Unofficial Copy 2003 Regular Session
C3 3lr1831

By: **Delegate Hurson**
Introduced and read first time: February 7, 2003
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Individual Health Insurance Availability Act

FOR the purpose of establishing certain requirements for premium rates for individual health benefit plans; requiring the Insurance Commissioner to adopt certain regulations; requiring an individual health insurance carrier to renew an individual health benefit plan under certain circumstances and with certain exceptions; requiring a carrier to offer certain health benefit plans to certain persons under certain conditions; establishing certain requirements for individual health benefit plans; authorizing the Commissioner to impose a certain assessment on carriers under certain circumstances; making a carrier liable for an assessment under certain circumstances; establishing the amount of the assessment; establishing certain penalties for failure to pay the assessment; requiring rates to be formulated to attain a certain loss ratio; requiring a carrier to submit certain documentation; requiring a carrier to refund to policy or contract holders a certain amount under certain circumstances; providing that certain provisions of law do not apply to a certain health benefit plan; repealing certain provisions of law concerning health benefit plan renewal and eligibility for insurance in the small group market; providing for the appointment of a Health Benefit Plan Committee for a certain purpose; providing for the effective date of certain rate adjustments; defining certain terms; and generally relating to individual health benefit plans.

BY repealing
Article - Insurance
Section 15-203 and 15-1203(c), (d), and (e)
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 15-1201(a)
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-1201(e) and (h)
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

BY adding to
Article - Insurance
Section 15-1601 through 15-1609, inclusive, to be under the new subtitle "Subtitle 16. Individual Health Insurance Availability Act"
Annotated Code of Maryland
(2002 Replacement Volume and 2002 Supplement)

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

Article - Insurance

[15-203.

Other than a policy of accident only insurance, each policy of health insurance in which the insurer reserves the right to refuse renewal on an individual basis shall contain a provision, endorsement, or rider that provides in substance:

(1) that, subject to the right to terminate the policy on nonpayment of premium when due, the right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each anniversary of the policy;

(2) that a refusal to renew shall be without prejudice to any claim that originates while the policy is in effect;

(3) that a renewal may not be refused solely because of a change in the health or physical or mental condition of the insured; and

(4) unless omitted at the insurer's option, that the right to refuse renewal of a policy of health insurance that was reinstated after lapse may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement.]

15-1201.

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

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

(i)] an individual who:

[1.] (I) 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.] (II) 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.

(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].

15-1203.

[(c) An individual is considered a small employer under this subtitle if the individual:

(1) works and resides in the State; and

(2) is a self-employed individual organized as a sole proprietorship or in any other legally recognized manner that a self-employed individual may organize:

(i) a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

(ii) who has filed the appropriate Internal Revenue form for the previous taxable year; and

(iii) for whom a copy of the appropriate Internal Revenue form or forms and schedule has been filed with the carrier.

(d) An individual is considered a small employer under this subtitle if the individual is a self-employed individual who is engaged in a licensed profession through a professional corporation organized in accordance with Title 5, Subtitle 1 of the Corporations and Associations Article and who received health benefits through a professional association on or before June 30, 1994.

(e) A person is considered a small employer under this subtitle if the person is 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 and has at least one eligible employee.]

SUBTITLE 16. INDIVIDUAL HEALTH INSURANCE AVAILABILITY ACT.

15-1601.

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

(B) "ADJUSTED COMMUNITY RATING" MEANS A METHOD USED TO DEVELOP A CARRIER'S PREMIUM THAT SPREADS FINANCIAL RISK WITHOUT REGARD TO HEALTH STATUS OR OCCUPATION OR ANY OTHER FACTOR NOT SPECIFICALLY AUTHORIZED UNDER THIS SUBTITLE.

(C) "CREDITABLE COVERAGE" HAS THE MEANING STATED IN § 15-1301(G) OF THIS TITLE.

(D) "ELIGIBLE PERSON" MEANS A PERSON WHO IS A RESIDENT OF THIS STATE WHO IS NOT ELIGIBLE TO BE INSURED UNDER AN EMPLOYER-SPONSORED GROUP HEALTH BENEFIT PLAN.

(E) "FEDERALLY DEFINED ELIGIBLE INDIVIDUAL" MEANS:

(1) AN INDIVIDUAL:

(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;

(II) WHOSE MOST RECENT PRIOR CREDITABLE COVERAGE WAS UNDER A GROUP HEALTH PLAN, GOVERNMENTAL PLAN, CHURCH PLAN, OR HEALTH INSURANCE COVERAGE OFFERED IN CONNECTION WITH ANY OF THESE TYPES OF PLANS;

(III) WHO IS NOT ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH PLAN, PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT (MEDICARE), OR A STATE PLAN UNDER TITLE XIX (MEDICAID) OF THE ACT OR ANY

SUCCESSOR PROGRAM, AND WHO DOES NOT HAVE OTHER HEALTH INSURANCE COVERAGE;

(IV) WITH RESPECT TO WHOM THE MOST RECENT COVERAGE WITHIN THE PERIOD OF AGGREGATE CREDITABLE COVERAGE WAS NOT TERMINATED BASED ON A FACTOR RELATING TO NONPAYMENT OF PREMIUMS OR FRAUD; AND

(V) WHO, IF OFFERED THE OPTION OF CONTINUATION COVERAGE UNDER A COBRA CONTINUATION PROVISION OR UNDER A SIMILAR STATE PROGRAM, BOTH ELECTED AND EXHAUSTED THAT COVERAGE; OR

(2) A CHILD WHO IS COVERED UNDER ANY CREDITABLE COVERAGE WITHIN 30 DAYS OF BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION, IF THE CHILD DOES NOT EXPERIENCE A SIGNIFICANT BREAK IN COVERAGE.

(F) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15-1301(L) OF THIS TITLE.

(G) "INDIVIDUAL CARRIER" MEANS A CARRIER THAT ISSUES OR OFFERS FOR ISSUANCE INDIVIDUAL HEALTH BENEFIT PLANS COVERING ONE OR MORE RESIDENTS OF THIS STATE.

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

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

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

(2) "INDIVIDUAL HEALTH BENEFIT PLAN" DOES NOT INCLUDE A CERTIFICATE ISSUED TO AN ELIGIBLE PERSON THAT EVIDENCES COVERAGE UNDER A PROFESSIONAL ASSOCIATION PLAN.

(I) (1) "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE 6 MONTHS PRECEDING THE ENROLLMENT DATE OF THE COVERAGE.

(2) "PREEXISTING CONDITION" DOES NOT INCLUDE A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED FOR THE FIRST TIME WHILE THE COVERED PERSON HELD CREDITABLE COVERAGE AND THAT WAS A COVERED BENEFIT UNDER THE PLAN,

PROVIDED THAT THE PRIOR CREDITABLE COVERAGE WAS CONTINUOUS TO A DATE NOT MORE THAN 90 DAYS PRIOR TO THE ENROLLMENT DATE OF THE NEW COVERAGE.

15-1602.

THE PROVISIONS OF THIS SUBTITLE CONCERNING INDIVIDUAL HEALTH BENEFIT PLANS AND THE INDIVIDUAL CARRIERS THAT OFFER THEM SHALL APPLY TO A HEALTH BENEFIT PLAN THAT COVERS ELIGIBLE PERSONS AND THEIR DEPENDENTS AND TO A CERTIFICATE ISSUED TO AN ELIGIBLE PERSON THAT EVIDENCES COVERAGE UNDER A POLICY OR CONTRACT ISSUED TO A TRUST OR ASSOCIATION OR OTHER SIMILAR GROUPING OF INDIVIDUALS, REGARDLESS OF THE SITUS OF DELIVERY OF THE POLICY OR CONTRACT, IF THE ELIGIBLE PERSON PAYS THE PREMIUM AND IS NOT COVERED UNDER THE POLICY OR CONTRACT PURSUANT TO CONTINUATION OF BENEFITS PROVISIONS APPLICABLE UNDER FEDERAL OR STATE LAW AND SHALL APPLY TO PROFESSIONAL ASSOCIATION PLANS AS SPECIFICALLY SET FORTH IN THIS SUBTITLE.

15-1603.

(A) PREMIUM RATES FOR HEALTH BENEFIT PLANS SUBJECT TO THIS SUBTITLE ARE SUBJECT TO THE FOLLOWING PROVISIONS:

(1) THE INDIVIDUAL CARRIER SHALL DEVELOP ITS RATES BASED ON AN ADJUSTED COMMUNITY RATE AND MAY ONLY VARY THE ADJUSTED COMMUNITY RATE FOR:

(I) GEOGRAPHIC AREA;

(II) FAMILY COMPOSITION; AND

(III) AGE; AND

(2) THE ADJUSTMENTS TO THE RATES FOR A HEALTH BENEFIT PLAN PERMITTED IN PARAGRAPH (1)(III) OF THIS SUBSECTION MAY NOT RESULT IN A RATE PER ENROLLEE FOR THE HEALTH BENEFIT PLAN OF MORE THAN 200% OF THE LOWEST RATE FOR ALL ADULT AGE GROUPS.

(B) THE PREMIUM CHARGED FOR A HEALTH BENEFIT PLAN MAY NOT BE ADJUSTED MORE FREQUENTLY THAN ANNUALLY EXCEPT THAT THE RATES MAY BE CHANGED TO REFLECT:

(1) CHANGES TO THE FAMILY COMPOSITION OF THE ELIGIBLE PERSON; OR

(2) CHANGES TO THE HEALTH BENEFIT PLAN REQUESTED BY THE ELIGIBLE PERSON.

(C) RATING FACTORS SHALL PRODUCE PREMIUMS FOR IDENTICAL ELIGIBLE PERSONS THAT DIFFER ONLY BY THE AMOUNTS ATTRIBUTABLE TO PLAN DESIGN

AND DO NOT REFLECT DIFFERENCES DUE TO THE NATURE OF THE ELIGIBLE PERSONS ASSUMED TO SELECT PARTICULAR HEALTH BENEFIT PLANS.

(D) THE COMMISSIONER SHALL ESTABLISH REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SECTION AND TO ASSURE THAT RATING PRACTICES USED BY INDIVIDUAL CARRIERS ARE CONSISTENT WITH THE PURPOSES OF THIS SUBTITLE.

15-1604.

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

(5) WHERE THE INDIVIDUAL NO LONGER RESIDES 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 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.

15-1605.

(A) (1) EVERY INDIVIDUAL CARRIER SHALL, AS A CONDITION OF TRANSACTING BUSINESS IN THIS STATE WITH INDIVIDUALS, ACTIVELY OFFER TO INDIVIDUALS ALL HEALTH BENEFIT PLANS IT ACTIVELY MARKETS TO INDIVIDUALS IN THIS STATE INCLUDING AT LEAST TWO HEALTH BENEFIT PLANS.

(2) ONE HEALTH BENEFIT PLAN OFFERED BY EACH INDIVIDUAL CARRIER SHALL BE A BASIC HEALTH BENEFIT PLAN AND ONE PLAN SHALL BE A STANDARD HEALTH BENEFIT PLAN.

(3) AN INDIVIDUAL CARRIER SHALL BE CONSIDERED TO BE ACTIVELY MARKETING A HEALTH BENEFIT PLAN IF IT OFFERS THAT PLAN TO AN INDIVIDUAL NOT CURRENTLY RECEIVING A HEALTH BENEFIT PLAN BY THAT INDIVIDUAL CARRIER.

(B) (1) AN INDIVIDUAL CARRIER SHALL ISSUE ANY INDIVIDUAL HEALTH BENEFIT PLAN TO ANY ELIGIBLE PERSON THAT APPLIES FOR THE PLAN DURING THE DESIGNATED OPEN ENROLLMENT PERIOD AND AGREES TO MAKE THE REQUIRED PREMIUM PAYMENTS.

(2) THE OPEN ENROLLMENT PERIOD SHALL BE BASED ON THE MONTH OF THE APPLICANT'S BIRTH SO THAT DURING THE MONTH OF THE APPLICANT'S BIRTH, THE APPLICANT CAN APPLY FOR AND BE ISSUED COVERAGE FROM ANY INDIVIDUAL CARRIER ISSUING INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.

(3) IF AN ELIGIBLE PERSON OTHER THAN A FEDERALLY DEFINED ELIGIBLE INDIVIDUAL APPLYING FOR AN INDIVIDUAL HEALTH BENEFIT PLAN HAD CREDITABLE COVERAGE, AN INDIVIDUAL CARRIER SHALL ISSUE AN INDIVIDUAL HEALTH BENEFIT PLAN TO THAT ELIGIBLE PERSON IF THE ELIGIBLE PERSON APPLIES FOR COVERAGE WITHIN 31 DAYS OF TERMINATION OF THE PRIOR COVERAGE.

(4) IF A FEDERALLY DEFINED ELIGIBLE INDIVIDUAL APPLIES FOR AN INDIVIDUAL HEALTH BENEFIT PLAN, AN INDIVIDUAL CARRIER SHALL ISSUE AN INDIVIDUAL HEALTH BENEFIT PLAN TO THAT FEDERALLY DEFINED ELIGIBLE INDIVIDUAL IF THE INDIVIDUAL APPLIES FOR COVERAGE WITHIN 90 DAYS OF TERMINATION OF THE PRIOR COVERAGE.

(C) (1) AN INDIVIDUAL CARRIER SHALL FILE WITH THE COMMISSIONER, IN A FORMAT AND MANNER PRESCRIBED BY THE COMMISSIONER, THE BASIC HEALTH BENEFIT PLANS AND THE STANDARD HEALTH BENEFIT PLANS TO BE USED BY THE CARRIER.

(2) A HEALTH BENEFIT PLAN FILED UNDER THIS PARAGRAPH MAY BE USED BY AN INDIVIDUAL CARRIER BEGINNING 30 DAYS AFTER IT IS FILED UNLESS THE COMMISSIONER DISAPPROVES ITS USE.

(D) INDIVIDUAL HEALTH BENEFIT PLANS SHALL COMPLY WITH THE FOLLOWING PROVISIONS:

(1) A HEALTH CARRIER MAY NOT IMPOSE AN EXCLUSION ON A FEDERALLY DEFINED ELIGIBLE INDIVIDUAL BECAUSE OF A PREEXISTING CONDITION;

(2) FOR ELIGIBLE PERSONS WHO ARE NOT FEDERALLY DEFINED ELIGIBLE INDIVIDUALS, A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED FOR THE FIRST TIME, EITHER WHILE THE ELIGIBLE PERSON HELD CREDITABLE COVERAGE OR DURING THE 90 DAYS PRIOR TO THE ENROLLMENT DATE OF NEW COVERAGE, SHALL NOT BE A CONDITION FOR WHICH A CARRIER MAY IMPOSE A PREEXISTING CONDITION

EXCLUSION, PROVIDED THAT THE TREATMENT WAS A COVERED BENEFIT UNDER THE CREDITABLE COVERAGE, AND PROVIDED THAT THE CREDITABLE COVERAGE WAS CONTINUOUS TO A DATE NOT MORE THAN 90 DAYS PRIOR TO THE ENROLLMENT DATE OF THE NEW COVERAGE;

(3) AN INDIVIDUAL HEALTH BENEFIT PLAN MAY NOT DENY, EXCLUDE, OR LIMIT BENEFITS FOR A COVERED ELIGIBLE PERSON FOR LOSSES INCURRED MORE THAN 6 MONTHS FOLLOWING THE EFFECTIVE DATE OF THE ELIGIBLE PERSON'S COVERAGE DUE TO A PREEXISTING CONDITION; AND

(4) GENETIC INFORMATION MAY NOT BE TREATED AS A CONDITION UNDER PARAGRAPH (2) OF THIS SUBSECTION FOR WHICH A PREEXISTING CONDITION EXCLUSION MAY BE IMPOSED IN THE ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE INFORMATION.

15-1606.

(A) INDIVIDUAL CARRIERS SHALL PROVIDE WRITTEN CERTIFICATION OF CREDITABLE COVERAGE TO INDIVIDUALS IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION.

(B) THE CERTIFICATION OF CREDITABLE COVERAGE SHALL BE PROVIDED:

(1) AT THE TIME AN INDIVIDUAL CEASES TO BE COVERED UNDER THE HEALTH BENEFIT 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 THAT PROVISION; AND

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

(C) INDIVIDUAL CARRIERS MAY PROVIDE THE CERTIFICATION OF CREDITABLE COVERAGE REQUIRED UNDER SUBSECTION (B)(1) OF THIS SECTION AT A TIME CONSISTENT WITH NOTICES REQUIRED UNDER AN APPLICABLE COBRA CONTINUATION PROVISION.

(D) THE CERTIFICATE OF CREDITABLE COVERAGE REQUIRED TO BE PROVIDED UNDER SUBSECTION (A) OF THIS SECTION SHALL CONTAIN:

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

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

15-1607.

(A) (1) ON OR BEFORE OCTOBER 1, 2004, A CARRIER SHALL, AS A CONDITION OF ISSUING HEALTH BENEFIT PLANS IN THE STATE, OFFER HEALTH BENEFIT PLANS IN THE INDIVIDUAL MARKET.

(2) A CARRIER SHALL BE DEEMED TO HAVE SATISFIED ITS OBLIGATION TO PROVIDE INDIVIDUAL HEALTH BENEFIT PLANS BY PAYING AN ASSESSMENT UNDER SUBSECTION (C)(2) OF THIS SECTION.

(B) (1) THE COMMISSIONER SHALL HAVE THE AUTHORITY TO ASSESS CARRIERS THEIR PROPORTIONATE SHARE OF INDIVIDUAL MARKET LOSSES AND ADMINISTRATIVE EXPENSES IN ACCORDANCE WITH THE PROVISIONS OF SUBSECTION (C) OF THIS SECTION, AND MAKE ADVANCE INTERIM ASSESSMENTS AS MAY BE REASONABLE AND NECESSARY FOR ORGANIZATIONAL AND REASONABLE OPERATING EXPENSES AND ESTIMATED LOSSES.

(2) AN INTERIM ASSESSMENT SHALL BE CREDITED AS AN OFFSET AGAINST ANY REGULAR ASSESSMENT DUE FOLLOWING THE CLOSE OF THE FISCAL YEAR.

(C) (1) IN THIS SUBSECTION, "REASONABLE ADMINISTRATIVE EXPENSES" MEANS THE ACTUAL EXPENSES OR A MAXIMUM OF 30%, WHICHEVER IS LESS.

(2) THE COMMISSIONER SHALL BY REGULATION ESTABLISH PROCEDURES FOR THE EQUITABLE SHARING OF PROGRAM LOSSES AMONG ALL CARRIERS IN ACCORDANCE WITH THEIR TOTAL MARKET SHARE AS PROVIDED IN THIS SUBSECTION.

(3) ON OR BEFORE MARCH 1, 2004 AND, FOLLOWING THE CLOSE OF THE CALENDAR YEAR THEREAFTER, ON A DATE ESTABLISHED BY THE COMMISSIONER:

(I) A CARRIER ISSUING HEALTH BENEFIT PLANS IN THE STATE SHALL FILE WITH THE COMMISSIONER ITS NET EARNED PREMIUM FOR THE PRECEDING CALENDAR YEAR ENDING DECEMBER 31;

(II) A CARRIER ISSUING INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE SHALL FILE WITH THE COMMISSIONER THE NET EARNED PREMIUM ON INDIVIDUAL HEALTH BENEFITS PLANS AND THE CLAIMS PAID AND THE ADMINISTRATIVE EXPENSES ATTRIBUTABLE TO THOSE PLANS; AND

(III) IF THE CLAIMS PAID AND REASONABLE ADMINISTRATIVE EXPENSES FOR THAT CALENDAR YEAR EXCEED THE NET EARNED PREMIUM AND ANY INVESTMENT INCOME THEREON, THE AMOUNT OF THE EXCESS SHALL BE THE NET PAID LOSS FOR THE CARRIER THAT SHALL BE REIMBURSABLE UNDER THIS SECTION.

(4) (I) A CARRIER SHALL BE LIABLE FOR AN ASSESSMENT TO REIMBURSE CARRIERS ISSUING INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE THAT SUSTAIN NET PAID LOSSES FOR THE PREVIOUS YEAR.

(II) THE ASSESSMENT OF EACH CARRIER SHALL BE IN THE PROPORTION THAT THE NET EARNED PREMIUM OF THE CARRIER FOR THE CALENDAR YEAR PRECEDING THE ASSESSMENT BEARS TO THE NET EARNED PREMIUM OF ALL CARRIERS FOR THE CALENDAR YEAR PRECEDING THE ASSESSMENT EXCLUDING PREMIUMS FOR CONVERTED POLICIES.

(5) (I) PAYMENT OF AN ASSESSMENT MADE UNDER THIS SECTION SHALL BE A CONDITION OF ISSUING HEALTH BENEFITS PLANS IN THE STATE FOR A CARRIER.

(II) FAILURE TO PAY THE ASSESSMENT SHALL BE GROUNDS FOR FORFEITURE OF A CARRIER'S AUTHORIZATION TO ISSUE HEALTH BENEFIT PLANS OF ANY KIND IN THE STATE, AS WELL AS ANY OTHER PENALTIES PERMITTED BY LAW.

(D) (1) (I) RATES SHALL BE FORMULATED ON CONTRACTS OR POLICIES REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SO THAT THE ANTICIPATED MINIMUM LOSS RATIO FOR A CONTRACT OR POLICY FORM IS NOT LESS THAN 70% OF THE PREMIUM.

(II) THE INDIVIDUAL CARRIER SHALL SUBMIT WITH ITS RATE FILING SUPPORTING DATA, AS DETERMINED BY THE COMMISSIONER, AND CERTIFICATION BY A MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES, OR OTHER INDIVIDUAL ACCEPTABLE TO THE COMMISSIONER, THAT THE CARRIER IS IN COMPLIANCE WITH THE PROVISIONS OF THIS SUBSECTION.

(2) (I) FOLLOWING THE CLOSE OF THE THIRD FULL CALENDAR YEAR AN INDIVIDUAL CARRIER HAS ISSUED INDIVIDUAL HEALTH BENEFIT PLANS, AND EACH CALENDAR YEAR THEREAFTER, IF THE COMMISSIONER DETERMINES THAT A CARRIER'S LOSS RATIO WAS LESS THAN 70% FOR THAT CALENDAR YEAR, THE CARRIER SHALL BE REQUIRED TO REFUND TO POLICY OR CONTRACT HOLDERS THE DIFFERENCE BETWEEN THE AMOUNT OF NET EARNED PREMIUM IT RECEIVED THAT YEAR AND THE AMOUNT THAT WOULD HAVE BEEN NECESSARY TO ACHIEVE THE 70% LOSS RATIO.

(II) THE LOSS RATIO CALCULATION MADE FOLLOWING THE CLOSE OF THE THIRD FULL CALENDAR YEAR A CARRIER HAS ISSUED INDIVIDUAL HEALTH BENEFIT PLANS SHALL INCLUDE ALL INDIVIDUAL BUSINESS WRITTEN SINCE OCTOBER 1, 2003 UNTIL THE CLOSE OF THE THIRD FULL CALENDAR YEAR.

(3) THE COMMISSIONER SHALL PRESCRIBE BY REGULATION THE METHODOLOGY TO BE USED IN DETERMINING THE LOSS RATIO.

15-1608.

ANY LAW REQUIRING THE COVERAGE OF A HEALTH CARE SERVICE OR BENEFIT, OR REQUIRING THE REIMBURSEMENT, UTILIZATION, OR INCLUSION OF A

SPECIFIC CATEGORY OF LICENSED HEALTH CARE PRACTITIONER, DOES NOT APPLY TO A BASIC HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR DELIVERY TO INDIVIDUALS IN THE STATE IN ACCORDANCE WITH THIS SUBTITLE.

15-1609.

(A) THE COMMISSIONER SHALL ADOPT REGULATIONS TO REQUIRE INDIVIDUAL CARRIERS, AS A CONDITION OF TRANSACTING BUSINESS WITH INDIVIDUALS IN THE STATE, TO REISSUE A HEALTH BENEFIT PLAN TO ANY INDIVIDUAL WHOSE HEALTH BENEFIT PLAN HAS BEEN TERMINATED OR NOT RENEWED BY THE CARRIER AFTER APRIL 1, 2003.

(B) THE COMMISSIONER MAY PRESCRIBE SUCH TERMS FOR THE REISSUE OF COVERAGE AS THE COMMISSIONER FINDS ARE REASONABLE AND NECESSARY TO PROVIDE CONTINUITY OF COVERAGE TO INDIVIDUALS.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Insurance Commissioner shall appoint a Health Benefit Plan Committee. The Committee shall be composed of representatives of carriers, consumers, health care providers, and producers.

(b) The Committee shall recommend the form and level of coverages to be made available by individual carriers under Section 1 of this Act.

(c) (1) The Committee shall recommend benefit levels, cost sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan.

(2) The Committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(3) The Committee shall submit the recommended health benefit plans to the Commissioner for approval on or before July 1, 2004.

SECTION 3. AND BE IT FURTHER ENACTED, That the adjustments to the rates for a health benefit plan permitted in § 15-1603(a)(2) of the Insurance Article as enacted by this Act shall take effect for all policies issued or renewed on or after October 1, 2008. For all policies issued or renewed between October 1, 2003 and September 30, 2005, the permitted rates for any age group shall be no more than 400% of the lowest rate for all adult age groups. For all policies issued or renewed between October 1, 2005 and September 30, 2008, the permitted rates for any age group shall be no more than 300% of the lowest rate for all adult age groups.

SECTION 4. AND BE IT FURTHER ENACTED, That, subject to Section 3 of this Act, this Act shall take effect October 1, 2003.