SENATE BILL 79

C3 (9lr0049)

ENROLLED BILL

—Finance/Health and Government Operations—

Introduced by **Chair, Finance Committee (By Request – Departmental – Insurance Administration, Maryland)**

Read and Examined by Proofreaders:

_______________________________ Proofreader.

_______________________________ Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this

_______ day of ______________ at ______________________ o'clock, ________M.

_______________________________ President.

CHAPTER ______

1 AN ACT concerning

2 **Health Insurance – Reform**

3 FOR the purpose of ~~expanding the applicability of certain provisions of law that limit~~
4 ~~the imposition of certain preexisting condition provisions by certain carriers to a~~
5 ~~policy or certificate issued to an individual in accordance with certain provisions~~
6 ~~of law; altering certain loss ratio requirements for certain health benefit plans~~
7 ~~and Medicare supplement policies;~~ prohibiting certain application forms from
8 containing inquiries about certain conditions, illnesses, diseases, or medical
9 procedures; prohibiting an insurer or nonprofit health service plan from
10 attaching an exclusionary rider to an individual health benefit plan unless the
11 insurer or nonprofit health service plan obtains the prior written consent of the
12 policyholder; authorizing an insurer or nonprofit health service plan to impose a
13 preexisting condition exclusion or limitation on an individual for a certain
14 condition under certain circumstances; prohibiting the imposition of a

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.
Italics indicate opposite chamber/conference committee amendments.

preexisting condition exclusion or limitation on a certain individual under certain circumstances; making a conforming change; requiring certain carriers that offer certain out–of–state association contracts to Maryland residents ~~also to offer certain individual health insurance contracts to Maryland residents; requiring the carriers~~ to make certain disclosures to a Maryland resident applying for coverage under an out–of–state association contract; requiring the carriers to disclose certain information on the enrollment application for coverage under an out–of–state association contract under certain circumstances; 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; prohibiting certain carriers from rescinding a contract or certificate under certain circumstances; requiring the carrier to have the burden of persuasion that a rescission complies with certain provisions of this Act; ~~altering a certain definition;~~ 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; defining certain terms; providing for the application of certain provisions of this Act; providing for the effective dates of this Act; and generally relating to health insurance.

BY repealing and reenacting, with amendments,
Article – Insurance
Section ~~15–508, 15–605(c)(1) and (2)(i), and 15–911(d)~~ 12–205
Annotated Code of Maryland
(~~2006~~ 2003 Replacement Volume and 2008 Supplement)

BY adding to
Article – Insurance
Section 15–508.1; and 15–1105 and 15–1106 to be under the amended subtitle "Subtitle 11. Miscellaneous Health Insurance Policies and Contracts and Health Benefit Plans"
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY adding to
Article – Health – General
Section 19–706(ttt)
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

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

Article – Insurance

1 12–205.

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

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

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

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

11 (b) A form may not:

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

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

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

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

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

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

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

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

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

31 (i) a preexisting condition, illness, or disease for which the
32 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.

~~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**]** **INDIVIDUAL, 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.~~

~~15–605.~~

~~(c) (1) For a health benefit plan that is issued under Subtitle 12 of this title, the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than [75%] **85%**.~~

~~(2) (i) Subject to subparagraph (ii) of this paragraph, for a health benefit plan that is issued to individuals the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than [60%] **80%**.~~

~~15–911.~~

~~(d) The minimum acceptable loss ratios for Medicare supplement policies are:~~

~~(1) for group Medicare supplement policies, at least [75%] **85%** of the aggregate amount of premiums earned; and~~

~~(2) for individual Medicare supplement policies or subscriber contracts that are issued or renewed on a policy anniversary after July 1, 1991, at least [65%] **80%** of the aggregate amount of premiums earned.~~

Subtitle 11. Miscellaneous Health Insurance Policies AND CONTRACTS AND HEALTH BENEFIT PLANS.

15–1105.

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

(2) "CARRIER" MEANS:

(I) AN INSURER; OR

(II) A NONPROFIT HEALTH SERVICE PLAN.

(3) "ELIGIBLE INDIVIDUAL" MEANS A MARYLAND RESIDENT WHO HAS MEMBERSHIP IN AN ASSOCIATION.

(4) "EVIDENCE OF INDIVIDUAL INSURABILITY" MEANS MEDICAL OR OTHER INFORMATION THAT INDICATES HEALTH STATUS, USED TO DETERMINE WHETHER COVERAGE OF AN INDIVIDUAL IS TO BE:

(I) ISSUED OR DENIED; OR

(II) ISSUED WITH OR WITHOUT AN EXCLUSIONARY RIDER.

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

(6) "HEALTH STATUS–RELATED FACTOR" HAS THE MEANING STATED IN § 15–1201 OF THIS TITLE.

(7) "INDIVIDUAL HEALTH INSURANCE CONTRACT" MEANS A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED IN THE STATE TO AN INDIVIDUAL.

(8) "MEMBER" MEANS AN ELIGIBLE INDIVIDUAL WHO PURCHASES COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT.

(9) "OUT–OF–STATE ASSOCIATION CONTRACT" MEANS A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED TO AN ASSOCIATION OUTSIDE THE STATE.

(B) THIS SECTION APPLIES TO A CARRIER THAT REQUIRES EVIDENCE OF INDIVIDUAL INSURABILITY FOR COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT.

~~**(C) A CARRIER THAT OFFERS COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT TO MARYLAND RESIDENTS ALSO SHALL OFFER AN INDIVIDUAL HEALTH BENEFIT PLAN TO MARYLAND RESIDENTS.**~~

~~**(D)**~~ (C) **A CARRIER SHALL DISCLOSE TO A MARYLAND RESIDENT APPLYING FOR COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT:**

(1) THAT COVERAGE IS CONDITIONED ON MEMBERSHIP IN THE ASSOCIATION THAT HOLDS THE OUT–OF–STATE ASSOCIATION CONTRACT;

(2) ALL COSTS RELATED TO JOINING AND MAINTAINING MEMBERSHIP IN THE ASSOCIATION;

(3) THAT MEMBERSHIP FEES OR DUES ARE IN ADDITION TO THE PREMIUM FOR COVERAGE UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT;

(4) THAT THE TERMS AND CONDITIONS OF COVERAGE UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT ARE DETERMINED BY THE ASSOCIATION AND THE CARRIER;

(5) THE MANDATED BENEFITS REQUIRED UNDER SUBTITLE 8 OF THIS TITLE THAT ARE NOT INCLUDED IN THE OUT–OF–STATE ASSOCIATION CONTRACT;

~~**(6) THAT THE MARYLAND RESIDENT MAY PURCHASE DIRECTLY FROM THE CARRIER AN INDIVIDUAL HEALTH BENEFIT PLAN THAT INCLUDES THE MANDATED BENEFITS REQUIRED UNDER SUBTITLE 8 OF THIS TITLE THAT ARE NOT INCLUDED IN THE OUT–OF–STATE ASSOCIATION CONTRACT;**~~

<u>**(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;**</u>

(7) THAT BENEFITS OFFERED UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT ARE NOT REGULATED BY THE COMMISSIONER; AND

(8) THAT THE TERMS AND CONDITIONS OF COVERAGE UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT MAY BE CHANGED BY AGREEMENT OF THE ASSOCIATION AND THE CARRIER WITHOUT THE CONSENT OF A MEMBER.

~~**(E) A CARRIER MAY SATISFY THE DISCLOSURE REQUIREMENT UNDER SUBSECTION (D)(6) OF THIS SECTION BY PROVIDING TO A MARYLAND RESIDENT, AT THE TIME APPLICATION IS MADE TO THE CARRIER FOR COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT INFORMATION ABOUT:**~~

~~**(1) HOW TO APPLY FOR COVERAGE UNDER AN INDIVIDUAL HEALTH BENEFIT PLAN OFFERED BY THE CARRIER THAT IS NOT CONDITIONED ON ASSOCIATION MEMBERSHIP; AND**~~

~~**(2) THE PREMIUM FOR THE COVERAGE.**~~

<u>**(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.**</u>

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

4 ~~(F)~~ (E) IF A CARRIER COLLECTS MEMBERSHIP FEES OR DUES ON
5 BEHALF OF AN ASSOCIATION, THE CARRIER SHALL DISCLOSE ON THE
6 ENROLLMENT APPLICATION FOR ~~COVERAGE UNDER~~ AN OUT–OF–STATE
7 ASSOCIATION CONTRACT THAT THE CARRIER BILLS AND COLLECTS
8 MEMBERSHIP FEES AND DUES ON BEHALF OF THE ASSOCIATION.

9 **15–1106.**

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

12 (2) "CARRIER" MEANS:

13 (I) AN INSURER;

14 (II) A NONPROFIT HEALTH SERVICE PLAN; OR

15 (III) A HEALTH MAINTENANCE ORGANIZATION.

16 (3) "EVIDENCE OF INDIVIDUAL INSURABILITY" HAS THE
17 MEANING STATED IN § 15–1105 OF THIS SUBTITLE.

18 (4) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN §
19 15–1301 OF THIS TITLE.

20 (B) IF A CARRIER CONDITIONS COVERAGE FOR A HEALTH BENEFIT
21 PLAN ON EVIDENCE OF INDIVIDUAL INSURABILITY, THE CARRIER MAY NOT
22 RESCIND A CONTRACT OR A CERTIFICATE ON THE BASIS OF WRITTEN
23 INFORMATION SUBMITTED ON OR WITH, OR OMITTED FROM, AN APPLICATION
24 FOR THE HEALTH BENEFIT PLAN UNLESS THE CARRIER COMPLETED MEDICAL
25 UNDERWRITING AND RESOLVED ALL REASONABLE MEDICAL QUESTIONS
26 RELATED TO THE WRITTEN INFORMATION SUBMITTED ON OR WITH, OR
27 OMITTED FROM, THE APPLICATION BEFORE ISSUING THE HEALTH BENEFIT
28 PLAN.

29 (C) THE CARRIER SHALL HAVE THE BURDEN OF PERSUASION THAT ITS
30 RESCISSION OF A HEALTH BENEFIT PLAN COMPLIES WITH SUBSECTION (B) OF
31 THIS SECTION.

32 **Article – Health – General**

19–706.

(TTT) THE PROVISIONS OF § 15–1106 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

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.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect on October 1, 2009, and apply to all policies, contracts, certificates, and health benefit plans issued, delivered, or renewed on or after ~~January 1, 2010~~ October 1, 2009.

SECTION ~~3.~~ 4. AND BE IT FURTHER ENACTED, That, except as provided in Section 3 of this Act, this Act shall take effect July 1, 2009.