HOUSE BILL 674

C3 9lr2418
CF SB 637

By: **Delegate Morhaim**
Introduced and read first time: February 9, 2009
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Small Group Market Regulation – Modifications

FOR the purpose of repealing the termination provision of certain provisions of law relating to the rating of certain health benefit plans; requiring the Maryland Health Care Commission to maintain a certain application on its website; requiring the Commission to update certain information at least quarterly; applying certain provisions of law relating to preexisting conditions to certain policies or certificates issued to small employers; authorizing certain carriers to offer certain health benefit plans that have greater benefits than those in the Comprehensive Standard Health Benefit Plan under certain circumstances; authorizing a carrier to offer benefits that differ from those in the Standard Plan under certain circumstances; repealing a requirement that the Commission require that the minimum benefits allowed to be offered in the Standard Plan meet a certain level; repealing certain provisions of law authorizing certain health benefit plans to require certain deductibles and cost–sharing for benefits for preexisting conditions; providing that certain benefits that vary from the Standard Plan and are approved by the Maryland Insurance Commissioner are subject to certain provisions of law applicable to the Standard Plan; authorizing the Commissioner to prohibit a carrier from offering benefits that vary from the Standard Plan under certain circumstances; altering the geographic areas for which a carrier may adjust the community rate for certain health benefit plans; altering certain limits on the rate a carrier may charge based on adjustments to the community rate for certain health benefit plans due to certain factors; altering the due date of a certain report; authorizing a carrier to adjust the community rate for certain health benefit plans for health status at certain rates under certain circumstances; authorizing a carrier to use certain health statements and health screenings to establish certain premium rates; prohibiting a carrier from limiting coverage or refusing to issue a health benefit plan to a certain small employer based on a health status–related factor; establishing that it is an unfair trade practice for a carrier knowingly to provide coverage to a small employer that discriminates

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

against certain individuals under certain circumstances; making certain conforming changes; requiring the Commission to conduct a certain study and report on its findings and recommendations to the Governor and the General Assembly on or before a certain date; providing for the termination of certain provisions of this Act; providing for the effective dates of this Act; providing for the application of certain provisions of this Act; and generally relating to health benefit plans offered in the small group market.

BY repealing and reenacting, with amendments,
Chapter 600 of the Acts of the General Assembly of 2007
Section 2

BY adding to
Article – Health – General
Section 19–108.1
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–508, 15–1204(a) through (d), 15–1205, 15–1207, 15–1208, and 15–1213
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

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

Chapter 600 of the Acts of 2007

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2007. **[**It shall remain effective for a period of 4 years and, at the end of June 30, 2011, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health – General

19–108.1.

(A) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL MAINTAIN ON ITS WEBSITE AN APPLICATION THAT A SMALL BUSINESS MAY USE TO COMPARE PREMIUMS OF HEALTH BENEFIT PLANS OFFERED BY HEALTH INSURANCE CARRIERS UNDER TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE.

(B) THE APPLICATION REQUIRED UNDER THIS SECTION SHALL PROVIDE INFORMATION ON:

(1) PREMIUMS FOR HEALTH BENEFIT PLANS SOLD UNDER TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE, CATEGORIZED BY AGE BANDS; AND

(2) PREMIUMS FOR HEALTH BENEFIT PLANS SOLD UNDER TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE THAT INCLUDE RIDERS TYPICALLY PURCHASED BY SMALL EMPLOYERS IN THE STATE.

(C) THE COMMISSION SHALL UPDATE THE INFORMATION REQUIRED UNDER THIS SECTION AT LEAST QUARTERLY.

Article – Insurance

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.

(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.

(5) "Preexisting condition provision" has the meaning stated in § 15–1301 of this title.

(6) "Late enrollee" has the meaning stated in § 15–1401 of this title.

(b) This section does not apply to a policy or certificate issued **[**to a small employer in accordance with Subtitle 12 of this title, or**]** to an individual in accordance with Subtitle 13 of this title.

(c) Except as otherwise provided in subsection (d) of this section, a carrier may impose a preexisting condition provision only if it:

(1) relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6–month period ending on the enrollment date;

(2) extends for a period of not more than 12 months after the enrollment date or 18 months in the case of a late enrollee; and

(3) is reduced by the aggregate of the periods of creditable coverage, as defined in Subtitle 14 of this title.

(d) (1) Subject to paragraph (4) of this subsection, a carrier may not impose any preexisting condition provision on an individual who, as of the last day of the 30–day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to paragraph (4) of this subsection, a carrier may not impose any preexisting condition provisions on a child who:

(i) is adopted or placed for adoption before attaining 18 years of age; and

(ii) as of the last day of the 30–day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage.

(3) A carrier may not impose any preexisting condition provisions relating to pregnancy.

(4) Paragraphs (1) and (2) of this subsection do not apply to an individual after the end of the first 63–day period during all of which the individual was not covered under any creditable coverage.

15–1204.

(a) In addition to any other requirement under this article, a carrier shall:

(1) have demonstrated the capacity to administer the health benefit plan, including adequate numbers and types of administrative personnel;

(2) have a satisfactory grievance procedure and ability to respond to enrollees' calls, questions, and complaints;

(3) provide, in the case of individuals covered under more than one health benefit plan, for coordination of coverage under all of those health benefit plans in an equitable manner; and

(4) design policies to help ensure adequate access to providers of health care.

(b) A person may not offer a health benefit plan in the State unless the person offers at least the Standard Plan.

(c) **[**A**]** **IF A CARRIER OFFERS AT LEAST THE STANDARD PLAN, THE** carrier **ALSO** may **[**not**]** offer a health benefit plan that has fewer **OR GREATER** benefits than those in the Standard Plan.

(d) A carrier may offer benefits **[**in addition to**]** **THAT DIFFER FROM** those in the Standard Plan if:

(1) the **[**additional**]** benefits:

(i) are offered and priced separately from benefits specified in accordance with § 15–1207 of this subtitle; and

(ii) do not have the effect of duplicating any of those benefits; and

(2) the carrier:

(i) clearly distinguishes the Standard Plan from other offerings of the carrier;

(ii) indicates the Standard Plan is the only plan required by State law; and

(iii) specifies that all enhancements to the Standard Plan are not required by State law.

15–1207.

(a) In accordance with Title 19, Subtitle 1 of the Health – General Article, the Commission shall adopt regulations that specify:

(1) the Comprehensive Standard Health Benefit Plan to apply under this subtitle; and

(2) the requirements for a wellness benefit offered by a carrier to apply under this subtitle.

(b) **[**The Commission shall require that the minimum benefits allowed to be offered in the Standard Plan:

(1) by a health maintenance organization, shall include at least the actuarial equivalent of the minimum benefits required to be offered by a federally qualified health maintenance organization; and

(2) by an insurer or nonprofit health service plan on an expense–incurred basis, shall be actuarially equivalent to at least the minimum benefits required to be offered under item (1) of this subsection.

(c)**]** (1) Subject to paragraph (2) of this subsection, the Commission shall exclude or limit benefits or adjust cost–sharing arrangements in the Standard Plan if the average rate for the Standard Plan exceeds 10% of the average annual wage in the State.

(2) The Commission annually shall determine the average rate for the Standard Plan by using the average rate submitted by each carrier that offers the Standard Plan.

[(d)**] (C)** In establishing benefits, the Commission shall judge preventive services, medical treatments, procedures, and related health services based on:

(1) their effectiveness in improving the health status of individuals;

(2) their impact on maintaining and improving health and on reducing the unnecessary consumption of health care services; and

(3) their impact on the affordability of health care coverage.

[(e)**] (D)** The Commission may exclude:

(1) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(2) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

[(f)**] (E)** The Standard Plan shall include uniform deductibles and cost–sharing associated with its benefits, as determined by the Commission.

[(g)**] (F)** In establishing cost–sharing as part of the Standard Plan, the Commission shall:

(1) include cost–sharing and other incentives to help prevent consumers from seeking unnecessary services;

(2) balance the effect of cost–sharing in reducing premiums and in affecting utilization of appropriate services; and

(3) limit the total cost–sharing that may be incurred by an individual in a year.

15–1208.

(a) (1) **[**A**]** **EXCEPT AS PROVIDED IN THIS SECTION AND IN § 15–508 OF THIS TITLE, 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;

(iii) a request for enrollment is made within 30 days after the eligible employee's marriage or the birth or adoption of a child; or

(iv) the individual or a family member of the individual who is eligible for enrollment under § 15–301.1 of the Health – General Article requests enrollment within 30 days after becoming eligible.

(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) Except as provided in subsection (d) of this section, 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.

(d) Subsection (c) of this section does not apply to an individual or a family member of an individual who is eligible for enrollment in the MCHP private option plan established under § 15–301.1 of the Health – General Article and is a late enrollee.**]**

15–1213.

(a) This section does not apply to any insurance enumerated in § 15–1201(f)(3)(i) through (xiii) of this subtitle.

(b) Each benefit offered **[**in addition to**]** **THAT VARIES FROM** the Standard Plan that increases access to care choices or lowers the cost–sharing arrangement in the Standard Plan **AND HAS BEEN APPROVED BY THE COMMISSIONER** is subject to all of the provisions of this subtitle applicable to the Standard Plan, including:

(1) guaranteed issuance;

(2) guaranteed renewal;

(3) adjusted community rating; and

(4) the prohibition on preexisting condition limitations.

(c) (1) Each benefit offered in addition to the Standard Plan that increases the type of services available or the frequency of services is not subject to guaranteed issuance but is subject to all other provisions of this subtitle applicable to the Standard Plan, including:

(i) guaranteed renewal;

(ii) adjusted community rating; and

(iii) the prohibition on preexisting condition limitations.

(2) For each additional benefit offered under this subsection, a carrier shall accept or reject the application of the entire group.

(3) The Commissioner may prohibit a carrier from offering **[**an additional benefit**]** **BENEFITS THAT VARY FROM THE STANDARD PLAN** under this subsection if the Commissioner finds that the **[**additional**]** **OFFERED** benefit will be sold in conjunction with the Standard Plan in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this subtitle.

(d) (1) A benefit offered in addition to the Standard Plan to lower the cost–sharing arrangement in the Standard Plan in accordance with § 15–301.1 of the Health – General Article is subject to:

(i) guaranteed issuance;

(ii) guaranteed renewal;

(iii) adjusted community rating; and

(iv) the prohibition on preexisting condition limitations.

(2) A carrier that offers a benefit under this subsection shall be required to guarantee issuance and guarantee renewal of the additional benefit only to employers who are participating in the MCHP private option plan established under § 15–301.1 of the Health – General Article.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–1205.

(a) (1) In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to **[**health status or occupation or**]** any **[**other**]** factor not specifically authorized under this subsection **OR SUBSECTION (F) OF THIS SECTION**.

(2) A carrier may adjust the community rate only for:

(i) age; **[**and**]**

(ii) geography based on the following contiguous areas of the State:

1. the Baltimore metropolitan area;

2. the District of Columbia metropolitan area;

3. Western Maryland; **[**and**]**

4. Eastern **MARYLAND;** and

5. Southern Maryland**; AND**

(III) HEALTH STATUS, AS PROVIDED IN SUBSECTION (F) OF THIS SECTION.

(3) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

(4) (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph (2) of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.

(ii) A discount offered under subparagraph (i) of this paragraph shall be:

1. applied to reduce the rate otherwise payable by the small employer;

2. actuarially justified;

3. offered uniformly to all small employers; and

4. approved by the Commissioner.

(b) A carrier shall apply all risk adjustment factors under **[**subsection (a)**]** **SUBSECTIONS (A) AND (F)** of this section consistently with respect to all health benefit plans that are issued, delivered, or renewed in the State.

(c) (1) Based on the adjustments allowed under subsection **[**(a)(2)**]** **(A)(2)(I) AND (II)** of this section, a carrier may charge a rate that is **[**40%**]** **65%** above or **[**50%**]** **65%** below the community rate.

(2) (i) On or before October 1, 2007, the Commission shall adopt regulations that require carriers to collect and report to the Commission data on participation, by rate band, in health benefit plans issued, delivered, or renewed under this subtitle.

(ii) On or before January 1, **[**2011**]** **2012**, the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee regarding the effect of the **[**50%**]** **65%** rate **[**adjustment**]** **ADJUSTMENTS** authorized under paragraph (1) of this subsection on participation in health benefit plans issued, delivered, or renewed under this subtitle.

(d) (1) A carrier shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles.

(2) A carrier that is a health maintenance organization and that includes a subrogation provision in its contract as authorized under § 19–713.1(d) of the Health – General Article shall:

(i) use in its rating methodology an adjustment that reflects the subrogation; and

(ii) identify in its rate filing with the Administration, and annually in a form approved by the Commissioner, all amounts recovered through subrogation.

(e) (1) A carrier may offer an administrative discount to a small employer if the small employer elects to purchase, for its employees, an annuity, dental insurance, disability insurance, life insurance, long term care insurance, vision insurance, or, with the approval of the Commissioner, any other insurance sold by the carrier.

(2) The administrative discount shall be offered under the same terms and conditions for all qualifying small employers.

(F) (1) A CARRIER MAY ADJUST THE COMMUNITY RATE FOR A HEALTH BENEFIT PLAN FOR HEALTH STATUS ONLY ON THE INITIAL ENROLLMENT OF THE SMALL EMPLOYER IN THE HEALTH BENEFIT PLAN.

(2) (I) BASED ON THE ADJUSTMENT ALLOWED UNDER PARAGRAPH (1) OF THIS SUBSECTION, IN ADDITION TO THE ADJUSTMENTS ALLOWED UNDER SUBSECTION (C)(1) OF THIS SECTION, A CARRIER MAY CHARGE:

1. IN THE FIRST YEAR OF ENROLLMENT, A RATE THAT IS 10% ABOVE OR BELOW THE COMMUNITY RATE;

2. IN THE SECOND YEAR OF ENROLLMENT, A RATE THAT IS 5% ABOVE OR BELOW THE COMMUNITY RATE; AND

3. IN THE THIRD YEAR OF ENROLLMENT, A RATE THAT IS 2% ABOVE OR BELOW THE COMMUNITY RATE.

(II) A CARRIER MAY NOT MAKE ANY ADJUSTMENT FOR HEALTH STATUS IN THE COMMUNITY RATE OF A HEALTH BENEFIT PLAN ISSUED UNDER THIS SUBTITLE AFTER THE THIRD YEAR OF ENROLLMENT OF A SMALL EMPLOYER IN THE HEALTH BENEFIT PLAN.

(3) A CARRIER MAY USE HEALTH STATEMENTS, IN A FORM APPROVED BY THE COMMISSIONER, AND HEALTH SCREENINGS TO ESTABLISH AN ADJUSTMENT TO THE COMMUNITY RATE FOR HEALTH STATUS AS PROVIDED IN THIS SUBSECTION.

(4) A CARRIER MAY NOT LIMIT COVERAGE OFFERED BY THE CARRIER, OR REFUSE TO ISSUE A HEALTH BENEFIT PLAN TO ANY SMALL EMPLOYER THAT MEETS THE REQUIREMENTS OF THIS SUBTITLE, BASED ON A HEALTH STATUS–RELATED FACTOR.

(5) IT IS AN UNFAIR TRADE PRACTICE FOR A CARRIER KNOWINGLY TO PROVIDE COVERAGE TO A SMALL EMPLOYER THAT DISCRIMINATES AGAINST AN EMPLOYEE OR APPLICANT FOR EMPLOYMENT,

BASED ON THE HEALTH STATUS OF THE EMPLOYEE OR APPLICANT OR A DEPENDENT OF THE EMPLOYEE OR APPLICANT, WITH RESPECT TO PARTICIPATION IN A HEALTH BENEFIT PLAN SPONSORED BY THE SMALL EMPLOYER.

SECTION 4. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–1205.

(a) (1) In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to health status or occupation or any other factor not specifically authorized under this subsection.

(2) A carrier may adjust the community rate only for:

(i) age; and

(ii) geography based on the following contiguous areas of the State:

1. the Baltimore metropolitan area;

2. the District of Columbia metropolitan area;

3. Western Maryland; **[**and**]**

4. Eastern **MARYLAND;** and

5. Southern Maryland.

(3) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

(4) (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph (2) of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.

(ii) A discount offered under subparagraph (i) of this paragraph shall be:

1. applied to reduce the rate otherwise payable by the small employer;

2. actuarially justified;

3. offered uniformly to all small employers; and

4. approved by the Commissioner.

(b) A carrier shall apply all risk adjustment factors under subsection (a) of this section consistently with respect to all health benefit plans that are issued, delivered, or renewed in the State.

(c) (1) Based on the adjustments allowed under subsection (a)(2) of this section, a carrier may charge a rate that is 40% above or 50% below the community rate.

(2) **[**(i)**]** On or before October 1, 2007, the Commission shall adopt regulations that require carriers to collect and report to the Commission data on participation, by rate band, in health benefit plans issued, delivered, or renewed under this subtitle.

[(ii) On or before January 1, 2011, the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee regarding the effect of the 50% rate adjustment authorized under paragraph (1) of this subsection on participation in health benefit plans issued, delivered, or renewed under this subtitle.**]**

(d) (1) A carrier shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles.

(2) A carrier that is a health maintenance organization and that includes a subrogation provision in its contract as authorized under § 19–713.1(d) of the Health – General Article shall:

(i) use in its rating methodology an adjustment that reflects the subrogation; and

(ii) identify in its rate filing with the Administration, and annually in a form approved by the Commissioner, all amounts recovered through subrogation.

(e) (1) A carrier may offer an administrative discount to a small employer if the small employer elects to purchase, for its employees, an annuity, dental insurance, disability insurance, life insurance, long term care insurance, vision insurance, or, with the approval of the Commissioner, any other insurance sold by the carrier.

(2) The administrative discount shall be offered under the same terms and conditions for all qualifying small employers.

SECTION 5. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission shall study options to implement the use of value–based health care services and increase efficiencies in the Comprehensive Standard Health Benefit Plan.

(b) On or before December 1, 2009, the Commission shall report on its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly.

SECTION 6. AND BE IT FURTHER ENACTED, That, Section 2 of this Act shall take effect October 1, 2009, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2009.

SECTION 7. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect October 1, 2009, and shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2009. It shall remain effective for a period of 5 years and, at the end of September 30, 2014, with no further action required by the General Assembly, Section 3 of this Act shall be abrogated and of no further force and effect.

SECTION 8. AND BE IT FURTHER ENACTED, That Section 4 of this Act shall take effect on the taking effect of the termination provision specified in Section 7 of this Act.

SECTION 9. AND BE IT FURTHER ENACTED, That, except as provided in Sections 6, 7, and 8 of this Act, this Act shall take effect July 1, 2009.