HOUSE BILL 91

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(PRE-FILED)

By: **Chairman, Economic Matters Committee (Departmental - Insurance Administration, Maryland)**
Requested: November 15, 1999
Introduced and read first time: January 12, 2000
Assigned to: Economic Matters

A BILL ENTITLED

AN ACT concerning

Maryland Health Insurance Portability and Accountability Act - Market Reforms

FOR the purpose of establishing certain market reforms consistent with the provisions of the federal Health Insurance Portability and Accountability Act; repealing the provision allowing a certain health benefit plan that does not use a preexisting condition provision to impose a certain waiting period or surcharge on enrollees; requiring certain carriers to provide a special enrollment period; allowing certain employees and dependents to enroll for coverage during a special enrollment period under certain conditions; altering when a certain carrier may cancel or refuse to renew a certain health benefit plan; requiring certain notice to be sent when a certain carrier elects not to renew a certain health benefit plan; defining certain terms; altering certain terms; making stylistic changes; and generally relating to the Maryland Health Insurance Portability and Accountability Act.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-1201, 15-1208, 15-1212, 15-1301(h), 15-1401(p), and 15-1406
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY adding to
Article - Insurance
Section 15-1208.1 and 15-1406.1
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

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

Article - Insurance

15-1201.

(a) In this subtitle the following words have the meanings indicated.

(b) "Board" means the Board of Directors of the Pool established under § 15-1216 of this subtitle.

(c) "Carrier" means a person that:

(1) offers health benefit plans in the State covering eligible employees of small employers; and

(2) is:

(i) an authorized insurer that provides health insurance in the State;

(ii) a nonprofit health service plan that is licensed to operate in the State;

(iii) a health maintenance organization that is licensed to operate in the State; or

(iv) any other person or organization that provides health benefit plans subject to State insurance regulation.

(d) "Commission" means the Maryland Health Care Commission established under Title 19, Subtitle 1 of the Health - General Article.

(e) (1) "Eligible employee" means:

(i) an individual who:

1. is an employee, sole proprietor, self-employed individual, partner of a partnership, or independent contractor who is included as an employee under a health benefit plan; and

2. works on a full-time basis and has a normal workweek of at least 30 hours; or

(ii) a sole employee of a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code who:

1. has a normal workweek of at least 20 hours; and

2. is not covered under a public or private plan for health insurance or other health benefit arrangement.

(2) "Eligible employee" does not include an individual who works:

(i) on a temporary or substitute basis; or

(ii) except for an individual described in paragraph (1)(ii) of this subsection, for less than 30 hours in a normal workweek.

(f) (1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" includes a policy or certificate for hospital or medical benefits that covers residents of this State who are eligible employees and that is issued through:

(i) a multiple employer trust or association located in this State or another state; or

(ii) a professional employer organization, coemployer, or other organization located in this State or another state that engages in employee leasing.

(3) "Health benefit plan" does not include:

(i) accident-only insurance;

(ii) fixed indemnity insurance;

(iii) credit health insurance;

(iv) Medicare supplement policies;

(v) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policies;

(vi) long-term care insurance;

(vii) disability income insurance;

(viii) coverage issued as a supplement to liability insurance;

(ix) workers' compensation or similar insurance;

(x) disease-specific insurance;

(xi) automobile medical payment insurance;

(xii) dental insurance; or

(xiii) vision insurance.

(G) "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.

[(g)] (H) "Late enrollee" means:

(1) an eligible employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period provided under the health benefit plan; or

(2) a self-employed individual described in § 15-1203(c) or (d) of this subtitle or dependent who requests enrollment in a health benefit plan after an annual open enrollment period for self-employed individuals established by the carrier in accordance with regulations adopted by the Commissioner.

[(h)] (I) "Pool" means the Maryland Small Employer Health Reinsurance Pool established under this subtitle.

[(i)] (J) "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 coverage.

[(j)] (K) "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.

[(k)] (L) "Reinsuring carrier" means a carrier that participates in the Pool.

[(l)] (M) "Risk-assuming carrier" means a carrier that does not participate in the Pool.

[(m)] (N) "Small employer" means:

(1) an employer described in § 15-1203 of this subtitle; or

(2) an entity that leases employees from a professional employer organization, coemployer, or other organization engaged in employee leasing and that otherwise meets the description of § 15-1203 of this subtitle.

(O) "SPECIAL ENROLLMENT PERIOD" MEANS A PERIOD DURING WHICH A GROUP HEALTH PLAN SHALL PERMIT CERTAIN INDIVIDUALS WHO ARE ELIGIBLE FOR COVERAGE, BUT NOT ENROLLED, TO ENROLL FOR COVERAGE UNDER THE TERMS OF THE GROUP HEALTH BENEFIT PLAN.

[(n)] (P) "Standard Plan" means the Comprehensive Standard Health Benefit Plan adopted by the Commission in accordance with § 15-1207 of this subtitle and Title 19, Subtitle 1 of the Health - General Article.

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.

(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 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 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.

15-1208.1.

(A) A CARRIER SHALL PROVIDE THE SPECIAL ENROLLMENT PERIODS DESCRIBED IN THIS SECTION IN EACH SMALL EMPLOYER HEALTH BENEFIT PLAN.

(B) IF THE SMALL EMPLOYER ELECTS TO OFFER COVERAGE TO ALL OF ITS EMPLOYEES WHO ARE COVERED UNDER ANOTHER PUBLIC OR PRIVATE PLAN OF HEALTH INSURANCE OR ANOTHER HEALTH BENEFIT ARRANGEMENT, A CARRIER SHALL ALLOW AN EMPLOYEE OR DEPENDENT WHO IS ELIGIBLE, BUT NOT ENROLLED, FOR COVERAGE UNDER THE TERMS OF THE EMPLOYER'S HEALTH BENEFIT 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 BENEFIT 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 BENEFIT PLAN WAS THE REASON FOR DECLINING ENROLLMENT, BUT ONLY IF THE PLAN SPONSOR OR CARRIER REQUIRES THE STATEMENT AND PROVIDES THE EMPLOYEE WITH NOTICE OF THE REQUIREMENT;

(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; AND

(4) UNDER THE TERMS OF THE PLAN, THE EMPLOYEE REQUESTS ENROLLMENT NOT LATER THAN 30 DAYS AFTER:

(I) THE DATE OF EXHAUSTION OF COVERAGE DESCRIBED IN ITEM (3)(I) OF THIS SUBSECTION; OR

(II) TERMINATION OF COVERAGE OR TERMINATION OF EMPLOYER CONTRIBUTIONS DESCRIBED IN ITEM (3)(II) OF THIS SUBSECTION.

(C) ALL SMALL EMPLOYER HEALTH BENEFIT PLANS SHALL PROVIDE A SPECIAL ENROLLMENT PERIOD DURING WHICH THE FOLLOWING PERSONS MAY BE ENROLLED UNDER THE HEALTH BENEFIT PLAN:

(1) A PERSON WHO BECOMES A DEPENDENT OF THE ELIGIBLE EMPLOYEE THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION;

(2) AN ELIGIBLE EMPLOYEE WHO ACQUIRES A NEW DEPENDENT THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION; AND

(3) THE SPOUSE OF AN ELIGIBLE EMPLOYEE AT THE BIRTH OR ADOPTION OF A CHILD, PROVIDED THE SPOUSE IS OTHERWISE ELIGIBLE FOR COVERAGE.

(D) THE SPECIAL ENROLLMENT PERIOD UNDER THIS SECTION SHALL BE A PERIOD OF NOT LESS THAN 31 DAYS AND SHALL BEGIN ON THE LATER OF:

(1) THE DATE DEPENDENT COVERAGE IS MADE AVAILABLE; OR

(2) THE DATE OF THE MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION, WHICHEVER IS APPLICABLE.

(E) IF AN ELIGIBLE EMPLOYEE ENROLLS ANY OF THE PERSONS DESCRIBED IN SUBSECTION (C) OF THIS SECTION DURING THE FIRST 31 DAYS OF THE SPECIAL ENROLLMENT PERIOD, THE COVERAGE SHALL BECOME EFFECTIVE AS FOLLOWS:

(1) IN THE CASE OF MARRIAGE, NOT LATER THAN THE FIRST DAY OF THE FIRST MONTH BEGINNING AFTER THE DATE THE COMPLETED REQUEST FOR ENROLLMENT IS RECEIVED;

(2) IN THE CASE OF A DEPENDENT'S BIRTH, AS OF THE DATE OF THE DEPENDENT'S BIRTH; AND

(3) IN THE CASE OF A DEPENDENT'S ADOPTION OR PLACEMENT FOR ADOPTION, THE DATE OF ADOPTION OR PLACEMENT FOR ADOPTION, WHICHEVER OCCURS FIRST.

15-1212.

(a) (1) Except as provided in subsections (b) [and], (c), AND (D) of this section, a carrier shall renew a health benefit plan at the option of the small employer.

(2) On renewal, a carrier may not exclude eligible employees or dependents from a health benefit plan.

(3) (i) A carrier shall mail a notice of renewal to the small employer at least 45 days before the expiration of a health benefit plan.

(ii) The notice of renewal shall include the dates of the renewal period, the health benefit plan rates, and the terms of coverage under the health benefit plan.

(4) Policies or certificates for hospital or medical benefits issued through a professional employer organization, coemployer, or other organization under this subtitle may, with the consent of the carrier, have a common renewal date.

(b) A carrier may cancel or refuse to renew a health benefit plan only:

(1) for nonpayment of premiums;

(2) for fraud or INTENTIONAL misrepresentation of MATERIAL FACT BY the small employer [or covered individuals or their representatives];

(3) for noncompliance with [reasonable provisions of the health benefit plan as approved by the Commissioner] A MATERIAL PLAN PROVISION RELATING TO EMPLOYER CONTRIBUTIONS OR GROUP PARTICIPATION RULES;

(4) [for repeated misuse, as defined by the Commissioner, of a provider network provision;

(5)] when the carrier elects not to renew:

(i) all of its health benefit plans that are issued to small employers in the State; or

(ii) the particular health benefit plan for all small employers in the State; OR

(5) 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.

[(6) if the Commissioner finds that continuation of coverage would:

(i) not be in the best interests of policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations; or

(7) for reasons stated in § 19-725(b) of the Health - General Article, if the carrier is a health maintenance organization.]

(c) When a carrier elects not to renew all health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected small employers and the insurance regulatory authority of each state in which an eligible employee or dependent resides at least 180 days before the effective date of nonrenewal;

(2) shall give notice to the Commissioner at least 30 working days before giving the notice specified in item (1) of this subsection; and

(3) may not write new business for small employers in the State for a period of 5 years beginning on the date of notice to the Commissioner.

(D) WHEN A CARRIER ELECTS NOT TO RENEW A PARTICULAR HEALTH BENEFIT PLAN FOR ALL SMALL EMPLOYERS IN THE STATE, THE CARRIER SHALL:

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

(I) EACH AFFECTED:

1. SMALL EMPLOYER; AND

2. ENROLLED EMPLOYEE; AND

(II) THE COMMISSIONER;

(2) OFFER TO EACH AFFECTED SMALL EMPLOYER THE OPTION TO PURCHASE ALL OTHER HEALTH BENEFIT PLANS CURRENTLY OFFERED BY THE CARRIER IN THE SMALL GROUP MARKET; AND

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

[(d)] (E) Within 7 days after cancellation or nonrenewal of a health benefit plan, the carrier shall send to each enrolled employee written notice of its action and the conversion rights available to each enrolled employee under § 15-412 of this article.

15-1301.

(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; OR

(iii) a State plan under Title XIX of the Social Security Act; [or

(iv) a health benefit plan;]

(3) WHO DOES NOT HAVE COVERAGE UNDER A HEALTH BENEFIT PLAN;

[(3)] (4) 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)] (5) 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.

15-1401.

(p) "Special enrollment period" means a period during which a group health plan shall permit [an employee] CERTAIN INDIVIDUALS who [is] ARE eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

15-1406.

(a) A carrier may not establish rules for eligibility of an individual to enroll under a group health [benefits] BENEFIT 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] BENEFIT 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] BENEFIT 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] BENEFIT 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[.]; AND

(4) UNDER THE TERMS OF THE PLAN, THE EMPLOYEE REQUESTS ENROLLMENT NOT LATER THAN 30 DAYS AFTER:

(I) THE DATE OF EXHAUSTION OF COVERAGE DESCRIBED IN ITEM (3)(I) OF THIS SUBSECTION; OR

(II) TERMINATION OF COVERAGE OR TERMINATION OF EMPLOYER CONTRIBUTIONS DESCRIBED IN ITEM (3)(II) OF THIS SUBSECTION.

15-1406.1.

(A) IN THIS SECTION, "INDIVIDUAL" MEANS:

(1) A PARTICIPANT UNDER THE GROUP HEALTH BENEFIT PLAN; OR

(2) A PERSON WHO:

(I) HAS MET ANY WAITING PERIOD APPLICABLE TO BECOMING A PARTICIPANT UNDER THE GROUP HEALTH BENEFIT PLAN;

(II) IS ELIGIBLE TO BE ENROLLED UNDER THE PLAN; AND

(III) IS NOT A PARTICIPANT IN THE GROUP HEALTH BENEFIT PLAN BECAUSE OF FAILURE TO ENROLL DURING A PREVIOUS ENROLLMENT PERIOD.

(B) THIS SECTION APPLIES IF A GROUP HEALTH BENEFIT PLAN MAKES COVERAGE AVAILABLE TO DEPENDENTS OF AN INDIVIDUAL.

(C) A GROUP HEALTH BENEFIT PLAN SUBJECT TO THIS SECTION SHALL PROVIDE A SPECIAL ENROLLMENT PERIOD DURING WHICH THE FOLLOWING PERSONS MAY BE ENROLLED UNDER THE GROUP HEALTH BENEFIT PLAN:

(1) A PERSON WHO BECOMES A DEPENDENT OF THE INDIVIDUAL THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION;

(2) AN INDIVIDUAL WHO ACQUIRES A NEW DEPENDENT THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION; AND

(3) THE SPOUSE OF AN INDIVIDUAL AT THE BIRTH OR ADOPTION OF A CHILD, PROVIDED THE SPOUSE IS OTHERWISE ELIGIBLE FOR COVERAGE.

(D) THE SPECIAL ENROLLMENT PERIOD UNDER THIS SECTION SHALL BE A PERIOD OF NOT LESS THAN 31 DAYS AND SHALL BEGIN ON THE LATER OF:

(1) THE DATE DEPENDENT COVERAGE IS MADE AVAILABLE; OR

(2) THE DATE OF THE MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION, WHICHEVER IS APPLICABLE.

(E) IF AN INDIVIDUAL ENROLLS ANY OF THE PERSONS DESCRIBED IN SUBSECTION (C) OF THIS SECTION DURING THE FIRST 31 DAYS OF THE SPECIAL ENROLLMENT PERIOD, THE COVERAGE SHALL BECOME EFFECTIVE AS FOLLOWS:

(1) IN THE CASE OF MARRIAGE, NOT LATER THAN THE FIRST DAY OF THE FIRST MONTH BEGINNING AFTER THE DATE THE COMPLETED REQUEST FOR ENROLLMENT IS RECEIVED;

(2) IN THE CASE OF A DEPENDENT'S BIRTH, AS OF THE DATE OF THE DEPENDENT'S BIRTH; AND

(3) IN THE CASE OF A DEPENDENT'S ADOPTION OR PLACEMENT FOR ADOPTION, THE DATE OF ADOPTION OR PLACEMENT FOR ADOPTION, WHICHEVER OCCURS FIRST.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2000.