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

A BILL ENTITLED

1 AN ACT concerning

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

4 FOR the purpose of establishing initial permit, permit renewal, and permit
5 reinstatement fees for a SHOP Exchange enrollment permit; repealing certain
6 conversion rights for certain kinds of group and blanket health insurance
7 contracts; repealing certain provisions of law governing bona fide wellness
8 programs; authorizing certain insurance carriers to include certain
9 participatory wellness programs as part of an individual or group health benefit
10 plan under certain circumstances; altering the circumstances under which a
11 carrier is required to allow a certain eligible employee or dependent to enroll for
12 certain coverage; establishing a special enrollment period under a small
13 employer health benefit plan for the placement of a child for foster care;
14 establishing a certain triggering event for an open enrollment period in the
15 SHOP Exchange; authorizing the Maryland Health Benefit Exchange to take
16 certain actions on the occurrence of a certain triggering event; authorizing an
17 eligible employee, on the occurrence of a certain triggering event, to enroll in a
18 qualified health plan or change from one qualified health plan to another a
19 certain number of times per month; repealing a requirement that, under certain
20 circumstances, an eligible employee or a dependent must select a qualified
21 health plan through the SHOP Exchange; altering the circumstances under
22 which a carrier that offers coverage to a small employer is required to offer
23 coverage to certain employees of the small employer; repealing a certain notice
24 requirement relating to cancellation or nonrenewal of certain health benefit
25 plans; repealing a certain reporting requirement relating to carrier declinations
26 for individual coverage; establishing certain triggering events for a special open
27 enrollment period in the Individual Exchange; altering the circumstances under
28 which a carrier, on the occurrence of a certain triggering event, must permit a
29 certain individual or dependent to access a certain special enrollment period;

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

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), 15–1208.1, 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:

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

6 (ii) fee for initial certificate of authority $200

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

10 (iv) fee for annual renewal of certificate of authority for domestic
11 insurers with their home or executive office outside the State, except those domestic
12 insurers that had their home or executive office outside the State before January 1,
13 1929:

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

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

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

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

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

24 (v) reinstatement of certificate of authority $500

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

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

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

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

33 (4) fees for certificates of qualification:

1 (i) application fee $25

2 (ii) managing general agent certificate of qualification:

3 1. fee for initial certificate $30

4 2. annual renewal fee $30

5 (iii) surplus lines broker certificate of qualification:

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

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

10 3. biennial renewal fee $200

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

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

14 (i) public adjuster license:

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

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

17 3. biennial renewal fee $50

18 (ii) adviser license:

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

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

21 3. biennial renewal fee $200

22 (iii) insurance producer license:

23 1. fee for initial license $54

24 2. biennial renewal fee $54

25 (iv) SHOP Exchange navigator license:

1 1. fee for initial license $54

2 2. biennial renewal fee $54

3 3. fee for reinstatement of license $100

4 **(V) SHOP EXCHANGE ENROLLMENT PERMIT:**

5 **1. FEE FOR INITIAL PERMIT $54**

6 **2. BIENNIAL RENEWAL FEE $54**

7 **3. FEE FOR REINSTATEMENT OF PERMIT $100**

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

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

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

14 (9) fees for required filings, including form and rate filings, under Title
15 11, Subtitles 2 through 4, Title 26, and §§ 12–203, 13–110, 14–126, and 27–613 of this
16 article $125

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

19 **[**15–414.

20 (a) This section applies to:

21 (1) each group or blanket contract that:

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

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

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

27 (2) each group contract that:

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

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

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

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

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

14 [15–509.

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

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

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

18 (ii) reduce or avoid poor clinical outcomes;

19 (iii) prevent complications from medical conditions;

20 (iv) promote healthy behaviors; or

21 (v) prevent and control injury.

22 (3) "Carrier" means:

23 (i) an insurer;

24 (ii) a nonprofit health service plan;

25 (iii) a health maintenance organization; or

26 (iv) a dental plan organization.

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

1 (i) health status;

2 (ii) medical condition;

3 (iii) claims experience;

4 (iv) receipt of health care;

5 (v) medical history;

6 (vi) evidence of insurability; or

7 (vii) disability.

8 (5) "Incentive" means:

9 (i) a discount of a premium or contribution;

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

12 (iii) the absence of a surcharge;

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

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

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

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

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

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

27 (iv) the bona fide wellness program does not condition an
28 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:

1 **(I) AN INSURER;**

2 **(II) A NONPROFIT HEALTH SERVICE PLAN; OR**

3 **(III) A HEALTH MAINTENANCE ORGANIZATION.**

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

6 **(5) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN §**
7 **15–1301 OF THIS TITLE.**

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

11 **(II) "HEALTH–CONTINGENT WELLNESS PROGRAM"**
12 **INCLUDES:**

13 **1. AN ACTIVITY–ONLY WELLNESS PROGRAM; AND**

14 **2. AN OUTCOME–BASED WELLNESS PROGRAM.**

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

17 **(I) HEALTH STATUS;**

18 **(II) MEDICAL CONDITION;**

19 **(III) CLAIMS EXPERIENCE;**

20 **(IV) RECEIPT OF HEALTH CARE;**

21 **(V) MEDICAL HISTORY;**

22 **(VI) GENETIC INFORMATION;**

23 **(VII) EVIDENCE OF INSURABILITY;**

24 **(VIII) DISABILITY; OR**

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

4 **(8) "INCENTIVE" MEANS:**

5 **(I) A DISCOUNT OF A PREMIUM OR CONTRIBUTION;**

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

8 **(III) THE ABSENCE OF A SURCHARGE;**

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

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

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

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

19 **(I) PROVIDE A REWARD; OR**

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

23 **(11) "REWARD" MEANS:**

24 **(I) OBTAINING AN INCENTIVE; OR**

25 **(II) AVOIDING A PENALTY.**

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

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

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

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

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

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

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

19 **(II) WHEN THE PLAN PROVIDES COVERAGE FOR FAMILY**
20 **MEMBERS, AND WHEN FAMILY MEMBERS ARE PERMITTED TO PARTICIPATE IN**
21 **THE ACTIVITY–ONLY WELLNESS PROGRAM, 30% OF THE COST OF THE**
22 **COVERAGE IN WHICH THE FAMILY MEMBERS ARE ENROLLED, EXCEPT THAT THE**
23 **APPLICABLE PERCENTAGE IS INCREASED BY AN ADDITIONAL 20 PERCENTAGE**
24 **POINTS TO THE EXTENT THAT THE ADDITIONAL PERCENTAGE IS IN**
25 **CONNECTION WITH A PROGRAM DESIGNED TO PREVENT OR REDUCE TOBACCO**
26 **USE;**

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

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

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

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

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

6 **(2) IS NOT OVERLY BURDENSOME;**

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

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

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

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

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

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

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

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

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

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

3 **(III) AN INDIVIDUAL, ON REQUEST, IS PROVIDED WITH A**
4 **REASONABLE ALTERNATIVE STANDARD REGARDLESS OF ANY MEDICAL**
5 **CONDITION OR OTHER HEALTH FACTOR.**

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

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

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

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

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

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

21 **(6) IF THE REASONABLE ALTERNATIVE STANDARD IS AN**
22 **OUTCOME–BASED WELLNESS PROGRAM, THE REASONABLE ALTERNATIVE**
23 **STANDARD MUST COMPLY WITH THE REQUIREMENTS FOR OUTCOME–BASED**
24 **WELLNESS PROGRAMS.**

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

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

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

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

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

18 15–1208.1.

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

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

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

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

35 (3) the eligible employee's or dependent's coverage described in item
36 (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

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

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

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

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

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

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

14 15–1208.2.

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (4) A triggering event occurs when:

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

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

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

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

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

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

33 (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.

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

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

11 **[**(7)**] (9)** An eligible employee or a dependent who meets the
12 requirements for the triggering event described in paragraph (4)(iv) of this subsection
13 shall have 60 days from the triggering event to select a qualified health plan **[**through
14 the SHOP Exchange**]**.

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

18 15–1210.

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

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

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

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

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

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

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

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

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

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

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

12 (c) A carrier may not be required to offer coverage under §§ 15–1209 and
13 15–1213 of this subtitle for as long as the Commissioner finds that the coverage would
14 place the carrier in a financially impaired condition.

15 15–1212.

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

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

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

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

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

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

29 (1) for nonpayment of premiums;

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

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

1 (4) when the carrier elects not to renew:

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

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

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

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

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

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

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

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

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

22 (i) each affected:

23 1. small employer; and

24 2. enrolled employee; and

25 (ii) the Commissioner;

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

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

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

4 15–1301.

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

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

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

13 (2) who is not eligible for coverage under:

14 (i) an employer sponsored plan;

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

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

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

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

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

23 (i) has elected that coverage; and

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

25 15–1303.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (ii) the Maryland Health Insurance Plan with:

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

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

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

24 15–1316.

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

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

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

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

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

5 (3) During the annual open enrollment period, an individual shall be
6 permitted to:

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

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

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

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

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

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

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

23 (4) A triggering event occurs when:

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

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

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

32 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:

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(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;

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

3 (vii) a State health benefits risk pool;

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

6 (ix) a public health plan as defined by federal regulations
7 authorized by the Public Health Service Act, § 2701(c)(1)(i), as amended by P.L.
8 104–191; or

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

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

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

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