SB0556/537971/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 556
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 3, after the first "of" insert "providing that certain requirements of the federal Patient Protection and Affordable Care Act relating to prescription drug benefits apply to certain coverage offered in certain markets; repealing a certain provision of law providing for the applicability of a certain limitation on certain deductibles for certain health insurance coverage;"; strike beginning with "requiring" in line 8 down through "device;" in line 15; in line 17, after "market;" insert "altering the circumstances under which certain health benefit plans are required to allow certain individuals to enroll for certain coverage;"; and in line 24, after "markets;" insert "establishing the circumstances under which a certain plan that has been modified is considered to be the same plan;".

On page 2, strike beginning with "altering" in line 1 down through "must" in line 2 and substitute "requiring certain carriers to"; strike beginning with "for" in line 2 down through "occurs" in line 4 and substitute "certain special enrollment periods"; in line 10, after "market;" insert "altering a certain exception to a requirement relating to the renewal of health benefit plans offered in the large group health insurance market; altering certain limitations on the cancellation or refusal to renew certain health benefit plans;"; in line 13, after "Exchange;" insert "altering and"; in line 18, after "Section" insert "15-137.1,"; in the same line, after "15-831," insert "15-10A-01(b)(1),"; in the same line, after "(i)," insert "15-1208.1(c),"; in line 19, after "15-1401," insert "15-1408,"; in the same line, after "27-210(h)" insert a comma; in the same line, strike "31-101(e-1) and (g)" and substitute "31-101(e-1), (g), and (z)(1)"; and in line 29, after "31-101(o-1)" insert "and (o-2)".

AMENDMENT NO. 2

On page 2, after line 39, insert:

(Over)

"15–137.1.

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

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

(2) preexisting condition exclusions;

(3) policy rescissions;

(4) bona fide wellness programs;

(5) lifetime limits;

(6) annual limits for essential benefits;

(7) waiting periods;

(8) designation of primary care providers;

(9) access to obstetrical and gynecological services;

(10) emergency services;

(11) summary of benefits and coverage explanation;

(12) minimum loss ratio requirements and premium rebates;

(13) disclosure of information;

(14) annual limitations on cost sharing;

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

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

(18) coverage for individuals participating in approved clinical trials;

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

(20) guaranteed availability of coverage**; AND**

(21) PRESCRIPTION DRUG BENEFIT REQUIREMENTS.

(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)**]** 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.".

AMENDMENT NO. 3

On page 7, strike in their entirety lines 21 through 26, inclusive; in lines 27 and 29, in each instance, strike the brackets; and in the same lines, strike "**(4)**" and "**(5)**", respectively.

On pages 8 and 9, strike in their entirety the lines beginning with line 32 on page 8 through line 12 on page 9, inclusive.

AMENDMENT NO. 4

On page 9, after line 12, insert:

"15–10A–01.

(b) (1) "Adverse decision" means:

(i) a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

1. a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

2. may result in noncoverage of the health care service; or

(ii) a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a **[**bona fide**]** wellness program under § 15–509 of this title.".

AMENDMENT NO. 5

On page 9, in line 14, after "means" insert "**, WITH RESPECT TO A CALENDAR MONTH,**"; and strike beginning with "**UNLESS**" in line 17 down through "**YEAR**" in line 18 and substitute "**AS DEFINED IN FEDERAL LAW**".

AMENDMENT NO. 6

On page 12, after line 3, insert:

"15–1208.1.

(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, placement for adoption, or placement for foster care;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, placement for adoption, **[**or**]** placement for foster care**, OR THROUGH A CHILD SUPPORT ORDER OR OTHER COURT ORDER**; **[**and**]**

(3) the spouse of an eligible employee at the birth or adoption of a child, **[**or**]** placement of a child for foster care, **OR THROUGH A CHILD SUPPORT ORDER OR OTHER COURT ORDER,** provided the spouse is otherwise eligible for coverage**; AND**

(4) AT THE OPTION OF THE SHOP EXCHANGE, AN ENROLLEE WHO IS THE ELIGIBLE EMPLOYEE OR THE SPOUSE OF THE ELIGIBLE EMPLOYEE, IF:

(I) THE ENROLLEE LOSES A DEPENDENT OR IS NO LONGER CONSIDERED TO BE A DEPENDENT DUE TO DIVORCE OR LEGAL SEPARATION; OR

(II) THE EMPLOYEE OR THE EMPLOYEE'S DEPENDENT DIES.".

AMENDMENT NO. 7

On page 14, in line 2, strike the brackets; strike beginning with "**DUE**" in line 3 down through "**(VII)**" in line 11; in line 15, after "misrepresentation," insert "**MISCONDUCT,**"; and in line 17, after "instrumentalities" insert "**, OR A NON-EXCHANGE ENTITY PROVIDING ENROLLMENT ASSISTANCE OR CONDUCTING ENROLLMENT ACTIVITIES**".

On page 15, in lines 6 and 10, strike "**(4)(VII)1**" and "**(4)(VII)2**", respectively, and substitute "**(4)(VI)1**" and "**(4)(VI)2**", respectively.

AMENDMENT NO. 8

On page 15, strike beginning with "**METAL**" in line 23 down through "**ACT**" in line 24 and substitute "**PARTICULAR COST-SHARING STRUCTURE, PROVIDER NETWORK**".

On page 16, after line 29, insert:

"**(D) (1) WITH RESPECT TO A PLAN THAT HAS BEEN MODIFIED AT THE TIME OF COVERAGE RENEWAL CONSISTENT WITH THIS SECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN IF:**

(I) 1. THE PLAN HAS THE SAME COST-SHARING STRUCTURE AS BEFORE THE MODIFICATION; OR

2. ANY VARIATION IN COST SHARING:

A. IS SOLELY RELATED TO CHANGES IN COST OR UTILIZATION OF MEDICAL CARE; OR

B. IS TO MAINTAIN THE SAME METAL LEVEL DESCRIBED IN § 1302(D) AND (E) OF THE AFFORDABLE CARE ACT;

(II) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME SERVICE AREA; AND

(III) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME PROVIDER NETWORK.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN TO THE EXTENT THAT THE MODIFICATIONS ARE:

(I) MADE UNIFORMLY AND SOLELY AS A RESULT OF A FEDERAL OR STATE REQUIREMENT;

(II) MADE WITHIN A REASONABLE TIME PERIOD AFTER THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT; AND

(III) DIRECTLY RELATED TO THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT.".

On page 17, in lines 1, 14, and 28, strike "**(D)**", "**(E)**", and "**(F)**", respectively, and substitute "**(E)**", "**(F)**", and "**(G)**", respectively; and in lines 1 and 2, strike "**(E), (F), AND (G)**" and substitute "**(F), (G), AND (H)**".

On page 18, in lines 5, 17, and 19, strike "**(G)**", "**(H)**", and "**(I)**", respectively, and substitute "**(H)**", "**(I)**", and "**(J)**", respectively.

On page 24, strike beginning with "**METAL**" in line 28 down through "**ACT**" in line 29 and substitute "**PARTICULAR COST-SHARING STRUCTURE, PROVIDER NETWORK**".

On page 26, after line 7, insert:

"**(D) (1) WITH RESPECT TO A PLAN THAT HAS BEEN MODIFIED AT THE TIME OF COVERAGE RENEWAL CONSISTENT WITH THIS SECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN IF:**

(I) 1. THE PLAN HAS THE SAME COST-SHARING STRUCTURE AS BEFORE THE MODIFICATION; OR

2. ANY VARIATION IN COST SHARING:

A. IS SOLELY RELATED TO CHANGES IN COST OR UTILIZATION OF MEDICAL CARE; OR

B. IS TO MAINTAIN THE SAME METAL LEVEL DESCRIBED IN § 1302(D) AND (E) OF THE AFFORDABLE CARE ACT;

(II) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME SERVICE AREA; AND

(III) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME PROVIDER NETWORK.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN TO THE EXTENT THAT THE MODIFICATIONS ARE:

(I) MADE UNIFORMLY AND SOLELY AS A RESULT OF A FEDERAL OR STATE REQUIREMENT;

(II) MADE WITHIN A REASONABLE TIME PERIOD AFTER THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT; AND

(III) DIRECTLY RELATED TO THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT.";

in lines 8 and 10, strike "**(D)**" and "**(E)**", respectively, and substitute "**(E)**" and "**(F)**", respectively; and in line 8, strike "**(E)**" and substitute "**(F)**".

On page 27, in lines 1 and 3, strike "**(F)**" and "**(G)**", respectively, and substitute "**(G)**" and "**(H)**", respectively.

AMENDMENT NO. 9

On page 17, in line 27, after "area" insert "**, PROVIDED NOTICE OF THE TERMINATION IS PROVIDED TO EACH SMALL EMPLOYER AND TO EACH EMPLOYEE COVERED UNDER THE HEALTH BENEFIT PLAN AT LEAST 90 CALENDAR DAYS BEFORE THE DATE COVERAGE WILL BE TERMINATED**".

AMENDMENT NO. 10

On page 26, in line 20, after "that" insert "**:**

(I)";

and in line 21, after "individuals" insert "**; AND**

(II) NOTICE OF THE TERMINATION IS PROVIDED TO THE INDIVIDUAL AT LEAST 90 CALENDAR DAYS BEFORE THE DATE COVERAGE WILL BE TERMINATED".

AMENDMENT NO. 11

On pages 29 through 33, strike beginning with "(1)" in line 28 on page 29 down through "days" in line 3 on page 33 and substitute "**A CARRIER PARTICIPATING IN THE INDIVIDUAL EXCHANGE SHALL PROVIDE THE SPECIAL ENROLLMENT PERIODS SPECIFIED IN 45 C.F.R. § 155.420 FOR INDIVIDUALS WHO PURCHASE COVERAGE THROUGH THE INDIVIDUAL EXCHANGE.**

(D) A CARRIER SHALL PROVIDE THE SPECIAL ENROLLMENT PERIODS SPECIFIED IN 45 C.F.R. § 147.104(B)(2) FOR INDIVIDUALS WHO PURCHASE COVERAGE OUTSIDE THE INDIVIDUAL EXCHANGE".

On page 33, in lines 4, 7, and 27, strike "(f)", "(g)", and "(h)", respectively, and substitute "**(E)**", "**(F)**", and "**(G)**", respectively.

AMENDMENT NO. 12

On page 42, after line 12, insert:

"15–1408.

A carrier shall renew group health benefit plans at the option of the policyholder or plan sponsor, except in any of the following cases:

(1) for nonpayment of the required premium;

(2) where the policyholder or plan sponsor has performed an act or practice that constitutes fraud;

(3) where the policyholder or plan sponsor has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the policyholder or plan sponsor has failed to comply with a material plan provision relating the employer contributions or group participation rules;

(5) where the carrier elects not to renew all group health benefit plans in the State;

(6) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area**, PROVIDED NOTICE OF THE NONRENEWAL IS PROVIDED TO EACH EMPLOYER AND TO EACH EMPLOYEE COVERED UNDER THE HEALTH BENEFIT PLAN AT LEAST 90 DAYS BEFORE THE DATE COVERAGE WILL BE TERMINATED**;

(7) in the case of a carrier that offers coverage only through one or more bona fide associations, when the membership of an employer in the association ceases and nonrenewal under this item is applied uniformly without regard to any health status–related factor relating to any covered individual; or

(8) the carrier makes an election under § 15–1409 of this subtitle.".

AMENDMENT NO. 13

On page 46, after line 22, insert:

"**(O-2)"PLAN YEAR" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.**

(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**]** **FOR PLAN YEARS THAT BEGIN BEFORE** January 1, 2016; and

(ii) 100 employees **[**if the preceding calendar year ended after**]** **FOR PLAN YEARS THAT BEGIN ON OR AFTER** January 1, 2016**, OR ANOTHER NUMBER OF EMPLOYEES OR DATE AS PROVIDED UNDER FEDERAL LAW**.".

AMENDMENT NO. 14

On page 22, strike beginning with "the" in line 1 down through "1." in line 3; in line 3, after "illness" insert "**IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS**"; in the same line, strike "and"; in line 4, strike "2." and substitute "**(IV)**"; after line 4, insert:

"**1. OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS;**";

in lines 5, 12, 16, and 22, strike "**A.**", "**B.**", "**C.**", and "**D.**", respectively, and substitute "**2.**", "**3.**", "**4.**", and "**5.**", respectively; in line 5, strike "**D**" and substitute "**5**"; in line 11, after "**CODE**" insert "**, PROVIDED THAT IF AN APPLICATION IS NOT REQUIRED AS PART OF THE RENEWAL PROCESS, THE CONTINUED PAYMENT OF PREMIUMS BY THE INDIVIDUAL AFTER RECEIPT OF THE NOTICE DESCRIBED IN ITEM 5B OF THIS ITEM IS DEEMED TO SATISFY THE ATTESTATION REQUIREMENT**"; strike beginning with "**FOR**" in line 22 down through "**CODE**" in line 29 and substitute "**A. FOR HOSPITAL INDEMNITY INSURANCE OR OTHER FIXED INDEMNITY INSURANCE CONTRACTS ISSUED BEFORE MAY 1, 2015, THAT REQUIRE AN APPLICATION AS PART OF THE RENEWAL PROCESS, THE INDIVIDUAL PROVIDES, ON OR BEFORE OCTOBER 1, 2016, A WRITTEN ATTESTATION ON THE APPLICATION THAT THE INDIVIDUAL HAS OTHER HEALTH INSURANCE COVERAGE THAT IS MINIMUM ESSENTIAL COVERAGE, OR THAT THE INDIVIDUAL IS DEEMED TO HAVE MINIMUM**

ESSENTIAL COVERAGE DUE TO THE INDIVIDUAL'S STATUS AS A BONA FIDE RESIDENT OF ANY POSSESSION OF THE UNITED STATES UNDER § 5000A(F)(4)(B) OF THE INTERNAL REVENUE CODE; OR

B. FOR HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE CONTRACTS ISSUED BEFORE MAY 1, 2015, THAT DO NOT REQUIRE AN APPLICATION AS PART OF THE RENEWAL PROCESS, THE ISSUER SENDS NO LATER THAN THE FIRST RENEWAL OF THE CONTRACT THAT OCCURS ON OR AFTER OCTOBER 1, 2016, A NOTICE, IN AT LEAST 14 POINT TYPE, TO THE INDIVIDUAL THAT INCLUDES THE FOLLOWING LANGUAGE: "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS.""; and

and in line 30, strike "(iv)" and substitute "**(V)**".

On page 45, in line 23, after "**CODE**" insert "**, PROVIDED THAT IF AN APPLICATION IS NOT REQUIRED AS PART OF THE RENEWAL PROCESS, THE CONTINUED PAYMENT OF PREMIUMS BY THE INDIVIDUAL AFTER RECEIPT OF THE NOTICE DESCRIBED IN ITEM 5B OF THIS ITEM IS DEEMED TO SATISFY THE ATTESTATION REQUIREMENT**".

On pages 45 and 46, strike beginning with "**FOR**" in line 34 on page 45 down through "**CODE**" in line 6 on page 46 and substitute "**A. FOR HOSPITAL INDEMNITY INSURANCE OR OTHER FIXED INDEMNITY INSURANCE CONTRACTS ISSUED BEFORE MAY 1, 2015, THAT REQUIRE AN APPLICATION AS PART OF THE RENEWAL PROCESS, THE INDIVIDUAL PROVIDES, ON OR BEFORE OCTOBER 1, 2016, A WRITTEN ATTESTATION ON THE APPLICATION THAT THE INDIVIDUAL HAS OTHER**

HEALTH INSURANCE COVERAGE THAT IS MINIMUM ESSENTIAL COVERAGE, OR THAT THE INDIVIDUAL IS DEEMED TO HAVE MINIMUM ESSENTIAL COVERAGE DUE TO THE INDIVIDUAL'S STATUS AS A BONA FIDE RESIDENT OF ANY POSSESSION OF THE UNITED STATES UNDER § 5000A(F)(4)(B) OF THE INTERNAL REVENUE CODE; OR

B. FOR HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE CONTRACTS ISSUED BEFORE MAY 1, 2015, THAT DO NOT REQUIRE AN APPLICATION AS PART OF THE RENEWAL PROCESS, THE ISSUER SENDS NO LATER THAN THE FIRST RENEWAL OF THE CONTRACT THAT OCCURS ON OR AFTER OCTOBER 1, 2016, A NOTICE, IN AT LEAST 14 POINT TYPE, TO THE INDIVIDUAL THAT INCLUDES THE FOLLOWING LANGUAGE: "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS."".