Unofficial Copy **2000 Regular Session**
SB0863/853092/1

BY: Economic Matters Committee

AMENDMENTS TO SENATE BILL NO. 863
(Third Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, strike "Children and Families Health Care Program" and substitute "Children's Health Program Expansion Act of 2000"; strike beginning with "altering" in line 3 down through "Program" in line 7, and substitute "expanding eligibility for the Children and Families Health Care Program to certain individuals under a private option plan; requiring that certain individuals enrolled in the Program receive health benefits through an employer-sponsored health benefit plan or a certain managed care organization; establishing certain criteria for approval of a certain employer-sponsored health benefit plan; providing that certain individuals enrolled in the Program receive health benefits through certain managed care organizations; requiring the Department of Health and Mental Hygiene to perform certain administrative duties; requiring certain parents and guardians to pay a certain family contribution; changing the name of the Children and Families Health Care Program; providing that certain individuals are exempt from certain enrollment restrictions; authorizing the Department to disapprove a certain application if the applicant was covered by certain insurance that was voluntarily terminated within a certain time frame; specifying that certain benefits offered under a certain employer-sponsored health benefit plan are subject to certain requirements; specifying that certain carriers that offer certain benefits are required to offer the benefits only to certain employers; making certain stylistic and technical changes; providing for the effective dates of this Act; defining certain terms; providing for delayed effective dates for portions of this Act; and generally relating to health insurance coverage for children"; and strike in their entirety lines 8 through 12, inclusive, and substitute:

"BY repealing
Article - Health - General
Section 15-301(e)
Annotated Code of Maryland
(1994 Replacement Volume and 1999 Supplement)

(Over)

BY adding to

Article - Health - General

Section 15-301.1

Annotated Code of Maryland

(1994 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,

Article - Health - General

Section 15-301 to be under the amended subtitle "Subtitle 3. Maryland Children's Health Program"

Annotated Code of Maryland

(1994 Replacement Volume and 1999 Supplement)

(As enacted by Section 1 of this Act)

BY repealing and reenacting, with amendments,

Article - Health - General

Section 15-101(f) and 15-302 through 15-304

Annotated Code of Maryland

(1994 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, without amendments,

Article - Health - General

Section 15-305

Annotated Code of Maryland

(1994 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,

Article - Insurance

Section 15-1208, 15-1213, 15-1406, and 27-220

Annotated Code of Maryland

(1997 Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,

Article - Health - General

Section 15-302(b)

Annotated Code of Maryland

(1994 Replacement Volume and 1999 Supplement)
(As enacted by Section 2 of this Act)".

AMENDMENT NO. 2

On pages 1 and 2, strike in their entirety the lines beginning with line 17 on page 1 through line 34 on page 2, inclusive, and substitute:

"[(e) (1) In this subsection, "family contribution" means the portion of the premium cost paid by an eligible individual to enroll and participate in the Children and Families Health Care Program.

(2) On or before July 1, 2000 and in addition to any other requirements of this subtitle, as a requirement to enroll and maintain participation in the Children and Families Health Care Program, an individual's parent or guardian shall agree to pay an annual family contribution amount determined by the Department in accordance with paragraph (3) of this subsection.

(3) (i) For eligible individuals whose family income is at or above 185 percent of the federal poverty level, the Department shall develop an annual family contribution amount payment system such that the cost of the family contribution is at least 1 percent of the annual family income but does not exceed 2 percent of the annual family income.

(ii) The Department shall determine by regulation the schedules and the method of collection for the family contribution amount under subparagraph (i) of this paragraph.

(iii) Before collecting a family contribution from any individual, the Department shall provide the individual with notice of the requirements of the family contribution amount and the options available to the individual to make premium payments.]

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

Article - Health - General

15-101.

(f) "Managed care organization" means:

(1) A certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; or

(2) A corporation that:

(i) Is a managed care system that is authorized to receive medical assistance prepaid capitation payments;

(ii) Enrolls only program recipients or individuals or families served under the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM; and

(iii) Is subject to the requirements of § 15-102.4 of this title.

Subtitle 3. [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM.

15-301.

(a) [In this section, "carrier" means:

(1) An insurer;

(2) A nonprofit service plan;

(3) A health maintenance organization; or

(4) Any other person that provides health benefit plans subject to regulation by the State.

(b)] There is a [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM.

[(c)] (B) The [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM shall provide, subject to the limitations of the State budget and any other requirements imposed by the State and as permitted by federal law or waiver, comprehensive medical care and other health care services to an individual who has a family income at or below [200] 300 percent of the federal poverty [level] GUIDELINES and who is under the age of 19 years.

[(d)] (C) The [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM shall be administered [through]:

(1) FOR INDIVIDUALS WHOSE FAMILY INCOME IS AT OR BELOW 200 PERCENT OF THE FEDERAL POVERTY GUIDELINES, THROUGH the program under Subtitle 1 of this title requiring individuals to enroll in managed care organizations; OR

(2) FOR ELIGIBLE INDIVIDUALS WHOSE FAMILY INCOME IS 200 PERCENT, BUT AT OR BELOW 300 PERCENT OF THE FEDERAL POVERTY GUIDELINES, THROUGH THE MCHP PRIVATE OPTION PLAN UNDER § 15-301.1 OF THIS SUBTITLE.

15-301.1.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION; OR

(IV) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(3) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL WHO QUALIFIES TO PARTICIPATE IN THE MARYLAND CHILDREN'S HEALTH PROGRAM UNDER § 15-301(B) OF THIS SUBTITLE AND WHOSE FAMILY INCOME IS ABOVE 200 PERCENT, BUT AT OR BELOW 300 PERCENT OF THE FEDERAL POVERTY GUIDELINES.

(4) "FAMILY CONTRIBUTION" MEANS THE PORTION OF THE PREMIUM COST PAID FOR AN ELIGIBLE INDIVIDUAL TO ENROLL AND PARTICIPATE IN THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(5) "MCHP PRIVATE OPTION PLAN" MEANS THE PLAN ESTABLISHED UNDER THIS SECTION TO PROVIDE ACCESS TO HEALTH INSURANCE COVERAGE TO ELIGIBLE INDIVIDUALS THROUGH EMPLOYER-SPONSORED HEALTH BENEFIT PLANS AND MANAGED CARE ORGANIZATIONS UNDER THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(B) THIS SECTION APPLIES ONLY TO INDIVIDUALS WHOSE FAMILY INCOME IS ABOVE 200 PERCENT, BUT AT OR BELOW 300 PERCENT OF THE FEDERAL POVERTY GUIDELINES.

(C) (1) AN ELIGIBLE INDIVIDUAL WHO IS ENROLLED IN THE MCHP PRIVATE OPTION PLAN SHALL BE INSURED THROUGH AN EMPLOYER'S HEALTH BENEFIT PLAN IF:

(I) THE EMPLOYER OFFERS FAMILY HEALTH INSURANCE COVERAGE TO THE PARENT OR GUARDIAN OF AN ELIGIBLE INDIVIDUAL;

(II) THE EMPLOYER ELECTS TO PARTICIPATE IN THE MCHP PRIVATE OPTION PLAN;

(III) THE PARENT OR GUARDIAN OF AN ELIGIBLE INDIVIDUAL IS INSURED UNDER THE EMPLOYER-SPONSORED HEALTH BENEFIT PLAN;

(IV) THE EMPLOYER CONTRIBUTES TO FAMILY HEALTH INSURANCE COVERAGE AT A RATE NO LESS THAN 50 PERCENT OF ANNUAL PREMIUMS;

(V) THE PLAN INCLUDES A BENEFIT PACKAGE THAT IS DETERMINED BY THE DEPARTMENT TO BE AT LEAST EQUIVALENT TO THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ESTABLISHED UNDER § 15-1207 OF THE INSURANCE ARTICLE; AND

(VI) THE PLAN DOES NOT IMPOSE COST-SHARING REQUIREMENTS ON ELIGIBLE INDIVIDUALS.

(2) IF AN EMPLOYER-SPONSORED HEALTH BENEFIT PLAN THAT MEETS THE CRITERIA UNDER PARAGRAPH (1) OF THIS SUBSECTION IS NOT AVAILABLE TO THE ELIGIBLE INDIVIDUAL, THE ELIGIBLE INDIVIDUAL SHALL BE INSURED THROUGH A MANAGED CARE ORGANIZATION AS DEFINED IN § 15-101(F) OF THIS TITLE.

(D) THE DEPARTMENT SHALL FACILITATE COVERAGE OF ELIGIBLE INDIVIDUALS UNDER AN EMPLOYER-SPONSORED HEALTH BENEFIT PLAN BY:

(1) EVALUATING EMPLOYER-SPONSORED HEALTH BENEFIT PLANS TO DETERMINE WHETHER SPECIFIC PLANS MEET APPLICABLE STATE AND FEDERAL REQUIREMENTS;

(2) ASSISTING EMPLOYERS THAT WISH TO PARTICIPATE IN THE MCHP PRIVATE OPTION PLAN TO MEET THE ELIGIBILITY CRITERIA ESTABLISHED UNDER SUBSECTION (C) OF THIS SECTION;

(3) COLLECTING THE FAMILY CONTRIBUTION UNDER SUBSECTION (E) OF THIS SECTION;

(4) FORWARDING THE FAMILY CONTRIBUTION AND THE STATE'S PORTION OF THE PREMIUM DIRECTLY TO THE CARRIER; AND

(5) ASSISTING EMPLOYERS IN ENROLLING THE ELIGIBLE DEPENDENTS OF EMPLOYEES IN THE EMPLOYER-SPONSORED HEALTH BENEFIT PLAN.

(E) (1) AS A REQUIREMENT OF ENROLLMENT AND PARTICIPATION IN THE MCHP PRIVATE OPTION PLAN, THROUGH EITHER AN EMPLOYER-SPONSORED HEALTH BENEFIT PLAN OR A MANAGED CARE ORGANIZATION, THE PARENT OR GUARDIAN OF AN ELIGIBLE INDIVIDUAL SHALL AGREE TO PAY THE FOLLOWING ANNUAL FAMILY CONTRIBUTION:

(I) FOR AN ELIGIBLE INDIVIDUAL WHOSE FAMILY INCOME IS ABOVE 200 PERCENT, BUT AT OR BELOW 250 PERCENT OF THE FEDERAL POVERTY GUIDELINES, AN AMOUNT EQUAL TO 2 PERCENT OF THE ANNUAL INCOME OF A FAMILY OF TWO AT 200 PERCENT OF THE FEDERAL POVERTY GUIDELINES; AND

(II) FOR AN ELIGIBLE INDIVIDUAL WHOSE FAMILY INCOME IS ABOVE 250 PERCENT, BUT AT OR BELOW 300 PERCENT OF THE FEDERAL POVERTY GUIDELINES, AN AMOUNT EQUAL TO 2 PERCENT OF THE ANNUAL INCOME OF A FAMILY OF TWO AT 250 PERCENT OF THE FEDERAL POVERTY GUIDELINES.

(2) THE FAMILY CONTRIBUTION AMOUNTS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION APPLY ON A PER FAMILY BASIS REGARDLESS OF THE NUMBER OF ELIGIBLE INDIVIDUALS EACH FAMILY HAS ENROLLED IN THE MCHP PRIVATE OPTION PLAN.

(F) THE DEPARTMENT SHALL ADOPT REGULATIONS NECESSARY TO IMPLEMENT THIS SECTION.

15-302.

(a) (1) The Department shall monitor applications to determine whether employers and employees have voluntarily terminated coverage under an employer sponsored health benefit

plan that included dependent coverage in order to participate in the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle.

(2) The Department, in particular, shall review applications of individuals who qualified for Program benefits under the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle.

(b) (1) An application may be disapproved if it is determined that an individual under the age of 19 years to be covered under the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM [established under § 15-301 of this subtitle], for whom the application was submitted, was covered by an employer sponsored health benefit plan with dependent coverage which was voluntarily terminated [within]:

(I) WITHIN 6 months preceding the date of the application OF AN INDIVIDUAL AT OR BELOW 200 PERCENT OF THE FEDERAL POVERTY GUIDELINES; OR

(II) WITHIN 12 MONTHS PRECEDING THE DATE OF THE APPLICATION OF AN INDIVIDUAL ABOVE 200 PERCENT, BUT AT OR BELOW 300 PERCENT OF THE FEDERAL POVERTY GUIDELINES.

(2) In determining whether an applicant has voluntarily terminated coverage under an employer sponsored health benefit plan for purposes of paragraph (1) of this subsection, a voluntary termination may not be construed to include:

(i) Loss of employment due to factors other than voluntary termination;

(ii) Change to a new employer that does not provide an option for dependent coverage;

(iii) Change of address so that no employer sponsored health benefit plan is available;

(iv) Discontinuation of health benefits to all dependents of employees of the applicant's employer; or

(v) Expiration of the applicant's continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

15-303.

(a) (1) The Department shall be responsible for enrolling program recipients [into] IN managed care organizations AND EMPLOYER-SPONSORED HEALTH BENEFIT PLANS under the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle.

(2) The Department may contract with an entity to perform any part or all of its enrollment responsibilities under paragraph (1) of this subsection.

(3) The Department or its enrollment contractor, to the extent feasible in its marketing, outreach, and enrollment programs, shall hire individuals receiving assistance under the Family Investment Program established under Article 88A of the Code.

(b) (1) To the extent allowed under federal law and regulations, the Secretary shall implement expedited eligibility for any individual who applies for the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle.

(2) The Secretary shall designate organizations that may:

(i) Assist individuals in the application process; and

(ii) Perform other outreach functions.

(3) In designating the organizations under paragraph (2) of this subsection, the Secretary shall ensure the inclusion of statewide and local organizations that provide services to

children of all ages in each region of the State, and shall provide such organizations with:

(i) Forms that are necessary for parents, guardians, and other individuals to submit applications to the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM on behalf of a child; and

(ii) Information on how to assist parents, guardians, and other individuals in completing and filing such applications.

15-304.

(a) (1) For purposes of increasing the number of eligible individuals who enroll in the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle, the Department shall develop and implement a school-based outreach program.

(2) As appropriate to carry out its responsibilities under paragraph (1) of this subsection, the Department may enter into contracts with county boards of education to provide information at public schools on the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle.

(b) (1) For purposes of this subsection, "community-based organization" includes day care centers, schools, and school-based health clinics.

(2) In addition to the school-based outreach program established under subsection (a) of this section, the Department, in consultation with the Maryland Medicaid Advisory Committee established under § 15-103(b) of this title, shall develop mechanisms for outreach for the program with a special emphasis on identifying children who may be eligible for program benefits under the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under [§ 15-301] §§ 15-301 AND 15-301.1 of this subtitle.

(3) From the mechanisms to be developed for outreach under paragraph (2) of this subsection, one mechanism shall include the development and dissemination of mail-in applications

and appropriate outreach materials through community-based organizations, community-based providers, the Office of the State Comptroller, the Departments of Human Resources and Health and Mental Hygiene, county boards of education, and any other appropriate State agency or unit the Department considers appropriate.

15-305.

The purpose of the Health Care Foundation under this section is to:

(1) Develop programs to expand the availability of health insurance coverage to low-income, uninsured children;

(2) Involve the private health insurance market in the delivery of health insurance coverage to low-income, uninsured children in the State and their families;

(3) Identify and aggressively pursue a mix of State, federal, and private funds, including grants, to enable the Foundation to provide and fund health care insurance coverage;

(4) Develop methods to minimize the effect of employers or employees terminating employer sponsored health insurance or privately purchased health care insurance; and

(5) Coordinate its activities with the other necessary entities in order to address the health care needs of the low-income, uninsured children of the State and their families.

Article - Insurance

15-1208.

(a) (1) A carrier may not limit coverage under a health benefit plan for a preexisting condition.

(2) An exclusion of coverage for preexisting conditions may not be applied to health care services furnished for pregnancy or newborns.

(b) (1) This subsection does not apply to a late enrollee if:

(i) the individual requests enrollment within 30 days after becoming an eligible employee;

(ii) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefit plan; [or]

(iii) a request for enrollment is made within 30 days after the eligible employee's marriage or the birth or adoption of a child; OR

(IV) THE INDIVIDUAL OR A FAMILY MEMBER OF THE INDIVIDUAL WHO IS ELIGIBLE FOR ENROLLMENT UNDER § 15-301.1 OF THE HEALTH - GENERAL ARTICLE REQUESTS ENROLLMENT WITHIN 30 DAYS AFTER BECOMING ELIGIBLE.

(2) Notwithstanding subsection (a) of this section, a late enrollee may be subject to a 12-month preexisting condition provision or a waiting period until the next open enrollment period not to exceed a 12-month period.

(c) [A] EXCEPT AS PROVIDED IN SUBSECTION (E) OF THIS SECTION, A health benefit plan that does not use a preexisting condition provision may impose on enrollees:

(1) a waiting period not to exceed 90 days; or

(2) for 1 year, a surcharge not to exceed 1.5 times the community rate established in accordance with § 15-1205 of this subtitle.

(d) [For] EXCEPT AS PROVIDED IN SUBSECTION (E) OF THIS SECTION, FOR a period not to exceed 6 months after the date an individual becomes an eligible employee, a health benefit plan may require deductibles and cost-sharing for benefits for a preexisting condition of the eligible employee in amounts not exceeding 1.5 times the amount of the standard deductibles and cost-sharing of other eligible employees if:

(1) the employee was not previously covered by a public or private plan of health insurance or another health benefit arrangement; and

(2) the employee was not previously employed by that employer.

(E) SUBSECTIONS (C) AND (D) OF THIS SECTION DO NOT APPLY TO AN INDIVIDUAL OR A FAMILY MEMBER OF AN INDIVIDUAL WHO IS ELIGIBLE FOR ENROLLMENT IN THE MCHP PRIVATE OPTION PLAN ESTABLISHED UNDER § 15-301.1 OF THE HEALTH - GENERAL ARTICLE AND IS A LATE ENROLLEE.

15-1213.

(a) This section does not apply to any insurance enumerated in § 15-1201(f)(3)(i) through (xiii) of this subtitle.

(b) Each benefit offered in addition to the Standard Plan that increases access to care choices or lowers the cost-sharing arrangement in the Standard Plan is subject to all of the provisions of this subtitle applicable to the Standard Plan, including:

(1) guaranteed issuance;

(2) guaranteed renewal;

(3) adjusted community rating; and

(4) the prohibition on preexisting condition limitations.

(c) (1) Each benefit offered in addition to the Standard Plan that increases the type of services available or the frequency of services is not subject to guaranteed issuance but is subject to all other provisions of this subtitle applicable to the Standard Plan, including:

(i) guaranteed renewal;

(ii) adjusted community rating; and

(iii) the prohibition on preexisting condition limitations.

(2) For each additional benefit offered under this subsection, a carrier shall accept or reject the application of the entire group.

(3) The Commissioner may prohibit a carrier from offering an additional benefit under this subsection if the Commissioner finds that the additional benefit will be sold in conjunction with the Standard Plan in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this subtitle.

(D) (1) A BENEFIT OFFERED IN ADDITION TO THE STANDARD PLAN TO LOWER THE COST-SHARING ARRANGEMENT IN THE STANDARD PLAN IN ACCORDANCE WITH § 15-301.1 OF THE HEALTH - GENERAL ARTICLE IS SUBJECT TO:

(I) GUARANTEED ISSUANCE;

(II) GUARANTEED RENEWAL;

(III) ADJUSTED COMMUNITY RATING; AND

(IV) THE PROHIBITION ON PREEXISTING CONDITION LIMITATIONS.

(2) A CARRIER THAT OFFERS A BENEFIT UNDER THIS SUBSECTION SHALL BE REQUIRED TO GUARANTEE ISSUANCE AND GUARANTEE RENEWAL OF THE ADDITIONAL BENEFIT ONLY TO EMPLOYERS WHO ARE PARTICIPATING IN THE MCHP PRIVATE OPTION PLAN ESTABLISHED UNDER § 15-301.1 OF THE HEALTH - GENERAL ARTICLE.

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.

(E) A CARRIER SHALL ALLOW AN EMPLOYEE OR DEPENDENT WHO IS ELIGIBLE, BUT NOT ENROLLED, FOR COVERAGE UNDER THE TERMS OF A GROUP HEALTH BENEFIT PLAN TO ENROLL FOR COVERAGE UNDER THE TERMS OF THE PLAN IF THE EMPLOYEE OR DEPENDENT REQUESTS ENROLLMENT WITHIN 30 DAYS AFTER THE EMPLOYEE OR DEPENDENT IS DETERMINED TO BE ELIGIBLE FOR COVERAGE UNDER THE MCHP PRIVATE OPTION PLAN IN ACCORDANCE WITH § 15-301.1 OF THE HEALTH - GENERAL ARTICLE.

27-220.

An agent, broker, or insurer may not refer an individual employee or dependent of an employee to the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under Title 15, Subtitle 3 of the Health - General Article or arrange for an individual employee or dependent of an employee to apply for the [Children and Families Health Care Program] MARYLAND CHILDREN'S HEALTH PROGRAM established under Title 15, Subtitle 3 of the Health - General Article if the agent, broker, or insurer has an economic interest in the referral or the arrangement and the agent's, broker's, or insurer's sole purpose is to separate that employee or that employee's dependent from group health insurance coverage provided in connection with the employee's employment.

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

Article - Health - General

15-302.

(b) (1) An application may be disapproved if it is determined that an individual under the age of 19 years to be covered under the Maryland Children's Health Program, for whom the application was submitted, was covered by an employer sponsored health benefit plan with

dependent coverage which was voluntarily terminated[:

(i) within] WITHIN 6 months preceding the date of the application [of an individual at or below 200 percent of the Federal Poverty Guidelines; or

(ii) within 12 months preceding the date of the application of an individual above 200 percent, but at or below 300 percent of the Federal Poverty Guidelines].

(2) In determining whether an applicant has voluntarily terminated coverage under an employer sponsored health benefit plan for purposes of paragraph (1) of this subsection, a voluntary termination may not be construed to include:

(i) Loss of employment due to factors other than voluntary termination;

(ii) Change to a new employer that does not provide an option for dependent coverage;

(iii) Change of address so that no employer sponsored health benefit plan is available;

(iv) Discontinuation of health benefits to all dependents of employees of the applicant's employer; or

(v) Expiration of the applicant's continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

SECTION 4. AND BE IT FURTHER ENACTED, That the publisher of the Annotated Code of Maryland, subject to the approval of the Department of Legislative Services, shall correct any references to the Children and Families Health Care Program throughout the Code that are rendered incorrect by this Act.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect June 1, 2000.

SECTION 6. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect July 1, 2003.

SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Sections 5 and 6 of this Act, this Act shall take effect July 1, 2001.".