**HOUSE BILL 43**

Unofficial Copy 1999 Regular Session
C3 (9lr0055)

***ENROLLED BILL***
*-- Economic Matters/Finance --*

Introduced by **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**

Read and Examined by Proofreaders:

_____
Proofreader.

_____
Proofreader.

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

_____
Speaker.

CHAPTER_____

AN ACT concerning

**Health Insurance - Standard Policy Provisions - *Task Force to Study the Non-Group Health Insurance Market***

FOR the purpose of ~~providing that certain provisions of law apply to contracts between nonprofit health service plans and their subscribers; requiring certain provisions to be included in certain group and blanket health insurance policies and nonprofit health service plan contracts; authorizing the use of certain other provisions in certain group and blanket health insurance policies and nonprofit health service plan contracts; and generally relating to certain policy provisions in group, individual, and blanket policies and nonprofit health service plan contracts~~ requiring the Insurance Commissioner to adopt regulations governing standard contract provisions to be used by certain insurers, nonprofit health service plans, and health maintenance organizations by a certain date; repealing certain provisions of law relating to standard health insurance policy provisions, subject to a certain contingency; *establishing a Task Force to Study the Non-Group Health Insurance Market; establishing the membership of the*

*Task Force; establishing duties of the Task Force; requiring the Task Force to make certain recommendations and to take into account and examine certain issues; providing that the Maryland Insurance Administration and the Maryland Health Care Access and Cost Commission shall provide staff support for the Task Force; requiring the Task Force to submit to the Governor and the General Assembly a preliminary report and a final report on its findings and recommendations on or before certain dates; providing that the implementation of a certain substantial, available, and affordable coverage product shall be suspended until the Task Force issues a certain preliminary report;* requiring the Insurance Commissioner to certify to certain committees and to the Department of Legislative Services that a certain contingency has occurred; providing for the effective date of this Act; and generally relating to standard health insurance contract provisions *and the non-group health insurance market*.

~~BY repealing and reenacting, with amendments,~~
~~Article - Insurance~~
~~Section 14-102~~
~~Annotated Code of Maryland~~
~~(1997 Volume and 1998 Supplement)~~
~~(As enacted by Chapter 774 of the Acts of the General Assembly of 1998)~~

~~BY repealing and reenacting, with amendments,~~
~~Article - Insurance~~
~~Section 15-303~~
~~Annotated Code of Maryland~~
~~(1997 Volume and 1998 Supplement)~~

~~BY adding to~~
~~Article - Insurance~~
~~Section 15-303.1, 15-303.2, 15-307.1, and 15-307.2~~
~~Annotated Code of Maryland~~
~~(1997 Volume and 1998 Supplement)~~

~~BY repealing and reenacting, without amendments,~~
~~Article - Insurance~~
~~Section 15-307~~
~~Annotated Code of Maryland~~
~~(1997 Volume and 1998 Supplement)~~

BY repealing
Article - Insurance
Section 15-303 and 15-307
Annotated Code of Maryland
(1997 Volume and 1998 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-706(i)
Annotated Code of Maryland
(1996 Volume and 1998 Supplement)

BY adding to
Article - Insurance
Section *15-126 and* 12-203(g)
Annotated Code of Maryland
(1997 ~~Replacement~~ Volume and 1998 Supplement)

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

**~~Article - Insurance~~**

~~14-102.~~

~~A corporation without capital stock organized for the purpose of establishing, maintaining, and operating a nonprofit health service plan through which health care providers provide health care services to subscribers to the plan under contracts that entitle each subscriber to certain health care services shall be governed and regulated by:~~

~~(1) this subtitle;~~

~~(2) Title 2, Subtitle 2 of this article and §§ 1-206, 3-127, and 12-210 of this article;~~

~~(3) Title 2, Subtitle 5 of this article;~~

~~(4) §§ 4-113 and 4-114 of this article;~~

~~(5) Title 5, Subtitles 1, 2, 3, 4, and 5 of this article;~~

~~(6) Title 7 of this article, except for § 7-706 and Subtitle 2 of Title 7;~~

~~(7) Title 9, Subtitles 1, 2, and 4 of this article;~~

~~(8) Title 10, Subtitle 1 of this article;~~

~~(9) Title 27 of this article; [and]~~

~~(10) §§ 15-207 THROUGH 15-221, 15-225 THROUGH 15-228, 15-303, 15-303.1, 15-303.2, 15-307, 15-307.1, AND 15-307.2 OF THIS ARTICLE; AND~~

~~(11) any other provision of this article that:~~

~~(i) is expressly referred to in this subtitle;~~

~~(ii) expressly refers to this subtitle; or~~

~~(iii) expressly refers to nonprofit health service plans or persons subject to this subtitle.~~

~~15-303.~~

~~(a) Each policy of group health insurance shall contain [in substance the provisions of this section] PROVISIONS THAT IN THE OPINION OF THE COMMISSIONER ARE AT LEAST AS FAVORABLE TO THE POLICYHOLDER OR INSURED AS THE PROVISIONS IN THIS SECTION.~~

~~(b) Each policy of group health insurance shall contain a provision that[, absent fraud, each statement made by an applicant, policyholder, or insured is considered to be a representation and not a warranty]:~~

~~(1) THE POLICY AND APPLICATION CONSTITUTE THE ENTIRE CONTRACT BETWEEN THE PARTIES;~~

~~(2) ABSENT FRAUD, EACH STATEMENT MADE BY AN APPLICANT, POLICYHOLDER, OR INSURED IS CONSIDERED TO BE A REPRESENTATION AND NOT A WARRANTY; AND~~

~~(3) A STATEMENT MADE BY A POLICYHOLDER MAY NOT BE USED IN DEFENSE TO A CLAIM UNDER THE POLICY UNLESS THE STATEMENT IS CONTAINED IN A WRITTEN APPLICATION.~~

~~(c) [Each policy of group health insurance shall contain a provision that a statement made to effectuate insurance does not avoid the insurance or reduce benefits under the policy unless the statement is contained in a written instrument signed by the policyholder or insured and a copy of the statement is given to the policyholder, insured, or beneficiary of the insured.]~~

~~(1) EACH POLICY OF GROUP HEALTH INSURANCE SHALL CONTAIN A PROVISION THAT WRITTEN NOTICE OF SICKNESS OR INJURY MUST BE GIVEN TO THE INSURER WITHIN 20 DAYS AFTER THE DATE ON WHICH THE SICKNESS OR INJURY OCCURS.~~

~~(2) FAILURE TO GIVE NOTICE WITHIN 20 DAYS AFTER THE DATE ON WHICH THE SICKNESS OR INJURY OCCURS DOES NOT INVALIDATE OR REDUCE A CLAIM IF IT IS SHOWN THAT:~~

~~(I) IT WAS NOT REASONABLY POSSIBLE TO GIVE NOTICE WITHIN 20 DAYS; AND~~

~~(II) NOTICE WAS GIVEN AS SOON AS WAS REASONABLY POSSIBLE.~~

~~(d) (1) Each policy of group health insurance shall contain a provision that the insurer will provide to the policyholder for delivery to each employee or member of the insured group, a statement that summarizes the essential features of the insurance coverage of the employee or member and that indicates to whom benefits under the policy are payable.~~

~~(2) If dependents are included in the coverage, only one statement need be issued for each family unit.~~

~~(e) Each policy of group health insurance shall contain a provision that eligible new employees, members, or dependents may be added periodically to the group originally insured in accordance with the terms of the policy.~~

~~(F) (1) EACH POLICY OF GROUP HEALTH INSURANCE SHALL REQUIRE THE INSURER TO PROVIDE TO EACH POLICYHOLDER FORMS FOR FILING PROOF OF LOSS.~~

~~(2) IF THE INSURER DOES NOT PROVIDE THE FORMS WITHIN 15 DAYS AFTER NOTICE OF SICKNESS OR INJURY IS GIVEN, THE CLAIMANT IS DEEMED TO HAVE COMPLIED WITH THE REQUIREMENTS OF THE POLICY ON PROOF OF LOSS IF THE CLAIMANT SUBMITS, WITHIN THE TIME FIXED IN THE POLICY FOR FILING PROOF OF LOSS, WRITTEN PROOF OF THE OCCURRENCE, CHARACTER, AND EXTENT OF THE LOSS FOR WHICH THE CLAIM IS MADE.~~

~~(G) (1) EACH POLICY OF GROUP HEALTH INSURANCE SHALL CONTAIN A PROVISION THAT:~~

~~(I) IF A CLAIM IS FOR LOSS OF TIME BECAUSE OF DISABILITY, WRITTEN PROOF OF LOSS MUST BE SUBMITTED TO THE INSURER WITHIN 30 DAYS AFTER THE BEGINNING OF THE PERIOD FOR WHICH THE INSURER IS LIABLE, AND SUBSEQUENT WRITTEN PROOF THAT THE DISABILITY CONTINUES MUST BE SUBMITTED TO THE INSURER AT THE INTERVALS THAT THE INSURER REASONABLY REQUIRES; AND~~

~~(II) IF A CLAIM IS FOR A LOSS OTHER THAN LOSS OF TIME BECAUSE OF DISABILITY, WRITTEN PROOF OF LOSS MUST BE SUBMITTED TO THE INSURER WITHIN 90 DAYS AFTER THE DATE OF THE LOSS.~~

~~(2) FAILURE TO SUBMIT PROOF OF LOSS WITHIN THE TIME REQUIRED DOES NOT INVALIDATE OR REDUCE A CLAIM IF IT IS SHOWN THAT:~~

~~(I) IT WAS NOT REASONABLY POSSIBLE TO SUBMIT THE PROOF OF LOSS WITHIN THE TIME REQUIRED; AND~~

~~(II) PROOF OF LOSS WAS SUBMITTED AS SOON AS WAS REASONABLY POSSIBLE.~~

~~(H) EACH POLICY OF GROUP HEALTH INSURANCE SHALL CONTAIN A PROVISION THAT:~~

~~(1) BENEFITS PAYABLE UNDER THE POLICY, OTHER THAN BENEFITS FOR LOSS OF TIME, ARE PAYABLE IMMEDIATELY ON THE INSURER'S RECEIPT OF WRITTEN PROOF OF LOSS; AND~~

~~(2) SUBJECT TO PROOF OF LOSS:~~

~~(I) ACCRUED BENEFITS PAYABLE UNDER THE POLICY FOR LOSS OF TIME ARE PAYABLE NO LATER THAN AT THE END OF EACH PERIOD OF 30 DAYS DURING THE PERIOD FOR WHICH THE INSURER IS LIABLE; AND~~

~~(II) ANY BALANCE REMAINING UNPAID AT THE END OF THAT PERIOD IS PAYABLE IMMEDIATELY ON THE INSURER'S RECEIPT OF PROOF OF LOSS.~~

~~(I) EACH POLICY OF GROUP HEALTH INSURANCE SHALL CONTAIN A PROVISION THAT, AT ITS OWN EXPENSE, AN INSURER MAY:~~

~~(1) EXAMINE THE PERSON OF THE INSURED WHEN AND AS OFTEN AS THE INSURER MAY REASONABLY REQUIRE DURING THE PENDENCY OF A CLAIM UNDER THE POLICY; AND~~

~~(2) MAKE AN AUTOPSY OF THE INSURED IF NOT PROHIBITED BY LAW.~~

~~(J) EACH POLICY OF GROUP HEALTH INSURANCE SHALL CONTAIN A PROVISION THAT AN ACTION AT LAW OR IN EQUITY MAY NOT BE BROUGHT TO RECOVER UNDER THE POLICY:~~

~~(1) EARLIER THAN 60 DAYS AFTER WRITTEN PROOF OF LOSS IS SUBMITTED IN ACCORDANCE WITH THE REQUIREMENTS OF THE POLICY; OR~~

~~(2) LATER THAN 3 YEARS AFTER THE TIME WRITTEN PROOF OF LOSS IS REQUIRED TO BE SUBMITTED.~~

~~15-303.1.~~

~~(A) (1) EACH POLICY OF GROUP HEALTH INSURANCE SHALL CONTAIN A PROVISION THAT STATES:~~

~~"GRACE PERIOD: A GRACE PERIOD OF 31 DAYS WILL BE GRANTED FOR PAYMENT OF EACH PREMIUM DUE AFTER THE FIRST PREMIUM, UNLESS THE INSURER DOES NOT INTEND TO RENEW THE POLICY BEYOND THE PERIOD FOR WHICH PREMIUM HAS BEEN ACCEPTED AND NOTICE OF THE INTENTION NOT TO RENEW IS DELIVERED TO THE POLICYHOLDER AT LEAST 45 DAYS BEFORE THE PREMIUM IS DUE. DURING THE GRACE PERIOD THE POLICY SHALL CONTINUE IN FORCE."~~

~~(2) ANY ADDITIONAL PROVISIONS RELATED TO THE GRACE PERIOD SHALL BE EXPRESSLY STATED IN THE POLICY SUBJECT TO THE FOLLOWING LIMITATIONS:~~

~~(I) UNLESS AN INSURER RECEIVES A NOTICE OF THE POLICYHOLDER'S INTENTION TO TERMINATE THE POLICY, THE INSURER MAY COLLECT PREMIUM FOR THE 31-DAY GRACE PERIOD;~~

~~(II) IF AN INSURER RECEIVES A NOTICE OF INTENTION TO TERMINATE THE POLICY, THE INSURER MAY COLLECT PREMIUM FOR THE PERIOD BEGINNING ON THE FIRST DAY OF THE GRACE PERIOD UNTIL THE DATE ON WHICH NOTICE IS RECEIVED OR THE DATE OF TERMINATION STATED IN THE NOTICE, WHICHEVER IS LATER;~~

~~(III) IF PREMIUM FOR THE 31-DAY GRACE PERIOD IS PAID AFTER THE GRACE PERIOD ENDS, AN INSURER MAY CHARGE INTEREST FOR THE PREMIUM; AND~~

~~(IV) INTEREST MAY NOT BEGIN TO ACCRUE DURING THE 31-DAY GRACE PERIOD.~~

~~(B) AN INSURER MAY SUBSTITUTE A CORRESPONDING PROVISION WITH WORDING DIFFERENT FROM THAT OF A PROVISION SET FORTH IN THIS SECTION IF THE CORRESPONDING PROVISION IS:~~

~~(1) APPROVED BY THE COMMISSIONER; AND~~

~~(2) AT LEAST AS FAVORABLE TO THE INSURED OR BENEFICIARY.~~

~~15-303.2.~~

~~(A) (1) A POLICY OF GROUP HEALTH INSURANCE MAY CONTAIN THE FOLLOWING PROVISION:~~

~~"ILLEGAL OCCUPATION: THE INSURER SHALL NOT BE LIABLE FOR ANY LOSS TO WHICH A CONTRIBUTING CAUSE WAS THE INSURED'S COMMISSION OF OR ATTEMPT TO COMMIT A FELONY OR TO WHICH A CONTRIBUTING CAUSE WAS THE INSURED'S BEING ENGAGED IN AN ILLEGAL OCCUPATION."~~

~~(2) A POLICY OF GROUP HEALTH INSURANCE MAY CONTAIN THE FOLLOWING PROVISION:~~

~~"INTOXICANTS AND NARCOTICS: THE INSURER SHALL NOT BE LIABLE FOR ANY LOSS SUSTAINED OR CONTRACTED IN CONSEQUENCE OF THE INSURED'S BEING INTOXICATED OR UNDER THE INFLUENCE OF ANY NARCOTIC UNLESS ADMINISTERED ON THE ADVICE OF A PHYSICIAN."~~

~~(B) AN INSURER MAY SUBSTITUTE A CORRESPONDING PROVISION WITH WORDING DIFFERENT FROM THAT OF A PROVISION SET FORTH IN THIS SECTION IF THE CORRESPONDING PROVISION IS:~~

~~(1) APPROVED BY THE COMMISSIONER; AND~~

~~(2) AT LEAST AS FAVORABLE TO THE INSURED OR BENEFICIARY.~~

~~15-307.~~

~~(a) Each policy of blanket health insurance shall contain provisions that in the opinion of the Commissioner are at least as favorable to the policyholder and insured as the provisions of this section.~~

~~(b) Each policy of blanket health insurance shall contain a provision that:~~

~~(1) the policy and application constitute the entire contract between the parties;~~

~~(2) absent fraud, each statement made by the policyholder is considered to be a representation and not a warranty; and~~

~~(3) a statement made by the policyholder may not be used in defense to a claim under the policy unless the statement is contained in a written application.~~

~~(c) (1) Each policy of blanket health insurance shall contain a provision that written notice of sickness or injury must be given to the insurer within 20 days after the date on which the sickness or injury occurred.~~

~~(2) Failure to give notice within the 20-day period does not invalidate or reduce a claim if it is shown that it was not reasonably possible to give notice within the time required, and that notice was given as soon as was reasonably possible.~~

~~(d) (1) Each policy of blanket health insurance shall contain a provision that the insurer shall provide to the policyholder forms for filing proof of loss.~~

~~(2) If the insurer does not provide the forms within 15 days after notice of sickness or injury is given, the claimant is deemed to have complied with the requirements of the policy on proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.~~

~~(e) (1) Each policy of blanket health insurance shall contain a provision that:~~

~~(i) if a claim is for loss of time because of disability, written proof of loss must be submitted to the insurer within 30 days after the beginning of the period for which the insurer is liable, and subsequent written proofs that the disability continues must be submitted to the insurer at the intervals that the insurer reasonably requires; and~~

~~(ii) if a claim is for a loss other than loss of time because of disability, written proof of loss must be submitted to the insurer within 90 days after the date of the loss.~~

~~(2) Failure to submit proof of loss within the time required does not invalidate or reduce a claim if it is shown that it was not reasonably possible to~~

~~submit the proof of loss within the time required, and that proof of loss was submitted as soon as was reasonably possible.~~

~~(f) Each policy of blanket health insurance shall contain a provision that:~~

~~(1) benefits payable under the policy, other than benefits for loss of time, are payable immediately on the insurer's receipt of written proof of loss; and~~

~~(2) subject to proof of loss:~~

~~(i) accrued benefits payable under the policy for loss of time are payable no later than at the end of each period of 30 days during the period for which the insurer is liable; and~~

~~(ii) any balance remaining unpaid at the end of that period is payable immediately on the insurer's receipt of proof of loss.~~

~~(g) Each policy of blanket health insurance shall contain a provision that at its own expense, the insurer may examine the person of the insured when and as often as the insurer may reasonably require during the pendency of a claim under the policy and may make an autopsy of the insured if not prohibited by law.~~

~~(h) Each policy of blanket health insurance shall contain a provision that an action at law or in equity may not be brought to recover under the policy:~~

~~(1) earlier than 60 days after written proof of loss is submitted in accordance with the requirements of the policy; or~~

~~(2) later than 3 years after the time written proof of loss is required to be submitted.~~

~~15-307.1.~~

~~(A) EACH POLICY OF BLANKET HEALTH INSURANCE SHALL CONTAIN THE FOLLOWING PROVISION:~~

~~"GRACE PERIOD: IF NOT LESS THAN 30 DAYS BEFORE THE PREMIUM DUE DATE, THE INSURER HAS DELIVERED TO THE POLICYHOLDER WRITTEN NOTICE OF ITS INTENTION NOT TO RENEW THE POLICY BEYOND THE PERIOD FOR WHICH THE PREMIUM HAS BEEN ACCEPTED, A GRACE PERIOD OF 31 DAYS WILL BE GRANTED FOR THE PAYMENT OF EACH PREMIUM FALLING DUE AFTER THE FIRST PREMIUM. DURING THE GRACE PERIOD, THIS POLICY SHALL CONTINUE IN FORCE. THE POLICYHOLDER WILL BE LIABLE FOR THE PREMIUM FOR THE PERIOD THE POLICY REMAINS IN FORCE DURING THE GRACE PERIOD."~~

~~(B) ANY ADDITIONAL PROVISIONS RELATED TO A GRACE PERIOD SHALL BE EXPRESSLY STATED IN THE POLICY SUBJECT TO THE FOLLOWING LIMITATIONS:~~

~~(1) UNLESS AN INSURER RECEIVES NOTICE OF THE POLICYHOLDER'S INTENTION TO TERMINATE A POLICY, THE INSURER MAY COLLECT PREMIUM FOR THE 31-DAY GRACE PERIOD;~~

~~(2) IF THE INSURER RECEIVES A NOTICE OF INTENTION TO TERMINATE A POLICY, THE INSURER MAY COLLECT PREMIUM FROM THE FIRST DAY OF THE GRACE PERIOD UNTIL THE LATER OF:~~

~~(I) THE DAY NOTICE IS RECEIVED; OR~~

~~(II) THE DATE OF TERMINATION STATED IN THE NOTICE;~~

~~(3) IF PREMIUM FOR THE 31-DAY GRACE PERIOD IS PAID AFTER THE GRACE PERIOD ENDS, THE INSURER MAY CHARGE INTEREST ON THE PREMIUM; AND~~

~~(4) INTEREST MAY NOT BEGIN TO ACCRUE DURING THE 31-DAY GRACE PERIOD.~~

~~(C) AN INSURER MAY SUBSTITUTE A CORRESPONDING PROVISION WITH WORDING DIFFERENT FROM THAT OF A PROVISION SET FORTH IN THIS SECTION IF THE CORRESPONDING PROVISION IS:~~

~~(1) APPROVED BY THE COMMISSIONER; AND~~

~~(2) AT LEAST AS FAVORABLE TO THE INSURED OR BENEFICIARY.~~

~~15-307.2.~~

~~(A) A POLICY OF BLANKET HEALTH INSURANCE MAY CONTAIN THE FOLLOWING PROVISION:~~

~~"ILLEGAL OCCUPATION: THE INSURER SHALL NOT BE LIABLE FOR ANY LOSS TO WHICH A CONTRIBUTING CAUSE WAS THE INSURED'S COMMISSION OF OR ATTEMPT TO COMMIT A FELONY OR TO WHICH A CONTRIBUTING CAUSE WAS THE INSURED'S BEING ENGAGED IN AN ILLEGAL OCCUPATION."~~

~~(B) A POLICY OF BLANKET HEALTH INSURANCE MAY CONTAIN THE FOLLOWING PROVISION:~~

~~"INTOXICANTS AND NARCOTICS: THE INSURER SHALL NOT BE LIABLE FOR ANY LOSS SUSTAINED OR CONTRACTED IN CONSEQUENCE OF THE INSURED'S BEING INTOXICATED OR UNDER THE INFLUENCE OF ANY NARCOTIC UNLESS ADMINISTERED ON THE ADVICE OF A PHYSICIAN."~~

~~(C) AN INSURER MAY SUBSTITUTE A CORRESPONDING PROVISION WITH WORDING DIFFERENT FROM THAT OF A PROVISION SET FORTH IN THIS SECTION IF THE CORRESPONDING PROVISION IS:~~

~~(1) APPROVED BY THE COMMISSIONER; AND~~

~~(2) AT LEAST AS FAVORABLE TO THE INSURED OR BENEFICIARY.~~

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 15-303 and 15-307 of Article - Insurance of the Annotated Code of Maryland be repealed.

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

**Article - Health - General**

19-706.

(i) The provisions of §§ 12-203(G), 15-105, 15-112, 15-113, 15-804, 15-812, 15-826, and 15-828 of the Insurance Article shall apply to health maintenance organizations.

**Article - Insurance**

12-203.

(G) BY REGULATION, THE COMMISSIONER SHALL ADOPT THE LANGUAGE AND FORMAT FOR STANDARD PROVISIONS REQUIRED UNDER § 12-102(A) OF THIS TITLE FOR CONTRACTS AND POLICIES ISSUED BY INSURERS, NONPROFIT HEALTH SERVICE PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS.

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

***Article - Insurance***

*15-126.*

*(A) THERE IS A TASK FORCE TO STUDY THE NON-GROUP HEALTH INSURANCE MARKET.*

*(B) THE TASK FORCE CONSISTS OF THE FOLLOWING MEMBERS:*

*(1) A MEMBER OF THE HOUSE OF DELEGATES, APPOINTED BY THE SPEAKER OF THE HOUSE;*

*(2) A MEMBER OF THE SENATE, APPOINTED BY THE PRESIDENT OF THE SENATE;*

*(3) THE COMMISSIONER;*

*(4) THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION;*

*(5) THE EXECUTIVE DIRECTOR OF THE HEALTH SERVICES COST REVIEW COMMISSION;*

*(6) A REPRESENTATIVE OF AN INSURER THAT MARKETS INDIVIDUAL POLICIES IN THE STATE, APPOINTED BY THE COMMISSIONER;*

*(7) A REPRESENTATIVE OF AN INSURER THAT MARKETS SMALL GROUP POLICIES IN THE STATE, APPOINTED BY THE COMMISSIONER;*

*(8) A REPRESENTATIVE OF A HEALTH MAINTENANCE ORGANIZATION THAT MARKETS INDIVIDUAL POLICIES IN THE STATE, APPOINTED BY THE COMMISSIONER;*

*(9) A REPRESENTATIVE OF A HEALTH MAINTENANCE ORGANIZATION THAT MARKETS SMALL GROUP POLICIES IN THE STATE, APPOINTED BY THE COMMISSIONER;*

*(10) A REPRESENTATIVE OF THE MARYLAND ASSOCIATION OF LIFE UNDERWRITERS OR THE MARYLAND ASSOCIATION OF HEALTH UNDERWRITERS, APPOINTED BY THE COMMISSIONER;*

*(11) A CONSUMER REPRESENTATIVE WHO HAS HEALTH INSURANCE COVERAGE WITH A CARRIER OPERATING IN THE INDIVIDUAL MARKET, APPOINTED BY THE COMMISSIONER;*

*(12) A REPRESENTATIVE OF MHA: THE ASSOCIATION OF MARYLAND HOSPITALS AND HEALTH SYSTEMS, APPOINTED BY THE COMMISSIONER; AND*

*(13) TWO MEMBERS OF THE GENERAL PUBLIC WITH EXPERIENCE OR KNOWLEDGE OF HEALTH INSURANCE, APPOINTED BY THE COMMISSIONER.*

*(C) THE TASK FORCE SHALL BE JOINTLY CHAIRED BY THE COMMISSIONER AND THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION.*

*(D) THE TASK FORCE SHALL REVIEW AND STUDY THE CHARACTERISTICS OF THE NON-GROUP MARKET, INCLUDING:*

*(1) AN ANALYSIS AND SURVEY OF NON-GROUP PRODUCTS AVAILABLE IN THE STATE;*

*(2) THE DEMOGRAPHICS OF THOSE INSURED IN THE NON-GROUP MARKET;*

*(3) THE AFFORDABILITY OF NON-GROUP PRODUCTS AND PRICING CONSIDERATIONS IN THE NON-GROUP MARKET; AND*

*(4) TRENDS IN PREMIUM COSTS FOR NON-GROUP PRODUCTS.*

*(E) BASED ON ITS ANALYSIS OF THE NON-GROUP MARKET, THE TASK FORCE SHALL RECOMMEND WHETHER CHANGES SHOULD BE MADE TO STATE LAWS GOVERNING THE NON-GROUP MARKET, TAKING INTO ACCOUNT AND EXAMINING ISSUES RELATED TO:*

*(1) THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1997;*

*(2) THE SUBSTANTIAL, AVAILABLE, AND AFFORDABLE COVERAGE PROGRAM;*

*(3) THE SMALL GROUP MARKET PLAN;*

*(4) HEALTH INSURANCE COVERAGE FOR SELF-EMPLOYED AND PART-TIME INDIVIDUALS;*

*(5) SUPPLEMENTAL POLICIES, INCLUDING STANDARDIZED AND PRESTANDARDIZED PRODUCTS, FOR MEDICARE;*

*(6) THE CREATION OF HIGH-RISK POOLS;*

*(7) CROSS-SUBSIDIZATION BETWEEN GROUP AND NON-GROUP PRODUCTS; AND*

*(8) PROVIDING INDIVIDUALS WITH INSURANCE THROUGH A LIST BILLING MECHANISM PROVIDED ON A PRETAX DOLLAR BASIS.*

*(F) A MEMBER OF THE TASK FORCE:*

*(1) MAY NOT RECEIVE COMPENSATION FOR SERVICE ON THE TASK FORCE; BUT*

*(2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.*

*(G) THE ADMINISTRATION AND THE MARYLAND HEALTH CARE ACCESS AND COST COMMISSION SHALL PROVIDE STAFF SUPPORT FOR THE TASK FORCE.*

*(H) THE TASK FORCE SHALL SUBMIT A PRELIMINARY REPORT ON ITS FINDINGS AND RECOMMENDATIONS TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY ON OR BEFORE DECEMBER 15, 1999 AND A FINAL REPORT IN THE SAME MANNER ON OR BEFORE DECEMBER 15, 2000.*

*SECTION 4. AND BE IT FURTHER ENACTED, That the implementation of a substantial, available, and affordable coverage product in a form other than that which was required or approved on July 1, 1998 shall be suspended until after the Task Force to Study the Non-Group Health Insurance Market, established under § 15-126 of the Insurance Article, as enacted by Section 3 of this Act, issues the preliminary report required under § 15-126.*

SECTION ~~3.~~ *5.* AND BE IT FURTHER ENACTED, That the regulations required under § 12-203(g) of the Insurance Article, as enacted by Section 2 of this Act, shall be submitted to the Administrative, Executive, and Legislative Review Committee by January 1, 2000.

SECTION ~~4.~~ *6.* AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect on the date that regulations adopted in accordance with this Act take effect. The Maryland Insurance Commissioner, in writing, shall certify to the House Economic Matters Committee, the Senate Finance Committee, and the Department of Legislative Services the date on which the regulations take effect.

*SECTION 7. AND BE IT FURTHER ENACTED, That Sections 3 and 4 of this Act shall take effect June 1, 1999.*

SECTION ~~2.~~ ~~5.~~ *8.* AND BE IT FURTHER ENACTED, That, subject to ~~Section 4~~ *Sections 6 and 7* of this Act, this Act shall take effect October 1, 1999.