

Article – Insurance

15-1A-06.

Commented [TA1]: Coverage of children up to the age of 26 years.

(A) IN THIS SECTION, “DEPENDENT CHILD” MEANS:

(1) A NATURAL CHILD, STEPCCHILD, FOSTER CHILD, GRANDCHILD, OR ADOPTED CHILD OF THE INSURED; OR

(2) A CHILD PLACED WITH THE INSURED FOR LEGAL ADOPTION.

(B) A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN, INCLUDING A GRANDFATHERED PLAN, THAT PROVIDES COVERAGE TO A DEPENDENT CHILD SHALL CONTINUE TO MAKE THE COVERAGE AVAILABLE FOR THE DEPENDENT CHILD UNTIL THE DEPENDENT CHILD IS 26 YEARS OF AGE.

(C) A CARRIER MAY NOT ESTABLISH RULES FOR ELIGIBILITY, INCLUDING CONTINUED ELIGIBILITY, FOR COVERAGE OF A DEPENDENT CHILD DESCRIBED IN SUBSECTION (B) OF THIS SECTION BASED ON ANY FACTOR OTHER THAN THE RELATIONSHIP BETWEEN THE DEPENDENT CHILD AND THE INSURED.

15-1A-07.

Commented [TA2]: Guaranteed availability of coverage

(A) SUBJECT TO §§ 15-1206(C), 15-1208.1, 15-1208.2, 15-1209, 15-1210, 15-1212, 15-1309, AND 15-1316, 15-1406, 15-1408, AND 15-1410, AND EXCEPT AS PROVIDED IN SUBSECTIONS (B) THROUGH (D) OF THIS SECTION, A CARRIER SHALL ACCEPT EVERY EMPLOYER AND INDIVIDUAL IN THE STATE THAT APPLIES FOR A HEALTH BENEFIT PLAN.

Commented [TA3]: 15-1212: renewal of health benefit plans
15-1309: renewal of individual health benefit plans
15-1406: eligibility of individual to enroll under group plan
15-1408: renewal of group benefit plan
15-1410: applicability of ACA provisions

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A CARRIER MAY RESTRICT ENROLLMENT TO OPEN OR SPECIAL ENROLLMENT PERIODS.

(2) A CARRIER THAT OFFERS A LARGE GROUP PLAN SHALL ALLOW AN EMPLOYER ELIGIBLE TO PURCHASE A LARGE GROUP PLAN TO PURCHASE A PLAN AT ANY TIME DURING THE YEAR.

(C) IF A CARRIER UTILIZES A NETWORK FOR A HEALTH BENEFIT PLAN, THE CARRIER:

(1) (I) MAY LIMIT THE EMPLOYERS THAT MAY APPLY FOR COVERAGE TO EMPLOYERS OF ELIGIBLE INDIVIDUALS WHO LIVE, WORK, OR RESIDE IN THE SERVICE AREA FOR THE NETWORK; ~~AND/OR~~

(II) MAY LIMIT THE INDIVIDUALS WHO MAY APPLY FOR COVERAGE IN THE INDIVIDUAL MARKET TO THOSE WHO LIVE OR RESIDE IN THE SERVICE AREA FOR THE NETWORK; OR

(2) MAY DENY COVERAGE WITHIN A SERVICE AREA IF THE CARRIER:

(I) DEMONSTRATES TO THE COMMISSIONER THAT:

1. THE CARRIER DOES NOT HAVE THE CAPACITY TO DELIVER ADEQUATE SERVICES TO ADDITIONAL ENROLLEES OF GROUPS OR ADDITIONAL INDIVIDUALS BECAUSE OF ITS OBLIGATIONS TO EXISTING GROUP CONTRACT HOLDERS AND ENROLLEES; AND

2. THE CARRIER APPLIES THIS PARAGRAPH UNIFORMLY TO ALL EMPLOYERS AND INDIVIDUALS WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTOR; AND

(II) DOES NOT OFFER COVERAGE WITHIN THE SERVICE AREA FOR 180 DAYS AFTER THE DATE THE CARRIER DENIED COVERAGE IN THE SERVICE AREA.

(D) A CARRIER MAY DENY COVERAGE IF THE CARRIER:

(1) DEMONSTRATES TO THE COMMISSIONER THAT:

(I) THE CARRIER DOES NOT HAVE THE FINANCIAL RESERVES NECESSARY TO UNDERWRITE ADDITIONAL COVERAGE; AND

(II) THE CARRIER APPLIES THIS PARAGRAPH UNIFORMLY TO ALL EMPLOYERS AND INDIVIDUALS WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTOR; AND

(2) UNLESS A LATER DATE IS OTHERWISE AUTHORIZED BY THE COMMISSIONER, DOES NOT OFFER THE DENIED COVERAGE FOR 180 DAYS AFTER THE DATE THE CARRIER DENIED THE COVERAGE.

15-1A-08.

Commented [TA4]: Preventive and wellness services and chronic disease management

(A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C) OF THIS SECTION, A CARRIER SHALL, AT A MINIMUM, PROVIDE COVERAGE FOR AND MAY NOT IMPOSE ANY COST-SHARING REQUIREMENTS, INCLUDING COPAYMENTS, COINSURANCE, OR DEDUCTIBLES FOR:

(1) EVIDENCE-BASED ITEMS OR SERVICES THAT HAVE IN EFFECT A RATING OF A OR B IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES PREVENTIVE SERVICES TASK FORCE WITH RESPECT TO THE INDIVIDUAL INVOLVED;

(2) IMMUNIZATIONS FOR ROUTINE USE IN CHILDREN, ADOLESCENTS, AND ADULTS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED, IF THE RECOMMENDATION:

(I) HAS BEEN ADOPTED BY THE DIRECTOR OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION; AND

(II) IS LISTED ON THE IMMUNIZATION SCHEDULES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR ROUTINE USE;

(3) WITH RESPECT TO INFANTS, CHILDREN, AND ADOLESCENTS, EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION; AND

(4) WITH RESPECT TO WOMEN, PREVENTIVE CARE AND SCREENINGS AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR PURPOSES OF § 2713(A)(4) OF THE PUBLIC HEALTH SERVICE ACT.

(B) TO THE EXTENT THAT COST-SHARING IS OTHERWISE PERMITTED UNDER FEDERAL OR STATE LAW, A HEALTH BENEFIT PLAN THAT USES A NETWORK OF PROVIDERS MAY IMPOSE COST-SHARING REQUIREMENTS ON THE

COVERAGE DESCRIBED IN SUBSECTION (A) OF THIS SECTION FOR ITEMS OR SERVICES DELIVERED BY AN OUT-OF-NETWORK PROVIDER.

(C) (1) A RELIGIOUS ORGANIZATION MAY REQUEST AND A CARRIER SHALL GRANT THE REQUEST FOR AN EXCLUSION FROM COVERAGE UNDER THE POLICY, PLAN, OR CONTRACT FOR THE COVERAGE REQUIRED UNDER SUBSECTION (A)(4) OF THIS SECTION IF THE REQUIRED COVERAGE CONFLICTS WITH THE RELIGIOUS ORGANIZATION'S BONA FIDE RELIGIOUS BELIEFS AND PRACTICES.

(2) A RELIGIOUS ORGANIZATION THAT OBTAINS AN EXCLUSION UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL PROVIDE ITS EMPLOYEES REASONABLE AND TIMELY NOTICE OF THE EXCEPTION.

Commented [TA5]: Taken from IN § 15-826 (coverage for contraceptive drugs)

~~(D)~~ NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT A CARRIER FROM PROVIDING COVERAGE FOR SERVICES IN ADDITION TO THOSE RECOMMENDED BY THE UNITED STATES PREVENTIVE SERVICES TASK FORCE OR TO DENY COVERAGE FOR SERVICES THAT ARE NOT RECOMMENDED BY THE TASK FORCE.

15-1A-09.

Commented [TA6]: Annual and lifetime limits

(A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C) OF THIS SECTION, A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN, INCLUDING A GRANDFATHERED PLAN, MAY NOT ESTABLISH LIFETIME LIMITS OR ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR ANY INSURED INDIVIDUAL.

(B) TO THE EXTENT THAT LIMITS ARE OTHERWISE AUTHORIZED UNDER FEDERAL OR STATE LAW, A GRANDFATHERED PLAN THAT IS AN INDIVIDUAL PLAN MAY ESTABLISH ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR AN INSURED INDIVIDUAL.

(C) TO THE EXTENT THAT LIMITS ARE OTHERWISE AUTHORIZED UNDER FEDERAL OR STATE LAW, THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT A CARRIER FROM PLACING ANNUAL OR LIFETIME PER BENEFICIARY LIMITS ON SPECIFIC COVERED BENEFITS THAT ARE NOT ESSENTIAL HEALTH BENEFITS.

15-1A-10.

Commented [TA7]: Waiting periods

A CARRIER OFFERING A GROUP PLAN, INCLUDING A GRANDFATHERED

PLAN, MAY NOT APPLY A WAITING PERIOD OF MORE THAN 90 DAYS THAT MUST PASS BEFORE COVERAGE BECOMES EFFECTIVE FOR AN INDIVIDUAL WHO IS OTHERWISE ELIGIBLE FOR THE GROUP PLAN.

These are additional sections that were suggested for inclusion in the bill.

Article – Insurance

15-817.

Commented [TA8]: Child wellness services — included to prohibit cost sharing on the coverage included in this section. (This goes with 15-1A-08.)

(a) In this section, “child wellness services” means preventive activities designed to protect children from morbidity and mortality and promote child development.

(b) This section applies to each individual hospital or major medical insurance policy, group or blanket health insurance policy, and nonprofit health service plan that:

(1) is delivered or issued for delivery in the State;

(2) is written on an expense-incurred basis; and

(3) provides coverage for a family member of the insured.

(c) (1) A policy or plan subject to this section shall include under the family member coverage a minimum package of child wellness services that are consistent with:

(i) public health policy;

(ii) professional standards; and

(iii) scientific evidence of effectiveness.

(2) The minimum package of child wellness services shall cover at least:

(i) all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(ii) visits for the collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age;

(iii) universal hearing screening of newborns provided by a hospital before discharge;

(iv) all visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;

(v) all visits for obesity evaluation and management;

(vi) all visits for and costs of developmental screening as recommended by the American Academy of Pediatrics;

(vii) a physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required under items (i), (ii), (iv), (v), and (vi) of this paragraph; and

(viii) any laboratory tests considered necessary by the physician as indicated by the services provided under items (i), (ii), (iv), (v), (vi), or (vii) of this paragraph.

(d) Except as provided in subsection (e) of this section, an insurer or nonprofit health service plan that issues a policy or plan subject to this section, on notification of the pregnancy of the insured and before the delivery date, shall:

(1) encourage and help the insured to choose and contact a primary care provider for the expected newborn before delivery; and

(2) provide the insured with information on postpartum home visits for the mother and the expected newborn, including the names of health care providers that are available for postpartum home visits.

(e) An insurer or nonprofit health service plan that does not require or encourage the insured to use a particular health care provider or group of health care providers that has contracted with the insurer or nonprofit health service plan to provide services to the insurer's or nonprofit health service plan's insureds need not comply with subsection (d) of this section.

(f) (1) A policy or plan subject to this section may not impose [a deductible] **ANY COST SHARING REQUIREMENTS, INCLUDING COPAYMENTS, COINSURANCE, OR DEDUCTIBLES**, on the coverage required under this section.

(2) Each health insurance policy and certificate shall contain a notice of the prohibition established by paragraph (1) of this subsection in a form approved by the Commissioner.

15-1106.

Commented [TA9]: Policy Rescissions – this already applied to the individual market; this version applies it to the group market as well.

(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 OR GROUP 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 reasonable 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.

Commented [TA10]: This section has been repealed.