HOUSE BILL 169

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By: **Delegates Hough, Afzali, Arentz, Aumann, Bates, Frank, George, Glass, Jacobs, Kipke, Krebs, McComas, McDermott, McDonough, Norman, Parrott, Ready, and Szeliga**

Introduced and read first time: January 15, 2014
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Rollback of Federal Patient Protection and Affordable Care Act Conforming Provisions

FOR the purpose of repealing the application to certain coverage in certain insurance markets of certain provisions of the federal Patient Protection and Affordable Care Act relating to annual limitations on cost sharing and deductibles, child–only plan offerings, minimum benefit requirements for catastrophic plans, health insurance premium rates, coverage for individuals participating in approved clinical trials, and contract requirements for certain dental plans; altering the definition of "child dependent" for purposes of certain provisions of law that require certain policies and contracts to provide certain health insurance coverage and benefits to child dependents; repealing the application of certain provisions of law relating to preexisting condition provisions to certain carriers for health benefit plan years that begin before a certain date; repealing the application of certain provisions of law relating to exclusionary riders to individual health benefit plans issued or delivered in the State before a certain date; altering the limits on incentives for certain wellness programs; requiring the Maryland Insurance Commissioner to transmit certain information to the Maryland Health Care Commission on or before a certain date each year; repealing a certain exception from the requirement that an insurer, a nonprofit health service plan, or a health maintenance organization take certain action in relation to a certain claim within a certain number of days; establishing certain disclosure requirements for certain out–of–state association contracts; authorizing the Maryland Insurance Commissioner to require a certain report on or before a certain date each year; requiring certain data to be reported in a certain manner; requiring a carrier to disclose certain information on an enrollment application for an out–of–state association contract under certain circumstances; establishing criteria for a person to be considered a "small employer" for purposes of certain provisions of law

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

governing the small group insurance market; authorizing certain carriers to request documentation to verify that a person meets certain criteria to be considered a small employer for certain purposes; repealing a prohibition on certain carriers from imposing a minimum participation requirement for a small employer group under certain circumstances; repealing a requirement that carriers in the small group insurance market set premium rates for the entire plan year for each small employer; repealing the application of certain provisions of law relating to the Comprehensive Standard Health Benefit Plan offered in the small group insurance market only to certain plans beginning on a certain date; requiring that certain special enrollment periods apply to certain employees; repealing a requirement that certain carriers establish a certain standardized annual open enrollment period for each small employer in the small group insurance market; repealing a requirement that certain carriers provide a certain open enrollment period for an employee who becomes an eligible employee outside certain enrollment periods; repealing a requirement that certain carriers provide certain enrollment periods for individuals who experience certain triggering events; altering the requirements a small employer must meet to be covered under a health benefit plan offered by a carrier in the small group insurance market; repealing a provision that limits application of certain provisions of law relating to increasing access to care choices or lowering the cost–sharing arrangement in the Standard Health Benefit Plan to certain grandfathered health plans beginning on a certain date; altering the scope of certain provisions of law governing carriers that offer health benefit plans to individuals in the State; authorizing a carrier to cancel health insurance coverage made available in the individual market only through certain associations under certain circumstances; repealing a requirement that certain qualified health plans issued on or after a certain date by certain carriers include a certain grace period provision; repealing a provision requiring and authorizing certain carriers issuing certain qualified health plans to take certain actions during a certain grace period; repealing a requirement that certain carriers that sell certain health benefit plans to individuals in the State establish a certain annual enrollment period; repealing an authorization for certain individuals to enroll in a health benefit plan or change from one health benefit plan in the Individual Exchange to another health benefit plan in the Individual Exchange a certain number of times per month; repealing a requirement that a carrier provide a limited open enrollment period for certain individuals; repealing a requirement that certain coverage for certain individuals be effective in accordance with certain federal requirements; repealing a provision authorizing a health maintenance organization to establish a certain limit and to deny coverage to individuals under certain circumstances; repealing a certain prohibition on certain health maintenance organizations from offering coverage in the individual market within a certain area for a certain period of time; repealing a provision authorizing a carrier to deny a health benefit plan to an individual under certain circumstances; repealing a certain prohibition on offering coverage in the individual market for a certain period of time by a carrier under certain circumstances; repealing a provision specifying the applicability of the

guaranteed issuance of coverage provision of the Affordable Care Act; altering and repealing certain definitions; defining certain terms; making conforming changes; providing for the applicability of certain provisions of law; and generally relating to the rollback of provisions conforming State insurance law to the federal Patient Protection and Affordable Care Act.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–137.1, 15–418, 15–508, 15–508.1, 15–509(b), 15–605(e) and (f), 15–1005(c), 15–1201, 15–1208.1, 15–1209(a), 15–1213, 15–1301, 15–1302, 15–1309(b), and 31–101(z)
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

BY adding to
Article – Insurance
Section 15–605(e), 15–1105, and 15–1203
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

BY repealing
Article – Insurance
Section 15–1205(h), 15–1206(c)(6), 15–1207(h), 15–1208.2, 15–1315, 15–1316, 15–1410, and 31–101(e–1)
Annotated Code of Maryland
(2011 Replacement Volume and 2013 Supplement)

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

Article – Insurance

15–137.1.

(a) Notwithstanding any other provisions of law, the following provisions of Title I, Subtitles A**[**,**]** **AND** 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; **AND**

(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.

(b) The annual limitation on deductibles for the employer–sponsored plans provision of Title I, Subtitle D of the Affordable Care Act applies to health insurance coverage offered in the small group market, as 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**]**.

[(c)**] (B)** The provisions of **[**subsections (a) and (b)**] SUBSECTION (A)** of this section do not apply to coverage for excepted benefits, as defined in 45 C.F.R. § 146.145(c).

[(d)**] (C)** The Commissioner may enforce this section under any applicable provisions of this article.

15–418.

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

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(3) "Child dependent" means an individual who:

(i) is:

1. the **NATURAL CHILD, STEPCHILD, ADOPTED CHILD, OR** grandchild of the insured; **[**or**]**

2. **A CHILD PLACED WITH THE INSURED FOR LEGAL ADOPTION; OR**

3. a child who is entitled to dependent coverage under § 15–403.1 of this subtitle;

(ii) **IS A DEPENDENT OF THE INSURED AS THAT TERM IS USED IN 26 U.S.C. §§ 104, 105, AND 106, AND ANY REGULATIONS ADOPTED UNDER THOSE SECTIONS;**

(III) is unmarried; and

[(iii)**] (IV)** is under the age of 25 years.

(b) (1) This section applies to:

(i) each policy of individual or group health insurance that is issued in the State;

(ii) each contract that is issued in the State by a nonprofit health service plan; and

(iii) each contract that is issued in the State by a health maintenance organization.

(2) Notwithstanding paragraph (1) of this subsection, this section does not apply to:

(i) a contract covering one or more, or any combination of the following:

1. coverage only for loss caused by an accident;

2. disability coverage;

3. credit–only insurance; or

4. long–term care coverage; or

(ii) the following benefits if they are provided under a separate contract:

1. dental coverage;

2. vision coverage;

3. Medicare supplement insurance;

4. coverage limited to benefits for a specified disease or diseases;

5. travel accident or sickness coverage; and

6. fixed indemnity limited benefit insurance that does not provide benefits on an expense incurred basis.

(c) Each policy or contract subject to this section that provides coverage for dependents shall:

(1) include coverage for a child dependent;

(2) provide the same health insurance benefits to a child dependent that are available to any other covered dependent; and

(3) provide health insurance benefits to a child dependent at the same rate or premium applicable to any other covered dependent.

(d) This section does not limit or alter any right to dependent coverage or to the continuation of coverage that is otherwise provided for in this article.

15–508.

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

(2) "Carrier" has the meaning stated in § 15–1301 of this title.

(3) "Enrollment date" has the meaning stated in § 15–1301 of this title.

[(4) "Plan year" means a calendar year or other consecutive 12–month period during which a health benefit plan provides coverage for health benefits.**]**

[(5)**] (4)** "Policy or certificate" means any group or blanket health insurance contract or policy that is issued or delivered in the State by an insurer or nonprofit health service plan that provides hospital, medical, or surgical benefits on an expense–incurred basis.

[(6)**] (5)** "Preexisting condition provision" has the meaning stated in § 15–1301 of this title.

[(7)**] (6)** "Late enrollee" has the meaning stated in § 15–1401 of this title.

(b) **[**(1)**]** This section does not apply to a policy or certificate issued to an individual in accordance with Subtitle 13 of this title.

[(2) This section applies to carriers for plan years that begin before January 1, 2014.**]**

(c) Except as otherwise provided in subsection (d) of this section, a carrier may impose a preexisting condition provision only if it:

(1) relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6–month period ending on the enrollment date;

(2) extends for a period of not more than 12 months after the enrollment date or 18 months in the case of a late enrollee; and

(3) is reduced by the aggregate of the periods of creditable coverage, as defined in Subtitle 14 of this title.

(d) (1) Subject to paragraph (4) of this subsection, a carrier may not impose any preexisting condition provision on an individual who, as of the last day of the 30–day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to paragraph (4) of this subsection, a carrier may not impose any preexisting condition provisions on a child who:

(i) is adopted or placed for adoption before attaining 18 years of age; and

(ii) as of the last day of the 30–day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage.

(3) A carrier may not impose any preexisting condition provisions relating to pregnancy.

(4) Paragraphs (1) and (2) of this subsection do not apply to an individual after the end of the first 63–day period during all of which the individual was not covered under any creditable coverage.

15–508.1.

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

(2) "Carrier" means an insurer or a nonprofit health service plan.

(3) "Creditable coverage" has the meaning stated in § 15–1301 of this title.

(4) "Exclusionary rider" means an endorsement to an individual health benefit plan that excludes benefits for one or more named conditions that are discovered by a carrier during the underwriting process.

(5) "Health benefit plan" has the meaning stated in § 15–1301 of this title.

(6) "Individual health benefit plan" means a health benefit plan issued by a carrier that insures:

(i) only one individual; or

(ii) one individual and one or more family members of the individual.

[(b) This section applies to individual health benefit plans that are issued or delivered in the State before January 1, 2014.**]**

[(c)**] (B)** A carrier may not attach an exclusionary rider to an individual health benefit plan unless the carrier obtains the prior written consent of the policyholder.

[(d)**] (C)** Except as provided in subsection **[**(e)**] (D)** of this section, a carrier may impose a preexisting condition exclusion or limitation on an individual for a

condition that was not discovered during the underwriting process for an individual health benefit plan only if the exclusion or limitation:

(1) relates to a condition of the individual, regardless of its cause, for which medical advice, diagnosis, care, or treatment was recommended or received within the 12–month period immediately preceding the effective date of the individual's coverage;

(2) extends for a period of not more than 12 months after the effective date of the individual's coverage; and

(3) is reduced by the aggregate of any applicable periods of creditable coverage.

[(e)**] (D)** (1) Subject to paragraph (2) of this subsection, a carrier may not impose a preexisting condition exclusion or limitation on an individual who, as of the last day of the 30–day period beginning with the date of the individual's birth, is covered under any creditable coverage.

(2) The limitation on the imposition of a preexisting condition exclusion or limitation under paragraph (1) of this subsection does not apply after the end of the first 63–day period during all of which the individual was not covered under any creditable coverage.

15–509.

(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%**] 20%** 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%**] 20%** 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.

15–605.

(E) (1) ON OR BEFORE MAY 1 OF EACH YEAR, THE COMMISSIONER SHALL TRANSMIT TO THE MARYLAND HEALTH CARE COMMISSION ANY INFORMATION IT NEEDS TO EVALUATE THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN AS REQUIRED UNDER § 15–1207 OF THIS TITLE.

(2) THE INFORMATION PROVIDED BY THE COMMISSIONER SHALL BE SPECIFIED IN REGULATIONS ADOPTED BY THE COMMISSIONER IN CONSULTATION WITH THE MARYLAND HEALTH CARE COMMISSION.

[(e)**] (F)** (1) (i) On or before March 1 of each year, unless, for good cause shown, the Commissioner extends the time for a reasonable period, each managed care organization shall file with the Commissioner a report that shows the financial condition of the managed care organization on the last day of the preceding calendar year and any other information that the Commissioner requires by bulletin or regulation.

(ii) At any time, the Commissioner may require a managed care organization to file an interim statement containing the information that the Commissioner considers necessary.

(iii) The annual and interim reports shall be filed in a form required by the Commissioner.

(2) (i) Except as provided in paragraph (3) of this subsection on or before June 1 of each year, each managed care organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(ii) The audited financial report shall:

1. be filed in a form required by the Commissioner; and

2. be certified by an audit of an independent certified public accountant.

(3) With 90 days' advance notice, the Commissioner may require a managed care organization to file an audited financial report earlier than the date specified in paragraph (2) of this subsection.

[(f)**] (G)** Each financial report filed under this section is a public record.

15–1005.

(c) **[**Except as provided in § 15–1315 of this title, within**] 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.

15–1105.

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

(2) "CARRIER" MEANS:

(I) AN INSURER; OR

(II) A NONPROFIT HEALTH SERVICE PLAN.

(3) "ELIGIBLE INDIVIDUAL" MEANS A MARYLAND RESIDENT WHO HAS MEMBERSHIP IN AN ASSOCIATION.

(4) "EVIDENCE OF INDIVIDUAL INSURABILITY" MEANS MEDICAL OR OTHER INFORMATION THAT INDICATES HEALTH STATUS, USED TO DETERMINE WHETHER COVERAGE OF AN INDIVIDUAL IS TO BE:

(I) ISSUED OR DENIED; OR

(II) ISSUED WITH OR WITHOUT AN EXCLUSIONARY RIDER.

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

(6) "HEALTH STATUS–RELATED FACTOR" HAS THE MEANING STATED IN § 15–1201 OF THIS TITLE.

(7) "INDIVIDUAL HEALTH INSURANCE CONTRACT" MEANS A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED IN THE STATE TO AN INDIVIDUAL.

(8) "MEMBER" MEANS AN ELIGIBLE INDIVIDUAL WHO PURCHASES COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT.

(9) "OUT–OF–STATE ASSOCIATION CONTRACT" MEANS A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED TO AN ASSOCIATION OUTSIDE OF THE STATE.

(B) THIS SECTION APPLIES TO A CARRIER THAT REQUIRES EVIDENCE OF INDIVIDUAL INSURABILITY FOR COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT.

(C) A CARRIER SHALL DISCLOSE TO A MARYLAND RESIDENT APPLYING FOR COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT:

(1) THAT COVERAGE IS CONDITIONED ON MEMBERSHIP IN THE ASSOCIATION THAT HOLDS THE OUT–OF–STATE ASSOCIATION CONTRACT;

(2) ALL COSTS RELATED TO JOINING AND MAINTAINING MEMBERSHIP IN THE ASSOCIATION;

(3) THAT MEMBERSHIP FEES OR DUES ARE IN ADDITION TO THE PREMIUM FOR COVERAGE UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT;

(4) THAT THE TERMS AND CONDITIONS OF COVERAGE UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT ARE DETERMINED BY THE ASSOCIATION AND THE CARRIER;

(5) THE MANDATED BENEFITS REQUIRED UNDER SUBTITLE 8 OF THIS TITLE THAT ARE NOT INCLUDED IN THE OUT–OF–STATE ASSOCIATION CONTRACT;

(6) THAT THE MARYLAND RESIDENT MAY PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN THAT INCLUDES THE MANDATED BENEFITS UNDER SUBTITLE 8 OF THIS TITLE THAT ARE NOT INCLUDED IN THE OUT–OF–STATE ASSOCIATION CONTRACT FROM A CARRIER LICENSED AND AUTHORIZED TO DO BUSINESS IN THE STATE;

(7) THAT BENEFITS OFFERED UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT ARE NOT REGULATED BY THE COMMISSIONER; AND

(8) THAT THE TERMS AND CONDITIONS OF COVERAGE UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT MAY BE CHANGED BY AGREEMENT OF THE ASSOCIATION AND THE CARRIER WITHOUT THE CONSENT OF A MEMBER.

(D) (1) THE COMMISSIONER MAY REQUIRE A CARRIER THAT OFFERS COVERAGE UNDER AN OUT–OF–STATE ASSOCIATION CONTRACT TO REPORT, ON OR BEFORE MARCH 1 OF EACH YEAR, THE NUMBER OF MARYLAND RESIDENTS COVERED IN THE PRECEDING CALENDAR YEAR UNDER THE OUT–OF–STATE ASSOCIATION CONTRACT.

(2) THE DATA REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE REPORTED IN A MANNER DETERMINED BY THE COMMISSIONER.

(E) IF A CARRIER COLLECTS MEMBERSHIP FEES OR DUES ON BEHALF OF AN ASSOCIATION, THE CARRIER SHALL DISCLOSE ON THE ENROLLMENT APPLICATION FOR AN OUT–OF–STATE ASSOCIATION CONTRACT THAT THE CARRIER BILLS AND COLLECTS MEMBERSHIP FEES AND DUES ON BEHALF OF THE ASSOCIATION.

15–1201.

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

(b) "Board" means the Board of Directors of the Pool established under § 15–1216 of this subtitle.

(c) "Carrier" means a person that:

(1) offers health benefit plans in the State covering eligible employees of small employers; and

(2) is:

(i) an authorized insurer that provides health insurance in the State;

(ii) a nonprofit health service plan that is licensed to operate in the State;

(iii) a health maintenance organization that is licensed to operate in the State; or

(iv) any other person or organization that provides health benefit plans subject to State insurance regulation.

(d) "Commission" means the Maryland Health Care Commission established under Title 19, Subtitle 1 of the Health – General Article.

(e) **[**"Coverage level" has the meaning stated in § 31–101 of this article.

(f) (1) "Eligible employee" means an employee who is offered coverage under a health benefit plan by a small employer.

(2) "Eligible employee", at the option of the small employer, may include:

(i) only full–time employees; or

(ii) full–time employees and part–time employees.

(g) "Employee" means an individual who is employed by a small employer.**]**

(1) "ELIGIBLE EMPLOYEE" MEANS:

(I) AN INDIVIDUAL WHO:

1. IS AN EMPLOYEE, A PARTNER OF A PARTNERSHIP, OR AN INDEPENDENT CONTRACTOR WHO IS INCLUDED AS AN EMPLOYEE UNDER A HEALTH BENEFIT PLAN; AND

2. WORKS ON A FULL–TIME BASIS AND HAS A NORMAL WORKWEEK OF AT LEAST 30 HOURS; OR

(II) A SOLE EMPLOYEE OF A NONPROFIT ORGANIZATION THAT HAS BEEN DETERMINED BY THE INTERNAL REVENUE SERVICE TO BE EXEMPT FROM TAXATION UNDER § 501(C)(3), (4), OR (6) OF THE INTERNAL REVENUE CODE WHO:

1. HAS A NORMAL WORKWEEK OF AT LEAST 20 HOURS; AND

2. IS NOT COVERED UNDER A PUBLIC OR PRIVATE PLAN FOR HEALTH INSURANCE OR OTHER HEALTH BENEFIT ARRANGEMENT.

(2) "ELIGIBLE EMPLOYEE" DOES NOT INCLUDE AN INDIVIDUAL WHO WORKS:

(I) ON A TEMPORARY OR SUBSTITUTE BASIS; OR

(II) EXCEPT FOR AN INDIVIDUAL DESCRIBED IN PARAGRAPH (1)(II) OF THIS SUBSECTION, FOR LESS THAN 30 HOURS IN A NORMAL WORKWEEK.

[(h) "Full–time employee" means an employee of a small employer who works, on average, at least 30 hours per week.**]**

[(i)**] (F)** (1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" includes a policy or certificate for hospital or medical benefits that covers residents of this State who are eligible employees and that is issued through:

(i) a multiple employer trust or association located in this State or another state; or

(ii) a professional employer organization, coemployer, or other organization located in this State or another state that engages in employee leasing.

(3) "Health benefit plan" does not include:

(i) accident–only insurance;

(ii) fixed indemnity insurance;

(iii) credit health insurance;

(iv) Medicare supplement policies;

(v) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policies;

(vi) long–term care insurance;

(vii) disability income insurance;

(viii) coverage issued as a supplement to liability insurance;

(ix) workers' compensation or similar insurance;

(x) disease–specific insurance;

(xi) automobile medical payment insurance;

(xii) dental insurance; or

(xiii) vision insurance.

[(j)**] (G)** "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability including conditions arising out of acts of domestic violence; or

(8) disability.

[(k)**] (H)** "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period provided under the health benefit plan.

[(l) "Minimum essential coverage" has the meaning stated in 45 C.F.R. § 155.20.

(m) "Part–time employee" means an employee of a small employer who:

(1) has a normal workweek of at least 17.5 hours; and

(2) is not a full–time employee.

(n) "Plan year" means a calendar year or other consecutive 12–month period during which a health benefit plan provides coverage for health care services.**]**

[(o)**] (I)** "Pool" means the Maryland Small Employer Health Reinsurance Pool established under this subtitle.

[(p)**] (J)** "Preexisting condition" means:

(1) a condition existing during a specified period immediately preceding the effective date of coverage, that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

[(q)**] (K)** "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

[(r) "Qualified employer" has the meaning stated in § 31–101 of this article.

(s) "Qualified health plan" has the meaning stated in § 31–101 of this article.**]**

[(t)**] (L)** "Reinsuring carrier" means a carrier that participates in the Pool.

[(u)**] (M)** "Risk–assuming carrier" means a carrier that does not participate in the Pool.

[(v) "SHOP Exchange" has the meaning stated in § 31–101 of this article.**]**

[(w)**] (N)** "Small employer" **[**has the meaning stated in § 31–101 of this article**] MEANS:**

(1) AN EMPLOYER DESCRIBED IN § 15–1203 OF THIS SUBTITLE; OR

(2) AN ENTITY THAT LEASES EMPLOYEES FROM A PROFESSIONAL EMPLOYER ORGANIZATION, COEMPLOYER, OR OTHER ORGANIZATION ENGAGED IN EMPLOYEE LEASING AND THAT OTHERWISE MEETS THE DESCRIPTION OF § 15–1203 OF THIS SUBTITLE.

[(x)**] (O)** "Special enrollment period" means a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

[(y)**] (P)** "Standard Plan" means the Comprehensive Standard Health Benefit Plan adopted by the Commission in accordance with § 15–1207 of this subtitle and Title 19, Subtitle 1 of the Health – General Article.

[(z)**] (Q)** "Wellness benefit" means a benefit that:

(1) includes a bona fide wellness program as defined in § 15–509 of this title; and

(2) complies with regulations adopted by the Commission.

[(aa)**] (R)** (1) "Wellness program" means a program or activity that:

(i) is designed to improve health status and reduce health care costs; and

(ii) complies with guidelines developed by the Commission.

(2) "Wellness program" includes programs and activities for:

(i) smoking cessation;

(ii) reduction of alcohol misuse;

(iii) weight reduction;

(iv) nutrition education; and

(v) automobile and motorcycle safety.

15–1203.

(A) A SMALL EMPLOYER UNDER THIS SUBTITLE IS A PERSON THAT MEETS THE CRITERIA SPECIFIED IN ANY SUBSECTION OF THIS SECTION.

(B) (1) A PERSON IS CONSIDERED A SMALL EMPLOYER UNDER THIS SUBTITLE IF THE PERSON:

(I) IS AN EMPLOYER THAT ON AT LEAST 50% OF ITS WORKING DAYS DURING THE PRECEDING CALENDAR QUARTER, EMPLOYED AT LEAST TWO BUT NOT MORE THAN 50 ELIGIBLE EMPLOYEES, THE MAJORITY OF WHOM ARE EMPLOYED IN THE STATE; AND

(II) IS A PERSON ACTIVELY ENGAGED IN BUSINESS OR IS THE GOVERNING BODY OF:

1. A CHARTER HOME–RULE COUNTY ESTABLISHED UNDER ARTICLE XI–A OF THE MARYLAND CONSTITUTION;

2. A CODE HOME–RULE COUNTY ESTABLISHED UNDER ARTICLE XI–F OF THE MARYLAND CONSTITUTION;

3. A COMMISSION COUNTY AS DEFINED IN § 1–101 OF THE LOCAL GOVERNMENT ARTICLE; OR

4. A MUNICIPAL CORPORATION ESTABLISHED OR OPERATING UNDER ARTICLE XI–E OF THE MARYLAND CONSTITUTION.

(2) NOTWITHSTANDING PARAGRAPH (1)(I) OF THIS SUBSECTION:

(I) A PERSON IS CONSIDERED A SMALL EMPLOYER UNDER THIS SUBTITLE IF THE EMPLOYER DID NOT EXIST DURING THE PRECEDING CALENDAR YEAR BUT ON AT LEAST 50% OF THE WORKING DAYS DURING ITS FIRST YEAR THE EMPLOYER EMPLOYS AT LEAST TWO BUT NOT MORE THAN 50 ELIGIBLE EMPLOYEES AND OTHERWISE SATISFIES THE CONDITIONS OF PARAGRAPH (1)(I) OF THIS SUBSECTION; AND

(II) IF THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) IS AMENDED TO EXCLUDE EMPLOYEE GROUPS UNDER A SPECIFIC SIZE, THIS SUBTITLE SHALL APPLY TO ANY EMPLOYEE GROUP SIZE THAT IS EXCLUDED FROM THAT ACT.

(3) IN DETERMINING THE GROUP SIZE SPECIFIED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION:

(I) COMPANIES THAT ARE AFFILIATED COMPANIES OR THAT ARE ELIGIBLE TO FILE A CONSOLIDATED FEDERAL INCOME TAX RETURN SHALL BE CONSIDERED ONE EMPLOYER; AND

(II) AN EMPLOYEE MAY NOT BE COUNTED WHO IS A PART–TIME EMPLOYEE AS DESCRIBED IN § 15–1210(A)(2) OF THIS SUBTITLE.

(4) A CARRIER MAY REQUEST DOCUMENTATION TO VERIFY THAT A PERSON MEETS THE CRITERIA UNDER THIS SUBSECTION TO BE CONSIDERED A SMALL EMPLOYER UNDER THIS SUBTITLE.

(5) NOTWITHSTANDING PARAGRAPH (1)(I) OF THIS SUBSECTION, A PERSON IS CONSIDERED TO BE A SMALL EMPLOYER UNDER THIS SUBTITLE IF THE PERSON MET THE CONDITIONS OF PARAGRAPH (1)(I) OF THIS SUBSECTION AND PURCHASED A HEALTH BENEFIT PLAN IN ACCORDANCE WITH THIS SUBTITLE, AND SUBSEQUENTLY ELIMINATED ALL BUT ONE EMPLOYEE.

(C) A PERSON IS CONSIDERED A SMALL EMPLOYER UNDER THIS SUBTITLE IF THE PERSON IS A NONPROFIT ORGANIZATION THAT HAS BEEN DETERMINED BY THE INTERNAL REVENUE SERVICE TO BE EXEMPT FROM TAXATION UNDER § 501(C)(3), (4), OR (6) OF THE INTERNAL REVENUE CODE AND HAS AT LEAST ONE ELIGIBLE EMPLOYEE.

15–1205.

[(h) A carrier shall set premium rates for the entire plan year for each small employer.**]**

15–1206.

(c) **[**(6) A carrier may not impose a minimum participation requirement for a small employer group if the small employer group applies for coverage during the period that begins on November 15 and extends through December 15 of any year.**]**

15–1207.

[(h) Beginning January 1, 2014, this section applies only to grandfathered health plans as defined in § 1251 of the Affordable Care Act.**]**

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 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;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, or placement for adoption; and

(3) the spouse of an eligible employee at the birth or adoption of a child, 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, 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.

[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.

(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) 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 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.**]**

15–1209.

(a) This section does not apply to any insurance enumerated in **[**§ 15–1201(i)(3)(i) through (xiii)**] § 15–1201(F)(3)(I) THROUGH (XIII)** of this subtitle.

15–1213.

(a) This section does not apply to any insurance enumerated in **[**§ 15–1201(i)(3)(i) through (xiii)**] § 15–1201(F)(3)(I) THROUGH (XIII)** of this subtitle.

(b) Each benefit offered in addition to the Standard Plan that increases access to care choices or lowers the cost–sharing arrangement in the Standard Plan is subject to all of the provisions of this subtitle applicable to the Standard Plan, including:

(1) guaranteed issuance;

(2) guaranteed renewal; and

(3) adjusted community rating.

(c) (1) Each benefit offered in addition to the Standard Plan that increases the type of services available or the frequency of services is not subject to guaranteed issuance but is subject to all other provisions of this subtitle applicable to the Standard Plan, including:

(i) guaranteed renewal; and

(ii) adjusted community rating.

(2) For each additional benefit offered under this subsection, a carrier shall accept or reject the application of the entire group.

(3) The Commissioner may prohibit a carrier from offering an additional benefit under this subsection if the Commissioner finds that the additional benefit will be sold in conjunction with the Standard Plan in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this subtitle.

(d) (1) A benefit offered in addition to the Standard Plan to lower the cost–sharing arrangement in the Standard Plan in accordance with § 15–301.1 of the Health – General Article is subject to:

(i) guaranteed issuance;

(ii) guaranteed renewal; and

(iii) adjusted community rating.

(2) A carrier that offers a benefit under this subsection shall be required to guarantee issuance and guarantee renewal of the additional benefit only to employers who are participating in the MCHP private option plan established under § 15–301.1 of the Health – General Article.

[(e) Beginning January 1, 2014, this section applies only to grandfathered health plans as defined in § 1251 of the Affordable Care Act.**]**

15–1301.

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

(b) "Affiliation period" means a period of time beginning on the date of enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee, during which a health maintenance organization does not collect premium, and coverage issued does not become effective.

(c) "Association" or "bona fide association" means an association that:

(1) has been actively in existence for at least 5 years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association–sponsored insurance;

(3) does not condition membership in the association on any health status–related factor relating to an individual, and states so clearly in all membership and application materials;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status–related factor relating to the members or individuals eligible for coverage and states so clearly in all membership and application materials;

(5) does not make health insurance coverage offered through the association available other than in connection with membership in the association, and states so clearly in all marketing and application materials; and

(6) provides and annually updates information necessary for the Commissioner to determine whether or not the association meets the definition of bona fide association before qualifying as an association under this subtitle.

[(d) "Benefit year" means a calendar year in which a health benefit plan provides coverage for health benefits.**]**

[(e)**] (D)** "Carrier" means a person that is:

(1) an insurer that holds a certificate of authority in the State and provides health insurance in the State;

(2) a health maintenance organization that is licensed to operate in the State;

(3) a nonprofit health service plan that is licensed to operate in the State; or

(4) any other person or organization that provides health benefit plans subject to State insurance regulation.

[(f)**] (E)** "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.

[(g)**] (F)** (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.

[(h)**] (G)** "Eligible individual" means an individual:

(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.

[(i)**] (H)** "Employer sponsored plan" means an employee welfare benefit plan that provides medical care to employees or their dependents, and is not subject to State regulation in accordance with the federal Employee Retirement Income Security Act of 1974.

[(j)**] (I)** "Enrollment date" means the date on which:

(1) an individual enrolls in a health benefit plan; or

(2) the first day of the waiting period before which the individual may enroll.

[(k)**] (J)** "Governmental plan" means a plan as defined in § 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

[(l)**] (K)** (1) "Health benefit plan" means a:

(i) hospital or medical policy or certificate, including those issued under multiple employer trusts or associations located in Maryland or any other state covering Maryland residents;

(ii) policy, contract, or certificate issued by a nonprofit health service plan that covers Maryland residents; or

(iii) health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" does not include:

(i) one or more, or any combination of the following:

1. coverage only for accident or disability income insurance;

2. coverage issued as a supplement to liability insurance;

3. liability insurance, including general liability insurance and automobile liability insurance;

4. workers' compensation or similar insurance;

5. automobile medical payment insurance;

6. credit–only insurance;

7. coverage for on–site medical clinics; and

8. other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104–191, under which benefits for medical care are secondary or incidental to other insurance benefits;

(ii) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of a plan:

1. limited scope dental or vision benefits;

2. benefits for long–term care, nursing home care, home health care, community–based care, or any combination of these benefits; and

3. such other similar, limited benefits as are specified in federal regulations issued pursuant to P.L. 104–191;

(iii) the following benefits if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness; and

2. hospital indemnity or other fixed indemnity insurance; or

(iv) the following benefits if offered as a separate insurance policy:

1. Medicare supplemental health insurance (as defined under § 1882(g)(1) of the Social Security Act);

2. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. similar supplemental coverage provided to coverage under an employer sponsored plan.

[(m)**] (L)** "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability including conditions arising out of acts of domestic violence; or

(8) disability.

[(n)**] (M)** "High level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is:

(1) at least 15% greater than the actuarial value of the low level policy form coverage offered by the carrier in this State; and

(2) at least 100% but not greater than 120% of the weighted average.

[(o) "Individual Exchange" has the meaning stated in § 31–101 of this article.**]**

[(p)**] (N)** (1) "Individual health benefit plan" means:

(i) a health benefit plan other than a converted policy or a professional association plan for eligible individuals and their dependents; and

(ii) a certificate issued to an eligible individual that evidences coverage under a policy or contract issued to a trust or association or other similar group of individuals, regardless of the situs of delivery of the policy or contract, if the eligible individual pays the premium and is not being covered under the policy or contract under either federal or State continuation of benefits provisions.

(2) "Individual health benefit plan" does not include short–term limited duration insurance.

[(q)**] (O)** "Low level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is at least 85% but not greater than 100% of the weighted average.

[(r) "Minimum essential coverage" has the meaning stated in 45 C.F.R. § 155.20.**]**

[(s)**] (P)** "Preexisting condition" means a condition that was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

[(t) "Qualified health plan" has the meaning stated in § 31–101 of this article.**]**

[(u)**] (Q)** "Waiting period" means the period of time that must pass before an individual is eligible to be covered for benefits under the terms of a group health benefit plan.

[(v)**] (R)** (1) "Weighted average" means the average actuarial value of the benefits provided by:

(i) all the health insurance coverages issued by the carrier in this State in the individual market during the previous calendar year, weighted by enrollment for the different coverages; or

(ii) all the health insurance coverages issued by all carriers in this State in the individual market, if the data are available, during the previous calendar year, weighted by enrollment for the different coverages.

(2) "Weighted average" does not include coverages issued under this subtitle.

15–1302.

(a) This subtitle applies to all carriers that offer health benefit plans to individuals in the State.

(b) This subtitle does not apply to a carrier that offers only conversion policies as required by law.

(c) This subtitle does not apply to a carrier that offers health insurance coverage only in connection with group health plans **OR THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, OR BOTH**.

15–1309.

(b) A carrier may not cancel or refuse to renew an individual health benefit plan except:

(1) for nonpayment of the required premiums;

(2) where the individual has performed an act or practice that constitutes fraud;

(3) where the individual has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the carrier elects not to renew all of its individual health benefit plans in the State in accordance with this article;

(5) where the individual no longer resides, lives, or works in the service area, provided that the coverage is terminated under this provision uniformly without regard to any health status–related factor of covered individuals; **[**or**]**

(6) for individual health benefit plans that are not grandfathered health plans, as defined in 45 C.F.R. § 147.140, where a carrier discontinues offering a particular type of health benefit plan coverage in the individual market, if the carrier:

(i) at least 90 days before discontinuation of the coverage, provides notice of the discontinuation to each individual provided coverage of this type;

(ii) offers each individual provided coverage of this type the option to purchase any other individual health benefit plan coverage offered by the carrier for individuals in the State; and

(iii) acts uniformly without regard to any health status–related factor of enrolled individuals or individuals who may become eligible for the coverage**; OR**

(7) WHERE, IN THE CASE OF HEALTH INSURANCE COVERAGE THAT IS MADE AVAILABLE IN THE INDIVIDUAL MARKET ONLY THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF THE INDIVIDUAL IN THE ASSOCIATION CEASES BUT ONLY IF SUCH COVERAGE IS TERMINATED UNDER THIS PARAGRAPH UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS–RELATED FACTOR OF COVERED INDIVIDUALS.

[15–1315.

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

(2) "Individual Exchange" has the meaning stated in § 31–101 of this article.

(3) "Qualified health plan" has the meaning stated in § 31–101 of this article.

(4) "Qualified individual" has the meaning stated in § 31–101 of this article.

(b) This section applies to a qualified health plan that is issued on or after January 1, 2014, by a carrier through the Individual Exchange.

(c) A qualified health plan subject to this section shall include a grace period provision applicable to a qualified individual who:

(1) is receiving advance payments of federal premium tax credits; and

(2) has paid at least 1 full month's premium during the benefit year.

(d) The grace period provision shall:

(1) provide a grace period of 3 consecutive months; and

(2) be in addition to any other grace period provision required by any other applicable State law.

(e) During the grace period, a carrier that issues a qualified health plan subject to this section:

(1) shall pay all appropriate claims for services rendered to the qualified individual during the first month of the grace period;

(2) may pend claims for services rendered to the qualified individual in the second and third months of the grace period;

(3) shall notify the federal Department of Health and Human Services that the qualified individual is in the grace period; and

(4) shall notify providers of the possibility that claims may be denied when a qualified individual is in the second and third months of the grace period.**]**

[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.

(3) 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.

(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;

(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) 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;

(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.

(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) of this subsection occurs, a carrier shall permit an individual or a dependent, whose existing coverage through 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.

(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.**]**

[15–1410.

(a) In this section, "plan year" has the meaning stated in § 15–1201 of this title.

(b) The guaranteed issuance of coverage provision in Title I, Subtitle C of the Affordable Care Act applies to each health benefit plan with a plan year that begins on or after January 1, 2014.**]**

31–101.

[(e–1) "Full–time employee" means an employee who works, on average, at least 30 hours per week.**]**

(z) (1) "Small employer" means an employer that, during the preceding calendar year, employed an average of not more than:

(i) 50 employees if the preceding calendar year ended on or before January 1, 2016; and

(ii) 100 employees if the preceding calendar year ended after January 1, 2016.

(2) For purposes of this subsection:

(i) all persons treated as a single employer under § 414(b), (c), (m), or (o) of the Internal Revenue Code shall be treated as a single employer;

(ii) an employer and any predecessor employer shall be treated as a single employer;

(iii) **[**the number of employees of an employer shall be determined by adding:

1. the number of full–time employees; and

2. the number of full–time equivalent employees, which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full–time employees for the month by 120**] ALL EMPLOYEES SHALL BE COUNTED, INCLUDING PART–TIME EMPLOYEES AND EMPLOYEES WHO ARE NOT ELIGIBLE FOR COVERAGE THROUGH THE EMPLOYER**;

(iv) if an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year; and

(v) an employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this title as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

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