SENATE BILL 843

Unofficial Copy 1997 Regular Session
C3 7lr2466

CF 7lr2420

By: Senators Bromwell and Young
Introduced and read first time: February 19, 1997
Assigned to: Rules

A BILL ENTITLED

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; providing for the effective date of this Act; providing for the
17 future codification of this Act; and generally relating to health insurance and health
18 benefits coverage.

19 BY renumbering
20 Article - Insurance
21 Section 15-1301 through 15-1307, respectively, and the subtitle "Subtitle 13.
22 Interdepartmental Committee on Mandated Health Insurance Benefits"
23 to be Section 15-1501 through 15-1507, respectively and the subtitle "Subtitle 15.
24 Interdepartmental Committee on Mandated Health Insurance Benefits"
25 Annotated Code of Maryland
26 (1995 Volume and 1996 Supplement)
27 (As enacted by Chapter_____ (H.B. 11) of the Acts of the General Assembly of
28 1997)

29 BY repealing and reenacting, with amendments,
30 Article 48A - Insurance Code
31 Section 490Y
32 Annotated Code of Maryland
33 (1994 Replacement Volume and 1996 Supplement)

1 BY adding to
2 Article 48A - Insurance Code
3 Section 703(h); 752 through 763, inclusive, and the new subtitle "59. Maryland
4 Health Insurance Portability and Accountability Act -- Individual Market
5 Reforms"; and 764 through 772, inclusive, and the new subtitle "60. Maryland
6 Health Insurance Portability and Accountability Act -- Large Group Market
7 Reforms"
8 Annotated Code of Maryland
9 (1994 Replacement Volume and 1996 Supplement)

10 BY adding to
11 Article - Health - General
12 Section 19-706(n)
13 Annotated Code of Maryland
14 (1996 Replacement Volume and 1996 Supplement)

15 BY repealing and reenacting, with amendments,
16 Article - Insurance
17 Section 15-1202
18 Annotated Code of Maryland
19 (1995 Volume and 1996 Supplement)
20 (As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of
21 1997)

22 BY adding to
23 Article - Insurance
24 Section 15-508; 15-1301 through 15-1312, inclusive, and the new subtitle "Subtitle
25 13. Maryland Health Insurance Portability and Accountability Act --
26 Individual Market Reforms"; and 15-1401 through 15-1409, inclusive, and the
27 new subtitle "Subtitle 14. Maryland Health Insurance Portability and
28 Accountability Act -- Large Group Market Reforms"
29 Annotated Code of Maryland
30 (1995 Volume and 1996 Supplement)
31 (As enacted by Chapter_____ (H.B. 11) of the Acts of the General Assembly of
32 1997)

33 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
34 MARYLAND, That Section(s) 15-1301 through 15-1307, respectively, and the subtitle
35 "Subtitle 13. Interdepartmental Committee on Mandated Health Insurance Benefits" of
36 Article - Insurance of the Annotated Code of Maryland (as enacted by
37 Chapter_____ (H.B. 11) of the Acts of the General Assembly of 1997) be renumbered to
38 be Section(s) 15-1501 through 15-1507, respectively, and the subtitle "Subtitle 15.
39 Interdepartmental Committee on Mandated Health Insurance Benefits".

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

1 **Article 48A - Insurance Code**

2 490Y.

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

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

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

10 (D) "PREEXISTING CONDITION PROVISION" HAS THE MEANING STATED IN §
11 752(R) OF THIS ARTICLE.

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

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

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

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

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

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

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

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

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

37 (ii) If any portion of a waiting period has not been satisfied under the
38 individual's prior policy or certificate, the insurer or nonprofit health service plan may

1 require the individual to satisfy the remaining portion of the waiting period under the
2 subsequent policy unless the subsequent policy has a shorter waiting period.

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

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

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

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

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

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

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

22 (I) IS ADOPTED OR PLACED FOR ADOPTION BEFORE ATTAINING
23 18 YEARS OF AGE; AND

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

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

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

32 703.

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

1 59. MARYLAND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT --
2 INDIVIDUAL MARKET REFORMS

3 752.

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

6 (B) "ACTUARIAL CERTIFICATION" MEANS A WRITTEN STATEMENT IN A FORM
7 APPROVED BY THE COMMISSIONER, SIGNED BY A MEMBER OF THE AMERICAN
8 ACADEMY OF ACTUARIES OR OTHER INDIVIDUAL ACCEPTABLE TO THE
9 COMMISSIONER THAT A CARRIER IS IN COMPLIANCE WITH THE PROVISIONS OF THIS
10 SUBTITLE.

11 (C) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED 2
12 MONTHS, DURING WHICH A HEALTH MAINTENANCE ORGANIZATION DOES NOT
13 COLLECT PREMIUM, AND COVERAGE ISSUED DOES NOT BECOME EFFECTIVE.

14 (D) "ASSOCIATION" OR "BONA FIDE ASSOCIATION" MEANS, AN ASSOCIATION
15 THAT:

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

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

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

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

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

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

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

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

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

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

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

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

7 (G) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL
8 UNDER:

9 (I) AN EMPLOYER SPONSORED PLAN;

10 (II) A HEALTH BENEFIT PLAN;

11 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY
12 ACT;

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

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

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

18 (VII) A STATE HEALTH BENEFITS RISK POOL;

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

22 (IX) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL
23 REGULATIONS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT, SECTION
24 2701(C)(1)(I), AS AMENDED BY P.L. 104-191; OR

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

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

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

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

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

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

5 (I) AN EMPLOYER SPONSORED PLAN;

6 (II) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY
7 ACT;

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

10 (IV) A HEALTH BENEFIT PLAN;

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

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

17 (I) HAS ELECTED THAT COVERAGE; AND

18 (II) HAS EXHAUSTED THAT COVERAGE.

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

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

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

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

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

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

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

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

36 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR
37 GROUP MASTER CONTRACT.

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

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

3 1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME
4 INSURANCE;

5 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY
6 INSURANCE;

7 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY
8 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

9 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

10 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

11 6. CREDIT-ONLY INSURANCE;

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

13 8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN
14 FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191, UNDER WHICH BENEFITS
15 FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE
16 BENEFITS; OR

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

20 1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

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

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

27 (1) HEALTH STATUS;

28 (2) MEDICAL CONDITION;

29 (3) CLAIMS EXPERIENCE;

30 (4) RECEIPT OF HEALTH CARE;

31 (5) MEDICAL HISTORY;

32 (6) GENETIC INFORMATION;

33 (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT
34 OF ACTS OF DOMESTIC VIOLENCE; OR

1 (8) DISABILITY.

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

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

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

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

9 (1) A HEALTH BENEFIT PLAN OTHER THAN A CONVERTED POLICY OR A
10 PROFESSIONAL ASSOCIATION PLAN FOR ELIGIBLE INDIVIDUALS AND THEIR
11 DEPENDENTS; AND

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

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

22 (Q) "PREEXISTING CONDITION" MEANS:

23 (1) A CONDITION EXISTING DURING A SPECIFIED PERIOD
24 IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE THAT WOULD
25 HAVE CAUSED AN ORDINARILY PRUDENT PERSON TO SEEK MEDICAL ADVICE,
26 DIAGNOSIS, CARE, OR TREATMENT; OR

27 (2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR
28 TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD
29 IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE.

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

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

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

38 (I) ALL THE HEALTH INSURANCE COVERAGES ISSUED BY THE
39 CARRIER IN THIS STATE IN THE INDIVIDUAL MARKET DURING THE PREVIOUS

1 CALENDAR YEAR, WEIGHTED BY ENROLLMENT FOR THE DIFFERENT COVERAGES;
2 OR

3 (II) ALL THE HEALTH INSURANCE COVERAGES ISSUED BY ALL
4 CARRIERS IN THIS STATE IN THE INDIVIDUAL MARKET, IF THE DATA ARE
5 AVAILABLE, DURING THE PREVIOUS CALENDAR YEAR, WEIGHTED BY ENROLLMENT
6 FOR THE DIFFERENT COVERAGES.

7 (2) "WEIGHTED AVERAGE" DOES NOT INCLUDE COVERAGES ISSUED
8 UNDER THIS SUBTITLE.

9 753.

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

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

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

17 754.

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

20 (1) HAVE DEMONSTRATED THE CAPACITY TO ADMINISTER THE
21 INDIVIDUAL HEALTH BENEFIT PLANS, INCLUDING ADEQUATE NUMBERS AND TYPES
22 OF ADMINISTRATIVE STAFF;

23 (2) HAVE A SATISFACTORY GRIEVANCE PROCEDURE AND ABILITY TO
24 RESPOND TO CALLS, QUESTIONS, AND COMPLAINTS FROM ENROLLEES OR
25 INSUREDS; AND

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

28 755.

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

32 756.

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

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

37 (2) IMPOSE ANY PREEXISTING CONDITION PROVISION ON AN ELIGIBLE
38 INDIVIDUAL.

1 (B) (1) A CARRIER THAT MAKES AN ELECTION UNDER § 757 OF THIS
2 SUBTITLE MAY CHOOSE TO OFFER AT LEAST TWO DIFFERENT POLICY FORMS, BOTH
3 OF WHICH ARE DESIGNED FOR, MADE GENERALLY AVAILABLE TO, ACTIVELY
4 MARKETED TO, AND ENROLL, BOTH ELIGIBLE INDIVIDUALS AND OTHER
5 INDIVIDUALS.

6 (2) POLICY FORMS THAT HAVE DIFFERENT COST-SHARING
7 ARRANGEMENTS OR DIFFERENT RIDERS SHALL BE CONSIDERED TO BE DIFFERENT
8 POLICY FORMS.

9 (C) POLICY FORMS SHALL COMPLY WITH THE REQUIREMENTS OF THIS
10 SUBTITLE.

11 757.

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

14 (1) AN ELECTION WHETHER TO OFFER:

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

18 (II) POLICY FORMS WITH THE LARGEST AND NEXT TO LARGEST
19 PREMIUM VOLUME OF ALL POLICY FORMS OFFERED BY THE CARRIER IN THIS
20 STATE; AND

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

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

25 (2) AFTER THE INITIAL 2-YEAR PERIOD, AND FOR EACH SUBSEQUENT
26 2-YEAR PERIOD, CARRIERS SHALL AGAIN MAKE THE ELECTIONS REQUIRED BY THIS
27 SECTION.

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

30 758.

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

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

1 759.

2 (A) SUBJECT TO SUBSECTIONS (C) AND (G) OF THIS SECTION, A CARRIER
3 SHALL ISSUE THE INDIVIDUAL HEALTH BENEFIT PLAN ELECTED UNDER § 756 OR §
4 757(A)(1) OF THIS SUBTITLE TO ANY ELIGIBLE INDIVIDUAL.

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

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

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

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

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

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

20 (II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

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

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

26 (2) UNTIL THE CARRIER HAS DEMONSTRATED, TO THE
27 COMMISSIONER'S SATISFACTION THAT THE CARRIER HAS SUFFICIENT
28 POLICYHOLDER SURPLUS TO UNDERWRITE ADDITIONAL COVERAGE.

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

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

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

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

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

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

7 760.

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

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

13 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUMS;

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

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

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

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

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

30 761.

31 (A) A CARRIER SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE
32 COVERAGE.

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

35 (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE
36 COVERED UNDER THE HEALTH BENEFITS PLAN AND WITHIN A REASONABLE
37 PERIOD AFTER CESSATION OF COVERAGE; AND

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

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

4 (D) THE CERTIFICATION SHALL CONTAIN:

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

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

11 (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE
12 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF
13 COVERAGE, THEN:

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

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

21 762.

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

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

28 763.

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

34 60. MARYLAND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT --
35 LARGE GROUP MARKET REFORMS

36 764.

37 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS
38 INDICATED.

1 (B) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED 2
2 MONTHS DURING WHICH A HEALTH MAINTENANCE ORGANIZATION DOES NOT
3 COLLECT PREMIUM AND COVERAGE ISSUED DOES NOT BECOME EFFECTIVE.

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (F) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL
38 UNDER:

39 (I) A GROUP HEALTH PLAN;

1 (II) HEALTH INSURANCE COVERAGE;

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

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

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

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

9 (VII) A STATE HEALTH BENEFITS RISK POOL;

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

13 (IX) A PUBLIC HEALTH PLAN AS DEFINED BY FEDERAL
14 REGULATIONS AUTHORIZED BY THE PUBLIC HEALTH SERVICE ACT, SECTION
15 2701(C)(1)(I), AS AMENDED BY P.L. 104-191; OR

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

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

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

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

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

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

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

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

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

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

3 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR
4 GROUP MASTER CONTRACT.

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

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

7 1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME
8 INSURANCE;

9 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY
10 INSURANCE;

11 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY
12 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

13 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

14 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

15 6. CREDIT-ONLY INSURANCE;

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

17 8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN
18 FEDERAL REGULATIONS ISSUED UNDER THE FEDERAL HEALTH INSURANCE
19 PORTABILITY AND ACCOUNTABILITY ACT UNDER WHICH BENEFITS FOR MEDICAL
20 CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS; OR

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

24 1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

28 3. SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE
29 SPECIFIED IN FEDERAL REGULATIONS ISSUED UNDER THE FEDERAL HEALTH
30 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

31 (K) "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;

1 (5) MEDICAL HISTORY;

2 (6) GENETIC INFORMATION;

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

5 (8) DISABILITY.

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

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

10 (2) A SPECIAL ENROLLMENT PERIOD.

11 (M) "PREEXISTING CONDITION" MEANS:

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

16 (2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR
17 TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD
18 IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE.

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

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

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

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

31 765.

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

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

1 766.

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 55 OF THIS ARTICLE.

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

15 (D) THE CERTIFICATION SHALL CONTAIN:

16 (1) WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE
17 COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN, AND THE
18 COVERAGE, IF APPLICABLE, UNDER THE APPLICABLE STATE OR FEDERAL
19 CONTINUATION PROVISION; AND

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

22 (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE
23 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF
24 COVERAGE, THEN:

25 (1) ON REQUEST OF THE GROUP HEALTH PLAN, THE ENTITY THAT
26 ISSUED THE CERTIFICATION PROVIDED BY THE INDIVIDUAL PROMPTLY SHALL
27 DISCLOSE TO THE REQUESTING GROUP HEALTH PLAN, INFORMATION REGARDING
28 COVERAGE OF CLASSES AND CATEGORIES OF HEALTH BENEFITS AVAILABLE
29 UNDER THE ENTITY'S PLAN OR POLICY; AND

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

32 767.

33 (A) IN DETERMINING A PERIOD OF CREDITABLE COVERAGE, ANY PERIOD
34 THAT AN INDIVIDUAL IS IN A WAITING PERIOD FOR ANY COVERAGE UNDER A
35 GROUP HEALTH BENEFIT PLAN OR AN AFFILIATION PERIOD MAY NOT BE TAKEN
36 INTO ACCOUNT IN DETERMINING ANY PERIOD OF CONTINUOUS CREDITABLE
37 COVERAGE.

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

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

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

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

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

13 (1) PROMINENTLY STATE IN ANY DISCLOSURE STATEMENTS
14 CONCERNING THE COVERAGE, AND TO EACH EMPLOYER AT THE TIME OF THE
15 OFFER OR SALE OF THE COVERAGE, THAT THE CARRIER HAS MADE THIS ELECTION;
16 AND

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

19 768.

20 AN INDIVIDUAL SHALL ESTABLISH THE INDIVIDUAL'S PERIOD OF CREDITABLE
21 COVERAGE BY PRESENTING THE CERTIFICATE DESCRIBED IN § 766 OF THIS
22 SUBTITLE.

23 769.

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

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

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

31 (2) PREVENT A CARRIER FROM ESTABLISHING LIMITATIONS OR
32 RESTRICTIONS ON THE AMOUNT, LEVEL, EXTENT, OR NATURE OF THE BENEFITS OR
33 COVERAGE FOR SIMILARLY SITUATED INDIVIDUALS ENROLLED IN THE HEALTH
34 BENEFIT PLAN.

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

37 770.

38 A CARRIER MAY NOT REQUIRE AN INDIVIDUAL MEMBER OF A GROUP TO PAY
39 A PREMIUM OR CONTRIBUTION THAT IS GREATER THAN THE PREMIUM OR

1 CONTRIBUTION FOR A SIMILARLY SITUATED INDIVIDUAL, BASED ON ANY HEALTH
2 STATUS-RELATED FACTOR.

3 771.

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

6 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUM;

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

9 (3) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS MADE AN
10 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE
11 COVERAGE;

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

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

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

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

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

26 772.

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

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

31 (I) POLICYHOLDER;

32 (II) PLAN SPONSOR;

33 (III) PARTICIPANT; AND

34 (IV) BENEFICIARY;

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

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

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

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

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

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

12 (3) MAY NOT WRITE NEW BUSINESS FOR GROUPS IN THE STATE FOR A
13 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE COMMISSIONER.

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

17 **Article - Health - General**

18 19-706.

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

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

23 **Article - Insurance**

24 15-508.

25 (A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS
26 INDICATED.

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

28 (3) "POLICY OR CERTIFICATE" MEANS ANY HEALTH INSURANCE
29 CONTRACT OR POLICY THAT IS ISSUED OR DELIVERED IN THE STATE BY AN
30 INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT PROVIDES HOSPITAL,
31 MEDICAL, OR SURGICAL BENEFITS ON AN EXPENSE-INCURRED BASIS.

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

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

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

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

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

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

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

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

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

20 (I) IS ADOPTED OR PLACED FOR ADOPTION BEFORE ATTAINING
21 18 YEARS OF AGE; AND

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

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

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

30 15-1202.

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

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

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

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

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

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

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

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

9 SUBTITLE 13. MARYLAND HEALTH INSURANCE PORTABILITY AND
10 ACCOUNTABILITY ACT -- INDIVIDUAL MARKET REFORMS.

11 15-1301.

12 (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS
13 INDICATED.

14 (B) "ACTUARIAL CERTIFICATION" MEANS A WRITTEN STATEMENT IN A FORM
15 APPROVED BY THE COMMISSIONER, SIGNED BY A MEMBER OF THE AMERICAN
16 ACADEMY OF ACTUARIES OR OTHER INDIVIDUAL ACCEPTABLE TO THE
17 COMMISSIONER THAT A CARRIER IS IN COMPLIANCE WITH THE PROVISIONS OF THIS
18 SUBTITLE.

19 (C) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED 2
20 MONTHS, DURING WHICH A HEALTH MAINTENANCE ORGANIZATION DOES NOT
21 COLLECT PREMIUM, AND COVERAGE ISSUED DOES NOT BECOME EFFECTIVE.

22 (D) "ASSOCIATION" OR "BONA FIDE ASSOCIATION" MEANS, AN ASSOCIATION
23 THAT:

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

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

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

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

36 (5) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED
37 THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH
38 MEMBERSHIP IN THE ASSOCIATION, AND STATES SO CLEARLY IN ALL MARKETING
39 AND APPLICATION MATERIALS; AND

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

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

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

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

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

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

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

16 (G) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL
17 UNDER:

18 (I) AN EMPLOYER SPONSORED PLAN;

19 (II) A HEALTH BENEFIT PLAN;

20 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY
21 ACT;

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

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

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

27 (VII) A STATE HEALTH BENEFITS RISK POOL;

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

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

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

36 (2) A PERIOD OF CREDITABLE COVERAGE SHALL NOT BE COUNTED,
37 WITH RESPECT TO ENROLLMENT OF AN INDIVIDUAL UNDER A HEALTH BENEFIT

1 PLAN OR AN EMPLOYER SPONSORED PLAN, IF, AFTER SUCH PERIOD AND BEFORE
2 THE ENROLLMENT DATE, THERE WAS A 63-DAY PERIOD DURING ALL OF WHICH THE
3 INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE.

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

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

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

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

12 (I) AN EMPLOYER SPONSORED PLAN;

13 (II) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY
14 ACT;

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

17 (IV) A HEALTH BENEFIT PLAN;

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

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

24 (I) HAS ELECTED THAT COVERAGE; AND

25 (II) HAS EXHAUSTED THAT COVERAGE.

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

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

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

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

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

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

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

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

6 (III) HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR
7 GROUP MASTER CONTRACT.

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

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

10 1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME
11 INSURANCE;

12 2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY
13 INSURANCE;

14 3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY
15 INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

16 4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

17 5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

18 6. CREDIT-ONLY INSURANCE;

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

20 8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN
21 FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191, UNDER WHICH BENEFITS
22 FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE
23 BENEFITS; OR

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

27 1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

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

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

34 (1) HEALTH STATUS;

35 (2) MEDICAL CONDITION;

36 (3) CLAIMS EXPERIENCE;

1 (4) RECEIPT OF HEALTH CARE;

2 (5) MEDICAL HISTORY;

3 (6) GENETIC INFORMATION;

4 (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT
5 OF ACTS OF DOMESTIC VIOLENCE; OR

6 (8) DISABILITY.

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

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

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

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

14 (1) A HEALTH BENEFIT PLAN OTHER THAN A CONVERTED POLICY OR A
15 PROFESSIONAL ASSOCIATION PLAN FOR ELIGIBLE INDIVIDUALS AND THEIR
16 DEPENDENTS; AND

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

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.

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

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

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

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

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

14 (2) "WEIGHTED AVERAGE" DOES NOT INCLUDE COVERAGES ISSUED
15 UNDER THIS SUBTITLE.

16 15-1302.

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

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

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

24 15-1303.

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

27 (1) HAVE DEMONSTRATED THE CAPACITY TO ADMINISTER THE
28 INDIVIDUAL HEALTH BENEFIT PLANS, INCLUDING ADEQUATE NUMBERS AND TYPES
29 OF ADMINISTRATIVE STAFF;

30 (2) HAVE A SATISFACTORY GRIEVANCE PROCEDURE AND ABILITY TO
31 RESPOND TO CALLS, QUESTIONS, AND COMPLAINTS FROM ENROLLEES OR
32 INSUREDS; AND

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

35 15-1304.

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

1 15-1305.

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

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

6 (2) IMPOSE ANY PREEXISTING CONDITION PROVISION ON AN ELIGIBLE
7 INDIVIDUAL.

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

13 (2) POLICY FORMS THAT HAVE DIFFERENT COST-SHARING
14 ARRANGEMENTS OR DIFFERENT RIDERS SHALL BE CONSIDERED TO BE DIFFERENT
15 POLICY FORMS.

16 (C) POLICY FORMS SHALL COMPLY WITH THE REQUIREMENTS OF THIS
17 SUBTITLE.

18 15-1306.

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

21 (1) AN ELECTION WHETHER TO OFFER:

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

25 (II) POLICY FORMS WITH THE LARGEST AND NEXT TO LARGEST
26 PREMIUM VOLUME OF ALL POLICY FORMS OFFERED BY THE CARRIER IN THIS
27 STATE; AND

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

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

32 (2) AFTER THE INITIAL 2-YEAR PERIOD, AND FOR EACH SUBSEQUENT
33 2-YEAR PERIOD, CARRIERS SHALL AGAIN MAKE THE ELECTIONS REQUIRED BY THIS
34 SECTION.

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

1 15-1307.

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

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

9 15-1308.

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

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

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

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

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

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

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

28 (II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

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

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

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

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

1 (F) WHEN A CARRIER ELECTS NOT TO RENEW ALL INDIVIDUAL HEALTH
2 BENEFIT 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 INDIVIDUALS IN THE STATE
8 FOR A 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE
9 COMMISSIONER.

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

13 15-1309.

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

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

19 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUMS;

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

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

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

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

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

36 15-1310.

37 (A) A CARRIER SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE
38 COVERAGE.

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

3 (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE
4 COVERED UNDER THE HEALTH BENEFITS PLAN AND WITHIN A REASONABLE
5 PERIOD AFTER CESSATION OF COVERAGE; AND

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

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

11 (D) THE CERTIFICATION SHALL CONTAIN:

12 (1) WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE
13 COVERAGE OF THE INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN, AND THE
14 COVERAGE, IF APPLICABLE, UNDER THE APPLICABLE STATE OR FEDERAL
15 CONTINUATION PROVISION; AND

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

18 (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE
19 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF
20 COVERAGE, THEN:

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

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

28 15-1311.

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

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

35 15-1312.

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

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

3 15-1401.

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

6 (B) "AFFILIATION PERIOD" MEANS A PERIOD OF TIME NOT TO EXCEED 2
7 MONTHS DURING WHICH A HEALTH MAINTENANCE ORGANIZATION DOES NOT
8 COLLECT PREMIUM AND COVERAGE ISSUED DOES NOT BECOME EFFECTIVE.

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (F) (1) "CREDITABLE COVERAGE" MEANS COVERAGE OF AN INDIVIDUAL
4 UNDER:

5 (I) A GROUP HEALTH PLAN;

6 (II) HEALTH INSURANCE COVERAGE;

7 (III) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY
8 ACT;

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

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

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

14 (VII) A STATE HEALTH BENEFITS RISK POOL;

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

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

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

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

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

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

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

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

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.

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

2 (1) HEALTH STATUS;

3 (2) MEDICAL CONDITION;

4 (3) CLAIMS EXPERIENCE;

5 (4) RECEIPT OF HEALTH CARE;

6 (5) MEDICAL HISTORY;

7 (6) GENETIC INFORMATION;

8 (7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT
9 OF ACTS OF DOMESTIC VIOLENCE; OR

10 (8) DISABILITY.

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

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

15 (2) A SPECIAL ENROLLMENT PERIOD.

16 (M) "PREEXISTING CONDITION" MEANS:

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

21 (2) A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR
22 TREATMENT WAS RECOMMENDED OR RECEIVED DURING A SPECIFIED PERIOD
23 IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THIS COVERAGE.

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

27 (O) "SECRETARY" MEANS THE SECRETARY OF THE FEDERAL DEPARTMENT
28 OF HEALTH AND HUMAN SERVICES.

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

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

1 15-1402.

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

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

6 15-1403.

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

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

12 (1) AUTOMATICALLY AT THE TIME AN INDIVIDUAL CEASES TO BE
13 COVERED UNDER THE PLAN AND WITHIN A REASONABLE PERIOD AFTER
14 CESSATION OF COVERAGE; AND

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

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

20 (D) THE CERTIFICATION SHALL CONTAIN:

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

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

27 (E) IF A GROUP HEALTH PLAN ENROLLS AN INDIVIDUAL FOR COVERAGE
28 UNDER THE PLAN AND THE INDIVIDUAL PROVIDES A CERTIFICATION OF
29 COVERAGE, THEN:

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

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

1 15-1404.

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

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

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

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

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

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

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

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

28 15-1405.

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

32 15-1406.

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

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

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

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

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

7 15-1407.

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

12 15-1408.

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

15 (1) FOR NONPAYMENT OF THE REQUIRED PREMIUM;

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

18 (3) WHERE THE POLICYHOLDER OR PLAN SPONSOR HAS MADE AN
19 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE
20 COVERAGE;

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

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

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

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

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

36 15-1409.

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

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

3 (I) POLICYHOLDER;

4 (II) PLAN SPONSOR;

5 (III) PARTICIPANT; AND

6 (IV) BENEFICIARY;

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

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

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

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

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

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

21 (3) MAY NOT WRITE NEW BUSINESS FOR GROUPS IN THE STATE FOR A
22 5-YEAR PERIOD BEGINNING ON THE DATE OF NOTICE TO THE COMMISSIONER.

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

26 **Article - Health - General**

27 19-706.

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

30 SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act
31 shall take effect June 1, 1997.

32 SECTION 5. AND BE IT FURTHER ENACTED, That Sections 1 and 3 this Act
33 shall take effect October 1, 1997.