SENATE BILL 96

C3 4lr0039

(PRE–FILED)

By: **Chair, Finance Committee (By Request – Departmental – Insurance Administration, Maryland)**
Requested: November 7, 2013
Introduced and read first time: January 8, 2014
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: February 11, 2014

CHAPTER _____

AN ACT concerning

Health Insurance – Conformity With and Implementation of the Federal Patient Protection and Affordable Care Act

FOR the purpose of establishing initial permit, permit renewal, and permit reinstatement fees for a SHOP Exchange enrollment permit; providing that certain provisions of the federal Patient Protection and Affordable Care Act relating to guaranteed availability of coverage apply to certain coverage offered in certain insurance markets; repealing certain conversion rights for certain kinds of group and blanket health insurance contracts; repealing certain provisions of law governing bona fide wellness programs; authorizing certain insurance carriers to include certain participatory wellness programs as part of an individual or group health benefit plan under certain circumstances; providing a certain exception to the requirement that certain insurance carriers take certain action in relation to a certain claim within a certain number of days; authorizing certain insurance carriers to suspend review of a claim for reimbursement for certain services under certain circumstances; altering the circumstances under which a carrier is required to allow a certain eligible employee or dependent to enroll for certain coverage; establishing a special enrollment period under a small employer health benefit plan for the placement of a child for foster care; establishing a certain triggering event for an open enrollment period in the SHOP Exchange; authorizing the Maryland Health Benefit Exchange to take certain actions on the occurrence of a certain triggering event; authorizing an eligible employee, on the occurrence of a certain

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.

triggering event, to enroll in a qualified health plan or change from one qualified health plan to another a certain number of times per month; repealing a requirement that, under certain circumstances, an eligible employee or a dependent must select a qualified health plan through the SHOP Exchange; altering the circumstances under which a carrier that offers coverage to a small employer is required to offer coverage to certain employees of the small employer; ~~repealing~~ altering a certain notice requirement relating to cancellation or nonrenewal of certain health benefit plans; repealing a certain reporting requirement relating to carrier declinations for individual coverage; altering the date by which carriers that sell health benefit plans to individuals in the State are required to establish a certain enrollment period; specifying the dates on which certain enrollment periods begin and end; providing for certain effective dates of coverage in the individual insurance market; establishing certain triggering events for a special open enrollment period in the Individual Exchange; altering the circumstances under which a carrier, on the occurrence of a certain triggering event, must permit a certain individual or dependent to access a certain special enrollment period; altering a certain definition; clarifying a certain definition; defining certain terms; repealing certain definitions; making conforming changes; providing for the effective date of certain provisions of this Act; and generally relating to conformity with and implementation of the federal Patient Protection and Affordable Care Act.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 2–112(a), 15–137.1(a), 15–1005, 15–1009, 15–1208.1, 15–1208.2, 15–1210, 15–1212, 15–1301(h), 15–1303, and 15–1316
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

BY repealing
Article – Insurance
Section 15–414 and 15–509
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

BY adding to
Article – Insurance
Section 15–509
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1301(g)
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

(As enacted by Chapter 692 of the Acts of the General Assembly of 2008, as amended by Chapter 734 of the Acts of the General Assembly of 2010)

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

Article – Insurance

2–112.

(a) Fees for the following certificates, licenses, **PERMITS,** and services shall be collected in advance by the Commissioner, and shall be paid by the appropriate persons to the Commissioner:

(1) fees for certificates of authority:

(i) application fee for initial certificate of authority, including filing the application, articles of incorporation and other charter documents, except as provided in item (2) of this subsection, bylaws, financial statement, examination report, power of attorney to the Commissioner, and all other documents and filings in connection with the application $1,000

(ii) fee for initial certificate of authority $200

(iii) fee for annual renewal of certificate of authority for all foreign insurers and for domestic insurers with their home or executive office in the State $500

(iv) fee for annual renewal of certificate of authority for domestic insurers with their home or executive office outside the State, except those domestic insurers that had their home or executive office outside the State before January 1, 1929:

1. with premiums written in the most recent calendar year not exceeding $500,000 ..... $2,500

2. with premiums written in the most recent calendar year not exceeding $1,000,000 ..... $5,000

3. with premiums written in the most recent calendar year not exceeding $2,000,000 ..... $7,000

4. with premiums written in the most recent calendar year not exceeding $5,000,000 ..... $9,000

5. with premiums written in the most recent calendar year of more than $5,000,000 ..... $11,000

(v) reinstatement of certificate of authority $500

(2) fees for articles of incorporation of a domestic insurer or foreign insurer, exclusive of fees required to be paid to the Department of Assessments and Taxation:

(i) fee for filing the articles of incorporation with the Commissioner for approval $25

(ii) fee for amendment of the articles of incorporation $10

(3) fees for filing bylaws or amendments to bylaws with the Commissioner $10

(4) fees for certificates of qualification:

(i) application fee $25

(ii) managing general agent certificate of qualification:

1. fee for initial certificate $30

2. annual renewal fee $30

(iii) surplus lines broker certificate of qualification:

1. fee for initial certificate within 1 year of renewal $100

2. fee for initial certificate over 1 year from renewal $100

3. biennial renewal fee $200

(5) fee for temporary insurance producer licenses and appointments $27

(6) fees for licenses **AND PERMITS**:

(i) public adjuster license:

1. fee for initial license within 1 year of renewal $25

2. fee for initial license over 1 year from renewal $50

3. biennial renewal fee $50

(ii) adviser license:

1. fee for initial license within 1 year of renewal $100

2. fee for initial license over 1 year from renewal $200

3. biennial renewal fee $200

(iii) insurance producer license:

1. fee for initial license $54

2. biennial renewal fee $54

(iv) SHOP Exchange navigator license:

1. fee for initial license $54

2. biennial renewal fee $54

3. fee for reinstatement of license $100

(V) SHOP EXCHANGE ENROLLMENT PERMIT:

1. FEE FOR INITIAL PERMIT $54

2. BIENNIAL RENEWAL FEE $54

3. FEE FOR REINSTATEMENT OF PERMIT $100

[(v)**] (VI)** application fee $25

(7) fee for each insurance vending machine license, for each machine, every second year $50

(8) fees for filing the annual statement by an unauthorized insurer applying for approval to become an accepted insurer or applying for approval to become an accepted reinsurer or surplus lines carrier or both $1,000

(9) fees for required filings, including form and rate filings, under Title 11, Subtitles 2 through 4, Title 26, and §§ 12–203, 13–110, 14–126, and 27–613 of this article $125

(10) service of legal process fee under §§ 3–318(d), 3–319(d), and 4–107 of this article $15

15–137.1.

(a) Notwithstanding any other provisions of law, the following provisions of Title I, Subtitles A, C, and D of the Affordable Care Act apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets, as those terms are defined in the federal Public Health Service Act, issued or delivered in the State by an authorized insurer, nonprofit health service plan, or health maintenance organization:

(1) coverage of children up to the age of 26 years;

(2) preexisting condition exclusions;

(3) policy rescissions;

(4) bona fide wellness programs;

(5) lifetime limits;

(6) annual limits for essential benefits;

(7) waiting periods;

(8) designation of primary care providers;

(9) access to obstetrical and gynecological services;

(10) emergency services;

(11) summary of benefits and coverage explanation;

(12) minimum loss ratio requirements and premium rebates;

(13) disclosure of information;

(14) annual limitations on cost sharing;

(15) child–only plan offerings in the individual market;

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

(18) coverage for individuals participating in approved clinical trials; **[**and**]**

(19) contract requirements for stand–alone dental plans sold on the Maryland Health Benefit Exchange**; AND**

(20) GUARANTEED AVAILABILITY OF COVERAGE.

[15–414.

(a) This section applies to:

(1) each group or blanket contract that:

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

(ii) provides hospital, medical, or surgical benefits for employees or subscribers and their dependents; and

(iii) allows an employee or subscriber to convert the coverage in the event of termination of employment or membership; and

(2) each group contract that:

(i) is delivered or issued for delivery in the State by a nonprofit health service plan;

(ii) provides hospital, medical, or surgical benefits for employees or members and their dependents; and

(iii) allows an employee or member to convert the coverage in the event of termination of employment or membership.

(b) Each group contract subject to this section shall provide the same conversion rights and conditions to a covered dependent spouse of an employee, member, or subscriber that are provided to the covered employee, member, or subscriber, if the dependent spouse ceases to be a qualified family member because of divorce or the death of the employee, member, or subscriber.

(c) Conversion rights shall be provided under this section without a physical examination or statement of health.**]**

[15–509.

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

(2) "Bona fide wellness program" means a program that is designed to:

(i) promote health or prevent or detect disease or illness;

(ii) reduce or avoid poor clinical outcomes;

(iii) prevent complications from medical conditions;

(iv) promote healthy behaviors; or

(v) prevent and control injury.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization; or

(iv) a dental plan organization.

(4) "Health factor" means, in relation to an individual, any of the following health status–related factors:

(i) health status;

(ii) medical condition;

(iii) claims experience;

(iv) receipt of health care;

(v) medical history;

(vi) evidence of insurability; or

(vii) disability.

(5) "Incentive" means:

(i) a discount of a premium or contribution;

(ii) a waiver of all or part of a cost–sharing mechanism, such as deductibles, copayments, or coinsurance;

(iii) the absence of a surcharge;

(iv) the value of a benefit that otherwise would not be provided under the policy or contract; or

(v) a rebate as permitted under § 27–210 of this article.

(b) (1) A carrier may provide reasonable incentives to an individual who is an insured, a subscriber, or a member for participation in a bona fide wellness program offered by the carrier if:

(i) the carrier does not make participation in the bona fide wellness program a condition of coverage under a policy or contract;

(ii) participation in the bona fide wellness program is voluntary and a penalty is not imposed on an insured, subscriber, or member for nonparticipation;

(iii) the carrier does not market the bona fide wellness program in a manner that reasonably could be construed to have as its primary purpose the provision of an incentive or inducement to purchase coverage from the carrier; and

(iv) the bona fide wellness program does not condition an incentive on an individual satisfying a standard that is related to a health factor.

(2) Notwithstanding paragraph (1)(iv) of this subsection, a carrier may condition an incentive for a bona fide wellness program on an individual satisfying a standard that is related to a health factor if:

(i) 1. all incentives for participation in the bona fide wellness program do not exceed 30% of the cost of employee–only coverage under the plan, except that the applicable percentage is increased by an additional 20 percentage points to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use; or

2. when the plan provides coverage for family members, all incentives for participation in the bona fide wellness program do not exceed 30% of the cost of the coverage in which the family members are enrolled, except that the applicable percentage is increased by an additional 20 percentage points to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use;

(ii) the bona fide wellness program is reasonably designed to promote health or prevent disease, as provided under subsection (c) of this section;

(iii) the bona fide wellness program gives individuals eligible for the bona fide wellness program the opportunity to qualify for the incentive under the bona fide wellness program at least once a year;

(iv) the bona fide wellness program is available to all similarly situated individuals; and

(v) individuals are provided a reasonable alternative standard or a waiver of the standard as required under subsection (d)(1) of this section.

(c) A bona fide wellness program shall be construed to be reasonably designed to promote health or prevent disease if the bona fide wellness program:

(1) has a reasonable chance of improving the health of or preventing disease in participating individuals;

(2) is not overly burdensome;

(3) is not a subterfuge for discriminating based on a health factor; and

(4) is not highly suspect in the method chosen to promote health or prevent disease.

(d) (1) A carrier shall provide a reasonable alternative standard, or a waiver of the otherwise applicable standard, for obtaining the incentive for any individual for whom it is:

(i) unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; or

(ii) medically inadvisable to attempt to satisfy the otherwise applicable standard.

(2) A carrier may seek verification, such as a statement from an individual's health care provider, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(3) (i) A carrier shall disclose the availability of a reasonable alternative standard or a waiver of the otherwise applicable standard in all policy forms pertaining to the bona fide wellness program.

(ii) A carrier may meet the disclosure requirements of this paragraph by using the following language or substantially similar language:

"If it is unreasonably difficult due to a medical condition for you to achieve the standards for the incentive under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the incentive under this program, call us at (insert telephone number), and we will work with you to develop another way to qualify for the incentive.".

(e) (1) In determining if a carrier's bona fide wellness program meets the requirements of this section, the Commissioner may request a review of the bona fide

wellness program by an independent review organization from the list compiled under § 15–10A–05(b) of this title.

(2) The expense of the review of the bona fide wellness program by an independent review organization shall be paid by the carrier, in the manner provided under § 15–10A–05(h) of this title.**]**

15–509.

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

(2) "ACTIVITY–ONLY WELLNESS PROGRAM" MEANS A TYPE OF HEALTH–CONTINGENT WELLNESS PROGRAM IN WHICH AN INDIVIDUAL IS REQUIRED TO PERFORM OR COMPLETE AN ACTIVITY RELATED TO A HEALTH FACTOR IN ORDER TO OBTAIN A REWARD, BUT WHICH DOES NOT REQUIRE THE INDIVIDUAL TO ATTAIN OR MAINTAIN A SPECIFIC HEALTH OUTCOME.

(3) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION.

(4) "GRANDFATHERED HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 1251 OF THE AFFORDABLE CARE ACT.

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

(6) (I) "HEALTH–CONTINGENT WELLNESS PROGRAM" MEANS A PROGRAM THAT REQUIRES AN INDIVIDUAL TO SATISFY A STANDARD RELATED TO A HEALTH FACTOR TO OBTAIN A REWARD.

(II) "HEALTH–CONTINGENT WELLNESS PROGRAM" INCLUDES:

1. AN ACTIVITY–ONLY WELLNESS PROGRAM; AND

2. AN OUTCOME–BASED WELLNESS PROGRAM.

(7) "HEALTH FACTOR" MEANS, IN RELATION TO AN INDIVIDUAL, ANY OF THE FOLLOWING HEALTH STATUS–RELATED FACTORS:

(I) HEALTH STATUS;

(II) MEDICAL CONDITION;

(III) CLAIMS EXPERIENCE;

(IV) RECEIPT OF HEALTH CARE;

(V) MEDICAL HISTORY;

(VI) GENETIC INFORMATION;

(VII) EVIDENCE OF INSURABILITY;

(VIII) DISABILITY; OR

(IX) ANY OTHER HEALTH STATUS–RELATED FACTOR DETERMINED APPROPRIATE BY THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES.

(8) "INCENTIVE" MEANS:

(I) A DISCOUNT OF A PREMIUM OR CONTRIBUTION;

(II) A WAIVER OF ALL OR PART OF A COST–SHARING MECHANISM, SUCH AS DEDUCTIBLES, COPAYMENTS, OR COINSURANCE;

(III) THE ABSENCE OF A SURCHARGE;

(IV) THE VALUE OF A BENEFIT THAT OTHERWISE WOULD NOT BE PROVIDED UNDER THE POLICY OR CONTRACT; OR

(V) A REBATE AS PERMITTED UNDER § 27–210 OF THIS ARTICLE.

(9) "OUTCOME–BASED WELLNESS PROGRAM" MEANS A TYPE OF HEALTH–CONTINGENT WELLNESS PROGRAM IN WHICH AN INDIVIDUAL MUST ATTAIN OR MAINTAIN A SPECIFIC HEALTH OUTCOME IN ORDER TO OBTAIN A REWARD.

(10) "PARTICIPATORY WELLNESS PROGRAM" MEANS A PROGRAM THAT DOES NOT:

(I) PROVIDE A REWARD; OR

(II) INCLUDE ANY CONDITIONS FOR OBTAINING A REWARD THAT ARE BASED ON AN INDIVIDUAL SATISFYING A STANDARD THAT IS RELATED TO A HEALTH FACTOR.

(11) "REWARD" MEANS:

(I) OBTAINING AN INCENTIVE; OR

(II) AVOIDING A PENALTY.

(B) THIS SECTION APPLIES TO GRANDFATHERED AND NONGRANDFATHERED INDIVIDUAL AND GROUP HEALTH BENEFIT PLANS.

(C) (1) A CARRIER MAY INCLUDE A PARTICIPATORY WELLNESS PROGRAM AS PART OF AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN.

(2) A PARTICIPATORY WELLNESS PROGRAM SHALL BE MADE AVAILABLE TO ALL SIMILARLY SITUATED INDIVIDUALS REGARDLESS OF HEALTH STATUS.

(D) A CARRIER MAY CONDITION A REWARD FOR AN ACTIVITY–ONLY WELLNESS PROGRAM IN A GROUP HEALTH BENEFIT PLAN IF:

(1) THE ACTIVITY–ONLY WELLNESS PROGRAM PROVIDES INDIVIDUALS WITH AN OPPORTUNITY TO QUALIFY FOR THE REWARD AT LEAST ONCE A YEAR;

(2) THE REWARD FOR THE ACTIVITY–ONLY WELLNESS PROGRAM, TOGETHER WITH THE REWARD FOR OTHER HEALTH–CONTINGENT WELLNESS PROGRAMS WITH RESPECT TO THE HEALTH BENEFIT PLAN, DOES NOT EXCEED:

(I) 30% OF THE TOTAL COST OF EMPLOYEE–ONLY COVERAGE UNDER THE HEALTH BENEFIT PLAN, EXCEPT THAT THE APPLICABLE PERCENTAGE IS INCREASED BY AN ADDITIONAL 20 PERCENTAGE POINTS TO THE EXTENT THAT THE ADDITIONAL PERCENTAGE IS IN CONNECTION WITH A PROGRAM DESIGNED TO PREVENT OR REDUCE TOBACCO USE; OR

(II) WHEN THE PLAN PROVIDES COVERAGE FOR FAMILY MEMBERS, AND WHEN FAMILY MEMBERS ARE PERMITTED TO PARTICIPATE IN THE ACTIVITY–ONLY WELLNESS PROGRAM, 30% OF THE COST OF THE COVERAGE IN WHICH THE FAMILY MEMBERS ARE ENROLLED, EXCEPT THAT THE APPLICABLE PERCENTAGE IS INCREASED BY AN ADDITIONAL 20 PERCENTAGE POINTS TO THE EXTENT THAT THE ADDITIONAL PERCENTAGE IS IN

CONNECTION WITH A PROGRAM DESIGNED TO PREVENT OR REDUCE TOBACCO USE;

(3) THE ACTIVITY–ONLY WELLNESS PROGRAM IS REASONABLY DESIGNED TO PROMOTE HEALTH OR PREVENT DISEASE;

(4) THE FULL REWARD UNDER THE ACTIVITY–ONLY WELLNESS PROGRAM IS AVAILABLE TO ALL SIMILARLY SITUATED INDIVIDUALS; AND

(5) THE CARRIER DISCLOSES THE AVAILABILITY OF A REASONABLE ALTERNATIVE STANDARD TO QUALIFY FOR THE REWARD IN ALL PLAN MATERIALS DESCRIBING THE TERMS OF AN ACTIVITY–ONLY WELLNESS PROGRAM.

(E) AN ACTIVITY–ONLY WELLNESS PROGRAM SHALL BE CONSTRUED TO BE REASONABLY DESIGNED TO PROMOTE HEALTH OR PREVENT DISEASE IF THE ACTIVITY–ONLY WELLNESS PROGRAM:

(1) HAS A REASONABLE CHANCE OF IMPROVING THE HEALTH OF OR PREVENTING DISEASE IN PARTICIPATING INDIVIDUALS;

(2) IS NOT OVERLY BURDENSOME;

(3) IS NOT A SUBTERFUGE FOR DISCRIMINATING BASED ON A HEALTH FACTOR;

(4) IS NOT HIGHLY SUSPECT IN THE METHOD CHOSEN TO PROMOTE HEALTH OR PREVENT DISEASE; AND

(5) PROVIDES A REASONABLE ALTERNATIVE STANDARD TO QUALIFY FOR THE REWARD FOR ALL INDIVIDUALS WHO DO NOT MEET THE INITIAL STANDARD THAT IS RELATED TO A HEALTH FACTOR.

(F) (1) FOR AN ACTIVITY–ONLY WELLNESS PROGRAM, A CARRIER SHALL PROVIDE A REASONABLE ALTERNATIVE STANDARD FOR OBTAINING THE REWARD FOR ANY INDIVIDUAL WHO REQUESTS AN ALTERNATIVE STANDARD AND FOR WHOM IT IS:

(I) UNREASONABLY DIFFICULT DUE TO A MEDICAL CONDITION TO SATISFY THE OTHERWISE APPLICABLE STANDARD; OR

(II) MEDICALLY INADVISABLE TO ATTEMPT TO SATISFY THE OTHERWISE APPLICABLE STANDARD.

(2) A CARRIER MAY SEEK VERIFICATION, SUCH AS A STATEMENT FROM AN INDIVIDUAL'S HEALTH CARE PROVIDER, THAT A HEALTH FACTOR MAKES IT UNREASONABLY DIFFICULT OR MEDICALLY INADVISABLE FOR THE INDIVIDUAL TO SATISFY OR ATTEMPT TO SATISFY THE OTHERWISE APPLICABLE STANDARD, IF REASONABLE UNDER THE CIRCUMSTANCES.

(G) (1) A CARRIER MAY CONDITION THE REWARD FOR AN OUTCOME–BASED WELLNESS PROGRAM IN A GROUP HEALTH BENEFIT PLAN IF:

(I) THE OUTCOME–BASED WELLNESS PROGRAM MEETS THE REQUIREMENTS UNDER SUBSECTIONS (D) AND (E) OF THIS SECTION;

(II) THE FULL REWARD IS AVAILABLE TO ALL SIMILARLY SITUATED INDIVIDUALS; AND

(III) AN INDIVIDUAL, ON REQUEST, IS PROVIDED WITH A REASONABLE ALTERNATIVE STANDARD ~~REGARDLESS OF ANY~~, PROVIDED THAT THE INDIVIDUAL DOES NOT MEET THE INITIAL STANDARD BECAUSE OF A MEDICAL CONDITION OR OTHER HEALTH FACTOR.

(2) IF THE REASONABLE ALTERNATIVE STANDARD IS AN EDUCATIONAL PROGRAM, THE CARRIER:

(I) SHALL MAKE THE EDUCATIONAL PROGRAM AVAILABLE OR ASSIST THE INDIVIDUAL IN FINDING A PROGRAM; AND

(II) MAY NOT REQUIRE AN INDIVIDUAL TO PAY FOR THE COST OF THE EDUCATIONAL PROGRAM.

(3) THE TIME COMMITMENT REQUIRED FOR THE ALTERNATIVE STANDARD SHALL BE REASONABLE.

(4) IF THE REASONABLE ALTERNATIVE IS A DIET PROGRAM, THE CARRIER IS NOT REQUIRED TO PAY FOR THE COST OF FOOD, BUT IS REQUIRED TO PAY ANY MEMBERSHIP OR PARTICIPATION FEE.

(5) IF THE REASONABLE ALTERNATIVE STANDARD IS AN ACTIVITY–ONLY WELLNESS PROGRAM, THE REASONABLE ALTERNATIVE STANDARD MUST COMPLY WITH THE REQUIREMENTS FOR ACTIVITY–ONLY WELLNESS PROGRAMS AS IF IT WERE AN INITIAL PROGRAM STANDARD.

(6) IF THE REASONABLE ALTERNATIVE STANDARD IS AN OUTCOME–BASED WELLNESS PROGRAM, THE REASONABLE ALTERNATIVE

STANDARD MUST COMPLY WITH THE REQUIREMENTS FOR OUTCOME–BASED WELLNESS PROGRAMS.

(7) THE REASONABLE ALTERNATIVE MAY NOT BE A REQUIREMENT TO MEET A DIFFERENT LEVEL OF THE SAME STANDARD WITHOUT ADDITIONAL TIME TO COMPLY THAT TAKES INTO ACCOUNT THE INDIVIDUAL'S CIRCUMSTANCES.

(8) AN INDIVIDUAL SHALL BE GIVEN THE OPPORTUNITY TO COMPLY WITH THE RECOMMENDATIONS OF THE INDIVIDUAL'S PERSONAL PHYSICIAN AS A SECOND REASONABLE ALTERNATIVE STANDARD TO MEETING THE REASONABLE ALTERNATIVE STANDARD DEFINED BY THE CARRIER, BUT ONLY IF THE PHYSICIAN JOINS IN THE REQUEST.

(H) A REWARD UNDER AN OUTCOME–BASED WELLNESS PROGRAM IS NOT AVAILABLE TO ALL SIMILARLY SITUATED INDIVIDUALS AS REQUIRED BY SUBSECTION (G)(1)(II) OF THIS SECTION UNLESS THE OUTCOME–BASED WELLNESS PROGRAM ALLOWS A REASONABLE ALTERNATIVE STANDARD, OR WAIVER OF THE OTHERWISE APPLICABLE STANDARD, FOR OBTAINING THE REWARD FOR ANY INDIVIDUAL WHO DOES NOT MEET THE INITIAL STANDARD BASED ON THE MEASUREMENT, TEST, OR SCREENING REQUIRED BY THE OUTCOME–BASED WELLNESS PROGRAM.

(I) (1) IN DETERMINING IF A CARRIER'S HEALTH–CONTINGENT WELLNESS PROGRAM MEETS THE REQUIREMENTS OF THIS SECTION, THE COMMISSIONER MAY REQUEST A REVIEW OF THE HEALTH–CONTINGENT WELLNESS PROGRAM BY AN INDEPENDENT REVIEW ORGANIZATION SELECTED FROM THE LIST COMPILED UNDER § 15–10A–05(B) OF THIS TITLE.

(2) THE EXPENSE OF THE REVIEW OF THE HEALTH–CONTINGENT WELLNESS PROGRAM BY AN INDEPENDENT REVIEW ORGANIZATION SHALL BE PAID BY THE CARRIER IN THE MANNER PROVIDED UNDER § 15–10A–05(H) OF THIS TITLE.

15–1005.

(a) In this section, "clean claim" means a claim for reimbursement, as defined in regulations adopted by the Commissioner under § 15–1003 of this subtitle.

(b) To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq., this section applies to an insurer, nonprofit health service plan, or health maintenance organization that acts as a third party administrator.

(c) Except as provided in § 15–1315 of this title **AND SUBSECTION (H) OF THIS SECTION**, within 30 days after receipt of a claim for reimbursement from a person entitled to reimbursement under § 15–701(a) of this title or from a hospital or related institution, as those terms are defined in § 19–301 of the Health – General Article, an insurer, nonprofit health service plan, or health maintenance organization shall:

(1) mail or otherwise transmit payment for the claim in accordance with this section; or

(2) send a notice of receipt and status of the claim that states:

(i) that the insurer, nonprofit health service plan, or health maintenance organization refuses to reimburse all or part of the claim and the reason for the refusal;

(ii) that, in accordance with § 15–1003(d)(1)(ii) of this subtitle, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or

(iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.

(d) (1) An insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service.

(2) If an insurer, nonprofit health service plan, or health maintenance organization wholly or partially denies a claim for reimbursement, the insurer, nonprofit health service plan, or health maintenance organization shall permit a provider a minimum of 90 working days after the date of denial of the claim to appeal the denial.

(3) If an insurer, nonprofit health service plan, or health maintenance organization erroneously denies a provider's claim for reimbursement submitted within the time period specified in paragraph (1) of this subsection because of a claims processing error, and the provider notifies the insurer, nonprofit health service plan, or health maintenance organization of the potential error within 1 year of the claim denial, the insurer, nonprofit health service plan, or health maintenance organization, on discovery of the error, shall reprocess the provider's claim without the necessity for the provider to resubmit the claim, and without regard to timely submission deadlines.

(e) (1) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(i) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall mail or

otherwise transmit payment for any undisputed portion of the claim within 30 days of receipt of the claim, in accordance with this section.

(2) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(ii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall:

(i) mail or otherwise transmit payment for any undisputed portion of the claim in accordance with this section; and

(ii) comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

(3) If an insurer, nonprofit health service plan, or health maintenance organization provides notice under subsection (c)(2)(iii) of this section, the insurer, nonprofit health service plan, or health maintenance organization shall comply with subsection (c)(1) or (2)(i) of this section within 30 days after receipt of the requested additional information.

(f) (1) If an insurer, nonprofit health service plan, or health maintenance organization fails to pay a clean claim for reimbursement or otherwise violates any provision of this section, the insurer, nonprofit health service plan, or health maintenance organization shall pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:

(i) 1.5% from the 31st day through the 60th day;

(ii) 2% from the 61st day through the 120th day; and

(iii) 2.5% after the 120th day.

(2) The interest paid under this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest.

(g) An insurer, nonprofit health service plan, or health maintenance organization that violates a provision of this section is subject to:

(1) a fine not exceeding $500 for each violation that is arbitrary and capricious, based on all available information; and

(2) the penalties prescribed under § 4–113(d) of this article for violations committed with a frequency that indicates a general business practice.

(H) (1) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION MAY SUSPEND REVIEW OF A CLAIM FOR

REIMBURSEMENT FOR A PREAUTHORIZED OR APPROVED HEALTH CARE SERVICE IF THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION SENDS WRITTEN NOTICE WITHIN 30 DAYS AFTER RECEIPT OF THE CLAIM THAT INFORMS THE PERSON FILING THE CLAIM, THAT:

(I) REVIEW OF THE CLAIM IS SUSPENDED DURING THE SECOND OR THIRD MONTH OF A GRACE PERIOD UNDER 45 C.F.R. § 156.270(D); AND

(II) ON RECEIPT OF THE PAYMENT OF PREMIUM, THE INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION IS REQUIRED TO COMPLY WITH PARAGRAPH (2) OF THIS SUBSECTION.

(2) WITHIN 30 DAYS AFTER RECEIPT OF THE PAYMENT OF PREMIUM, AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION SHALL COMPLY WITH SUBSECTION (C)(1) OR (2) OF THIS SECTION.

15–1009.

(a) In this section, "carrier" means:

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other person that provides health benefit plans subject to regulation by the State.

(b) If a health care service for a patient has been preauthorized or approved by a carrier or the carrier's private review agent, the carrier may not deny reimbursement to a health care provider for the preauthorized or approved service delivered to that patient unless:

(1) the information submitted to the carrier regarding the service to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the carrier regarding the service to be delivered to the patient was omitted such that the carrier's determination would have been different had it known the critical information;

(3) a planned course of treatment for the patient that was approved by the carrier was not substantially followed by the health care provider; or

(4) on the date the preauthorized or approved service was delivered:

(i) the patient was not covered by the carrier;

(ii) the carrier maintained an automated eligibility verification system that was available to the contracting provider by telephone or via the Internet; and

(iii) according to the verification system, the patient was not covered by the carrier.

(C) NOTWITHSTANDING SUBSECTION (B) OF THIS SECTION, A CARRIER MAY SUSPEND REVIEW OF A CLAIM FOR REIMBURSEMENT OF A PREAUTHORIZED OR APPROVED HEALTH CARE SERVICE IF:

(1) THE PATIENT IS IN THE SECOND OR THIRD MONTH OF A GRACE PERIOD UNDER 45 C.F.R. § 156.270(D);

(2) THE CARRIER MAINTAINS AN AUTOMATED ELIGIBILITY VERIFICATION SYSTEM THAT WAS AVAILABLE TO THE HEALTH CARE PROVIDER BY TELEPHONE OR VIA THE INTERNET AT THE TIME THE HEALTH CARE SERVICE WAS PROVIDED;

(3) ACCORDING TO THE VERIFICATION SYSTEM, THE PROVIDER IS INFORMED THAT:

(I) THE PATIENT IS IN THE SECOND OR THIRD MONTH OF A GRACE PERIOD AND REVIEW OF A CLAIM FOR REIMBURSEMENT MAY BE SUSPENDED; AND

(II) A CARRIER IS NOT PROHIBITED FROM DENYING A CLAIM FOR REIMBURSEMENT OF A SUSPENDED CLAIM; AND

(4) THE CARRIER COMPLIES WITH THE NOTICE AND CLAIM PAYMENT REQUIREMENTS UNDER § 15–1005 OF THIS SUBTITLE.

[(c)**] (D)** A carrier shall pay a claim for a preauthorized or approved covered health care service in accordance with §§ 15–1005 and 15–1008 of this subtitle.

15–1208.1.

(a) A carrier shall provide the special enrollment periods described in this section in each small employer health benefit plan.

(b) **[**If the small employer elects under § 15–1210(a)(3) of this subtitle to offer coverage to all of its eligible employees who are covered under another public or private plan of health insurance or another health benefit arrangement, a**]** **A** carrier shall allow an eligible employee or dependent who is eligible, but not enrolled, for coverage under the terms of the employer's health benefit plan to enroll for coverage under the terms of the plan if:

(1) the eligible employee or dependent was covered under an employer–sponsored plan or group health benefit plan at the time coverage was previously offered to the employee or dependent;

(2) the eligible employee states in writing, at the time coverage was previously offered, that coverage under an employer–sponsored plan or group health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier requires the statement and provides the employee with notice of the requirement;

(3) the eligible employee's or dependent's coverage described in item (1) of this subsection:

(i) was under a COBRA continuation provision, and the coverage under that provision was exhausted; or

(ii) was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and

(4) under the terms of the plan, the eligible employee requests enrollment not later than 30 days after:

(i) the date of exhaustion of coverage described in item (3)(i) of this subsection; or

(ii) termination of coverage or termination of employer contributions described in item (3)(ii) of this subsection.

(c) All small employer health benefit plans shall provide a special enrollment period during which the following individuals may be enrolled under the health benefit plan:

(1) an individual who becomes a dependent of the eligible employee through marriage, birth, adoption, **[**or**]** placement for adoption**, OR PLACEMENT FOR FOSTER CARE**;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, **[**or**]** placement for adoption**, OR PLACEMENT FOR FOSTER CARE**; and

(3) the spouse of an eligible employee at the birth or adoption of a child**, OR PLACEMENT OF A CHILD FOR FOSTER CARE**, provided the spouse is otherwise eligible for coverage.

(d) An eligible employee may not enroll a dependent during a special enrollment period unless the eligible employee:

(1) is enrolled under the health benefit plan; or

(2) applies for coverage for the eligible employee during the same special enrollment period.

(e) The special enrollment period under subsection (c) of this section shall be a period of not less than 31 days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, adoption, **[**or**]** placement for adoption**, OR PLACEMENT FOR FOSTER CARE**, whichever is applicable.

(f) If an eligible employee enrolls any of the individuals described in subsection (c) of this section during the first 31 days of the special enrollment period, the coverage shall become effective as follows:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of a dependent's birth, as of the date of the dependent's birth; **[**and**]**

(3) in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption, whichever occurs first**; AND**

(4) IN THE CASE OF A DEPENDENT'S PLACEMENT FOR FOSTER CARE, THE DATE OF PLACEMENT.

15–1208.2.

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

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with an eligible employee.

(3) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

(b) (1) A carrier shall establish a standardized annual open enrollment period of at least 30 days for each small employer.

(2) The annual open enrollment period shall occur before the end of the small employer's plan year.

(3) During the annual open enrollment period, each eligible employee of the small employer shall be permitted to:

(i) enroll in a health benefit plan offered by the small employer;

(ii) discontinue enrollment in a health benefit plan offered by the small employer; or

(iii) change enrollment from one health benefit plan offered by the small employer to a different health benefit plan offered by the small employer.

(c) A carrier shall provide an open enrollment period of at least 30 days for each employee who becomes an eligible employee outside the initial or annual open enrollment period.

(d) (1) A carrier shall provide an open enrollment period for each individual who experiences a triggering event described in paragraph (4) of this subsection.

(2) The open enrollment period shall be for at least 30 days, beginning on the date of the triggering event.

(3) During the open enrollment period for an individual who experiences a triggering event, a carrier shall permit the individual to enroll in or change from one health benefit plan offered by the small employer to another health benefit plan offered by the small employer.

(4) A triggering event occurs when:

(i) subject to paragraph (5) of this subsection, an eligible employee or dependent loses minimum essential coverage;

(ii) an eligible employee or a dependent who is enrolled in a qualified health plan in the SHOP Exchange:

1. adequately demonstrates to the SHOP Exchange that the qualified health plan in which the eligible employee or a dependent is enrolled substantially violated a material provision of the qualified health plan's contract in relation to the eligible employee or a dependent;

2. gains access to new qualified health plans as a result of a permanent move; or

3. demonstrates to the SHOP Exchange, in accordance with guidelines issued by the federal Department of Health and Human Services, that the eligible employee or a dependent meets other exceptional circumstances as the SHOP Exchange may provide;

(iii) an eligible employee or a dependent is enrolled in an employer–sponsored health benefit plan that is not qualifying coverage in an eligible employer–sponsored plan and is allowed to terminate existing coverage; **[**or**]**

(iv) an eligible employee or dependent:

1. loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act; or

2. becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid plan or state child health plan, including any waiver or demonstration project conducted under or in relation to a Medicaid plan or a state child health plan**; OR**

(V) FOR SHOP EXCHANGE HEALTH BENEFIT PLANS:

1. AN ELIGIBLE EMPLOYEE'S OR DEPENDENT'S ENROLLMENT OR NONENROLLMENT IN A QUALIFIED HEALTH PLAN IS, AS EVALUATED AND DETERMINED BY THE EXCHANGE:

A. UNINTENTIONAL, INADVERTENT, OR ERRONEOUS; AND

B. THE RESULT OF THE ERROR, MISREPRESENTATION, OR INACTION OF AN OFFICER, EMPLOYEE, OR AGENT OF THE EXCHANGE OR THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR ITS INSTRUMENTALITIES; OR

2. AN ELIGIBLE EMPLOYEE IS AN INDIAN AS DEFINED IN § 4 OF THE FEDERAL INDIAN HEALTH CARE IMPROVEMENT ACT.

(5) Loss of minimum essential coverage under paragraph (4)(i) of this subsection does not include loss of coverage due to:

(i) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(ii) a rescission authorized under 45 C.F.R. § 147.128.

(6) If an eligible employee or a dependent meets the requirements for the triggering event described in paragraph (4)(iii) of this subsection, the open enrollment period shall:

(i) apply only to health benefit plans offered by the carrier in the SHOP Exchange; and

(ii) begin at least 60 days before the end of the eligible employee's or dependent's coverage under the employer–sponsored plan.

(7) IF AN ELIGIBLE EMPLOYEE OR DEPENDENT MEETS THE REQUIREMENTS FOR THE TRIGGERING EVENT DESCRIBED IN PARAGRAPH (4)(V)1 OF THIS SUBSECTION, THE EXCHANGE MAY TAKE ANY ACTION NECESSARY TO CORRECT OR ELIMINATE THE EFFECTS OF THE ERROR, MISREPRESENTATION, OR INACTION.

(8) IF AN ELIGIBLE EMPLOYEE MEETS THE REQUIREMENTS FOR THE TRIGGERING EVENT DESCRIBED IN PARAGRAPH (4)(V)2 OF THIS SUBSECTION, THE ELIGIBLE EMPLOYEE MAY ENROLL IN A QUALIFIED HEALTH PLAN OR CHANGE FROM ONE QUALIFIED HEALTH PLAN TO ANOTHER ONE TIME PER MONTH.

[(7)**] (9)** An eligible employee or a dependent who meets the requirements for the triggering event described in paragraph (4)(iv) of this subsection shall have 60 days from the triggering event to select a ~~qualified~~ health **BENEFIT** plan **[**through the SHOP Exchange**]**.

(e) If an individual enrolls for coverage during one of the open enrollment periods described in this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

15–1210.

(a) A carrier that offers coverage to a small employer shall:

(1) offer coverage to all of its eligible employees and all of their eligible dependents; **AND**

(2) at the election of the small employer, offer coverage to all of its part–time employees who have a normal workweek of at least 17 1/2 but less than 30 hours per week **[**and have been continuously employed for at least 4 consecutive months; and

(3) at the election of the small employer, offer coverage to all of its employees who are covered under another public or private plan of health insurance or another health benefit arrangement**]**.

(b) (1) A health maintenance organization need not offer coverage:

(i) to a small employer that is outside of the health maintenance organization's approved service areas;

(ii) to an eligible employee who resides outside of the health maintenance organization's approved service areas; or

(iii) within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity in its network of providers to deliver service adequately because of obligations to existing group contract holders and enrollees.

(2) A health maintenance organization that does not offer coverage under paragraph (1)(iii) of this subsection may not offer coverage in the applicable area to any employer groups until the later of:

(i) 180 days after a refusal to do so; or

(ii) the date on which the health maintenance organization notifies the Commissioner that it has regained capacity to deliver services to small employer groups in that area.

(c) A carrier may not be required to offer coverage under §§ 15–1209 and 15–1213 of this subtitle for as long as the Commissioner finds that the coverage would place the carrier in a financially impaired condition.

15–1212.

(a) (1) Except as provided in subsections (b), (c), and (d) of this section, a carrier shall renew a health benefit plan at the option of the small employer.

(2) On renewal, a carrier may not exclude eligible employees or dependents from a health benefit plan.

(3) (i) A carrier shall mail a notice of renewal to the small employer at least 45 days before the expiration of a health benefit plan.

(ii) The notice of renewal shall include the dates of the renewal period, the health benefit plan rates, and the terms of coverage under the health benefit plan.

(4) Policies or certificates for hospital or medical benefits issued through a professional employer organization, coemployer, or other organization under this subtitle may, with the consent of the carrier, have a common renewal date.

(b) A carrier may cancel or refuse to renew a health benefit plan only:

(1) for nonpayment of premiums;

(2) for fraud or intentional misrepresentation of material fact by the small employer;

(3) for noncompliance with a material plan provision relating to employer contributions or group participation rules;

(4) when the carrier elects not to renew:

(i) all of its health benefit plans that are issued to small employers in the State; or

(ii) the particular health benefit plan for all small employers in the State; or

(5) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area.

(c) When a carrier elects not to renew all health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected small employers and the insurance regulatory authority of each state in which an eligible employee or dependent resides at least 180 days before the effective date of nonrenewal;

(2) shall give notice to the Commissioner at least 30 working days before giving the notice specified in item (1) of this subsection; and

(3) may not write new business for small employers in the State for a period of 5 years beginning on the date of notice to the Commissioner.

(d) When a carrier elects not to renew a particular health benefit plan for all small employers in the State, the carrier shall:

(1) provide notice of the nonrenewal at least 90 days before the date of the nonrenewal to:

(i) each affected:

1. small employer; and

2. enrolled employee; and

(ii) the Commissioner;

(2) offer to each affected small employer the option to purchase all other health benefit plans currently offered by the carrier in the small group market; and

(3) act uniformly without regard to the claims experience of any affected small employer, or any health status–related factor of any affected individual.

~~[~~(e) Within 7 days after cancellation or nonrenewal of a health benefit plan, the carrier shall send to each enrolled employee written notice of its action ~~and the conversion rights available to each enrolled employee under § 15–412 of this title.~~**]**

15–1301.

(h) "Eligible individual" means an individual **WHO APPLIES FOR OR IS COVERED UNDER AN INDIVIDUAL HEALTH BENEFIT PLAN[**:

(1) (i) for whom, as of the date on which the individual seeks coverage under this subtitle, the aggregate of the periods of creditable coverage is 18 or more months; and

(ii) whose most recent prior creditable coverage was under an employer sponsored plan, governmental plan, church plan, or health benefit plan offered in connection with any of these plans;

(2) who is not eligible for coverage under:

(i) an employer sponsored plan;

(ii) Part A or Part B of Title XVIII of the Social Security Act; or

(iii) a State plan under Title XIX of the Social Security Act;

(3) who does not have coverage under a health benefit plan;

(4) who has not had the most recent prior creditable coverage described in paragraph (1)(ii) of this subsection terminated for nonpayment of premiums or fraud by the individual; and

(5) who, if the individual has been offered the option of continuation coverage under a State or federal continuation provision:

(i) has elected that coverage; and

(ii) has exhausted that coverage**]**.

15–1303.

(a) In addition to any other requirements under this article, a carrier that offers individual health benefit plans in this State shall:

(1) have demonstrated the capacity to administer the individual health benefit plans, including adequate numbers and types of administrative staff;

(2) have a satisfactory grievance procedure and ability to respond to calls, questions, and complaints from enrollees or insureds; and

(3) design policies to help ensure that enrollees or insureds have adequate access to providers of health care.

(b) (1) Except as provided in this subsection and § 31–110(f) of this article, a carrier may not offer individual health benefit plans in the State unless the carrier also offers qualified health plans, as defined in § 31–101 of this article, in the Individual Exchange of the Maryland Health Benefit Exchange in compliance with the requirements of Title 31 of this article.

(2) A carrier is exempt from the requirement in paragraph (1) of this subsection if:

(i) 1. the reported total aggregate annual earned premium from all individual health benefit plans in the State for the carrier and any other carriers in the same insurance holding company system, as defined in § 7–101 of this article, is less than $10,000,000; or

2. the only individual health benefit plans that the carrier offers in the State are student health plans as defined in 45 C.F.R. § 147.145;

(ii) the Commissioner determines that the carrier complies with the procedures established under paragraph (3) of this subsection; and

(iii) when the carrier ceases to meet the requirements for the exemption, the carrier provides to the Commissioner immediate notice and its plan for complying with the requirement in paragraph (1) of this subsection.

(3) The Commissioner shall establish procedures for a carrier to submit evidence each year that the carrier meets the requirements necessary to qualify for an exemption under paragraph (2) of this subsection.

(4) Notwithstanding the exemption provided in paragraph (2) of this subsection, any carrier that offers a catastrophic plan, as defined by the Affordable Care Act, in the State also must offer at least one catastrophic plan in the Maryland Health Benefit Exchange.

(5) Notwithstanding the exemption provided in paragraph (2) of this subsection, the Commissioner, in consultation with the Maryland Health Benefit Exchange:

(i) may assess the impact of the exemption provided in paragraph (2) of this subsection and, based on that assessment, alter the limit on the amount of annual premiums that may not be exceeded to qualify for the exemption; and

(ii) shall make any change in the exemption requirement by regulation.

[(c) (1) For each calendar quarter, a carrier that offers individual health benefit plans in the State shall submit to the Commissioner a report that includes:

(i) the number of applications submitted to the carrier for individual coverage; and

(ii) the number of declinations issued by the carrier for individual coverage.

(2) The report required under paragraph (1) of this subsection shall be filed with the Commissioner no later than 30 days after the last day of the quarter for which the information is provided.

(d) (1) If a carrier denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market, the carrier shall provide:

(i) the individual with specific information regarding the availability of coverage under the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of this article; and

(ii) the Maryland Health Insurance Plan with:

1. the name and address of the individual who was denied coverage; and

2. if the individual applied for coverage through an insurance producer, the name and, if available, the address of the insurance producer.

(2) The information provided by a carrier under this subsection shall be provided in a manner and form required by the Commissioner.**]**

15–1316.

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

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with another individual.

(3) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

~~(b) (1) Beginning October 15, 2014, a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.~~

~~(2) The annual open enrollment period shall begin on October 15 and extend through December 7 each year.~~

(b) (1) Beginning **[**October 15, 2014,**]** **NOVEMBER 15, 2014, UNLESS AN ALTERNATIVE DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES,** a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.

(2) THE ANNUAL OPEN ENROLLMENT PERIOD FOR 2014 SHALL BEGIN ON NOVEMBER 15, 2014, AND EXTEND THROUGH JANUARY 15, 2015, UNLESS ALTERNATIVE DATES ARE ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

[(2)**] (3)** The annual open enrollment period **FOR YEARS BEGINNING ON AND AFTER JANUARY 1, 2015,** shall begin on October 15 and extend through December 7 each year.

~~(3)~~ **(4)** During the annual open enrollment period, an individual shall be permitted to:

(i) enroll in a health benefit plan offered by the carrier;

(ii) discontinue enrollment in a health benefit plan offered by the carrier; or

(iii) change enrollment in a health benefit plan offered by the carrier to a different health benefit plan offered by the carrier.

~~(4) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period, the effective date of coverage shall be January 1 of the following calendar year.~~

(5) IF AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER DURING THE ANNUAL OPEN ENROLLMENT PERIOD FOR 2014, THE EFFECTIVE DATE OF COVERAGE SHALL BE:

(I) JANUARY 1, 2015, IF THE APPLICATION IS RECEIVED BY THE CARRIER ON OR BEFORE DECEMBER 15, 2014, UNLESS AN ALTERNATIVE DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND

(II) FEBRUARY 1, 2015, IF THE APPLICATION IS RECEIVED BY THE CARRIER FROM DECEMBER 16, 2014, THROUGH JANUARY 15, 2015, UNLESS AN ALTERNATIVE DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

[(4)**] (6)** If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period **FOR YEARS BEGINNING ON AND AFTER JANUARY 1, 2015**, the effective date of coverage shall be January 1 of the following calendar year.

(c) (1) A carrier shall provide a special open enrollment period for each individual who experiences a triggering event.

(2) The special open enrollment period shall be for at least 60 days, beginning on the date of the triggering event.

(3) During the special open enrollment period, a carrier shall permit an individual who experiences a triggering event to enroll in or change from one health benefit plan offered by the carrier to another health benefit plan offered by the carrier.

(4) A triggering event occurs when:

(i) subject to paragraph (5) of this subsection, an individual or dependent loses minimum essential coverage;

(ii) an individual gains a dependent or becomes a dependent through marriage, birth, adoption, **[**or**]** placement for adoption**, OR PLACEMENT IN FOSTER CARE**;

(iii) an individual's or a dependent's enrollment or nonenrollment in a qualified health plan is, as evaluated and determined by the Individual Exchange:

1. unintentional, inadvertent, or erroneous; and

2. the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Individual Exchange or the U.S. Department of Health and Human Services or its instrumentalities;

(iv) an individual or a dependent who is enrolled in a qualified health plan in the Individual Exchange adequately demonstrates to the Individual Exchange that the qualified health plan in which the individual or dependent is enrolled substantially violated a material provision of the qualified health plan's contract in relation to the individual or dependent;

(v) **1.** an individual or a dependent enrolled in the same health benefit plan is determined newly eligible or newly ineligible for advance payments of federal premium tax credits or has a change in eligibility for federal cost–sharing reductions; **OR**

2. AN INDIVIDUAL OR A DEPENDENT WHO IS ENROLLED IN AN ELIGIBLE EMPLOYER–SPONSORED PLAN IS DETERMINED NEWLY ELIGIBLE FOR ADVANCE PAYMENTS OF FEDERAL PREMIUM TAX CREDITS BASED IN PART ON A FINDING THAT THE INDIVIDUAL IS INELIGIBLE FOR QUALIFYING COVERAGE IN AN ELIGIBLE EMPLOYER–SPONSORED PLAN IN ACCORDANCE WITH 26 C.F.R. § 1.36B–2(C)(3), INCLUDING AS A RESULT OF THE EMPLOYEE'S EMPLOYER DISCONTINUING OR CHANGING AVAILABLE COVERAGE WITHIN THE NEXT 60 DAYS, PROVIDED THAT THE INDIVIDUAL IS ALLOWED TO TERMINATE EXISTING COVERAGE;

(vi) an individual or a dependent gains access to a new health benefit plan as a result of a permanent move;

(vii) the individual or dependent is enrolled in an employer–sponsored health benefit plan that is not qualifying coverage in an eligible employer–sponsored plan and is allowed to terminate existing coverage; **[**or**]**

(viii) for a health benefit plan offered through the Individual Exchange:

1. an individual who was not previously a citizen, national, or lawfully present individual becomes a citizen, national, or lawfully present individual; or

2. an individual or a dependent demonstrates to the Individual Exchange, in accordance with guidelines issued by the U.S. Department of Health and Human Services, that the individual or dependent meets other exceptional circumstances as the Individual Exchange may provide**; OR**

(IX) IT HAS BEEN DETERMINED BY THE EXCHANGE THAT A QUALIFIED INDIVIDUAL WAS NOT ENROLLED IN A QUALIFIED HEALTH PLAN, WAS NOT ENROLLED IN THE QUALIFIED HEALTH PLAN SELECTED BY THE INDIVIDUAL, OR IS ELIGIBLE FOR, BUT IS NOT RECEIVING, ADVANCE FEDERAL PREMIUM TAX CREDITS OR COST–SHARING REDUCTIONS AS A RESULT OF MISCONDUCT ON THE PART OF A NON–EXCHANGE ENTITY PROVIDING ENROLLMENT ASSISTANCE OR CONDUCTING ENROLLMENT ACTIVITIES.

(5) Loss of minimum essential coverage under paragraph (4)(i) of this subsection does not include loss of coverage due to:

(i) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

(ii) a rescission authorized under 45 C.F.R. § 147.128.

(6) If a triggering event described in paragraph (4)(iii) of this subsection occurs, the Individual Exchange may take action as may be necessary to correct or eliminate the effects of the error, misrepresentation, or inaction.

(7) If a triggering event described in paragraph **[**(4)(v)**] (4)(V)2** of this subsection occurs, a carrier shall permit an individual or a dependent**[**, whose existing coverage through**] WHO IS ENROLLED IN** an employer–sponsored plan **[**will no longer be affordable or provide minimum value for the upcoming plan year of the individual's employer, to access the special open enrollment period before the end of the individual's coverage through the employer–sponsored plan**] AND WHO WILL LOSE ELIGIBILITY FOR QUALIFYING COVERAGE IN AN ELIGIBLE EMPLOYER–SPONSORED PLAN WITHIN THE NEXT 60 DAYS TO ACCESS THE SPECIAL ENROLLMENT PERIOD PRIOR TO THE END OF THE INDIVIDUAL'S EXISTING COVERAGE, ALTHOUGH THE INDIVIDUAL IS NOT ELIGIBLE FOR ADVANCE PAYMENT OF THE FEDERAL PREMIUM TAX CREDIT UNTIL THE END OF THE INDIVIDUAL'S COVERAGE IN AN ELIGIBLE EMPLOYER–SPONSORED PLAN**.

(8) If an individual or a dependent meets the requirements for the triggering event described in paragraph (4)(vii) of this subsection, the special open

enrollment period shall begin at least 60 days before the end of the individual's or dependent's coverage under the employer–sponsored plan.

(d) An individual who is an Indian, as defined in § 4 of the federal Indian Health Care Improvement Act, may enroll in a health benefit plan in the Individual Exchange or change from one health benefit plan in the Individual Exchange to another health benefit plan in the Individual Exchange one time per month.

(e) (1) A carrier shall provide a limited open enrollment period for an individual who is enrolled in a noncalendar year individual health benefit plan to enroll in a health benefit plan issued by the carrier.

(2) The limited enrollment period required by paragraph (1) of this subsection shall:

(i) begin on the date that is at least 30 calendar days before the date the noncalendar year health benefit plan's policy year ends in 2014; and

(ii) last at least 60 days.

(f) If an individual enrolls for coverage during one of the open enrollment or special open enrollment periods described in this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

(g) (1) A health maintenance organization may:

(i) limit the individuals who may apply for coverage to those who live or reside in the health maintenance organization's service area; and

(ii) deny coverage to individuals if the health maintenance organization has demonstrated to the Commissioner that:

1. it will not have the capacity to deliver services adequately to any additional individuals because of its obligations to existing enrollees; and

2. it is applying the provisions of this paragraph uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A health maintenance organization that denies coverage to an individual in accordance with paragraph (1) of this subsection may not offer coverage in the individual market within the service area to any individual for a period of 180 days after the date the coverage is denied.

(3) Paragraph (2) of this subsection does not:

(i) limit the health maintenance organization's ability to renew coverage already in force; or

(ii) relieve the health maintenance organization of the responsibility to renew coverage already in force.

(h) (1) A carrier may deny a health benefit plan to an individual if the carrier has demonstrated to the Commissioner that:

(i) it does not have the financial reserves necessary to offer additional coverage; and

(ii) it is applying the provisions of this paragraph uniformly to all individuals in the individual market in the State without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A carrier that denies a health benefit plan to an individual in the State under paragraph (1) of this subsection may not offer coverage in the individual market before the later of:

(i) the 181st day after the date the carrier denies coverage; and

(ii) the date the carrier demonstrates to the Commissioner that the carrier has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (2) of this subsection does not:

(i) limit the carrier's ability to renew coverage already in force; or

(ii) relieve the carrier of the responsibility to renew coverage already in force.

(4) Health benefit plans offered after the time period described in paragraph (2) of this subsection are subject to the requirements of this section.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–1301.

(g) (1) "Creditable coverage" means coverage of an individual under:

(i) an employer sponsored plan;

(ii) a health benefit plan;

(iii) Part A or Part B of Title XVIII of the Social Security Act;

(iv) Title XIX **OR TITLE XXI** of the Social Security Act, other than coverage consisting solely of benefits under § 1928 of that Act;

(v) Chapter 55 of Title 10 of the United States Code;

(vi) a medical care program of the Indian Health Service or of a tribal organization;

(vii) a State health benefits risk pool;

(viii) a health plan offered under the Federal Employees Health Benefits Program (FEHBP), Title 5, Chapter 89 of the United States Code;

(ix) a public health plan as defined by federal regulations authorized by the Public Health Service Act, § 2701(c)(1)(i), as amended by P.L. 104–191; or

(x) a health benefit plan under § 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a health benefit plan or an employer sponsored plan, if, after such period and before the enrollment date, there was a 63–day period during all of which the individual was not covered under any creditable coverage.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect on the taking effect of the termination provision specified in Section 6 of Chapter 692 of the Acts of the General Assembly of 2008, as amended by Chapter 734 of the Acts of the General Assembly of 2010.

SECTION 4. AND BE IT FURTHER ENACTED, That, except as provided in Section 3 of this Act, this Act shall take effect July 1, 2014.