

Article - Insurance

[Previous][Next]

§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 November 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services, a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.

(2) The annual open enrollment period for 2014 shall begin on November 15, 2014, and extend through January 15, 2015, unless alternative dates are adopted by the federal Department of Health and Human Services.

(3) The annual open enrollment period for years beginning on and after January 1, 2015, shall be the dates adopted by the federal Department of Health and Human Services.

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

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

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

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

(5) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for 2014, the effective date of coverage shall be:

(i) January 1, 2015, if the application is received by the carrier on or before December 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services;

(ii) February 1, 2015, if the application is received by the carrier from December 16, 2014, through January 15, 2015, unless an alternative date is adopted

by the federal Department of Health and Human Services; and

(iii) March 1, 2015, if the application is received by the carrier from January 16, 2015, through February 15, 2015, unless an alternative date is adopted by the federal Department of Health and Human Services.

(6) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for years beginning on and after January 1, 2015, the effective date of coverage shall be the date adopted by the federal Department of Health and Human Services.

(c) 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.

(e) 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.

(f) (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.

(g) (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.

[Previous][Next]