CHAPTER 653

(House Bill 32)

AN ACT concerning

Health Insurance – Limitations on Preexisting Condition Provisions – ~~Applicability~~ Individual Health Benefit Plans

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 a certain definition;~~ 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; defining certain terms; making a conforming change; providing for the application of this Act; and generally relating to preexisting condition limitations.

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

BY adding to
Article – Insurance
Section 15–508.1
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:

Article – Insurance

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 ~~DEPENDENTS~~ *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.~~

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

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

Approved by the Governor, May 19, 2009.