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
Re-referred to: Finance, February 24, 1997

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 21, 1997

CHAPTER ____

AN ACT concerning

Maryland Health Insurance Portability and Accountability Act

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

BY renumbering
Article - Insurance
Section 15-1301 through 15-1307, respectively, and the subtitle "Subtitle 13. Interdepartmental Committee on Mandated Health Insurance Benefits"

to be Section 15-1501 through 15-1507, respectively and the subtitle "Subtitle 15. Interdepartmental Committee on Mandated Health Insurance Benefits"
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter_____ (H.B. 11) of the Acts of the General Assembly of 1997)

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

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

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

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

BY adding to
Article - Insurance
Section 15-508; 15-1301 through 15-1312, inclusive, and the new subtitle "Subtitle 13. Maryland Health Insurance Portability and Accountability Act -- Individual Market Reforms"; and 15-1401 through 15-1409, inclusive, and the new subtitle "Subtitle 14. Maryland Health Insurance Portability and Accountability Act -- Large Group Market Reforms"
Annotated Code of Maryland

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(1995 Volume and 1996 Supplement)
(As enacted by Chapter_____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-706(n)
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)
(As enacted by Section 2 of this Act)

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

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

Article 48A - Insurance Code

490Y.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

703.

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

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

752.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) AN EMPLOYER SPONSORED PLAN;

(II) A HEALTH BENEFIT PLAN;

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

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

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

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

(VII) A STATE HEALTH BENEFITS RISK POOL;

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

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

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

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

(H) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL:

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

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

(2) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER:

(I) AN EMPLOYER SPONSORED PLAN;

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

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

(IV) A HEALTH BENEFIT PLAN;

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

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

(I) HAS ELECTED THAT COVERAGE; AND

(II) HAS EXHAUSTED THAT COVERAGE.

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

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

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

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

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

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

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

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

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

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

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

1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

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

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT-ONLY INSURANCE;

7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

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

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

1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

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

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

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

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

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

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

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

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

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

(1) HEALTH STATUS;

(2) MEDICAL CONDITION;

(3) CLAIMS EXPERIENCE;

(4) RECEIPT OF HEALTH CARE;

(5) MEDICAL HISTORY;

(6) GENETIC INFORMATION;

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

(8) DISABILITY.

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

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

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

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

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

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

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

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

(Q) "PREEXISTING CONDITION" MEANS~~:~~

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

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

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

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

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

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

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

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

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

753.

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

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

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

754.

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

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

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

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

755.

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

756.

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

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

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

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

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

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

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

757.

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

(1) AN ELECTION WHETHER TO OFFER:

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

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

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

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

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

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

758.

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

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

759.

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

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

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

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

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

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

(I) ANY HEALTH STATUS-RELATED FACTOR; AND

(II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

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

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

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

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

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

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

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

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

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

760.

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

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

(1) FOR NONPAYMENT OF THE REQUIRED PREMIUMS;

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

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

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

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

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

761.

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

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

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

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

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

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

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

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

(D) THE CERTIFICATION SHALL CONTAIN:

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

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

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

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

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

762.

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

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

763.

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

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

764.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(VII) A STATE HEALTH BENEFITS RISK POOL;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

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

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT-ONLY INSURANCE;

7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

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

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

1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

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

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

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

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

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

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

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

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

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

(1) HEALTH STATUS;

(2) MEDICAL CONDITION;

(3) CLAIMS EXPERIENCE;

(4) RECEIPT OF HEALTH CARE;

(5) MEDICAL HISTORY;

(6) GENETIC INFORMATION;

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

(8) DISABILITY.

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

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

(2) A SPECIAL ENROLLMENT PERIOD.

(M) "PREEXISTING CONDITION" MEANS~~:~~

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

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

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

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

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

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

765.

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

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

766.

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

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

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

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

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

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

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

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

(D) THE CERTIFICATION SHALL CONTAIN:

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

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

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

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

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

767.

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

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

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

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

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

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

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

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

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

768.

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

769.

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

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

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

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

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

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

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

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

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

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

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

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

770.

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

771.

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

(1) FOR NONPAYMENT OF THE REQUIRED PREMIUM;

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

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

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

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

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

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

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

772.

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

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

(I) POLICYHOLDER;

(II) PLAN SPONSOR;

(III) PARTICIPANT; AND

(IV) BENEFICIARY;

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

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

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

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

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

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

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

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

Article - Health - General

19-706.

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

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

Article - Insurance

15-508.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15-1202.

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

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

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

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

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

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

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

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

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

15-1301.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) AN EMPLOYER SPONSORED PLAN;

(II) A HEALTH BENEFIT PLAN;

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

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

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

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

(VII) A STATE HEALTH BENEFITS RISK POOL;

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

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

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

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

(H) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL:

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

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

(2) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER:

(I) AN EMPLOYER SPONSORED PLAN;

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

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

(IV) A HEALTH BENEFIT PLAN;

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

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

(I) HAS ELECTED THAT COVERAGE; AND

(II) HAS EXHAUSTED THAT COVERAGE.

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

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

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

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

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

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

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

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

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

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

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

1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

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

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT-ONLY INSURANCE;

7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

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

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

1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

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

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

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

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

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

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

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

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

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

(1) HEALTH STATUS;

(2) MEDICAL CONDITION;

(3) CLAIMS EXPERIENCE;

(4) RECEIPT OF HEALTH CARE;

(5) MEDICAL HISTORY;

(6) GENETIC INFORMATION;

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

(8) DISABILITY.

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

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

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

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

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

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

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

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

(Q) "PREEXISTING CONDITION" MEANS~~:~~

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

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

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

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

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

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

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

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

15-1302.

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

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

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

15-1303.

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

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

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

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

15-1304.

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

15-1305.

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

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

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

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

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

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

15-1306.

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

(1) AN ELECTION WHETHER TO OFFER:

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

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

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

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

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

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

15-1307.

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

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

15-1308.

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

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

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

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

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

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

(I) ANY HEALTH STATUS-RELATED FACTOR; AND

(II) WHETHER THE INDIVIDUALS ARE ELIGIBLE INDIVIDUALS.

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

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

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

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

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

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

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

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

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

15-1309.

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

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

(1) FOR NONPAYMENT OF THE REQUIRED PREMIUMS;

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

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

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

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

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

15-1310.

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

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

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

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

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

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

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

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

(D) THE CERTIFICATION SHALL CONTAIN:

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

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

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

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

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

15-1311.

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

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

15-1312.

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

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

15-1401.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(VII) A STATE HEALTH BENEFITS RISK POOL;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

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

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT-ONLY INSURANCE;

7. COVERAGE FOR ON-SITE MEDICAL CLINICS; AND

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

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

1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

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

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

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

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

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

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

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

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

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

(1) HEALTH STATUS;

(2) MEDICAL CONDITION;

(3) CLAIMS EXPERIENCE;

(4) RECEIPT OF HEALTH CARE;

(5) MEDICAL HISTORY;

(6) GENETIC INFORMATION;

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

(8) DISABILITY.

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

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

(2) A SPECIAL ENROLLMENT PERIOD.

(M) "PREEXISTING CONDITION" MEANS:

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

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

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

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

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

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

15-1402.

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

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

15-1403.

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

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

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

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

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

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

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

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

(D) THE CERTIFICATION SHALL CONTAIN:

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

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

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

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

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

15-1404.

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

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

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

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

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

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

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

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

15-1405.

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

15-1406.

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

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

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

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

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

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

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

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

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

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

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

15-1407.

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

15-1408.

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

(1) FOR NONPAYMENT OF THE REQUIRED PREMIUM;

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

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

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

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

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

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

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

15-1409.

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

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

(I) POLICYHOLDER;

(II) PLAN SPONSOR;

(III) PARTICIPANT; AND

(IV) BENEFICIARY;

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

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

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

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

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

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

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

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

Article - Health - General

~~19-706.~~

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

19-706.

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

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

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

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

SECTION 7. AND BE IT FURTHER ENACTED, That the requirements regarding guaranteed issue, guaranteed renewal, and preexisting conditions with respect to eligible individuals, as enacted by Sections 2 and 3 of this Act, shall be implemented no later than January 1, 1998.

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

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