SB0079/837375/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 79
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, strike beginning with "expanding" in line 3 down through "policies;" in line 7 and substitute "prohibiting certain application forms from containing inquiries about certain conditions, illnesses, diseases, or medical procedures; prohibiting an insurer or nonprofit health service plan from attaching an exclusionary rider to an individual health benefit plan unless the insurer or nonprofit health service plan obtains the prior written consent of the policyholder; authorizing an insurer or nonprofit health service plan to impose a preexisting condition exclusion or limitation on an individual for a certain condition under certain circumstances; prohibiting the imposition of a preexisting condition exclusion or limitation on a certain individual under certain circumstances; making a conforming change;"; strike beginning with "also" in line 8 down through "carriers" in line 10; in line 13, after "circumstances;" insert "authorizing the Maryland Insurance Commissioner to require the carriers to make a certain report in a certain manner on or before a certain date of each year;"; strike beginning with "altering" in line 16 down through "definition;" in line 17 and substitute "requiring the Maryland Insurance Administration, in consultation with the Maryland Health Care Commission and certain stakeholders, to study certain options in a certain manner; requiring the Administration to report on certain findings to certain committees of the General Assembly in a certain manner on or before a certain date;"; in line 17, after "of" insert "certain provisions of"; in the same line, after "Act;" insert "providing for the effective dates of this Act;"; in line 21, strike "15–508, 15–605(c)(1) and (2)(i), and 15–911(d)" and substitute "12–205"; in line 23, strike "2006" and substitute "2003".

On page 2, in line 1, after "Section" insert "15–508.1; and".

AMENDMENT NO. 2

On page 2, after line 13, insert:

(Over)

"12–205.

(a) (1) The Commissioner shall disapprove a form or withdraw the previous approval of a form filed under § 12–203 of this subtitle if the form does not meet the requirements of subsection (b) of this section.

(2) The order of disapproval or withdrawal of approval shall inform the insurer of:

(i) a statutory or regulatory basis for the disapproval or withdrawal of approval; and

(ii) an explanation of the application of the statutory or regulatory basis for the disapproval or withdrawal of approval.

(b) A form may not:

(1) in any respect violate or fail to comply with this article;

(2) contain or incorporate by reference, if the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) have a title, heading, or other indication of its provisions that is likely to mislead the policyholder or certificate holder;

(4) contain an inequitable provision of insurance without substantial benefit to the policyholder;

(5) be printed or otherwise reproduced so as to make a provision of the form substantially illegible;

(6) provide benefits in a health insurance policy that are unreasonable in relation to the premium charged;

(7) contain, irrespective of the premium charged, a benefit that is not sufficient to be of real economic value to the insured;

(8) fail to provide minimum benefits or coverages that the Commissioner considers necessary to meet the minimum needs of the insured; or

(9) in a health insurance application form **OR A NONPROFIT HEALTH SERVICE PLAN APPLICATION FORM**, contain inquiries about:

(i) a preexisting condition, illness, or disease for which the applicant has not received medical care or advice from a licensed health care provider**:**

1. during the 7 years immediately before the date of **[**the**]** application; or

2. FOR AN APPLICATION FOR AN INDIVIDUAL HEALTH BENEFIT PLAN THAT IS SUBJECT TO § 15-508.1 OF THIS ARTICLE, DURING THE 5 YEARS IMMEDIATELY BEFORE THE DATE OF APPLICATION; OR

(ii) medical screening, testing, monitoring, or any other similar medical procedure that the Commissioner specifies and that the applicant received**:**

1. more than 7 years before the date of application**; OR**

2. FOR AN APPLICATION FOR AN INDIVIDUAL HEALTH BENEFIT PLAN THAT IS SUBJECT TO § 15-508.1 OF THIS ARTICLE, MORE THAN 5 YEARS BEFORE THE DATE OF APPLICATION.

15-508.1.

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

(2) "CARRIER" MEANS AN INSURER OR A NONPROFIT HEALTH SERVICE PLAN.

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

(4) "EXCLUSIONARY RIDER" MEANS AN ENDORSEMENT TO AN INDIVIDUAL HEALTH BENEFIT PLAN THAT EXCLUDES BENEFITS FOR ONE OR MORE NAMED CONDITIONS THAT ARE DISCOVERED BY A CARRIER DURING THE UNDERWRITING PROCESS.

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

(6) "INDIVIDUAL HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN ISSUED BY A CARRIER THAT INSURES:

(I) ONLY ONE INDIVIDUAL; OR

(II) ONE INDIVIDUAL AND ONE OR MORE FAMILY MEMBERS OF THE INDIVIDUAL.

(B) A CARRIER MAY NOT ATTACH AN EXCLUSIONARY RIDER TO AN INDIVIDUAL HEALTH BENEFIT PLAN UNLESS THE CARRIER OBTAINS THE PRIOR WRITTEN CONSENT OF THE POLICYHOLDER.

(C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, A CARRIER MAY IMPOSE A PREEXISTING CONDITION EXCLUSION OR LIMITATION ON AN INDIVIDUAL FOR A CONDITION THAT WAS NOT DISCOVERED DURING THE UNDERWRITING PROCESS FOR AN INDIVIDUAL HEALTH BENEFIT PLAN ONLY IF THE EXCLUSION OR LIMITATION:

(1) RELATES TO A CONDITION OF THE INDIVIDUAL, REGARDLESS OF ITS CAUSE, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN THE 12-MONTH PERIOD IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE INDIVIDUAL'S COVERAGE;

(2) EXTENDS FOR A PERIOD OF NOT MORE THAN 12 MONTHS AFTER THE EFFECTIVE DATE OF THE INDIVIDUAL'S COVERAGE; AND

(3) IS REDUCED BY THE AGGREGATE OF ANY APPLICABLE PERIODS OF CREDITABLE COVERAGE.

(D) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A CARRIER MAY NOT IMPOSE A PREEXISTING CONDITION EXCLUSION OR LIMITATION ON AN INDIVIDUAL WHO, AS OF THE LAST DAY OF THE 30-DAY PERIOD BEGINNING WITH THE DATE OF THE INDIVIDUAL'S BIRTH, IS COVERED UNDER ANY CREDITABLE COVERAGE.

(2) THE LIMITATION ON THE IMPOSITION OF A PREEXISTING CONDITION EXCLUSION OR LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION DOES NOT APPLY AFTER THE END OF THE FIRST 63-DAY PERIOD DURING ALL OF WHICH THE INDIVIDUAL WAS NOT COVERED UNDER ANY CREDITABLE COVERAGE.".

On pages 2 through 4, strike in their entirety the lines beginning with line 14 on page 2 through line 3 on page 4, inclusive.

AMENDMENT NO. 3

On page 5, strike in their entirety lines 7 through 9, inclusive; in line 10, strike "**(D)**" and substitute "**(C)**"; and strike in their entirety lines 24 through 27, inclusive, and substitute:

"**(6) THAT THE MARYLAND RESIDENT MAY PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN THAT INCLUDES THE MANDATED BENEFITS UNDER SUBTITLE 8 OF THIS TITLE THAT ARE NOT INCLUDED IN THE OUT–OF–STATE ASSOCIATION CONTRACT FROM A CARRIER LICENSED AND AUTHORIZED TO DO BUSINESS IN THE STATE;**".

AMENDMENT NO. 4

On page 6, strike in their entirety lines 1 through 9, inclusive, and substitute:

"**(D) (1) THE COMMISSIONER MAY REQUIRE A CARRIER THAT OFFERS COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT TO REPORT, ON OR BEFORE MARCH 1 OF EACH YEAR, THE NUMBER OF MARYLAND RESIDENTS COVERED IN THE PRECEDING CALENDAR YEAR UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT.**

(2) THE DATA REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE REPORTED IN A MANNER DETERMINED BY THE COMMISSIONER.";

in line 10, strike "**(F)**" and substitute "**(E)**"; in line 12, strike "**COVERAGE UNDER**"; and in line 31, after "**ALL**" insert "**REASONABLE**".

AMENDMENT NO. 5

On page 7, after line 9, insert:

"SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) (1) The Maryland Insurance Administration, in consultation with the Maryland Health Care Commission and appropriate stakeholders, shall study options to raise or define medical loss ratio requirements in the individual, small group, and large group health insurance markets that incentivize reduction of health care costs and improvement of health care quality.

(2) In conducting the study required under this section, the Administration shall study medical loss ratio requirements in other states to determine innovative ways to encourage health insurance carriers to:

(i) incentivize adoption of electronic health records;

(ii) implement wellness programs;

(iii) implement chronic care management programs; and

(iv) adopt other policies that reduce health care costs and improve health care quality.

(3) The study required under this section also shall examine the feasibility and desirability of tiered medical loss ratio requirements in the small group market by looking at the impact of tiered medical loss ratio requirements in other states.

(b) On or before December 1, 2009, the Administration shall report, in accordance with § 2–1246 of the State Government Article, to the Senate Finance Committee and House Health and Government Operations Committee on its findings under this section.";

in line 10, strike "2." and substitute "3."; in the same line, after "That" insert "Section 1 of"; in the same line, after "shall" insert "take effect on October 1, 2009, and"; in line 12, strike "January 1, 2010" and substitute "October 1, 2009"; in line 13, strike "3." and substitute "4."; and in the same line, after "That" insert ", except as provided in Section 3 of this Act,".