELECTION SHALL BE MADE ON A FORM AND IN A MANNER  
26 REQUIRED BY THE COMMISSIONER.

27 758.

28 (A) THE ACTUARIAL VALUE OF BENEFITS PROVIDED UNDER INDIVIDUAL  
29 HEALTH INSURANCE COVERAGE SHALL BE CALCULATED BASED ON A  
30 STANDARDIZED POPULATION AND A SET OF STANDARDIZED UTILIZATION AND  
31 COST FACTORS.

32 (B) A CARRIER SHALL SUBMIT ANY INFORMATION THE COMMISSIONER MAY  
33 REQUIRE TO SUPPORT AND JUSTIFY THE CARRIER'S CALCULATIONS OF ACTUARIAL  
34 VALUES.

35 759.

36 (A) SUBJECT TO SUBSECTIONS (C) AND (G) OF THIS SECTION, A CARRIER  
37 SHALL ISSUE THE INDIVIDUAL HEALTH BENEFIT PLAN ELECTED UNDER § 756 OR §  
38 757(A)(1) OF THIS SUBTITLE TO ANY ELIGIBLE INDIVIDUAL.

13

1 (B) (1) A CARRIER MAY NOT LIMIT COVERAGE UNDER ANY INDIVIDUAL  
2 HEALTH BENEFIT PLAN ISSUED TO AN ELIGIBLE INDIVIDUAL UNDER A  
3 PREEXISTING CONDITION PROVISION.

4 (2) A CARRIER MAY IMPOSE A PREEXISTING CONDITION PROVISION ON  
5 AN INDIVIDUAL WHO HAS HAD A PERIOD OF AT LEAST 63 DAYS DURING ALL OF  
6 WHICH THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE  
7 AND WHO WOULD OTHERWISE HAVE BEEN AN ELIGIBLE INDIVIDUAL.

8 (C) A CARRIER MAY REFUSE TO ISSUE AN INDIVIDUAL HEALTH BENEFIT  
9 PLAN TO AN ELIGIBLE INDIVIDUAL, IF THE CARRIER DEMONSTRATES TO THE  
10 SATISFACTION OF THE COMMISSIONER THAT:

11 (1) IT DOES NOT HAVE THE POLICYHOLDER SURPLUS NECESSARY TO  
12 UNDERWRITE ADDITIONAL COVERAGE; AND

13 (2) IT IS APPLYING THIS SECTION UNIFORMLY TO ALL INDIVIDUALS IN  
14 THE INDIVIDUAL MARKET IN THIS STATE WITHOUT REGARD TO:

15 (I) ANY HEALTH STATUS-RELATED FACTOR; AND

16 (II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

17 (D) A CARRIER THAT DENIES INDIVIDUAL HEALTH INSURANCE COVERAGE  
18 UNDER SUBSECTION (C) OF THIS SECTION MAY NOT OFFER COVERAGE IN THE  
19 INDIVIDUAL MARKET UNTIL THE LATER OF:

20 (1) A PERIOD OF 180 DAYS AFTER THE DATE THE COVERAGE IS DENIED;  
21 OR

22 (2) UNTIL THE CARRIER HAS DEMONSTRATED, TO THE  
23 COMMISSIONER'S SATISFACTION THAT THE CARRIER HAS SUFFICIENT  
24 POLICYHOLDER SURPLUS TO UNDERWRITE ADDITIONAL COVERAGE.

25 (E) A CARRIER MAY ELECT NOT TO RENEW ALL INDIVIDUAL HEALTH  
26 BENEFIT PLANS IN THE STATE.

27 (F) WHEN A CARRIER ELECTS NOT TO RENEW ALL INDIVIDUAL HEALTH  
28 BENEFIT PLANS IN THE STATE, THE CARRIER:

29 (1) SHALL GIVE NOTICE OF ITS DECISION TO THE AFFECTED  
30 INDIVIDUALS AT LEAST 180 DAYS BEFORE THE EFFECTIVE DATE OF NONRENEWAL;

31 (2) AT LEAST 30 WORKING DAYS BEFORE THAT NOTICE, SHALL GIVE  
32 NOTICE TO THE COMMISSIONER; AND

33 (3) MAY NOT WRITE NEW BUSINESS FOR INDIVIDUALS IN THE STATE  
34 FOR A 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE  
35 COMMISSIONER.

36 (G) A HEALTH MAINTENANCE ORGANIZATION NEED NOT OFFER COVERAGE  
37 TO AN INDIVIDUAL WHO DOES NOT LIVE, RESIDE, OR WORK WITHIN THE HEALTH  
38 MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREAS.

14

1 760.

2 (A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, A CARRIER  
3 SHALL RENEW AN INDIVIDUAL HEALTH BENEFIT PLAN AT THE OPTION OF THE  
4 ELIGIBLE INDIVIDUAL.

5 (B) A CARRIER MAY NOT CANCEL OR REFUSE TO RENEW AN INDIVIDUAL  
6 HEALTH BENEFIT PLAN EXCEPT:

7 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUMS;

8 (2) WHERE THE INDIVIDUAL HAS PERFORMED AN ACT OR PRACTICE  
9 THAT CONSTITUTES FRAUD;

10 (3) WHERE THE INDIVIDUAL HAS MADE AN INTENTIONAL  
11 MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE COVERAGE;

12 (4) WHERE THE CARRIER ELECTS NOT TO RENEW ALL OF ITS  
13 INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

14 (5) WHERE THE ELIGIBLE INDIVIDUAL NO LONGER RESIDES, LIVES, OR  
15 WORKS IN THE SERVICE AREA, PROVIDED THAT THE COVERAGE IS TERMINATED  
16 UNDER THIS PROVISION UNIFORMLY WITHOUT REGARD TO ANY HEALTH  
17 STATUS-RELATED FACTOR OF COVERED INDIVIDUALS; OR

18 (6) WHERE, IN THE CASE OF HEALTH INSURANCE COVERAGE THAT IS  
19 MADE AVAILABLE IN THE INDIVIDUAL MARKET ONLY THROUGH ONE OR MORE  
20 BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF THE ELIGIBLE INDIVIDUAL IN THE  
21 ASSOCIATION CEASES BUT ONLY IF SUCH COVERAGE IS TERMINATED UNDER THIS  
22 PARAGRAPH UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS-RELATED  
23 FACTOR OF COVERED INDIVIDUALS.

24 761.

25 (A) A CARRIER SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE  
26 COVERAGE.

27 (B) THE CERTIFICATION OF CREDITABLE COVERAGE DESCRIBED IN  
28 SUBSECTION (A) OF THIS SECTION SHALL BE PROVIDED:

29 ~~(1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE~~  
30 ~~COVERED UNDER THE HEALTH BENEFITS PLAN AND WITHIN A REASONABLE~~  
31 ~~PERIOD AFTER CESSATION OF COVERAGE; AND~~

32 ~~(2) AT THE REQUEST OF THE INDIVIDUAL, IN NO EVENT LATER THAN 24~~  
33 ~~MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE.~~

34 (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE  
35 COVERED UNDER THE HEALTH BENEFITS PLAN OR OTHERWISE BECOMES COVERED  
36 UNDER A COBRA CONTINUATION PROVISION;

37 (2) IN THE CASE OF AN INDIVIDUAL WHO BECOMES COVERED UNDER A  
38 COBRA CONTINUATION PROVISION, AT THE TIME THE INDIVIDUAL CEASES TO BE  
39 COVERED UNDER THE PROVISION; AND

15

1                   (3) ON THE REQUEST ON BEHALF OF AN INDIVIDUAL MADE NOT LATER  
2 THAN 24 MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE DESCRIBED  
3 IN ITEM (1) OR (2) OF THIS SUBSECTION, WHICHEVER IS LATER.

4           (C) THE CERTIFICATION MAY BE PROVIDED AT A TIME CONSISTENT WITH  
5 NOTICES REQUIRED UNDER ANY APPLICABLE STATE OR FEDERAL CONTINUATION  
6 PROVISION.

7           (D) THE CERTIFICATION SHALL CONTAIN:

8                   (1) WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE  
9 COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN, AND THE  
10 COVERAGE, IF APPLICABLE, UNDER THE APPLICABLE STATE OR FEDERAL  
11 CONTINUATION PROVISION; AND

12                   (2) THE WAITING PERIOD, IF ANY, IMPOSED WITH RESPECT TO THE  
13 INDIVIDUAL FOR ANY COVERAGE UNDER THE HEALTH BENEFIT PLAN.

14           (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE  
15 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF  
16 COVERAGE, THEN:

17                   (1) UPON REQUEST OF THE GROUP HEALTH PLAN, THE ENTITY WHICH  
18 ISSUED THE CERTIFICATION PROVIDED BY THE INDIVIDUAL SHALL PROMPTLY  
19 DISCLOSE TO THE REQUESTING GROUP HEALTH PLAN, INFORMATION REGARDING  
20 COVERAGE OF CLASSES AND CATEGORIES OF HEALTH BENEFITS AVAILABLE  
21 UNDER THE ENTITY'S PLAN OR POLICY; AND

22                   (2) THE ENTITY MAY CHARGE THE REQUESTING PLAN FOR THE  
23 REASONABLE COST OF DISCLOSING THE INFORMATION.

24 762.

25           (A) IN DETERMINING A PERIOD OF CREDITABLE COVERAGE, ANY PERIOD  
26 THAT AN INDIVIDUAL IS IN A WAITING PERIOD FOR COVERAGE UNDER A GROUP  
27 HEALTH BENEFIT PLAN OR AN AFFILIATION PERIOD MAY NOT BE TAKEN INTO  
28 ACCOUNT IN DETERMINING ANY PERIOD OF CONTINUOUS CREDITABLE COVERAGE.

29           (B) A CARRIER SHALL COUNT A PERIOD OF CREDITABLE COVERAGE  
30 WITHOUT REGARD TO THE SPECIFIC BENEFITS COVERED DURING THE PERIOD.

31 763.

32           A CARRIER THAT ELECTS TO OFFER A HIGH LEVEL AND LOW LEVEL POLICY  
33 FORM UNDER § 757 OF THIS SUBTITLE MAY NOT CHARGE A RATE TO ELIGIBLE  
34 INDIVIDUALS THAT IS GREATER THAN 200% OF THE RATE THE CARRIER NORMALLY  
35 WOULD CHARGE FOR THE SAME OR SIMILAR POLICY FORMS TO OTHER  
36 INDIVIDUALS.

16

1 60. MARYLAND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT --  
2 LARGE GROUP MARKET REFORMS

3 764.

4 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS  
5 INDICATED.

6 (B) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME BEGINNING ON THE  
7 DATE OF ENROLLMENT AND NOT TO EXCEED 2 MONTHS, OR 3 MONTHS IN THE CASE  
8 OF A LATE ENROLLEE, DURING WHICH A HEALTH MAINTENANCE ORGANIZATION  
9 DOES NOT COLLECT PREMIUM AND COVERAGE ISSUED DOES NOT BECOME  
10 EFFECTIVE.

11 (C) "ASSOCIATION" OR "BONA FIDE ASSOCIATION" MEANS, WITH RESPECT TO  
12 HEALTH INSURANCE COVERAGE OFFERED IN THIS STATE, AN ASSOCIATION THAT:

13 (1) HAS BEEN ACTIVELY IN EXISTENCE FOR AT LEAST 5 YEARS;

14 (2) HAS BEEN FORMED AND MAINTAINED IN GOOD FAITH FOR  
15 PURPOSES OTHER THAN OBTAINING INSURANCE AND DOES NOT CONDITION  
16 MEMBERSHIP ON THE PURCHASE OF ASSOCIATION-SPONSORED INSURANCE;

17 (3) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON ANY  
18 HEALTH STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL, AND STATES SO  
19 CLEARLY IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

20 (4) MAKES HEALTH INSURANCE COVERAGE OFFERED THROUGH THE  
21 ASSOCIATION AVAILABLE TO ALL MEMBERS REGARDLESS OF ANY HEALTH  
22 STATUS-RELATED FACTOR RELATING TO THE MEMBERS OR INDIVIDUALS ELIGIBLE  
23 FOR COVERAGE THROUGH A MEMBER AND STATES SO CLEARLY IN ALL  
24 MEMBERSHIP AND APPLICATION MATERIALS;

25 (5) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED  
26 THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH  
27 MEMBERSHIP IN THE ASSOCIATION AND STATES SO CLEARLY IN ALL MARKETING  
28 AND APPLICATION MATERIALS; AND

29 (6) PROVIDES AND ANNUALLY UPDATES INFORMATION NECESSARY  
30 FOR THE COMMISSIONER TO DETERMINE WHETHER OR NOT THE ASSOCIATION  
31 MEETS THE DEFINITION OF BONA FIDE ASSOCIATION BEFORE QUALIFYING AS AN  
32 ASSOCIATION UNDER THIS SUBTITLE.

33 (D) "CARRIER" MEANS A PERSON THAT IS:

34 (1) AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE  
35 STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

36 (2) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO  
37 OPERATE IN THE STATE;

38 (3) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO  
39 OPERATE IN THE STATE; OR

17

1 (4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH  
2 BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

3 (E) "CHURCH PLAN" MEANS A PLAN AS DEFINED UNDER SECTION 3(33) OF  
4 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

5 (F) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL  
6 UNDER:

7 (I) ~~A GROUP HEALTH AN EMPLOYER-SPONSORED PLAN;~~

8 (II) ~~HEALTH INSURANCE COVERAGE BENEFIT PLAN;~~

9 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY  
10 ACT;

11 (IV) TITLE XIX OF THE SOCIAL SECURITY ACT, OTHER THAN  
12 COVERAGE CONSISTING SOLELY OF BENEFITS UNDER SECTION 1928 OF THAT ACT;

13 (V) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE;

14 (VI) A MEDICAL CARE PROGRAM OF THE INDIAN HEALTH SERVICE  
15 OR OF A TRIBAL ORGANIZATION;

16 (VII) A STATE HEALTH BENEFITS RISK POOL;

17 (VIII) A HEALTH PLAN OFFERED UNDER THE FEDERAL EMPLOYEES  
18 HEALTH BENEFITS PROGRAM (FEHBP), TITLE 5, CHAPTER 89 OF THE UNITED STATES  
19 CODE;

20 (IX) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL  
21 REGULATIONS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT, SECTION  
22 2701(C)(1)(I), AS AMENDED BY P.L. 104-191; OR

23 (X) A HEALTH BENEFIT PLAN UNDER SECTION 5(E) OF THE PEACE  
24 CORPS ACT, 22 U.S.C. 2504(E).

25 (2) A PERIOD OF CREDITABLE COVERAGE SHALL NOT BE COUNTED,  
26 WITH RESPECT TO ENROLLMENT OF AN INDIVIDUAL UNDER A GROUP HEALTH  
27 PLAN, IF, AFTER SUCH PERIOD AND BEFORE THE ENROLLMENT DATE, THERE WAS A  
28 63-DAY PERIOD DURING ALL OF WHICH THE INDIVIDUAL WAS NOT COVERED  
29 UNDER ANY CREDITABLE COVERAGE.

30 (G) "EMPLOYER SPONSORED PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT  
31 PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THEIR DEPENDENTS, AND  
32 IS NOT SUBJECT TO STATE REGULATION IN ACCORDANCE WITH THE FEDERAL  
33 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

34 (H) "ENROLLMENT DATE" MEANS THE DATE ON WHICH:

35 (1) AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN; OR

36 (2) THE FIRST DAY OF THE WAITING PERIOD BEFORE WHICH THE  
37 INDIVIDUAL MAY ENROLL.

18

1 (I) "GOVERNMENTAL PLAN" MEANS A PLAN AS DEFINED IN SECTION 3(32) OF  
2 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 AND ANY FEDERAL  
3 GOVERNMENTAL PLAN.

4 (J) (1) "HEALTH BENEFIT PLAN" MEANS ANY:

5 (I) HOSPITAL OR MEDICAL POLICY, INCLUDING THOSE ISSUED  
6 UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS LOCATED IN MARYLAND  
7 OR ANY OTHER STATE COVERING MARYLAND RESIDENTS;

8 (II) POLICY OR CONTRACT ISSUED BY A NONPROFIT HEALTH  
9 SERVICE PLAN THAT COVERS MARYLAND RESIDENTS; OR

10 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR  
11 GROUP MASTER CONTRACT.

12 (2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

13 (I) ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

14 1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME  
15 INSURANCE;

16 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY  
17 INSURANCE;

18 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY  
19 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

20 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

21 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

22 6. CREDIT-ONLY INSURANCE;

23 7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

24 8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN  
25 FEDERAL REGULATIONS ISSUED UNDER THE FEDERAL HEALTH INSURANCE  
26 PORTABILITY AND ACCOUNTABILITY ACT UNDER WHICH BENEFITS FOR MEDICAL  
27 CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS; ~~OR~~

28 (II) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A  
29 SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE  
30 OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:

31 1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

32 2. BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE,  
33 HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF THESE  
34 BENEFITS; AND

35 3. SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE  
36 SPECIFIED IN FEDERAL REGULATIONS ISSUED UNDER THE FEDERAL HEALTH  
37 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT;

19

1 (III) THE FOLLOWING BENEFITS IF OFFERED AS INDEPENDENT,  
2 NONCOORDINATED BENEFITS:

3 1. COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS;  
4 AND

5 2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY  
6 INSURANCE; OR

7 (IV) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE  
8 INSURANCE POLICY:

9 1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE (AS  
10 DEFINED UNDER § 1882(G)(1) OF THE SOCIAL SECURITY ACT);

11 2. COVERAGE SUPPLEMENTAL TO THE COVERAGE  
12 PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE; AND

13 3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO  
14 COVERAGE UNDER AN EMPLOYER SPONSORED PLAN.

15 (K) "HEALTH STATUS-RELATED FACTOR" MEANS A FACTOR RELATED TO:

16 (1) HEALTH STATUS;

17 (2) MEDICAL CONDITION;

18 (3) CLAIMS EXPERIENCE;

19 (4) RECEIPT OF HEALTH CARE;

20 (5) MEDICAL HISTORY;

21 (6) GENETIC INFORMATION;

22 (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT  
23 OF ACTS OF DOMESTIC VIOLENCE; OR

24 (8) DISABILITY.

25 (L) "LATE ENROLLEE" MEANS A MEMBER, SUBSCRIBER, OR DEPENDENT WHO  
26 ENROLLS IN A GROUP HEALTH BENEFIT PLAN OTHER THAN DURING:

27 (1) THE FIRST PERIOD IN WHICH THE INDIVIDUAL IS ELIGIBLE TO  
28 ENROLL UNDER THE PLAN; OR

29 (2) A SPECIAL ENROLLMENT PERIOD.

30 (M) "PREEXISTING CONDITION" MEANS:

31 ~~(1) A CONDITION EXISTING DURING A SPECIFIED PERIOD~~  
32 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE THAT WOULD~~  
33 ~~HAVE CAUSED AN ORDINARILY PRUDENT PERSON TO SEEK MEDICAL ADVICE,~~  
34 ~~DIAGNOSIS, CARE, OR TREATMENT; OR~~

1           ~~(2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR~~  
2 ~~TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD~~  
3 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE A CONDITION~~  
4 ~~THAT WAS PRESENT BEFORE THE DATE OF ENROLLMENT FOR COVERAGE.~~  
5 WHETHER OR NOT ANY MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS  
6 RECOMMENDED OR RECEIVED BEFORE THAT DATE.

7           (N) "PREEXISTING CONDITION PROVISION" MEANS A PROVISION IN A  
8 HEALTH BENEFIT PLAN THAT DENIES, EXCLUDES, OR LIMITS BENEFITS FOR AN  
9 ENROLLEE FOR EXPENSES OR SERVICES RELATED TO A PREEXISTING CONDITION.

10          (O) "SECRETARY" MEANS THE SECRETARY OF THE FEDERAL DEPARTMENT  
11 OF HEALTH AND HUMAN SERVICES.

12          (P) "SPECIAL ENROLLMENT PERIOD" MEANS A PERIOD DURING WHICH A  
13 GROUP HEALTH PLAN SHALL PERMIT AN EMPLOYEE WHO IS ELIGIBLE FOR  
14 COVERAGE, BUT NOT ENROLLED, TO ENROLL FOR COVERAGE UNDER THE TERMS  
15 OF THE GROUP HEALTH BENEFIT PLAN.

16          (Q) "WAITING PERIOD" MEANS THE PERIOD OF TIME THAT MUST PASS  
17 BEFORE AN INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE  
18 TERMS OF A GROUP HEALTH BENEFIT PLAN.

19 765.

20          (A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, THIS SUBTITLE APPLIES TO  
21 ALL CARRIERS IN CONNECTION WITH GROUP HEALTH BENEFIT PLANS.

22          (B) EXCEPT AS PROVIDED IN § 766 OF THIS SUBTITLE, THIS SUBTITLE DOES  
23 NOT APPLY TO POLICIES ISSUED UNDER SUBTITLE 55 OF THIS ARTICLE.

24 766.

25          (A) A CARRIER SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE  
26 COVERAGE IN CONNECTION WITH GROUP HEALTH BENEFIT PLANS, INCLUDING  
27 THOSE ISSUED IN ACCORDANCE WITH SUBTITLE 55 OF THIS ARTICLE.

28          (B) THE CERTIFICATION OF CREDITABLE COVERAGE DESCRIBED IN  
29 SUBSECTION (A) OF THIS SECTION SHALL BE PROVIDED:

30           ~~(1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE~~  
31 ~~COVERED UNDER THE PLAN AND WITHIN A REASONABLE PERIOD AFTER~~  
32 ~~CESSATION OF COVERAGE; AND~~

33           ~~(2) AT THE REQUEST OF THE INDIVIDUAL, IN NO EVENT LATER THAN 24~~  
34 ~~MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE.~~

35           (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE  
36 COVERED UNDER THE HEALTH BENEFITS PLAN OR OTHERWISE BECOMES COVERED  
37 UNDER A COBRA CONTINUATION PROVISION;

38           (2) IN THE CASE OF AN INDIVIDUAL WHO BECOMES COVERED UNDER A  
39 COBRA CONTINUATION PROVISION, AT THE TIME THE INDIVIDUAL CEASES TO BE  
40 COVERED UNDER THE PROVISION; AND

1                   (3) ON THE REQUEST ON BEHALF OF AN INDIVIDUAL MADE NOT LATER  
2 THAN 24 MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE DESCRIBED  
3 IN ITEM (1) OR (2) OF THIS SUBSECTION, WHICHEVER IS LATER.

4           (C) THE CERTIFICATION MAY BE PROVIDED AT A TIME CONSISTENT WITH  
5 NOTICES REQUIRED UNDER ANY APPLICABLE STATE OR FEDERAL CONTINUATION  
6 PROVISION.

7           (D) THE CERTIFICATION SHALL CONTAIN:

8                   (1) WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE  
9 COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN, AND THE  
10 COVERAGE, IF APPLICABLE, UNDER THE APPLICABLE STATE OR FEDERAL  
11 CONTINUATION PROVISION; AND

12                   (2) THE WAITING PERIOD, IF ANY, IMPOSED WITH RESPECT TO THE  
13 INDIVIDUAL FOR ANY COVERAGE UNDER THE HEALTH BENEFIT PLAN.

14           (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE  
15 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF  
16 COVERAGE, THEN:

17                   (1) ON REQUEST OF THE GROUP HEALTH PLAN, THE ENTITY THAT  
18 ISSUED THE CERTIFICATION PROVIDED BY THE INDIVIDUAL PROMPTLY SHALL  
19 DISCLOSE TO THE REQUESTING GROUP HEALTH PLAN, INFORMATION REGARDING  
20 COVERAGE OF CLASSES AND CATEGORIES OF HEALTH BENEFITS AVAILABLE  
21 UNDER THE ENTITY'S PLAN OR POLICY; AND

22                   (2) THE ENTITY MAY CHARGE THE REQUESTING PLAN FOR THE  
23 REASONABLE COST OF DISCLOSING THE INFORMATION.

24 767.

25           (A) IN DETERMINING A PERIOD OF CREDITABLE COVERAGE, ANY PERIOD  
26 THAT AN INDIVIDUAL IS IN A WAITING PERIOD FOR ANY COVERAGE UNDER A  
27 GROUP HEALTH BENEFIT PLAN OR AN AFFILIATION PERIOD MAY NOT BE TAKEN  
28 INTO ACCOUNT IN DETERMINING ANY PERIOD OF CONTINUOUS CREDITABLE  
29 COVERAGE.

30           (B) EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION, A CARRIER  
31 SHALL COUNT A PERIOD OF CREDITABLE COVERAGE WITHOUT REGARD TO THE  
32 SPECIFIC BENEFITS COVERED DURING THE PERIOD.

33           (C) (1) A CARRIER MAY ELECT TO REDUCE THE PERIOD OF ANY  
34 PREEXISTING CONDITION PROVISION BASED ON COVERAGE OF BENEFITS WITHIN  
35 ANY CLASS OR CATEGORY OF BENEFITS SPECIFIED BY THE SECRETARY BY  
36 REGULATION.

37                   (2) ANY ELECTION MADE UNDER THIS SECTION SHALL BE MADE ON A  
38 UNIFORM BASIS FOR ALL COVERED INDIVIDUALS.

39                   (3) A CARRIER THAT MAKES AN ELECTION UNDER THIS SECTION SHALL  
40 COUNT A PERIOD OF CREDITABLE COVERAGE WITH RESPECT TO ANY CLASS OR

22

1 CATEGORY OF BENEFITS IF ANY LEVEL OF BENEFITS IS COVERED WITHIN THAT  
2 CLASS OR CATEGORY.

3 (D) A CARRIER THAT MAKES AN ELECTION UNDER SUBSECTION (C) OF THIS  
4 SECTION SHALL:

5 (1) PROMINENTLY STATE IN ANY DISCLOSURE STATEMENTS  
6 CONCERNING THE COVERAGE, AND TO EACH EMPLOYER AT THE TIME OF THE  
7 OFFER OR SALE OF THE COVERAGE, THAT THE CARRIER HAS MADE THIS ELECTION;  
8 AND

9 (2) INCLUDE IN THE STATEMENT A DESCRIPTION OF THE EFFECT OF  
10 THE ELECTION ON THE MEMBER OR SUBSCRIBER.

11 768.

12 AN INDIVIDUAL SHALL ESTABLISH THE INDIVIDUAL'S PERIOD OF CREDITABLE  
13 COVERAGE BY PRESENTING THE CERTIFICATE DESCRIBED IN § 766 OF THIS  
14 SUBTITLE.

15 769.

16 (A) A CARRIER MAY NOT ESTABLISH RULES FOR ELIGIBILITY OF AN  
17 INDIVIDUAL TO ENROLL UNDER A GROUP HEALTH BENEFITS PLAN BASED ON ANY  
18 HEALTH STATUS-RELATED FACTOR.

19 (B) SUBSECTION (A) OF THIS SECTION DOES NOT:

20 (1) REQUIRE A CARRIER TO PROVIDE PARTICULAR BENEFITS OTHER  
21 THAN THOSE PROVIDED UNDER THE TERMS OF THE PARTICULAR HEALTH BENEFIT  
22 PLAN; OR

23 (2) PREVENT A CARRIER FROM ESTABLISHING LIMITATIONS OR  
24 RESTRICTIONS ON THE AMOUNT, LEVEL, EXTENT, OR NATURE OF THE BENEFITS OR  
25 COVERAGE FOR SIMILARLY SITUATED INDIVIDUALS ENROLLED IN THE HEALTH  
26 BENEFIT PLAN.

27 (C) RULES FOR ELIGIBILITY TO ENROLL UNDER A PLAN INCLUDES RULES  
28 DEFINING ANY APPLICABLE WAITING PERIODS FOR ENROLLMENT.

29 (D) A CARRIER SHALL ALLOW AN EMPLOYEE OR DEPENDENT WHO IS  
30 ELIGIBLE, BUT NOT ENROLLED, FOR COVERAGE UNDER THE TERMS OF A GROUP  
31 HEALTH BENEFITS PLAN TO ENROLL FOR COVERAGE UNDER THE TERMS OF THE  
32 PLAN IF:

33 (1) THE EMPLOYEE OR DEPENDENT WAS COVERED UNDER AN  
34 EMPLOYER-SPONSORED PLAN OR GROUP HEALTH BENEFITS PLAN AT THE TIME  
35 COVERAGE WAS PREVIOUSLY OFFERED TO THE EMPLOYEE OR DEPENDENT;

36 (2) THE EMPLOYEE STATES IN WRITING, AT THE TIME COVERAGE WAS  
37 PREVIOUSLY OFFERED, THAT COVERAGE UNDER AN EMPLOYER-SPONSORED PLAN  
38 OR GROUP HEALTH BENEFITS PLAN WAS THE REASON FOR DECLINING  
39 ENROLLMENT, BUT ONLY IF THE PLAN SPONSOR OR ISSUER REQUIRES THE

23

1 STATEMENT AND PROVIDES THE EMPLOYEE WITH NOTICE OF THE REQUIREMENT;  
2 AND

3 (3) THE EMPLOYEE'S OR DEPENDENT'S COVERAGE DESCRIBED IN ITEM  
4 (1) OF THIS SUBSECTION:

5 (I) WAS UNDER A COBRA CONTINUATION PROVISION, AND THE  
6 COVERAGE UNDER THAT PROVISION WAS EXHAUSTED; OR

7 (II) WAS NOT UNDER A COBRA CONTINUATION PROVISION, AND  
8 EITHER THE COVERAGE WAS TERMINATED AS A RESULT OF LOSS OF ELIGIBILITY  
9 FOR THE COVERAGE, INCLUDING LOSS OF ELIGIBILITY AS A RESULT OF LEGAL  
10 SEPARATION, DIVORCE, DEATH, TERMINATION OF EMPLOYMENT, OR REDUCTION  
11 IN THE NUMBER OF HOURS OF EMPLOYMENT, OR EMPLOYER CONTRIBUTIONS  
12 TOWARDS THE COVERAGE WERE TERMINATED.

13 770.

14 A CARRIER MAY NOT REQUIRE AN INDIVIDUAL MEMBER OF A GROUP TO PAY  
15 A PREMIUM OR CONTRIBUTION THAT IS GREATER THAN THE PREMIUM OR  
16 CONTRIBUTION FOR A SIMILARLY SITUATED INDIVIDUAL, BASED ON ANY HEALTH  
17 STATUS-RELATED FACTOR.

18 771.

19 A CARRIER SHALL RENEW GROUP HEALTH BENEFIT PLANS AT THE OPTION OF  
20 THE POLICYHOLDER OR PLAN SPONSOR, EXCEPT IN ANY OF THE FOLLOWING CASES:

21 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUM;

22 (2) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS PERFORMED  
23 AN ACT OR PRACTICE THAT CONSTITUTES FRAUD;

24 (3) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS MADE AN  
25 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE  
26 COVERAGE;

27 (4) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS FAILED TO  
28 COMPLY WITH A MATERIAL PLAN PROVISION RELATING TO THE EMPLOYER  
29 CONTRIBUTIONS OR GROUP PARTICIPATION RULES;

30 (5) WHERE THE CARRIER ELECTS NOT TO RENEW ALL GROUP HEALTH  
31 BENEFIT PLANS IN THE STATE;

32 (6) IN THE CASE OF A HEALTH MAINTENANCE ORGANIZATION, WHERE  
33 THERE IS NO LONGER ANY ENROLLEE WHO LIVES, RESIDES, OR WORKS IN THE  
34 HEALTH MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREA;

35 (7) IN THE CASE OF A CARRIER THAT OFFERS COVERAGE ONLY  
36 THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, WHEN THE MEMBERSHIP OF  
37 AN EMPLOYER IN THE ASSOCIATION CEASES AND NONRENEWAL UNDER THIS ITEM  
38 IS APPLIED UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS-RELATED  
39 FACTOR RELATING TO ANY COVERED INDIVIDUAL; OR

24

1 (8) THE CARRIER MAKES AN ELECTION UNDER § 772 OF THIS SUBTITLE.

2 772.

3 (A) A CARRIER THAT ELECTS NOT TO RENEW ALL OF A PARTICULAR TYPE OF  
4 COVERAGE OR POLICY FORM IN THE STATE SHALL:

5 (1) PROVIDE NOTICE OF THE NONRENEWAL AT LEAST 90 DAYS BEFORE  
6 THE DATE OF THE NONRENEWAL TO EACH AFFECTED:

7 (I) POLICYHOLDER;

8 (II) PLAN SPONSOR;

9 (III) PARTICIPANT; AND

10 (IV) BENEFICIARY;

11 (2) OFFER TO EACH AFFECTED PLAN SPONSOR THE OPTION TO  
12 PURCHASE ANY OTHER HEALTH INSURANCE COVERAGE CURRENTLY BEING  
13 OFFERED BY THE CARRIER; AND

14 (3) ACT UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE  
15 OF ANY AFFECTED PLAN SPONSOR, OR ANY HEALTH STATUS-RELATED FACTOR OF  
16 ANY AFFECTED INDIVIDUAL.

17 (B) A CARRIER MAY ELECT NOT TO RENEW ALL GROUP HEALTH BENEFIT  
18 PLANS IN THE STATE.

19 (C) WHEN A CARRIER ELECTS NOT TO RENEW ALL GROUP HEALTH BENEFIT  
20 PLANS IN THE STATE, THE CARRIER:

21 (1) SHALL GIVE NOTICE OF ITS DECISION TO THE AFFECTED  
22 INDIVIDUALS AT LEAST 180 DAYS BEFORE THE EFFECTIVE DATE OF NONRENEWAL;

23 (2) AT LEAST 30 WORKING DAYS BEFORE THAT NOTICE, SHALL GIVE  
24 NOTICE TO THE COMMISSIONER; AND

25 (3) MAY NOT WRITE NEW BUSINESS FOR GROUPS IN THE STATE FOR A  
26 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE COMMISSIONER.

27 (D) A HEALTH MAINTENANCE ORGANIZATION NEED NOT OFFER COVERAGE  
28 TO AN INDIVIDUAL WHO DOES NOT LIVE, RESIDE, OR WORK WITHIN THE HEALTH  
29 MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREAS.

30 **Article - Health - General**

31 19-706.

32 (N) THE PROVISIONS OF SUBTITLES 59 AND 60 OF ARTICLE 48A OF THE CODE  
33 APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

34 SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland  
35 read as follows:

25

1 **Article - Insurance**

2 15-508.

3 (A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS  
4 INDICATED.

5 (2) "CARRIER" HAS THE MEANING STATED IN § 15-1301 OF THIS TITLE.

6 (3) "POLICY OR CERTIFICATE" MEANS ANY GROUP OR BLANKET  
7 HEALTH INSURANCE CONTRACT OR POLICY THAT IS ISSUED OR DELIVERED IN THE  
8 STATE BY AN INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT PROVIDES  
9 HOSPITAL, MEDICAL, OR SURGICAL BENEFITS ON AN EXPENSE-INCURRED BASIS.

10 (4) "PREEXISTING CONDITION PROVISION" HAS THE MEANING STATED  
11 IN § 15-1301 OF THIS TITLE.

12 (5) "LATE ENROLLEE" HAS THE MEANING STATED IN § 15-1401 OF THIS  
13 TITLE.

14 (B) THIS SECTION DOES NOT APPLY TO A POLICY OR CERTIFICATE ISSUED TO  
15 A SMALL EMPLOYER IN ACCORDANCE WITH SUBTITLE 12 OF THIS TITLE, OR TO AN  
16 INDIVIDUAL IN ACCORDANCE WITH SUBTITLE 13 OF THIS TITLE.

17 (C) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (D) OF THIS SECTION,  
18 A CARRIER MAY IMPOSE A PREEXISTING CONDITION PROVISION ONLY IF IT:

19 (1) RELATES TO A CONDITION, REGARDLESS OF THE CAUSE OF THE  
20 CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS  
21 RECOMMENDED OR RECEIVED WITHIN THE 6-MONTH PERIOD ENDING ON THE  
22 ENROLLMENT DATE;

23 (2) EXTENDS FOR A PERIOD OF NOT MORE THAN 12 MONTHS AFTER  
24 THE ENROLLMENT DATE OR 18 MONTHS IN THE CASE OF A LATE ENROLLEE; AND

25 (3) IS REDUCED BY THE AGGREGATE OF THE PERIODS OF CREDITABLE  
26 COVERAGE, AS DEFINED IN SUBTITLE 14 OF THIS TITLE.

27 (D) (1) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, A CARRIER MAY  
28 NOT IMPOSE ANY PREEXISTING CONDITION PROVISION ON AN INDIVIDUAL WHO, AS  
29 OF THE LAST DAY OF THE 30-DAY PERIOD BEGINNING WITH THE DATE OF BIRTH, IS  
30 COVERED UNDER CREDITABLE COVERAGE.

31 (2) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, A CARRIER MAY  
32 NOT IMPOSE ANY PREEXISTING CONDITION PROVISIONS ON A CHILD WHO:

33 (I) IS ADOPTED OR PLACED FOR ADOPTION BEFORE ATTAINING  
34 18 YEARS OF AGE; AND

35 (II) AS OF THE LAST DAY OF THE 30-DAY PERIOD BEGINNING ON  
36 THE DATE OF ADOPTION OR PLACEMENT FOR ADOPTION, IS COVERED UNDER  
37 CREDITABLE COVERAGE.

26

1 (3) A CARRIER MAY NOT IMPOSE ANY PREEXISTING CONDITION  
2 PROVISIONS RELATING TO PREGNANCY.

3 (4) PARAGRAPHS (1) AND (2) OF THIS SUBSECTION DO NOT APPLY TO AN  
4 INDIVIDUAL AFTER THE END OF THE FIRST 63-DAY PERIOD DURING ALL OF WHICH  
5 THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE.

6 15-1202.

7 (A) This subtitle applies only to a health benefit plan that:

8 (1) covers eligible employees of small employers in the State; and

9 (2) is issued or renewed on or after July 1, 1994, if:

10 (i) any part of the premium or benefits is paid by or on behalf of the  
11 small employer;

12 (ii) any eligible employee or dependent is reimbursed, through wage  
13 adjustments or otherwise, by or on behalf of the small employer for any part of the  
14 premium;

15 (iii) the health benefit plan is treated by the employer or any eligible  
16 employee or dependent as part of a plan or program under the United States Internal  
17 Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or

18 (iv) the small employer allows eligible employees to pay for the health  
19 benefit plan through payroll deductions.

20 (B) A CARRIER IS SUBJECT TO THE REQUIREMENTS OF § 15-1403 OF THIS  
21 TITLE IN CONNECTION WITH HEALTH BENEFIT PLANS ISSUED UNDER THIS  
22 SUBTITLE.

23 SUBTITLE 13. MARYLAND HEALTH INSURANCE PORTABILITY AND  
24 ACCOUNTABILITY ACT -- INDIVIDUAL MARKET REFORMS.

25 15-1301.

26 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS  
27 INDICATED.

28 (B) "ACTUARIAL CERTIFICATION" MEANS A WRITTEN STATEMENT IN A FORM  
29 APPROVED BY THE COMMISSIONER, SIGNED BY A MEMBER OF THE AMERICAN  
30 ACADEMY OF ACTUARIES OR OTHER INDIVIDUAL ACCEPTABLE TO THE  
31 COMMISSIONER THAT A CARRIER IS IN COMPLIANCE WITH THE PROVISIONS OF THIS  
32 SUBTITLE.

33 (C) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME BEGINNING ON THE  
34 DATE OF ENROLLMENT AND NOT TO EXCEED 2 MONTHS, OR 3 MONTHS IN THE CASE  
35 OF A LATE ENROLLEE, DURING WHICH A HEALTH MAINTENANCE ORGANIZATION  
36 DOES NOT COLLECT PREMIUM, AND COVERAGE ISSUED DOES NOT BECOME  
37 EFFECTIVE.

27

1 (D) "ASSOCIATION" OR "BONA FIDE ASSOCIATION" MEANS, AN ASSOCIATION  
2 THAT:

3 (1) HAS BEEN ACTIVELY IN EXISTENCE FOR AT LEAST 5 YEARS;

4 (2) HAS BEEN FORMED AND MAINTAINED IN GOOD FAITH FOR  
5 PURPOSES OTHER THAN OBTAINING INSURANCE AND DOES NOT CONDITION  
6 MEMBERSHIP ON THE PURCHASE OF ASSOCIATION-SPONSORED INSURANCE;

7 (3) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON ANY  
8 HEALTH STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL, AND STATES SO  
9 CLEARLY IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

10 (4) MAKES HEALTH INSURANCE COVERAGE OFFERED THROUGH THE  
11 ASSOCIATION AVAILABLE TO ALL MEMBERS REGARDLESS OF ANY HEALTH  
12 STATUS-RELATED FACTOR RELATING TO THE MEMBERS OR INDIVIDUALS ELIGIBLE  
13 FOR COVERAGE AND STATES SO CLEARLY IN ALL MEMBERSHIP AND APPLICATION  
14 MATERIALS;

15 (5) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED  
16 THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH  
17 MEMBERSHIP IN THE ASSOCIATION, AND STATES SO CLEARLY IN ALL MARKETING  
18 AND APPLICATION MATERIALS; AND

19 (6) PROVIDES AND ANNUALLY UPDATES INFORMATION NECESSARY  
20 FOR THE COMMISSIONER TO DETERMINE WHETHER OR NOT THE ASSOCIATION  
21 MEETS THE DEFINITION OF BONA FIDE ASSOCIATION BEFORE QUALIFYING AS AN  
22 ASSOCIATION UNDER THIS SUBTITLE.

23 (E) "CARRIER" MEANS A PERSON THAT IS:

24 (1) AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE  
25 STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

26 (2) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO  
27 OPERATE IN THE STATE;

28 (3) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO  
29 OPERATE IN THE STATE; OR

30 (4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH  
31 BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

32 (F) "CHURCH PLAN" MEANS A PLAN AS DEFINED UNDER SECTION 3(33) OF  
33 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

34 (G) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL  
35 UNDER:

36 (I) AN EMPLOYER SPONSORED PLAN;

37 (II) A HEALTH BENEFIT PLAN;

28

1 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY  
2 ACT;

3 (IV) TITLE XIX OF THE SOCIAL SECURITY ACT, OTHER THAN  
4 COVERAGE CONSISTING SOLELY OF BENEFITS UNDER SECTION 1928 OF THAT ACT;

5 (V) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE;

6 (VI) A MEDICAL CARE PROGRAM OF THE INDIAN HEALTH SERVICE  
7 OR OF A TRIBAL ORGANIZATION;

8 (VII) A STATE HEALTH BENEFITS RISK POOL;

9 (VIII) A HEALTH PLAN OFFERED UNDER THE FEDERAL EMPLOYEES  
10 HEALTH BENEFITS PROGRAM (FEHBP), TITLE 5, CHAPTER 89 OF THE UNITED STATES  
11 CODE;

12 (IX) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL  
13 REGULATIONS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT, SECTION  
14 2701(C)(1)(I), AS AMENDED BY P.L. 104-191; OR

15 (X) A HEALTH BENEFIT PLAN UNDER SECTION 5(E) OF THE PEACE  
16 CORPS ACT, 22 U.S.C. 2504(E).

17 (2) A PERIOD OF CREDITABLE COVERAGE SHALL NOT BE COUNTED,  
18 WITH RESPECT TO ENROLLMENT OF AN INDIVIDUAL UNDER A HEALTH BENEFIT  
19 PLAN OR AN EMPLOYER SPONSORED PLAN, IF, AFTER SUCH PERIOD AND BEFORE  
20 THE ENROLLMENT DATE, THERE WAS A 63-DAY PERIOD DURING ALL OF WHICH THE  
21 INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE.

22 (H) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL:

23 (1) (I) FOR WHOM, AS OF THE DATE ON WHICH THE INDIVIDUAL  
24 SEEKS COVERAGE UNDER THIS SUBTITLE, THE AGGREGATE OF THE PERIODS OF  
25 CREDITABLE COVERAGE IS 18 OR MORE MONTHS; AND

26 (II) WHOSE MOST RECENT PRIOR CREDITABLE COVERAGE WAS  
27 UNDER AN EMPLOYER SPONSORED PLAN, GOVERNMENTAL PLAN, CHURCH PLAN,  
28 OR HEALTH BENEFIT PLAN OFFERED IN CONNECTION WITH ANY OF THESE PLANS;

29 (2) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER:

30 (I) AN EMPLOYER SPONSORED PLAN;

31 (II) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY  
32 ACT;

33 (III) A STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY  
34 ACT; OR

35 (IV) A HEALTH BENEFIT PLAN;

29

1 (3) WHO HAS NOT HAD THE MOST RECENT PRIOR CREDITABLE  
2 COVERAGE DESCRIBED IN PARAGRAPH (1)(II) OF THIS SUBSECTION TERMINATED  
3 FOR NONPAYMENT OF PREMIUMS OR FRAUD BY THE INDIVIDUAL; AND

4 (4) WHO, IF THE INDIVIDUAL HAS BEEN OFFERED THE OPTION OF  
5 CONTINUATION COVERAGE UNDER A STATE OR FEDERAL CONTINUATION  
6 PROVISION:

7 (I) HAS ELECTED THAT COVERAGE; AND

8 (II) HAS EXHAUSTED THAT COVERAGE.

9 (I) "ENROLLMENT DATE" MEANS THE DATE ON WHICH:

10 (1) AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN; OR

11 (2) THE FIRST DAY OF THE WAITING PERIOD BEFORE WHICH THE  
12 INDIVIDUAL MAY ENROLL.

13 (J) "GOVERNMENTAL PLAN" MEANS A PLAN AS DEFINED IN SECTION 3(32) OF  
14 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 AND ANY FEDERAL  
15 GOVERNMENTAL PLAN.

16 (K) "EMPLOYER SPONSORED PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT  
17 PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THEIR DEPENDENTS, AND  
18 IS NOT SUBJECT TO STATE REGULATION IN ACCORDANCE WITH THE FEDERAL  
19 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

20 (L) (1) "HEALTH BENEFIT PLAN" MEANS A:

21 (I) HOSPITAL OR MEDICAL POLICY OR CERTIFICATE, INCLUDING  
22 THOSE ISSUED UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS LOCATED  
23 IN MARYLAND OR ANY OTHER STATE COVERING MARYLAND RESIDENTS;

24 (II) POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A NONPROFIT  
25 HEALTH SERVICE PLAN THAT COVERS MARYLAND RESIDENTS; OR

26 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR  
27 GROUP MASTER CONTRACT.

28 (2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

29 (I) ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

30 1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME  
31 INSURANCE;

32 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY  
33 INSURANCE;

34 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY  
35 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

36 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

30

- 1 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;
- 2 6. CREDIT-ONLY INSURANCE;
- 3 7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND
- 4 8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN
- 5 FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191, UNDER WHICH BENEFITS
- 6 FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE
- 7 BENEFITS; ~~OR~~

8 (II) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A  
9 SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE  
10 OTHERWISE NOT AN INTEGRAL PART OF A PLAN:

- 11 1. LIMITED SCOPE DENTAL OR VISION BENEFITS;
- 12 2. BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE,
- 13 HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF THESE
- 14 BENEFITS; AND
- 15 3. SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE
- 16 SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191;

17 (III) THE FOLLOWING BENEFITS IF OFFERED AS INDEPENDENT,  
18 NONCOORDINATED BENEFITS:

- 19 1. COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS;
- 20 AND
- 21 2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY
- 22 INSURANCE; OR

23 (IV) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE  
24 INSURANCE POLICY:

- 25 1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE (AS
- 26 DEFINED UNDER § 1882(G)(1) OF THE SOCIAL SECURITY ACT);
- 27 2. COVERAGE SUPPLEMENTAL TO THE COVERAGE
- 28 PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE; AND
- 29 3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO
- 30 COVERAGE UNDER AN EMPLOYER SPONSORED PLAN.

31 (M) "HEALTH STATUS-RELATED FACTOR" MEANS A FACTOR RELATED TO:

- 32 (1) HEALTH STATUS;
- 33 (2) MEDICAL CONDITION;
- 34 (3) CLAIMS EXPERIENCE;
- 35 (4) RECEIPT OF HEALTH CARE;
- 36 (5) MEDICAL HISTORY;

31

1 (6) GENETIC INFORMATION;

2 (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT  
3 OF ACTS OF DOMESTIC VIOLENCE; OR

4 (8) DISABILITY.

5 (N) "HIGH LEVEL POLICY FORM" MEANS A POLICY OR PLAN UNDER WHICH  
6 THE ACTUARIAL VALUE OF THE BENEFIT UNDER THE COVERAGE IS:

7 (1) AT LEAST 15% GREATER THAN THE ACTUARIAL VALUE OF THE LOW  
8 LEVEL POLICY FORM COVERAGE OFFERED BY THE CARRIER IN THIS STATE; AND

9 (2) AT LEAST 100% BUT NOT GREATER THAN 120% OF THE WEIGHTED  
10 AVERAGE.

11 (O) (1) "INDIVIDUAL HEALTH BENEFIT PLAN" MEANS:

12 ~~(1)~~ (I) A HEALTH BENEFIT PLAN OTHER THAN A CONVERTED POLICY  
13 OR A PROFESSIONAL ASSOCIATION PLAN FOR ELIGIBLE INDIVIDUALS AND THEIR  
14 DEPENDENTS; AND

15 ~~(2)~~ (II) A CERTIFICATE ISSUED TO AN ELIGIBLE INDIVIDUAL THAT  
16 EVIDENCES COVERAGE UNDER A POLICY OR CONTRACT ISSUED TO A TRUST OR  
17 ASSOCIATION OR OTHER SIMILAR GROUP OF INDIVIDUALS, REGARDLESS OF THE  
18 SITUS OF DELIVERY OF THE POLICY OR CONTRACT, IF THE ELIGIBLE INDIVIDUAL  
19 PAYS THE PREMIUM AND IS NOT BEING COVERED UNDER THE POLICY OR  
20 CONTRACT UNDER EITHER FEDERAL OR STATE CONTINUATION OF BENEFITS  
21 PROVISIONS.

22 (2) "INDIVIDUAL HEALTH BENEFIT PLAN" DOES NOT INCLUDE  
23 SHORT-TERM LIMITED DURATION INSURANCE.

24 (P) "LOW LEVEL POLICY FORM" MEANS A POLICY OR PLAN UNDER WHICH  
25 THE ACTUARIAL VALUE OF THE BENEFIT UNDER THE COVERAGE IS AT LEAST 85%  
26 BUT NOT GREATER THAN 100% OF THE WEIGHTED AVERAGE.

27 (Q) "PREEXISTING CONDITION" MEANS:

28 ~~(1) A CONDITION EXISTING DURING A SPECIFIED PERIOD~~  
29 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE THAT WOULD~~  
30 ~~HAVE CAUSED AN ORDINARILY PRUDENT PERSON TO SEEK MEDICAL ADVICE,~~  
31 ~~DIAGNOSIS, CARE, OR TREATMENT; OR~~

32 ~~(2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR~~  
33 ~~TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD~~  
34 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE~~ A CONDITION  
35 THAT WAS PRESENT BEFORE THE DATE OF ENROLLMENT FOR COVERAGE,  
36 WHETHER OR NOT ANY MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS  
37 RECOMMENDED OR RECEIVED BEFORE THAT DATE.

32

1 (R) "PREEXISTING CONDITION PROVISION" MEANS A PROVISION IN A  
2 HEALTH BENEFIT PLAN THAT DENIES, EXCLUDES, OR LIMITS BENEFITS FOR AN  
3 ENROLLEE FOR EXPENSES OR SERVICES RELATED TO A PREEXISTING CONDITION.

4 (S) "WAITING PERIOD" MEANS THE PERIOD OF TIME THAT MUST PASS  
5 BEFORE AN INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE  
6 TERMS OF A GROUP HEALTH BENEFIT PLAN.

7 (T) (1) "WEIGHTED AVERAGE" MEANS THE AVERAGE ACTUARIAL VALUE  
8 OF THE BENEFITS PROVIDED BY:

9 (I) ALL THE HEALTH INSURANCE COVERAGES ISSUED BY THE  
10 CARRIER IN THIS STATE IN THE INDIVIDUAL MARKET DURING THE PREVIOUS  
11 CALENDAR YEAR, WEIGHTED BY ENROLLMENT FOR THE DIFFERENT COVERAGES;  
12 OR

13 (II) ALL THE HEALTH INSURANCE COVERAGES ISSUED BY ALL  
14 CARRIERS IN THIS STATE IN THE INDIVIDUAL MARKET, IF THE DATA ARE  
15 AVAILABLE, DURING THE PREVIOUS CALENDAR YEAR, WEIGHTED BY ENROLLMENT  
16 FOR THE DIFFERENT COVERAGES.

17 (2) "WEIGHTED AVERAGE" DOES NOT INCLUDE COVERAGES ISSUED  
18 UNDER THIS SUBTITLE.

19 15-1302.

20 (A) THIS SUBTITLE APPLIES TO ALL CARRIERS THAT OFFER HEALTH BENEFIT  
21 PLANS TO INDIVIDUALS IN THE STATE.

22 (B) THIS SUBTITLE DOES NOT APPLY TO A CARRIER THAT OFFERS ONLY  
23 CONVERSION POLICIES AS REQUIRED BY LAW.

24 (C) THIS SUBTITLE DOES NOT APPLY TO A CARRIER THAT OFFERS HEALTH  
25 INSURANCE COVERAGE ONLY IN CONNECTION WITH GROUP HEALTH PLANS OR  
26 THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, OR BOTH.

27 15-1303.

28 IN ADDITION TO ANY OTHER REQUIREMENTS UNDER THIS ARTICLE, A  
29 CARRIER THAT OFFERS INDIVIDUAL HEALTH BENEFIT PLANS IN THIS STATE SHALL:

30 (1) HAVE DEMONSTRATED THE CAPACITY TO ADMINISTER THE  
31 INDIVIDUAL HEALTH BENEFIT PLANS, INCLUDING ADEQUATE NUMBERS AND TYPES  
32 OF ADMINISTRATIVE STAFF;

33 (2) HAVE A SATISFACTORY GRIEVANCE PROCEDURE AND ABILITY TO  
34 RESPOND TO CALLS, QUESTIONS, AND COMPLAINTS FROM ENROLLEES OR  
35 INSURED; AND

36 (3) DESIGN POLICIES TO HELP ENSURE THAT ENROLLEES OR INSURED  
37 HAVE ADEQUATE ACCESS TO PROVIDERS OF HEALTH CARE.

33

1 15-1304.

2 A CARRIER MAY NOT OFFER ANY INDIVIDUAL HEALTH BENEFIT PLANS IN THIS  
3 STATE UNLESS THE CARRIER OFFERS, AND ACTIVELY MARKETS, THE POLICIES  
4 REQUIRED BY THIS SUBTITLE.

5 15-1305.

6 (A) UNLESS A CARRIER MAKES AN ELECTION UNDER § 15-1306 OF THIS  
7 SUBTITLE, THE CARRIER MAY NOT:

8 (1) DECLINE TO OFFER COVERAGE TO, OR DENY ENROLLMENT OF AN  
9 ELIGIBLE INDIVIDUAL; OR

10 (2) IMPOSE ANY PREEXISTING CONDITION PROVISION ON AN ELIGIBLE  
11 INDIVIDUAL.

12 (B) (1) A CARRIER THAT MAKES AN ELECTION UNDER § 15-1306 OF THIS  
13 SUBTITLE MAY CHOOSE TO OFFER AT LEAST TWO DIFFERENT POLICY FORMS, BOTH  
14 OF WHICH ARE DESIGNED FOR, MADE GENERALLY AVAILABLE TO, ACTIVELY  
15 MARKETED TO, AND ENROLL, BOTH ELIGIBLE INDIVIDUALS AND OTHER  
16 INDIVIDUALS.

17 (2) POLICY FORMS THAT HAVE DIFFERENT COST-SHARING  
18 ARRANGEMENTS OR DIFFERENT RIDERS SHALL BE CONSIDERED TO BE DIFFERENT  
19 POLICY FORMS.

20 (C) POLICY FORMS SHALL COMPLY WITH THE REQUIREMENTS OF THIS  
21 SUBTITLE.

22 15-1306.

23 (A) A CARRIER THAT INTENDS TO OFFER TWO POLICY FORMS SHALL SUBMIT  
24 IN WRITING TO THE COMMISSIONER BOTH:

25 (1) AN ELECTION WHETHER TO OFFER:

26 (I) A HIGH LEVEL AND LOW LEVEL POLICY FORM, EACH OF  
27 WHICH INCLUDES BENEFITS SUBSTANTIALLY SIMILAR TO OTHER INDIVIDUAL  
28 HEALTH INSURANCE COVERAGE OFFERED BY THE CARRIER IN THIS STATE; OR

29 (II) POLICY FORMS WITH THE LARGEST AND NEXT TO LARGEST  
30 PREMIUM VOLUME OF ALL POLICY FORMS OFFERED BY THE CARRIER IN THIS  
31 STATE; AND

32 (2) AN ELECTION WHETHER TO USE THE WEIGHTED AVERAGE  
33 VALUATION DESCRIBED IN § 15-1301(T)(1)(I) OR (II) OF THIS SUBTITLE.

34 (B) (1) AN ELECTION MADE UNDER THIS SECTION SHALL BE BINDING FOR  
35 A 2-YEAR PERIOD.

36 (2) AFTER THE INITIAL 2-YEAR PERIOD, AND FOR EACH SUBSEQUENT  
37 2-YEAR PERIOD, CARRIERS SHALL AGAIN MAKE THE ELECTIONS REQUIRED BY THIS  
38 SECTION.

34

1 (3) AN ELECTION SHALL BE MADE ON A FORM AND IN A MANNER  
2 REQUIRED BY THE COMMISSIONER.

3 15-1307.

4 (A) THE ACTUARIAL VALUE OF BENEFITS PROVIDED UNDER INDIVIDUAL  
5 HEALTH INSURANCE COVERAGE SHALL BE CALCULATED BASED ON A  
6 STANDARDIZED POPULATION AND A SET OF STANDARDIZED UTILIZATION AND  
7 COST FACTORS.

8 (B) A CARRIER SHALL SUBMIT ANY INFORMATION THE COMMISSIONER MAY  
9 REQUIRE TO SUPPORT AND JUSTIFY THE CARRIER'S CALCULATIONS OF ACTUARIAL  
10 VALUES.

11 15-1308.

12 (A) SUBJECT TO SUBSECTIONS (C) AND (G) OF THIS SECTION, A CARRIER  
13 SHALL ISSUE THE INDIVIDUAL HEALTH BENEFIT PLAN ELECTED UNDER § 15-1305 OR  
14 § 15-1306(A)(1) OF THIS SUBTITLE TO ANY ELIGIBLE INDIVIDUAL.

15 (B) (1) A CARRIER MAY NOT LIMIT COVERAGE UNDER ANY INDIVIDUAL  
16 HEALTH BENEFIT PLAN ISSUED TO AN ELIGIBLE INDIVIDUAL UNDER A  
17 PREEXISTING CONDITION PROVISION.

18 (2) A CARRIER MAY IMPOSE A PREEXISTING CONDITION PROVISION ON  
19 AN INDIVIDUAL WHO HAS HAD A PERIOD OF AT LEAST 63 DAYS DURING ALL OF  
20 WHICH THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE  
21 AND WHO WOULD OTHERWISE HAVE BEEN AN ELIGIBLE INDIVIDUAL.

22 (C) A CARRIER MAY REFUSE TO ISSUE AN INDIVIDUAL HEALTH BENEFIT  
23 PLAN TO AN ELIGIBLE INDIVIDUAL, IF THE CARRIER DEMONSTRATES TO THE  
24 SATISFACTION OF THE COMMISSIONER THAT:

25 (1) IT DOES NOT HAVE THE POLICYHOLDER SURPLUS NECESSARY TO  
26 UNDERWRITE ADDITIONAL COVERAGE; AND

27 (2) IT IS APPLYING THIS SECTION UNIFORMLY TO ALL INDIVIDUALS IN  
28 THE INDIVIDUAL MARKET IN THIS STATE WITHOUT REGARD TO:

29 (I) ANY HEALTH STATUS-RELATED FACTOR; AND

30 (II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

31 (D) A CARRIER THAT DENIES INDIVIDUAL HEALTH INSURANCE COVERAGE  
32 UNDER SUBSECTION (C) OF THIS SECTION MAY NOT OFFER COVERAGE IN THE  
33 INDIVIDUAL MARKET UNTIL THE LATER OF:

34 (1) A PERIOD OF 180 DAYS AFTER THE DATE THE COVERAGE IS DENIED;  
35 OR

36 (2) UNTIL THE CARRIER HAS DEMONSTRATED, TO THE  
37 COMMISSIONER'S SATISFACTION THAT THE CARRIER HAS SUFFICIENT  
38 POLICYHOLDER SURPLUS TO UNDERWRITE ADDITIONAL COVERAGE.

35

1 (E) A CARRIER MAY ELECT NOT TO RENEW ALL INDIVIDUAL HEALTH  
2 BENEFIT PLANS IN THE STATE.

3 (F) WHEN A CARRIER ELECTS NOT TO RENEW ALL INDIVIDUAL HEALTH  
4 BENEFIT PLANS IN THE STATE, THE CARRIER:

5 (1) SHALL GIVE NOTICE OF ITS DECISION TO THE AFFECTED  
6 INDIVIDUALS AT LEAST 180 DAYS BEFORE THE EFFECTIVE DATE OF NONRENEWAL;

7 (2) AT LEAST 30 WORKING DAYS BEFORE THAT NOTICE, SHALL GIVE  
8 NOTICE TO THE COMMISSIONER; AND

9 (3) MAY NOT WRITE NEW BUSINESS FOR INDIVIDUALS IN THE STATE  
10 FOR A 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE  
11 COMMISSIONER.

12 (G) A HEALTH MAINTENANCE ORGANIZATION NEED NOT OFFER COVERAGE  
13 TO AN INDIVIDUAL WHO DOES NOT LIVE, RESIDE, OR WORK WITHIN THE HEALTH  
14 MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREAS.

15 15-1309.

16 (A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, A CARRIER  
17 SHALL RENEW AN INDIVIDUAL HEALTH BENEFIT PLAN AT THE OPTION OF THE  
18 ELIGIBLE INDIVIDUAL.

19 (B) A CARRIER MAY NOT CANCEL OR REFUSE TO RENEW AN INDIVIDUAL  
20 HEALTH BENEFIT PLAN EXCEPT:

21 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUMS;

22 (2) WHERE THE INDIVIDUAL HAS PERFORMED AN ACT OR PRACTICE  
23 THAT CONSTITUTES FRAUD;

24 (3) WHERE THE INDIVIDUAL HAS MADE AN INTENTIONAL  
25 MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE COVERAGE;

26 (4) WHERE THE CARRIER ELECTS NOT TO RENEW ALL OF ITS  
27 INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE;

28 (5) WHERE THE ELIGIBLE INDIVIDUAL NO LONGER RESIDES, LIVES, OR  
29 WORKS IN THE SERVICE AREA, PROVIDED THAT THE COVERAGE IS TERMINATED  
30 UNDER THIS PROVISION UNIFORMLY WITHOUT REGARD TO ANY HEALTH  
31 STATUS-RELATED FACTOR OF COVERED INDIVIDUALS; OR

32 (6) WHERE, IN THE CASE OF HEALTH INSURANCE COVERAGE THAT IS  
33 MADE AVAILABLE IN THE INDIVIDUAL MARKET ONLY THROUGH ONE OR MORE  
34 BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF THE ELIGIBLE INDIVIDUAL IN THE  
35 ASSOCIATION CEASES BUT ONLY IF SUCH COVERAGE IS TERMINATED UNDER THIS  
36 PARAGRAPH UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS-RELATED  
37 FACTOR OF COVERED INDIVIDUALS.

36

1 15-1310.

2 (A) A CARRIER SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE  
3 COVERAGE.

4 (B) THE CERTIFICATION OF CREDITABLE COVERAGE DESCRIBED IN  
5 SUBSECTION (A) OF THIS SECTION SHALL BE PROVIDED:

6 ~~(1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE~~  
7 ~~COVERED UNDER THE HEALTH BENEFITS PLAN AND WITHIN A REASONABLE~~  
8 ~~PERIOD AFTER CESSATION OF COVERAGE; AND~~

9 ~~(2) AT THE REQUEST OF THE INDIVIDUAL, IN NO EVENT LATER THAN 24~~  
10 ~~MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE.~~

11 (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE  
12 COVERED UNDER THE HEALTH BENEFITS PLAN OR OTHERWISE BECOMES COVERED  
13 UNDER A COBRA CONTINUATION PROVISION;

14 (2) IN THE CASE OF AN INDIVIDUAL WHO BECOMES COVERED UNDER A  
15 COBRA CONTINUATION PROVISION, AT THE TIME THE INDIVIDUAL CEASES TO BE  
16 COVERED UNDER THE PROVISION; AND

17 (3) ON THE REQUEST ON BEHALF OF AN INDIVIDUAL MADE NOT LATER  
18 THAN 24 MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE DESCRIBED  
19 IN ITEM (1) OR (2) OF THIS SUBSECTION, WHICHEVER IS LATER.

20 (C) THE CERTIFICATION MAY BE PROVIDED AT A TIME CONSISTENT WITH  
21 NOTICES REQUIRED UNDER ANY APPLICABLE STATE OR FEDERAL CONTINUATION  
22 PROVISION.

23 (D) THE CERTIFICATION SHALL CONTAIN:

24 (1) WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE  
25 COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN, AND THE  
26 COVERAGE, IF APPLICABLE, UNDER THE APPLICABLE STATE OR FEDERAL  
27 CONTINUATION PROVISION; AND

28 (2) THE WAITING PERIOD, IF ANY, IMPOSED WITH RESPECT TO THE  
29 INDIVIDUAL FOR ANY COVERAGE UNDER THE HEALTH BENEFIT PLAN.

30 (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE  
31 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF  
32 COVERAGE, THEN:

33 (1) UPON REQUEST OF THE GROUP HEALTH PLAN, THE ENTITY WHICH  
34 ISSUED THE CERTIFICATION PROVIDED BY THE INDIVIDUAL SHALL PROMPTLY  
35 DISCLOSE TO THE REQUESTING GROUP HEALTH PLAN, INFORMATION REGARDING  
36 COVERAGE OF CLASSES AND CATEGORIES OF HEALTH BENEFITS AVAILABLE  
37 UNDER THE ENTITY'S PLAN OR POLICY; AND

38 (2) THE ENTITY MAY CHARGE THE REQUESTING PLAN FOR THE  
39 REASONABLE COST OF DISCLOSING THE INFORMATION.

37

1 15-1311.

2 (A) IN DETERMINING A PERIOD OF CREDITABLE COVERAGE, ANY PERIOD  
3 THAT AN INDIVIDUAL IS IN A WAITING PERIOD FOR COVERAGE UNDER A GROUP  
4 HEALTH BENEFIT PLAN OR AN AFFILIATION PERIOD MAY NOT BE TAKEN INTO  
5 ACCOUNT IN DETERMINING ANY PERIOD OF CONTINUOUS CREDITABLE COVERAGE.

6 (B) A CARRIER SHALL COUNT A PERIOD OF CREDITABLE COVERAGE  
7 WITHOUT REGARD TO THE SPECIFIC BENEFITS COVERED DURING THE PERIOD.

8 15-1312.

9 A CARRIER THAT ELECTS TO OFFER A HIGH LEVEL AND LOW LEVEL POLICY  
10 FORM, UNDER § 15-1306 OF THIS SUBTITLE MAY NOT CHARGE A RATE TO ELIGIBLE  
11 INDIVIDUALS THAT IS GREATER THAN 200% OF THE RATE THE CARRIER NORMALLY  
12 WOULD CHARGE FOR THE SAME OR SIMILAR POLICY FORMS TO OTHER  
13 INDIVIDUALS.

14 SUBTITLE 14. MARYLAND HEALTH INSURANCE PORTABILITY AND  
15 ACCOUNTABILITY ACT -- LARGE GROUP MARKET REFORMS.

16 15-1401.

17 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS  
18 INDICATED.

19 (B) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME BEGINNING ON THE  
20 DATE OF ENROLLMENT AND NOT TO EXCEED 2 MONTHS, OR 3 MONTHS IN THE CASE  
21 OF A LATE ENROLLEE, DURING WHICH A HEALTH MAINTENANCE ORGANIZATION  
22 DOES NOT COLLECT PREMIUM AND COVERAGE ISSUED DOES NOT BECOME  
23 EFFECTIVE.

24 (C) "ASSOCIATION" OR "BONA FIDE ASSOCIATION" MEANS, WITH RESPECT TO  
25 HEALTH INSURANCE COVERAGE OFFERED IN THIS STATE, AN ASSOCIATION THAT:

26 (1) HAS BEEN ACTIVELY IN EXISTENCE FOR AT LEAST 5 YEARS;

27 (2) HAS BEEN FORMED AND MAINTAINED IN GOOD FAITH FOR  
28 PURPOSES OTHER THAN OBTAINING INSURANCE AND DOES NOT CONDITION  
29 MEMBERSHIP ON THE PURCHASE OF ASSOCIATION-SPONSORED INSURANCE;

30 (3) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON ANY  
31 HEALTH STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL, AND STATES SO  
32 CLEARLY IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

33 (4) MAKES HEALTH INSURANCE COVERAGE OFFERED THROUGH THE  
34 ASSOCIATION AVAILABLE TO ALL MEMBERS REGARDLESS OF ANY HEALTH  
35 STATUS-RELATED FACTOR RELATING TO THE MEMBERS OR INDIVIDUALS ELIGIBLE  
36 FOR COVERAGE THROUGH A MEMBER AND STATES SO CLEARLY IN ALL  
37 MEMBERSHIP AND APPLICATION MATERIALS;

38 (5) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED  
39 THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH

38

1 MEMBERSHIP IN THE ASSOCIATION AND STATES SO CLEARLY IN ALL MARKETING  
2 AND APPLICATION MATERIALS; AND

3 (6) PROVIDES AND ANNUALLY UPDATES INFORMATION NECESSARY  
4 FOR THE COMMISSIONER TO DETERMINE WHETHER OR NOT THE ASSOCIATION  
5 MEETS THE DEFINITION OF BONA FIDE ASSOCIATION BEFORE QUALIFYING AS AN  
6 ASSOCIATION UNDER THIS SUBTITLE.

7 (D) "CARRIER" MEANS A PERSON THAT IS:

8 (1) AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE  
9 STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

10 (2) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO  
11 OPERATE IN THE STATE;

12 (3) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO  
13 OPERATE IN THE STATE; OR

14 (4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH  
15 BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

16 (E) "CHURCH PLAN" MEANS A PLAN AS DEFINED UNDER SECTION 3(33) OF  
17 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

18 (F) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL  
19 UNDER:

20 (I) ~~A GROUP HEALTH~~ AN EMPLOYER-SPONSORED PLAN;

21 (II) ~~HEALTH INSURANCE COVERAGE~~ BENEFIT PLAN;

22 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY  
23 ACT;

24 (IV) TITLE XIX OF THE SOCIAL SECURITY ACT, OTHER THAN  
25 COVERAGE CONSISTING SOLELY OF BENEFITS UNDER SECTION 1928 OF THAT ACT;

26 (V) CHAPTER 55 OF TITLE 10 OF THE UNITED STATES CODE;

27 (VI) A MEDICAL CARE PROGRAM OF THE INDIAN HEALTH SERVICE  
28 OR OF A TRIBAL ORGANIZATION;

29 (VII) A STATE HEALTH BENEFITS RISK POOL;

30 (VIII) A HEALTH PLAN OFFERED UNDER THE FEDERAL EMPLOYEES  
31 HEALTH BENEFITS PROGRAM (FEHBP), TITLE 5, CHAPTER 89 OF THE UNITED STATES  
32 CODE;

33 (IX) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL  
34 REGULATIONS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT, SECTION  
35 2701(C)(1)(I), AS AMENDED BY P.L. 104-191; OR

36 (X) A HEALTH BENEFIT PLAN UNDER SECTION 5(E) OF THE PEACE  
37 CORPS ACT, 22 U.S.C. 2504(E).

39

1 (2) A PERIOD OF CREDITABLE COVERAGE SHALL NOT BE COUNTED,  
2 WITH RESPECT TO ENROLLMENT OF AN INDIVIDUAL UNDER A GROUP HEALTH  
3 PLAN, IF, AFTER SUCH PERIOD AND BEFORE THE ENROLLMENT DATE, THERE WAS A  
4 63-DAY PERIOD DURING ALL OF WHICH THE INDIVIDUAL WAS NOT COVERED  
5 UNDER ANY CREDITABLE COVERAGE.

6 (G) "EMPLOYER SPONSORED PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT  
7 PLAN THAT PROVIDES MEDICAL CARE TO EMPLOYEES OR THEIR DEPENDENTS, AND  
8 IS NOT SUBJECT TO STATE REGULATION IN ACCORDANCE WITH THE FEDERAL  
9 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

10 (H) "ENROLLMENT DATE" MEANS THE DATE ON WHICH:

11 (1) AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN; OR

12 (2) THE FIRST DAY OF THE WAITING PERIOD BEFORE WHICH THE  
13 INDIVIDUAL MAY ENROLL.

14 (I) "GOVERNMENTAL PLAN" MEANS A PLAN AS DEFINED IN SECTION 3(32) OF  
15 THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 AND ANY FEDERAL  
16 GOVERNMENTAL PLAN.

17 (J) (1) "HEALTH BENEFIT PLAN" MEANS ANY:

18 (I) HOSPITAL OR MEDICAL POLICY, INCLUDING THOSE ISSUED  
19 UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS LOCATED IN MARYLAND  
20 OR ANY OTHER STATE COVERING MARYLAND RESIDENTS;

21 (II) POLICY OR CONTRACT ISSUED BY A NONPROFIT HEALTH  
22 SERVICE PLAN THAT COVERS MARYLAND RESIDENTS; OR

23 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR  
24 GROUP MASTER CONTRACT.

25 (2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

26 (I) ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

27 1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME  
28 INSURANCE;

29 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY  
30 INSURANCE;

31 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY  
32 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

33 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

34 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

35 6. CREDIT-ONLY INSURANCE;

36 7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

40

1                               8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN  
2 FEDERAL REGULATIONS ISSUED UNDER THE FEDERAL HEALTH INSURANCE  
3 PORTABILITY AND ACCOUNTABILITY ACT, UNDER WHICH BENEFITS FOR MEDICAL  
4 CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS; ~~OR~~

5                               (II) THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A  
6 SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE  
7 OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:

8                               1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

9                               2. BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE,  
10 HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF THESE  
11 BENEFITS; AND

12                              3. SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE  
13 SPECIFIED IN FEDERAL REGULATIONS ISSUED UNDER THE FEDERAL HEALTH  
14 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT;

15                              (III) THE FOLLOWING BENEFITS IF OFFERED AS INDEPENDENT,  
16 NONCOORDINATED BENEFITS:

17                              1. COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS;  
18 AND

19                              2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY  
20 INSURANCE; OR

21                              (IV) THE FOLLOWING BENEFITS IF OFFERED AS A SEPARATE  
22 INSURANCE POLICY:

23                              1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE (AS  
24 DEFINED UNDER § 1882(G)(1) OF THE SOCIAL SECURITY ACT);

25                              2. COVERAGE SUPPLEMENTAL TO THE COVERAGE  
26 PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE; AND

27                              3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO  
28 COVERAGE UNDER AN EMPLOYER SPONSORED PLAN.

29                              (K) "HEALTH STATUS-RELATED FACTOR" MEANS A FACTOR RELATED TO:

30                              (1) HEALTH STATUS;

31                              (2) MEDICAL CONDITION;

32                              (3) CLAIMS EXPERIENCE;

33                              (4) RECEIPT OF HEALTH CARE;

34                              (5) MEDICAL HISTORY;

35                              (6) GENETIC INFORMATION;

41

1 (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT  
2 OF ACTS OF DOMESTIC VIOLENCE; OR

3 (8) DISABILITY.

4 (L) "LATE ENROLLEE" MEANS A MEMBER, SUBSCRIBER, OR DEPENDENT WHO  
5 ENROLLS IN A GROUP HEALTH BENEFIT PLAN OTHER THAN DURING:

6 (1) THE FIRST PERIOD IN WHICH THE INDIVIDUAL IS ELIGIBLE TO  
7 ENROLL UNDER THE PLAN; OR

8 (2) A SPECIAL ENROLLMENT PERIOD.

9 (M) "PREEXISTING CONDITION" MEANS:

10 ~~(1) A CONDITION EXISTING DURING A SPECIFIED PERIOD~~  
11 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE THAT WOULD~~  
12 ~~HAVE CAUSED ANY ORDINARILY PRUDENT PERSON TO SEEK MEDICAL ADVICE,~~  
13 ~~DIAGNOSIS, CARE, OR TREATMENT; OR~~

14 ~~(2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR~~  
15 ~~TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD~~  
16 ~~IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE~~ A CONDITION  
17 THAT WAS PRESENT BEFORE THE DATE OF ENROLLMENT FOR COVERAGE,  
18 WHETHER OR NOT ANY MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS  
19 RECOMMENDED OR RECEIVED BEFORE THAT DATE.

20 (N) "PREEXISTING CONDITION PROVISION" MEANS A PROVISION IN A  
21 HEALTH BENEFIT PLAN THAT DENIES, EXCLUDES, OR LIMITS BENEFITS FOR AN  
22 ENROLLEE FOR EXPENSES OR SERVICES RELATED TO A PREEXISTING CONDITION.

23 (O) "SECRETARY" MEANS THE SECRETARY OF THE FEDERAL DEPARTMENT  
24 OF HEALTH AND HUMAN SERVICES.

25 (P) "SPECIAL ENROLLMENT PERIOD" MEANS A PERIOD DURING WHICH A  
26 GROUP HEALTH PLAN SHALL PERMIT AN EMPLOYEE WHO IS ELIGIBLE FOR  
27 COVERAGE, BUT NOT ENROLLED, TO ENROLL FOR COVERAGE UNDER THE TERMS  
28 OF THE GROUP HEALTH BENEFIT PLAN.

29 (Q) "WAITING PERIOD" MEANS THE PERIOD OF TIME THAT MUST PASS  
30 BEFORE AN INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE  
31 TERMS OF A GROUP HEALTH BENEFIT PLAN.

32 15-1402.

33 (A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, THIS SUBTITLE APPLIES TO  
34 ALL CARRIERS IN CONNECTION WITH GROUP HEALTH BENEFIT PLANS.

35 (B) EXCEPT AS PROVIDED IN § 15-1403 OF THIS SUBTITLE, THIS SUBTITLE  
36 DOES NOT APPLY TO POLICIES ISSUED UNDER SUBTITLE 12 OF THIS TITLE.

42

1 15-1403.

2 (A) A CARRIER SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE  
3 COVERAGE IN CONNECTION WITH GROUP HEALTH BENEFIT PLANS, INCLUDING  
4 THOSE ISSUED IN ACCORDANCE WITH SUBTITLE 12 OF THIS TITLE.

5 (B) THE CERTIFICATION OF CREDITABLE COVERAGE DESCRIBED IN  
6 SUBSECTION (A) OF THIS SECTION SHALL BE PROVIDED:

7 ~~(1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE~~  
8 ~~COVERED UNDER THE PLAN AND WITHIN A REASONABLE PERIOD AFTER~~  
9 ~~CESSATION OF COVERAGE; AND~~

10 ~~(2) AT THE REQUEST OF THE INDIVIDUAL, IN NO EVENT LATER THAN 24~~  
11 ~~MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE.~~

12 (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE  
13 COVERED UNDER THE HEALTH BENEFITS PLAN OR OTHERWISE BECOMES COVERED  
14 UNDER A COBRA CONTINUATION PROVISION;

15 (2) IN THE CASE OF AN INDIVIDUAL WHO BECOMES COVERED UNDER A  
16 COBRA CONTINUATION PROVISION, AT THE TIME THE INDIVIDUAL CEASES TO BE  
17 COVERED UNDER THE PROVISION; AND

18 (3) ON THE REQUEST ON BEHALF OF AN INDIVIDUAL MADE NOT LATER  
19 THAN 24 MONTHS AFTER THE DATE OF CESSATION OF THE COVERAGE DESCRIBED  
20 IN ITEM (1) OR (2) OF THIS SUBSECTION, WHICHEVER IS LATER.

21 (C) THE CERTIFICATION MAY BE PROVIDED AT A TIME CONSISTENT WITH  
22 NOTICES REQUIRED UNDER ANY APPLICABLE STATE OR FEDERAL CONTINUATION  
23 PROVISION.

24 (D) THE CERTIFICATION SHALL CONTAIN:

25 (1) WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE  
26 COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN, AND THE  
27 COVERAGE, IF APPLICABLE, UNDER THE APPLICABLE STATE OR FEDERAL  
28 CONTINUATION PROVISION; AND

29 (2) THE WAITING PERIOD, IF ANY, IMPOSED WITH RESPECT TO THE  
30 INDIVIDUAL FOR ANY COVERAGE UNDER THE HEALTH BENEFIT PLAN.

31 (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE  
32 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF  
33 COVERAGE, THEN:

34 (1) ON REQUEST OF THE GROUP HEALTH PLAN, THE ENTITY THAT  
35 ISSUED THE CERTIFICATION PROVIDED BY THE INDIVIDUAL PROMPTLY SHALL  
36 DISCLOSE TO THE REQUESTING GROUP HEALTH PLAN, INFORMATION REGARDING  
37 COVERAGE OF CLASSES AND CATEGORIES OF HEALTH BENEFITS AVAILABLE  
38 UNDER THE ENTITY'S PLAN OR POLICY; AND

43

1 (2) THE ENTITY MAY CHARGE THE REQUESTING PLAN FOR THE  
2 REASONABLE COST OF DISCLOSING THE INFORMATION.

3 15-1404.

4 (A) IN DETERMINING A PERIOD OF CREDITABLE COVERAGE, ANY PERIOD  
5 THAT AN INDIVIDUAL IS IN A WAITING PERIOD FOR ANY COVERAGE UNDER A  
6 GROUP HEALTH BENEFIT PLAN OR AN AFFILIATION PERIOD MAY NOT BE TAKEN  
7 INTO ACCOUNT IN DETERMINING ANY PERIOD OF CONTINUOUS CREDITABLE  
8 COVERAGE.

9 (B) EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION, A CARRIER  
10 SHALL COUNT A PERIOD OF CREDITABLE COVERAGE WITHOUT REGARD TO THE  
11 SPECIFIC BENEFITS COVERED DURING THE PERIOD.

12 (C) (1) A CARRIER MAY ELECT TO REDUCE THE PERIOD OF ANY  
13 PREEXISTING CONDITION PROVISION BASED ON COVERAGE OF BENEFITS WITHIN  
14 ANY CLASS OR CATEGORY OF BENEFITS SPECIFIED BY THE SECRETARY BY  
15 REGULATION.

16 (2) ANY ELECTION MADE UNDER THIS SECTION SHALL BE MADE ON A  
17 UNIFORM BASIS FOR ALL COVERED INDIVIDUALS.

18 (3) A CARRIER THAT MAKES AN ELECTION UNDER THIS SECTION SHALL  
19 COUNT A PERIOD OF CREDITABLE COVERAGE WITH RESPECT TO ANY CLASS OR  
20 CATEGORY OF BENEFITS IF ANY LEVEL OF BENEFITS IS COVERED WITHIN THAT  
21 CLASS OR CATEGORY.

22 (D) A CARRIER THAT MAKES AN ELECTION UNDER SUBSECTION (C) OF THIS  
23 SECTION SHALL:

24 (1) PROMINENTLY STATE IN ANY DISCLOSURE STATEMENTS  
25 CONCERNING THE COVERAGE, AND TO EACH EMPLOYER AT THE TIME OF THE  
26 OFFER OR SALE OF THE COVERAGE, THAT THE CARRIER HAS MADE THIS ELECTION;  
27 AND

28 (2) INCLUDE IN THE STATEMENT A DESCRIPTION OF THE EFFECT OF  
29 THE ELECTION ON THE MEMBER OR SUBSCRIBER.

30 15-1405.

31 AN INDIVIDUAL SHALL ESTABLISH THE INDIVIDUAL'S PERIOD OF CREDITABLE  
32 COVERAGE BY PRESENTING THE CERTIFICATE DESCRIBED IN § 15-1403 OF THIS  
33 SUBTITLE.

34 15-1406.

35 (A) A CARRIER MAY NOT ESTABLISH RULES FOR ELIGIBILITY OF AN  
36 INDIVIDUAL TO ENROLL UNDER A GROUP HEALTH BENEFITS PLAN BASED ON ANY  
37 HEALTH STATUS-RELATED FACTOR.

38 (B) SUBSECTION (A) OF THIS SECTION DOES NOT:

44

1 (1) REQUIRE A CARRIER TO PROVIDE PARTICULAR BENEFITS OTHER  
2 THAN THOSE PROVIDED UNDER THE TERMS OF THE PARTICULAR HEALTH BENEFIT  
3 PLAN; OR

4 (2) PREVENT A CARRIER FROM ESTABLISHING LIMITATIONS OR  
5 RESTRICTIONS ON THE AMOUNT, LEVEL, EXTENT, OR NATURE OF THE BENEFITS OR  
6 COVERAGE FOR SIMILARLY SITUATED INDIVIDUALS ENROLLED IN THE HEALTH  
7 BENEFIT PLAN.

8 (C) RULES FOR ELIGIBILITY TO ENROLL UNDER A PLAN INCLUDES RULES  
9 DEFINING ANY APPLICABLE WAITING PERIODS FOR ENROLLMENT.

10 (D) A CARRIER SHALL ALLOW AN EMPLOYEE OR DEPENDENT WHO IS  
11 ELIGIBLE, BUT NOT ENROLLED, FOR COVERAGE UNDER THE TERMS OF A GROUP  
12 HEALTH BENEFITS PLAN TO ENROLL FOR COVERAGE UNDER THE TERMS OF THE  
13 PLAN IF:

14 (1) THE EMPLOYEE OR DEPENDENT WAS COVERED UNDER AN  
15 EMPLOYER-SPONSORED PLAN OR GROUP HEALTH BENEFITS PLAN AT THE TIME  
16 COVERAGE WAS PREVIOUSLY OFFERED TO THE EMPLOYEE OR DEPENDENT;

17 (2) THE EMPLOYEE STATES IN WRITING, AT THE TIME COVERAGE WAS  
18 PREVIOUSLY OFFERED, THAT COVERAGE UNDER AN EMPLOYER-SPONSORED PLAN  
19 OR GROUP HEALTH BENEFITS PLAN WAS THE REASON FOR DECLINING  
20 ENROLLMENT, BUT ONLY IF THE PLAN SPONSOR OR ISSUER REQUIRES THE  
21 STATEMENT AND PROVIDES THE EMPLOYEE WITH NOTICE OF THE REQUIREMENT;  
22 AND

23 (3) THE EMPLOYEE'S OR DEPENDENT'S COVERAGE DESCRIBED IN ITEM  
24 (1) OF THIS SUBSECTION;

25 (I) WAS UNDER A COBRA CONTINUATION PROVISION, AND THE  
26 COVERAGE UNDER THAT PROVISION WAS EXHAUSTED; OR

27 (II) WAS NOT UNDER A COBRA CONTINUATION PROVISION, AND  
28 EITHER THE COVERAGE WAS TERMINATED AS A RESULT OF LOSS OF ELIGIBILITY  
29 FOR THE COVERAGE, INCLUDING LOSS OF ELIGIBILITY AS A RESULT OF LEGAL  
30 SEPARATION, DIVORCE, DEATH, TERMINATION OF EMPLOYMENT, OR REDUCTION  
31 IN THE NUMBER OF HOURS OF EMPLOYMENT, OR EMPLOYER CONTRIBUTIONS  
32 TOWARDS THE COVERAGE WERE TERMINATED.

33 15-1407.

34 A CARRIER MAY NOT REQUIRE AN INDIVIDUAL MEMBER OF A GROUP TO PAY  
35 A PREMIUM OR CONTRIBUTION THAT IS GREATER THAN THE PREMIUM OR  
36 CONTRIBUTION FOR A SIMILARLY SITUATED INDIVIDUAL, BASED ON ANY HEALTH  
37 STATUS-RELATED FACTOR.

38 15-1408.

39 A CARRIER SHALL RENEW GROUP HEALTH BENEFIT PLANS AT THE OPTION OF  
40 THE POLICYHOLDER OR PLAN SPONSOR, EXCEPT IN ANY OF THE FOLLOWING CASES:

45

1 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUM;

2 (2) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS PERFORMED  
3 AN ACT OR PRACTICE THAT CONSTITUTES FRAUD;

4 (3) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS MADE AN  
5 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE  
6 COVERAGE;

7 (4) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS FAILED TO  
8 COMPLY WITH A MATERIAL PLAN PROVISION RELATING THE EMPLOYER  
9 CONTRIBUTIONS OR GROUP PARTICIPATION RULES;

10 (5) WHERE THE CARRIER ELECTS NOT TO RENEW ALL GROUP HEALTH  
11 BENEFIT PLANS IN THE STATE;

12 (6) IN THE CASE OF A HEALTH MAINTENANCE ORGANIZATION, WHERE  
13 THERE IS NO LONGER ANY ENROLLEE WHO LIVES, RESIDES, OR WORKS IN THE  
14 HEALTH MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREA;

15 (7) IN THE CASE OF A CARRIER THAT OFFERS COVERAGE ONLY  
16 THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, WHEN THE MEMBERSHIP OF  
17 AN EMPLOYER IN THE ASSOCIATION CEASES AND NONRENEWAL UNDER THIS ITEM  
18 IS APPLIED UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS-RELATED  
19 FACTOR RELATING TO ANY COVERED INDIVIDUAL; OR

20 (8) THE CARRIER MAKES AN ELECTION UNDER § 15-1409 OF THIS  
21 SUBTITLE.

22 15-1409.

23 (A) A CARRIER THAT ELECTS NOT TO RENEW ALL OF A PARTICULAR TYPE OF  
24 COVERAGE OR POLICY FORM IN THE STATE SHALL:

25 (1) PROVIDE NOTICE OF THE NONRENEWAL AT LEAST 90 DAYS BEFORE  
26 THE DATE OF THE NONRENEWAL TO EACH AFFECTED:

27 (I) POLICYHOLDER;

28 (II) PLAN SPONSOR;

29 (III) PARTICIPANT; AND

30 (IV) BENEFICIARY;

31 (2) OFFER TO EACH AFFECTED PLAN SPONSOR THE OPTION TO  
32 PURCHASE ANY OTHER HEALTH INSURANCE COVERAGE CURRENTLY BEING  
33 OFFERED BY THE CARRIER; AND

34 (3) ACT UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE  
35 OF ANY AFFECTED PLAN SPONSOR, OR ANY HEALTH STATUS-RELATED FACTOR OF  
36 ANY AFFECTED INDIVIDUAL.

37 (B) A CARRIER MAY ELECT NOT TO RENEW ALL GROUP HEALTH BENEFIT  
38 PLANS IN THE STATE.

46

1 (C) WHEN A CARRIER ELECTS NOT TO RENEW ALL GROUP HEALTH BENEFIT  
2 PLANS IN THE STATE, THE CARRIER:

3 (1) SHALL GIVE NOTICE OF ITS DECISION TO THE AFFECTED  
4 INDIVIDUALS AT LEAST 180 DAYS BEFORE THE EFFECTIVE DATE OF NONRENEWAL;

5 (2) AT LEAST 30 WORKING DAYS BEFORE THAT NOTICE, SHALL GIVE  
6 NOTICE TO THE COMMISSIONER; AND

7 (3) MAY NOT WRITE NEW BUSINESS FOR GROUPS IN THE STATE FOR A  
8 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE COMMISSIONER.

9 (D) A HEALTH MAINTENANCE ORGANIZATION NEED NOT OFFER COVERAGE  
10 TO AN INDIVIDUAL WHO DOES NOT LIVE, RESIDE, OR WORK WITHIN THE HEALTH  
11 MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREAS.

12 **Article - Health - General**

13 19-706.

14 ~~(N) THE PROVISIONS OF TITLE 15, SUBTITLES 13 AND 14 OF THE INSURANCE~~  
15 ~~ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.~~

16 (n) The provisions of [Subtitles 59 and 60 of Article 48A of the Code] TITLE 15,  
17 SUBTITLES 13 AND 14 OF THE INSURANCE ARTICLE apply to health maintenance  
18 organizations.

19 SECTION 4. AND BE IT FURTHER ENACTED, That the Insurance  
20 Commissioner may adopt regulations to enable the Maryland Insurance Administration  
21 to establish and administer such standards relating to the provisions of this Act as may be  
22 necessary to: (i) implement the requirements of this Act; and (ii) assure that the  
23 Maryland Insurance Administration's regulation of health insurance carriers is not  
24 preempted by P. L. 104-191 (The Health Insurance Portability and Accountability Act of  
25 1996). The Commissioner may revise or amend the regulations and may broaden the  
26 scope of the regulations to the extent necessary to maintain federal approval of  
27 Maryland's program for regulation of health insurance carriers pursuant to the  
28 requirements established by the United States Department of Health and Human  
29 Services.

30 SECTION 5. AND BE IT FURTHER ENACTED, That, in accordance with §  
31 2-1312 of the State Government Article, the Insurance Commissioner shall report  
32 annually to the Senate Finance Committee and the House Economic Matters Committee  
33 regarding the effect of this Act on rates in the individual health insurance market, and  
34 any proposed changes to existing law. The Commissioner's report shall be made by  
35 December 1 of each year, beginning in 1999.

36 SECTION 6. AND BE IT FURTHER ENACTED, That, except for the  
37 requirements relating to certification of creditable coverage, the requirements of Section  
38 2 of this Act relating to group contracts issued under this Act shall take effect July 1,  
39 1997.

40 SECTION 7. AND BE IT FURTHER ENACTED, That the requirements  
41 regarding guaranteed issue, guaranteed renewal, and preexisting conditions with respect

1 to eligible individuals, as enacted by Sections 2 and 3 of this Act, shall be implemented no  
2 later than January 1, 1998.

3           SECTION 4. 8. AND BE IT FURTHER ENACTED, That ~~Section 2 of~~ , except  
4 for Sections 1 and 3 of this Act, and subject to the provisions of Sections 6 and 7 of this  
5 Act, this Act shall take effect June 1, 1997.

6           SECTION ~~5.~~ 9. AND BE IT FURTHER ENACTED, That, subject to the  
7 provisions of Section 7 of this Act, Sections 1 and 3 of this Act shall take effect October  
8 1, 1997.