SENATE BILL 79

C3 9lr0049

(PRE–FILED)

By: **Chair, Finance Committee (By Request – Departmental – Insurance Administration, Maryland)**
Requested: September 30, 2008
Introduced and read first time: January 14, 2009
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Reform

FOR the purpose of expanding the applicability of certain provisions of law that limit the imposition of certain preexisting condition provisions by certain carriers to a policy or certificate issued to an individual in accordance with certain provisions of law; altering certain loss ratio requirements for certain health benefit plans and Medicare supplement policies; 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; 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; defining certain terms; providing for the application 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)
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY adding to
Article – Insurance

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

Section 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

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) 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;

(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.

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

15–1106.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION.

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

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

(B) IF A CARRIER CONDITIONS COVERAGE FOR A HEALTH BENEFIT PLAN ON EVIDENCE OF INDIVIDUAL INSURABILITY, THE CARRIER MAY NOT RESCIND A CONTRACT OR A CERTIFICATE ON THE BASIS OF WRITTEN INFORMATION SUBMITTED ON OR WITH, OR OMITTED FROM, AN APPLICATION FOR THE HEALTH BENEFIT PLAN UNLESS THE CARRIER COMPLETED MEDICAL UNDERWRITING AND RESOLVED ALL MEDICAL QUESTIONS RELATED TO THE

WRITTEN INFORMATION SUBMITTED ON OR WITH, OR OMITTED FROM, THE APPLICATION BEFORE ISSUING THE HEALTH BENEFIT PLAN.

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

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 this Act shall apply to all policies, contracts, certificates, and health benefit plans issued, delivered, or renewed on or after January 1, 2010.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2009.