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23 BY repealing

2004 Regular Session 4lr0123

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 Committee Report: Favorable House action: Adopted Read second time: March 18, 2004						
1	AN ACT concerning					
2 3	Health Insurance - HIPAA - Maryland Health Insurance Plan - Alternative Mechanism					
4 5 6 7 8 9 10 11 12	alternative to the standard coverage required under the federal Health					
13 14 15 16 17	Section 14-501, 15-508(a), 15-1301, 15-1308, and 15-1312 Annotated Code of Maryland					
18 19 20 21 22	Section 14-508 Annotated Code of Maryland					

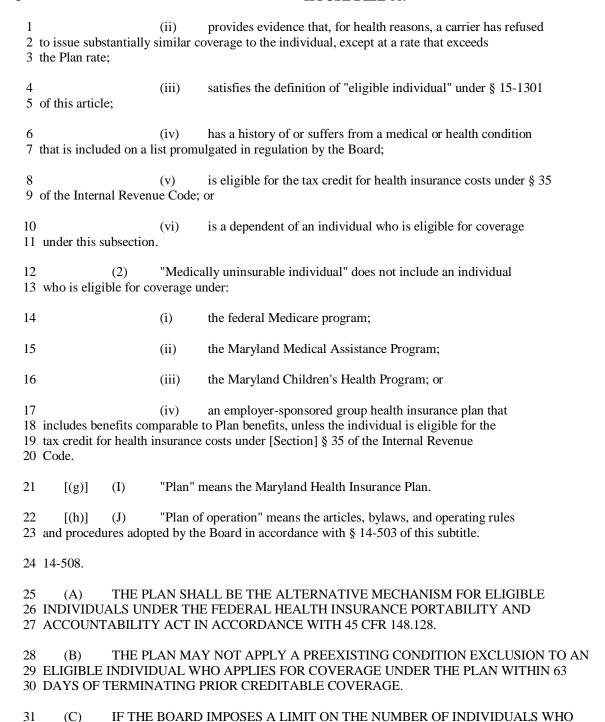
1 Article - Insurance 2 Section 15-1304, 15-1305, and 15-1306 3 Annotated Code of Maryland (2002 Replacement Volume and 2003 Supplement) 4 5 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF 6 MARYLAND, That the Laws of Maryland read as follows: 7 **Article - Insurance** 8 14-501. In this subtitle the following words have the meanings indicated. 9 (a) 10 (b) "Administrator" means: 11 (1) a person that is registered as an administrator under Title 8, Subtitle 12 3 of this article; or 13 (2) a carrier as defined under subsection (d) of this section. 14 "Board" means the Board of Directors for the Maryland Health Insurance (c) 15 Plan. "Carrier" means: 16 (d) 17 (1) an authorized insurer that provides health insurance in the State; 18 (2) a nonprofit health service plan that is licensed to operate in the 19 State; or 20 (3) a health maintenance organization that is licensed to operate in the 21 State. 22 "CREDITABLE COVERAGE" HAS THE MEANING STATED IN § 15-1301 OF THIS (E) 23 TITLE. "ELIGIBLE INDIVIDUAL" HAS THE MEANING STATED IN § 15-1301 OF THIS (F) 25 TITLE. 26 (G) "Fund" means the Maryland Health Insurance Plan Fund. [(e)]27 [(f)](H) (1) "Medically uninsurable individual" means an individual who is 28 a resident of the State and who: 29

30 to issue substantially similar coverage to the individual;

provides evidence that, for health reasons, a carrier has refused

33 INDIVIDUALS.

HOUSE BILL 669



32 CAN PARTICIPATE IN THE PLAN, THE LIMIT MAY NOT BE APPLIED TO HIPAA ELIGIBLE

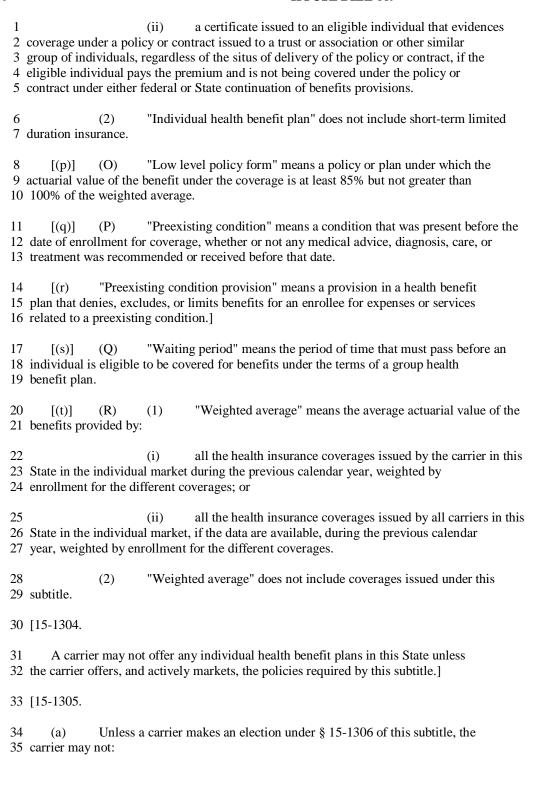
1	15-508.						
2	(a)	(1)	In this s	ection the following words have the meanings indicated.			
3		(2)	"Carrier	" has the meaning stated in § 15-1301 of this title.			
4 5	THIS TITLI	(3) E.	"ENRO	LLMENT DATE" HAS THE MEANING STATED IN § 15-1301 OF			
8		alth servi	ce plan th	"Policy or certificate" means any group or blanket health at is issued or delivered in the State by an insurer or nat provides hospital, medical, or surgical benefits on			
10 11	15-1301 of	[(4)] this title.	(5)	"Preexisting condition provision" has the meaning stated in §			
12 13	15-1301.	[(5)]	(6)	"Late enrollee" has the meaning stated in § 15-1401 of this title.			
14	(a)	In this s	ubtitle th	e following words have the meanings indicated.			
17	[(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.]						
21	[(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.						
23	[(d)]	(C)	"Associa	ation" or "bona fide association" means[,] an association that:			
24		(1)	has been	actively in existence for at least 5 years;			
	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;						
	8 (3) does not condition membership in the association on any health 9 status-related factor relating to an individual, and states so clearly in all 0 membership and application materials;						
33	(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;						

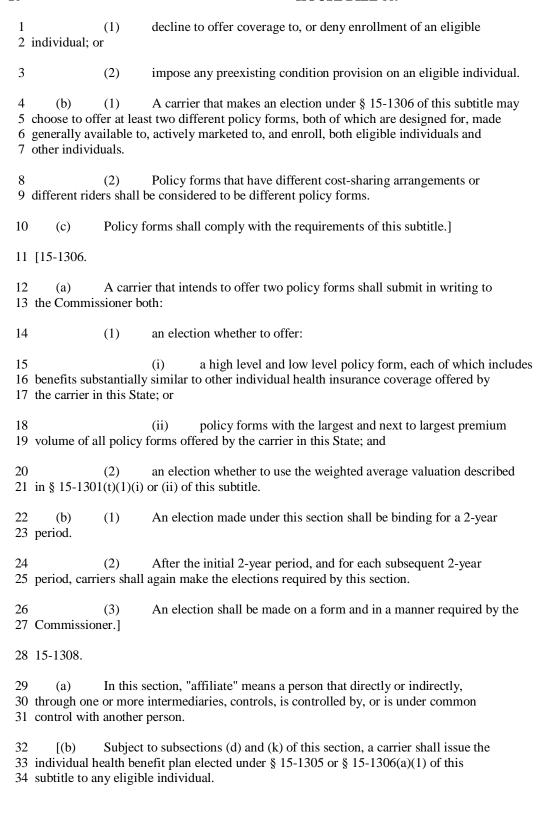
	(5) does not make health insurance coverage offered through the association available other than in connection with membership in the association, and states so clearly in all marketing and application materials; and						
	(6) provides and annually updates information necessary for the Commissioner to determine whether or not the association meets the definition of bona fide association before qualifying as an association under this subtitle.						
7	[(e)]	(D)	"Carrier" means a person that is:				
8 9	provides heal	(1) Ith insura	an insurer that holds a certificate of authority in the State and nce in the State;				
10 11	State;	(2)	a health maintenance organization that is licensed to operate in the				
12 13	State; or	(3)	a nonprofit health service plan that is licensed to operate in the				
14 15	subject to St	(4) ate insur	any other person or organization that provides health benefit plans ance regulation.				
16 17	[(f)] (E) "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.						
18	[(g)]	(F)	(1)	"Creditable coverage" means coverage of an individual under:			
19			(i)	an employer sponsored plan;			
20			(ii)	a health benefit plan;			
21			(iii)	Part A or Part B of Title XVIII of the Social Security Act;			
22 23	2 (iv) Title XIX of the Social Security Act, other than coverage 3 consisting solely of benefits under § 1928 of that Act;						
24			(v)	Chapter 55 of Title 10 of the United States Code;			
25 26	tribal organi	zation;	(vi)	a medical care program of the Indian Health Service or of a			
27			(vii)	a State health benefits risk pool;			
28 29	8 (viii) a health plan offered under the Federal Employees Health 9 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						

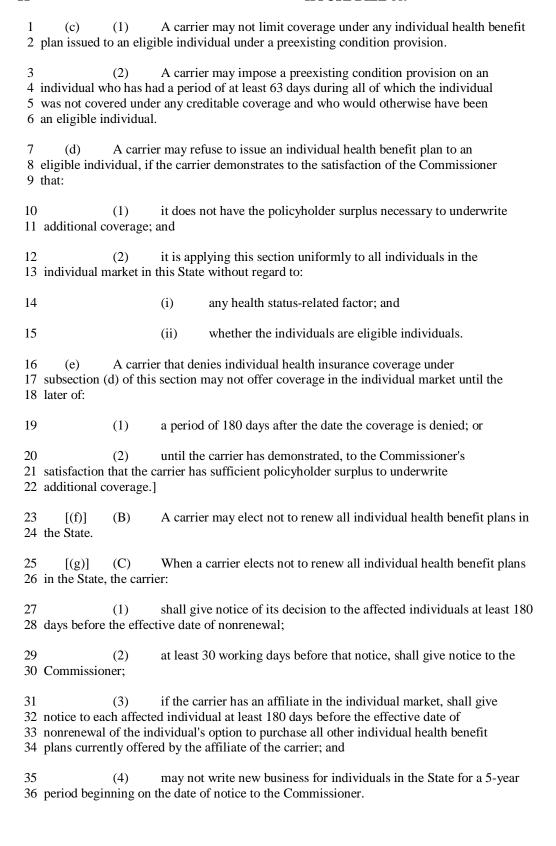
1 2	U.S.C. 2504(e).	(x)	a health benefit plan under § 5(e) of the Peace Corps Act, 22		
5	(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan or an employer sponsored plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.					
7	[(h)]	(G)	"Eligible	e individual" means an individual:		
		(1) otitle, the	(i) e aggregat	for whom, as of the date on which the individual seeks coverage te of the periods of creditable coverage is 18 or more		
	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;					
14		(2)	who is n	ot eligible for coverage under:		
15			(i)	an employer sponsored plan;		
16			(ii)	Part A or Part B of Title XVIII of the Social Security Act; or		
17			(iii)	a State plan under Title XIX of the Social Security Act;		
18		(3)	who doe	s not have coverage under a health benefit plan;		
			f this sub	not had the most recent prior creditable coverage described section terminated for nonpayment of premiums or		
22 23		(5) ler a Stat		he individual has been offered the option of continuation ral continuation provision:		
24			(i)	has elected that coverage; and		
25			(ii)	has exhausted that coverage.		
26	[(i)]	(H)	"Enrolln	nent date" means the date on which:		
27		(1)	an indivi	idual enrolls in a health benefit plan; or		
28 29	enroll.	(2)	the first	day of the waiting period before which the individual may		
	L ()/ J	(I) etiremen		mental plan" means a plan as defined in § 3(32) of the Security Act of 1974 and any federal governmental		

3	[(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.						
5	[(1)]	(K)	(1)	"Health	benefit plan" means a:		
	under multip covering Ma			hospital or medical policy or certificate, including those issued as or associations located in Maryland or any other state			
9 10	(ii) policy, contract, or certificate issued by a nonprofit health service plan that covers Maryland residents; or						
11 12	contract.		(iii)	health n	naintenance organization subscriber or group master		
13		(2)	"Health	benefit p	lan" does not include:		
14			(i)	one or n	nore, or any combination of the following:		
15				1.	coverage only for accident or disability income insurance;		
16				2.	coverage issued as a supplement to liability insurance;		
17 18	and automo	bile liabil	lity insura	3. ance;	liability insurance, including general liability insurance		
19				4.	workers' compensation or similar insurance;		
20				5.	automobile medical payment insurance;		
21				6.	credit-only insurance;		
22				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;						
	26 (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:						
29				1.	limited scope dental or vision benefits;		
30 31	health care,	commun	ity-based	2. care, or	benefits for long-term care, nursing home care, home any combination of these benefits; and		
32 33	2 3. such other similar, limited benefits as are specified in 3 federal regulations issued pursuant to P.L. 104-191;						

1 2	benefits:		(iii)	the follo	owing benefits if offered as independent, noncoordinated	
3				1.	coverage only for a specified disease or illness; and	
4				2.	hospital indemnity or other fixed indemnity insurance; or	
5			(iv)	the follo	owing benefits if offered as a separate insurance policy:	
6 7	under § 1882	2(g)(1) of	the Soci	1. al Securi	Medicare supplemental health insurance (as defined ty Act);	
8 9	Chapter 55 o	of Title 10), United	2. States C	coverage supplemental to the coverage provided under ode; and	
10 11	an employer	sponsor	ed plan.	3.	similar supplemental coverage provided to coverage under	
12	[(m)]	(L)	"Health	status-re	elated factor" means a factor related to:	
13		(1)	health s	tatus;		
14		(2)	medical condition;			
15		(3)	claims experience;			
16		(4)	receipt of health care;			
17		(5)	medical	history;		
18		(6)	genetic	informat	ion;	
19 20	19 (7) evidence of insurability including conditions arising out of acts of 20 domestic violence; or					
21		(8)	disabilit	y.		
22 23	[(n)] actuarial val	(M) lue of the			ey form" means a policy or plan under which the coverage is:	
24 25	24 (1) at least 15% greater than the actuarial value of the low level policy 25 form coverage offered by the carrier in this State; and					
26		(2)	at least	100% bu	t not greater than 120% of the weighted average.	
27	[(o)]	(N)	(1)	"Individ	lual health benefit plan" means:	
28 29	professional	associat	(i) ion plan t		benefit plan other than a converted policy or a le individuals and their dependents; and	







- 1 [(h)] (D) A carrier that offers an individual health benefit plan shall offer an
- 2 individual health benefit plan to an individual who is nonrenewed by an affiliate of
- 3 the carrier under subsection [(g)] (C) of this section on a guarantee issue basis, if the
- 4 individual applies for coverage no later than 63 days after the effective date of
- 5 nonrenewal.
- 6 [(i)] (E) A carrier that issues coverage under subsection [(h)] (D) of this
- 7 section may not rate the coverage on a substandard basis unless the individual was
- 8 rated on a substandard basis under the prior coverage provided to the individual by
- 9 the affiliate of the carrier.
- 10 [(j)] (F) (1) Subject to paragraph (2) of this subsection, a carrier that issues
- 11 coverage under subsection [(h)] (D) of this section shall waive the waiting period for
- 12 coverage of a preexisting condition to the extent that the individual has satisfied a
- 13 waiting period under the individual's prior contract or policy.
- 14 (2) The carrier that issues coverage under subsection [(h)] (D) of this
- 15 section may require the individual to satisfy the remaining part of the waiting period
- 16 if any part of the waiting period under the individual's prior contract or policy has not
- 17 been satisfied, unless the coverage issued under subsection [(h)] (D) of this section
- 18 has a shorter waiting period.
- 19 [(k)] (G) A health maintenance organization need not offer coverage to an
- 20 individual who does not live, reside, or work within the health maintenance
- 21 organization's approved service areas.
- 22 15-1312.
- 23 A carrier that [elects to offer] ISSUED a high level [and] OR low level policy
- 24 form[, under § 15-1306 of this subtitle] PRIOR TO JULY 1, 2004, may not charge a rate
- 25 to eligible individuals UNDER THE HIGH LEVEL OR LOW LEVEL POLICY FORM that is
- 26 greater than 200% of the rate the carrier normally would charge for the same or
- 27 similar policy forms to other individuals.
- 28 SECTION 2. AND BE IT FURTHER ENACTED, That a carrier may not
- 29 terminate a health benefit plan that was issued to an eligible individual prior to July
- 30 1, 2004, unless the carrier complies with the terms of §§ 15-1308 and 15-1309 of the
- 31 Insurance Article.
- 32 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take
- 33 effect July 1, 2004.