Chapter 106

(House Bill 360)

AN ACT concerning

Health Insurance – Repeal of Obsolete Provisions of Law

FOR the purpose of repealing certain provisions of law that authorize health maintenance organizations to offer certain benefit packages that provide certain limited benefits; repealing certain provisions of law that authorize certain group health insurance policies to provide for the continuation of all or part of certain benefit provisions after the death of a certain individual; repealing certain provisions of law that entitle certain insured individuals, whose coverage under certain group insurance policies is terminated for a certain reason, to certain individual insurance policies; repealing certain provisions of law that require certain succeeding insurers to provide to an employer certain information relating to preexisting conditions, exclusions, or similar policy provisions and to identify certain individuals under certain circumstances; repealing certain provisions of law that prohibit certain individual, group, or blanket health insurance policies from being denied by an insurer or nonprofit health service plan, or, on renewal, from imposing a waiting period or certain exclusion, solely because the insured has had a breast implant; repealing certain provisions of law relating to preexisting condition protections for certain employer group plans; repealing certain provisions of law requiring nonprofit health service plans to offer certain catastrophic health insurance policies; providing for a delayed effective date; and generally relating to health insurance and the repeal of obsolete provisions of law.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–703
Annotated Code of Maryland
(2009 Replacement Volume and 2012 Supplement)

BY repealing
Article – Insurance
Section 15–410, 15–412, 15–415, 15–504, 15–507, and 15–1101
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)

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

Article – Health – General

19–703.

(a) This subtitle does not:

(1) Authorize any person to engage directly or indirectly in the practice of any health occupation except as otherwise authorized by law;

(2) Authorize any person to regulate, interfere, or intervene in the relationship between any provider of health care services and the patients of the provider; or

(3) Prohibit any health maintenance organization from meeting the requirements of any federal law that authorizes the health maintenance organization to:

(i) Receive federal financial assistance; or

(ii) Enroll beneficiaries assisted by federal funds.

(b) A health maintenance organization or a part of it that is also a community health center organized under the federal Public Health Service Act and receives federal funds under 42 U.S.C. § 254c is not required to provide hospitalization for individuals for whom services are provided by those funds.

(c) Health maintenance organizations shall offer as an option to all of their members or subscribers benefits for hospice services provided by a hospice care program, as defined in § 19–901(c) of this title.

(d) Health maintenance organizations shall provide continuation coverage required under §§ 15–407 through 15–409 of the Insurance Article.

(e) **[**(1) Notwithstanding any other provision of this subtitle, a health maintenance organization may offer a benefit package that provides at a minimum benefits required by former Article 48A, § 490–O for a limited benefits policy.

(2) A benefit package offered under paragraph (1) of this subsection shall:

(i) Be subject to the approval of the Insurance Commissioner; and

(ii) Satisfy the requirements of former Article 48A, § 490–O.

(f)**]** Notwithstanding any other provision of this subtitle, a health maintenance organization may provide a limited set of health benefits if the limited

set of health benefits is for subscribers or members who are enrolled in a county program to provide health care services for low–income individuals.

[(g)**]** **(F)** (1) In addition to the requirements of § 19–706(i) of this subtitle and § 15–10B–09 of the Insurance Article, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, a health maintenance organization shall provide as part of its hospitalization services provided to members and subscribers payment for the cost of additional hospitalization for the newborn for up to 4 days.

(2) The attending physician or certified nurse midwife of the mother, or the designee of the attending physician or certified nurse midwife, shall provide notice to the mother of the provisions of paragraph (1) of this subsection.

Article – Insurance

[15–410.

A group health insurance policy under which an insurer pays benefits for expenses incurred for hospital, nursing, medical, or surgical services for family members or dependents of an individual in the insured group may provide for the continuation of all or part of the benefit provisions after the death of the individual in the insured group.**]**

[15–412.

(a) In this section, "insured individual" includes:

(1) an employee or member who is covered under a group policy; and

(2) an eligible dependent of an employee or member who is covered under a group policy.

(b) (1) This section applies to:

(i) each group insurance policy that insures employees or members for hospital, surgical, or major medical insurance on an expense–incurred or service basis, other than a policy that provides coverage only for specific diseases or for accidental injuries; and

(ii) each group insurance policy that is delivered or issued for delivery in the State by a nonprofit health service plan and that insures employees or members and their dependents for hospital, medical, major medical, or surgical insurance on an expense–incurred or service basis, other than a policy that provides coverage only for specific diseases or for accidental injuries.

(2) This section applies to each group policy that is delivered or renewed in the State on the effective date or renewal anniversary date, whichever is later, of the policy.

(c) Each group policy subject to this section shall provide that an insured individual whose coverage under the group policy is terminated for any reason other than failure of the insured individual to pay a required premium or contribution is entitled, on timely written request and without evidence of insurability, to an individual policy of hospital and medical insurance.

(d) The Commissioner may:

(1) exempt from the requirements of this section certain types of group policies or certain types of coverage under group policies that the Commissioner considers appropriate; and

(2) establish conditions under which the conversion privilege does not apply, which may include the replacement of terminated coverage by similar group coverage or by a health program sponsored by a government or the group policyholder.

(e) An individual policy issued under this section shall cover the insured individual whose coverage under the group policy is terminated and any eligible dependents of that insured individual who were covered under the group policy.

(f) An individual policy issued under this section shall take effect immediately after the termination of coverage under the group policy.

(g) (1) An individual policy issued under this section shall provide the benefits that the Commissioner requires.

(2) The Commissioner may establish different requirements and levels of benefits for various types of group policies and coverage.

(3) In establishing minimum requirements, the Commissioner may establish exclusions and benefit limitations that the Commissioner considers appropriate.

(h) The premium for an individual policy issued under this section shall be determined in accordance with the insurer's or nonprofit health service plan's table of premium rates that is applicable to the age and class of risk of each individual covered under the policy and to the type and amount of insurance provided.

(i) (1) The Commissioner shall establish requirements that govern:

(i) notification by the insurer or nonprofit health service plan to the insured individual whose coverage under the group policy is being terminated of the right of conversion to an individual policy; and

(ii) the timely election of the conversion privilege.

(2) The notification requirements shall include a provision in each certificate provided to individuals covered under group or blanket health insurance policies that set forth the conditions applicable to election of the conversion privilege.

(j) Except as otherwise provided in this article, continuation of group coverage at the expense of the insured individual may be required for a period not exceeding 6 months.**]**

[15–415.

(a) (1) In this section the following words have the meanings indicated.

(2) "Group contract" means a health insurance contract or policy that:

(i) is issued or delivered in the State to an employer by an insurer or nonprofit health service plan;

(ii) provides hospital, medical, or surgical benefits on an expense–incurred basis; and

(iii) covers a group of 100 or fewer individuals.

(3) "Succeeding insurer" means the insurer or nonprofit health service plan that issues a succeeding policy.

(4) "Succeeding policy" means a group contract that:

(i) replaces or succeeds a group contract; and

(ii) takes effect within 65 days after the date on which the replaced or succeeded group contract terminates.

(b) (1) Before entering into a group contract, a succeeding insurer shall provide the employer with a written statement that:

(i) describes any waiting periods for preexisting conditions, exclusions, or similar policy provisions in the succeeding policy that limit or exclude coverage; and

(ii) identifies each individual who is covered under the replaced or succeeded group contract but who is ineligible for full coverage under the succeeding policy.

(2) The statement required under paragraph (1) of this subsection must be sufficiently clear and specific so that an individual of average intelligence can understand the statement without making further inquiry to the succeeding insurer.**]**

[15–504.

An individual, group, or blanket health insurance policy:

(1) may not be denied by an insurer or nonprofit health service plan solely because the insured has had a breast implant; and

(2) on renewal, may not impose a waiting period or exclusion for a preexisting condition that limits or excludes coverage solely because the insured has had a breast implant.**]**

[15–507.

(a) (1) This section applies to each group or blanket health insurance contract or policy that is issued or delivered in the State to an employer by an insurer or nonprofit health service plan and that provides hospital, medical, or surgical benefits on an expense–incurred basis.

(2) This section does not apply to a health insurance contract or policy that is issued to a small employer under Subtitle 12 of this title.

(b) Subject to subsections (c) and (d) of this section, an insurer or nonprofit health service plan shall provide coverage to an individual under a contract or policy subject to this section regardless of the health of the individual if:

(1) the individual had coverage under a prior contract or policy issued by the insurer or nonprofit health service plan; and

(2) within 30 days after the coverage under the prior contract or policy terminates, the individual becomes eligible for and accepts coverage from the insurer or nonprofit health service plan under the subsequent contract or policy.

(c) An insurer or nonprofit health service plan may exclude coverage under a contract or policy subject to this section for a medical condition of an individual who obtains coverage under subsection (b) of this section to the extent that:

(1) the contract or policy is issued as part of a group contract; and

(2) the exclusion is applicable to each individual insured under the group contract.

(d) (1) Subject to paragraph (2) of this subsection, an insurer or nonprofit health service plan that issues a subsequent contract or policy to an individual under subsection (b) of this section shall waive a waiting period for coverage of a preexisting condition under the subsequent contract or policy to the extent that the individual has satisfied a waiting period under the individual's prior contract or policy with the insurer or nonprofit health service plan.

(2) If any part of the waiting period under the individual's prior contract or policy has not been satisfied, the insurer or nonprofit health service plan may require the individual to satisfy the remaining part of the waiting period under the subsequent contract or policy, unless the subsequent contract or policy has a shorter waiting period.

(e) This section does not prohibit an insurer or nonprofit health service plan from requiring an individual who was previously insured by the insurer or nonprofit health service plan to complete an application that includes information about the individual's health when applying for subsequent coverage.**]**

[15–1101.

(a) Each nonprofit health service plan that issues or delivers a hospital insurance policy in the State shall offer a catastrophic health insurance policy.

(b) The catastrophic health insurance policy shall provide full coverage for the reasonable cost of necessary health care incurred by the insured up to $1,000,000.

(c) (1) The catastrophic health insurance policy may provide for a deductible for each benefit period.

(2) The deductible may be satisfied by the insured's basic health insurance coverage or major medical health insurance coverage.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2014.

Approved by the Governor, April 9, 2013.