Unofficial Copy 2004 Regular Session
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By: **Chairman, Health and Government Operations Committee (By Request - Departmental - Insurance Administration, Maryland)**
Introduced and read first time: February 4, 2004
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance - HIPAA - Maryland Health Insurance Plan - Alternative Mechanism

FOR the purpose of making the Maryland Health Insurance Plan the alternative to the standard coverage for eligible individuals under the federal Health Insurance Portability and Accountability Act (HIPAA) as required by certain provisions of law; defining certain terms; deleting certain provisions made unnecessary under the alternative mechanism; clarifying certain continuation of coverage provisions applying to certain individuals; making certain stylistic changes; and generally relating to the Maryland Health Insurance Plan as an alternative to the standard coverage required under the federal Health Insurance Portability and Accountability Act.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 14-501, 15-508(a), 15-1301, 15-1308, and 15-1312
Annotated Code of Maryland
(2002 Replacement Volume and 2003 Supplement)

BY adding to
Article - Insurance
Section 14-508
Annotated Code of Maryland
(2002 Replacement Volume and 2003 Supplement)

BY repealing
Article - Insurance
Section 15-1304, 15-1305, and 15-1306
Annotated Code of Maryland
(2002 Replacement Volume and 2003 Supplement)

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

Article - Insurance

14-501.

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

(b) "Administrator" means:

(1) a person that is registered as an administrator under Title 8, Subtitle 3 of this article; or

(2) a carrier as defined under subsection (d) of this section.

(c) "Board" means the Board of Directors for the Maryland Health Insurance Plan.

(d) "Carrier" means:

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

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

(3) a health maintenance organization that is licensed to operate in the State.

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

(F) "ELIGIBLE INDIVIDUAL" HAS THE MEANING STATED IN § 15-1301 OF THIS TITLE.

[(e)] (G) "Fund" means the Maryland Health Insurance Plan Fund.

[(f)] (H) (1) "Medically uninsurable individual" means an individual who is a resident of the State and who:

(i) provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual;

(ii) provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual, except at a rate that exceeds the Plan rate;

(iii) satisfies the definition of "eligible individual" under § 15-1301 of this article;

(iv) has a history of or suffers from a medical or health condition that is included on a list promulgated in regulation by the Board;

(v) is eligible for the tax credit for health insurance costs under § 35 of the Internal Revenue Code; or

(vi) is a dependent of an individual who is eligible for coverage under this subsection.

(2) "Medically uninsurable individual" does not include an individual who is eligible for coverage under:

(i) the federal Medicare program;

(ii) the Maryland Medical Assistance Program;

(iii) the Maryland Children's Health Program; or

(iv) an employer-sponsored group health insurance plan that includes benefits comparable to Plan benefits, unless the individual is eligible for the tax credit for health insurance costs under [Section] § 35 of the Internal Revenue Code.

[(g)] (I) "Plan" means the Maryland Health Insurance Plan.

[(h)] (J) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with § 14-503 of this subtitle.

14-508.

(A) THE PLAN SHALL BE THE ALTERNATIVE MECHANISM FOR ELIGIBLE INDIVIDUALS UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT IN ACCORDANCE WITH 45 CFR 148.128.

(B) THE PLAN MAY NOT APPLY A PREEXISTING CONDITION EXCLUSION TO AN ELIGIBLE INDIVIDUAL WHO APPLIES FOR COVERAGE UNDER THE PLAN WITHIN 63 DAYS OF TERMINATING PRIOR CREDITABLE COVERAGE.

(C) IF THE BOARD IMPOSES A LIMIT ON THE NUMBER OF INDIVIDUALS WHO CAN PARTICIPATE IN THE PLAN, THE LIMIT MAY NOT BE APPLIED TO HIPAA ELIGIBLE INDIVIDUALS.

15-508.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" has the meaning stated in § 15-1301 of this title.

(3) "ENROLLMENT DATE" HAS THE MEANING STATED IN § 15-1301 OF THIS TITLE.

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

[(4)] (5) "Preexisting condition provision" has the meaning stated in § 15-1301 of this title.

[(5)] (6) "Late enrollee" has the meaning stated in § 15-1401 of this title.
15-1301.

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

[(b) "Actuarial certification" means a written statement in a form approved by the Commissioner, signed by a member of the American Academy of Actuaries or other individual acceptable to the Commissioner that a carrier is in compliance with the provisions of this subtitle.]

[(c)] (B) "Affiliation period" means a period of time beginning on the date of enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee, during which a health maintenance organization does not collect premium, and coverage issued does not become effective.

[(d)] (C) "Association" or "bona fide association" means[,] an association that:

(1) has been actively in existence for at least 5 years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association-sponsored insurance;

(3) does not condition membership in the association on any health status-related factor relating to an individual, and states so clearly in all membership and application materials;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage and states so clearly in all membership and application materials;

(5) does not make health insurance coverage offered through the association available other than in connection with membership in the association, and states so clearly in all marketing and application materials; and

(6) provides and annually updates information necessary for the Commissioner to determine whether or not the association meets the definition of bona fide association before qualifying as an association under this subtitle.

[(e)] (D) "Carrier" means a person that is:

(1) an insurer that holds a certificate of authority in the State and provides health insurance in the State;

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

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

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

[(f)] (E) "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.

[(g)] (F) (1) "Creditable coverage" means coverage of an individual under:

(i) an employer sponsored plan;

(ii) a health benefit plan;

(iii) Part A or Part B of Title XVIII of the Social Security Act;

(iv) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under § 1928 of that Act;

(v) Chapter 55 of Title 10 of the United States Code;

(vi) a medical care program of the Indian Health Service or of a tribal organization;

(vii) a State health benefits risk pool;

(viii) a health plan offered under the Federal Employees Health Benefits Program (FEHBP), Title 5, Chapter 89 of the United States Code;

(ix) a public health plan as defined by federal regulations authorized by the Public Health Service Act, § 2701(c)(1)(i), as amended by P.L. 104-191; or

(x) a health benefit plan under § 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan or an employer sponsored plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

[(h)] (G) "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;

(3) who does not have coverage under a health benefit plan;

(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

(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.

[(i)] (H) "Enrollment date" means the date on which:

(1) an individual enrolls in a health benefit plan; or

(2) the first day of the waiting period before which the individual may enroll.

[(j)] (I) "Governmental plan" means a plan as defined in § 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

[(k)] (J) "Employer sponsored plan" means an employee welfare benefit plan that provides medical care to employees or their dependents, and is not subject to State regulation in accordance with the federal Employee Retirement Income Security Act of 1974.

[(l)] (K) (1) "Health benefit plan" means a:

(i) hospital or medical policy or certificate, including those issued under multiple employer trusts or associations located in Maryland or any other state covering Maryland residents;

(ii) policy, contract, or certificate issued by a nonprofit health service plan that covers Maryland residents; or

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

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

(i) one or more, or any combination of the following:

1. coverage only for accident or disability income insurance;

2. coverage issued as a supplement to liability insurance;

3. liability insurance, including general liability insurance and automobile liability insurance;

4. workers' compensation or similar insurance;

5. automobile medical payment insurance;

6. credit-only insurance;

7. coverage for on-site medical clinics; and

8. other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits;

(ii) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of a plan:

1. limited scope dental or vision benefits;

2. benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; and

3. such other similar, limited benefits as are specified in federal regulations issued pursuant to P.L. 104-191;

(iii) the following benefits if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness; and

2. hospital indemnity or other fixed indemnity insurance; or

(iv) the following benefits if offered as a separate insurance policy:

1. Medicare supplemental health insurance (as defined under § 1882(g)(1) of the Social Security Act);

2. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. similar supplemental coverage provided to coverage under an employer sponsored plan.

[(m)] (L) "Health status-related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability including conditions arising out of acts of domestic violence; or

(8) disability.

[(n)] (M) "High level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is:

(1) at least 15% greater than the actuarial value of the low level policy form coverage offered by the carrier in this State; and

(2) at least 100% but not greater than 120% of the weighted average.

[(o)] (N) (1) "Individual health benefit plan" means:

(i) a health benefit plan other than a converted policy or a professional association plan for eligible individuals and their dependents; and

(ii) a certificate issued to an eligible individual that evidences coverage under a policy or contract issued to a trust or association or other similar group of individuals, regardless of the situs of delivery of the policy or contract, if the eligible individual pays the premium and is not being covered under the policy or contract under either federal or State continuation of benefits provisions.

(2) "Individual health benefit plan" does not include short-term limited duration insurance.

[(p)] (O) "Low level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is at least 85% but not greater than 100% of the weighted average.

[(q)] (P) "Preexisting condition" means a condition that was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

[(r) "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.]

[(s)] (Q) "Waiting period" means the period of time that must pass before an individual is eligible to be covered for benefits under the terms of a group health benefit plan.

[(t)] (R) (1) "Weighted average" means the average actuarial value of the benefits provided by:

(i) all the health insurance coverages issued by the carrier in this State in the individual market during the previous calendar year, weighted by enrollment for the different coverages; or

(ii) all the health insurance coverages issued by all carriers in this State in the individual market, if the data are available, during the previous calendar year, weighted by enrollment for the different coverages.

(2) "Weighted average" does not include coverages issued under this subtitle.

[15-1304.

A carrier may not offer any individual health benefit plans in this State unless the carrier offers, and actively markets, the policies required by this subtitle.]

[15-1305.

(a) Unless a carrier makes an election under § 15-1306 of this subtitle, the carrier may not:

(1) decline to offer coverage to, or deny enrollment of an eligible individual; or

(2) impose any preexisting condition provision on an eligible individual.

(b) (1) A carrier that makes an election under § 15-1306 of this subtitle may choose to offer at least two different policy forms, both of which are designed for, made generally available to, actively marketed to, and enroll, both eligible individuals and other individuals.

(2) Policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

(c) Policy forms shall comply with the requirements of this subtitle.]

[15-1306.

(a) A carrier that intends to offer two policy forms shall submit in writing to the Commissioner both:

(1) an election whether to offer:

(i) a high level and low level policy form, each of which includes benefits substantially similar to other individual health insurance coverage offered by the carrier in this State; or

(ii) policy forms with the largest and next to largest premium volume of all policy forms offered by the carrier in this State; and

(2) an election whether to use the weighted average valuation described in § 15-1301(t)(1)(i) or (ii) of this subtitle.

(b) (1) An election made under this section shall be binding for a 2-year period.

(2) After the initial 2-year period, and for each subsequent 2-year period, carriers shall again make the elections required by this section.

(3) An election shall be made on a form and in a manner required by the Commissioner.]

15-1308.

(a) In this section, "affiliate" means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

[(b) Subject to subsections (d) and (k) of this section, a carrier shall issue the individual health benefit plan elected under § 15-1305 or § 15-1306(a)(1) of this subtitle to any eligible individual.

(c) (1) A carrier may not limit coverage under any individual health benefit plan issued to an eligible individual under a preexisting condition provision.

(2) A carrier may impose a preexisting condition provision on an individual who has had a period of at least 63 days during all of which the individual was not covered under any creditable coverage and who would otherwise have been an eligible individual.

(d) A carrier may refuse to issue an individual health benefit plan to an eligible individual, if the carrier demonstrates to the satisfaction of the Commissioner that:

(1) it does not have the policyholder surplus necessary to underwrite additional coverage; and

(2) it is applying this section uniformly to all individuals in the individual market in this State without regard to:

(i) any health status-related factor; and

(ii) whether the individuals are eligible individuals.

(e) A carrier that denies individual health insurance coverage under subsection (d) of this section may not offer coverage in the individual market until the later of:

(1) a period of 180 days after the date the coverage is denied; or

(2) until the carrier has demonstrated, to the Commissioner's satisfaction that the carrier has sufficient policyholder surplus to underwrite additional coverage.]

[(f)] (B) A carrier may elect not to renew all individual health benefit plans in the State.

[(g)] (C) When a carrier elects not to renew all individual health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected individuals at least 180 days before the effective date of nonrenewal;

(2) at least 30 working days before that notice, shall give notice to the Commissioner;

(3) if the carrier has an affiliate in the individual market, shall give notice to each affected individual at least 180 days before the effective date of nonrenewal of the individual's option to purchase all other individual health benefit plans currently offered by the affiliate of the carrier; and

(4) may not write new business for individuals in the State for a 5-year period beginning on the date of notice to the Commissioner.

[(h)] (D) A carrier that offers an individual health benefit plan shall offer an individual health benefit plan to an individual who is nonrenewed by an affiliate of the carrier under subsection [(g)] (C) of this section on a guarantee issue basis, if the individual applies for coverage no later than 63 days after the effective date of nonrenewal.

[(i)] (E) A carrier that issues coverage under subsection [(h)] (D) of this section may not rate the coverage on a substandard basis unless the individual was rated on a substandard basis under the prior coverage provided to the individual by the affiliate of the carrier.

[(j)] (F) (1) Subject to paragraph (2) of this subsection, a carrier that issues coverage under subsection [(h)] (D) of this section shall waive the waiting period for coverage of a preexisting condition to the extent that the individual has satisfied a waiting period under the individual's prior contract or policy.

(2) The carrier that issues coverage under subsection [(h)] (D) of this section may require the individual to satisfy the remaining part of the waiting period if any part of the waiting period under the individual's prior contract or policy has not been satisfied, unless the coverage issued under subsection [(h)] (D) of this section has a shorter waiting period.

[(k)] (G) A health maintenance organization need not offer coverage to an individual who does not live, reside, or work within the health maintenance organization's approved service areas.

15-1312.

A carrier that [elects to offer] ISSUED a high level [and] OR low level policy form[, under § 15-1306 of this subtitle] PRIOR TO JULY 1, 2004, may not charge a rate to eligible individuals UNDER THE HIGH LEVEL OR LOW LEVEL POLICY FORM that is greater than 200% of the rate the carrier normally would charge for the same or similar policy forms to other individuals.

SECTION 2. AND BE IT FURTHER ENACTED, That a carrier may not terminate a health benefit plan that was issued to an eligible individual prior to July 1, 2004, unless the carrier complies with the terms of §§ 15-1308 and 15-1309 of the Insurance Article.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2004.