

# HOUSE BILL 801

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By: **Chair, Health and Government Operations Committee (By Request –  
Departmental – Maryland Insurance Administration)**

Introduced and read first time: February 8, 2016

Assigned to: Health and Government Operations

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## A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Conformity With Federal Law**

3 FOR the purpose of repealing certain provisions of law permitting certain preexisting  
4 condition limitations in group and blanket health insurance contracts and policies;  
5 altering certain provisions of law relating to certain preexisting condition exclusions  
6 in individual health benefit plans to comply with certain requirements of the federal  
7 Patient Protection and Affordable Care Act; altering the definition of “member”, for  
8 purposes of provisions of law governing a certain complaint process for coverage  
9 decisions, to include a certain individual who is denied coverage under a health  
10 benefit plan; altering a certain provision of law relating to participation  
11 requirements for health benefit plans in the small employer market to refer to a  
12 bronze level health plan instead of a Standard Plan; altering certain provisions of  
13 law relating to certain special open enrollment periods in the small employer health  
14 insurance market; making conforming changes; correcting a certain cross reference;  
15 and generally relating to health insurance and conformity with federal law.

16 BY repealing and reenacting, with amendments,

17 Article – Insurance

18 Section 15–137.1(b), 15–508.1, 15–10D–01(k), 15–1206(c), 15–1208.1, and  
19 15–1208.2(d)

20 Annotated Code of Maryland

21 (2011 Replacement Volume and 2015 Supplement)

22 BY repealing

23 Article – Insurance

24 Section 15–508

25 Annotated Code of Maryland

26 (2011 Replacement Volume and 2015 Supplement)

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EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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

3 **Article – Insurance**

4 15–137.1.

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

7 [15–508.

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

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

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

11 (4) “Late enrollee” has the meaning stated in § 15–1401 of this title.

12 (5) “Plan year” means a calendar year or other consecutive 12–month  
13 period during which a health benefit plan provides coverage for health benefits.

14 (6) “Policy or certificate” means any group or blanket health insurance  
15 contract or policy that is issued or delivered in the State by an insurer or nonprofit health  
16 service plan that provides hospital, medical, or surgical benefits on an expense–incurred  
17 basis.

18 (7) “Preexisting condition provision” has the meaning stated in § 15–1301  
19 of this title.

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

22 (2) This section applies to carriers for plan years that begin before January  
23 1, 2014.

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

26 (1) relates to a condition, regardless of the cause of the condition, for which  
27 medical advice, diagnosis, care, or treatment was recommended or received within the  
28 6–month period ending on the enrollment date;

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

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

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

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

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

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

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

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

17 15-508.1.

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

19                   (2) “Carrier” means an insurer or a nonprofit health service plan.

20                   (3) [“Creditable coverage” has the meaning stated in § 15-1301 of this title.

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

24                   [(5)] (4) “Health benefit plan” has the meaning stated in § 15-1301 of this  
25 title.

26                   [(6)] (5) “Individual health benefit plan” means a health benefit plan  
27 issued by a carrier that insures:

28                           (i) only one individual; or

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

1 (b) This section applies to individual health benefit plans that are issued or  
2 delivered in the State before ~~[January 1, 2014]~~ **MARCH 23, 2010**.

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

5 (d) ~~[Except as provided in subsection (e) of this section, a]~~ **A** carrier may impose  
6 a preexisting condition exclusion or limitation on an individual for a condition that was not  
7 discovered during the underwriting process for an individual health benefit plan only if the  
8 exclusion or limitation:

9 (1) relates to a condition of the individual, regardless of its cause, for which  
10 medical advice, diagnosis, care, or treatment was recommended or received within the  
11 12-month period immediately preceding the effective date of the individual's coverage; **AND**

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

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

16 ~~[(e) (1) Subject to paragraph (2) of this subsection, a carrier may not impose a~~  
17 ~~preexisting condition exclusion or limitation on an individual who, as of the last day of the~~  
18 ~~30-day period beginning with the date of the individual's birth, is covered under any~~  
19 ~~creditable coverage.~~

20 (2) The limitation on the imposition of a preexisting condition exclusion or  
21 limitation under paragraph (1) of this subsection does not apply after the end of the first  
22 63-day period during all of which the individual was not covered under any creditable  
23 coverage.]

24 15-10D-01.

25 (k) (1) "Member" means:

26 **(I)** a person entitled to health care services under a policy, plan, or  
27 contract issued or delivered in the State by a carrier; **OR**

28 **(II) WITH REGARD TO AN INDIVIDUAL WHO IS DETERMINED BY A**  
29 **CARRIER NOT TO BE ELIGIBLE FOR A HEALTH BENEFIT PLAN, AN INDIVIDUAL WHO**  
30 **HAS APPLIED FOR COVERAGE UNDER A HEALTH BENEFIT PLAN.**

31 (2) "Member" includes:

32 (i) a subscriber; and

1 (ii) unless preempted by federal law, a Medicare recipient.

2 (3) “Member” does not include a Medicaid recipient.

3 15–1206.

4 (c) (1) Subject to the approval of the Commissioner and as provided under this  
5 subsection and § 15–1209(d) of this subtitle, a carrier may impose reasonable minimum  
6 participation requirements.

7 (2) A carrier may not impose a requirement for minimum participation by  
8 the eligible employees of a small employer that is greater than 75%.

9 (3) In applying a minimum participation requirement to determine  
10 whether the applicable percentage of participation is met, a carrier may not consider as  
11 eligible employees:

12 (i) those who have group spousal coverage under a public or private  
13 plan of health insurance or another employer’s health benefit arrangement, including  
14 Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the  
15 benefits provided under [the Standard Plan] **A BRONZE LEVEL HEALTH PLAN AS**  
16 **DESCRIBED IN 45 C.F.R. § 156.140**; or

17 (ii) employees who are under the age of 26 years who are covered  
18 under their parent’s health benefit plan.

19 (4) A carrier may not impose a minimum participation requirement for a  
20 small employer group if any member of the group participates in a medical savings account.

21 (5) A carrier may not impose a minimum participation requirement for a  
22 qualified employer if the qualified employer designates a coverage level within which its  
23 employees may choose any qualified health plan in the SHOP Exchange, as provided for in  
24 § 31–111(c)(1) of this article.

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

28 15–1208.1.

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

31 (b) A carrier shall allow an eligible employee or dependent who is eligible, but not  
32 enrolled, for coverage under the terms of the employer’s health benefit plan to enroll for  
33 coverage under the terms of the plan if:

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

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

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

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

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

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

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

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

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

26 (1) an individual who becomes a dependent of the eligible employee  
27 through marriage, birth, adoption, placement for adoption, or placement for foster care;

28 (2) an eligible employee who acquires a new dependent through marriage,  
29 birth, adoption, placement for adoption, placement for foster care, or through a child  
30 support order or other court order;

31 (3) the spouse of an eligible employee at the birth or adoption of a child,  
32 placement of a child for foster care, or through a child support order or other court order,  
33 provided the spouse is otherwise eligible for coverage; and

34 (4) at the option of the SHOP Exchange, an enrollee who is the eligible  
35 employee or the spouse of the eligible employee, if:

1 (i) the enrollee loses a dependent or is no longer considered to be a  
2 dependent due to divorce or legal separation; or

3 (ii) the employee or the employee's dependent dies.

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

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

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

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

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

12 (2) the date of the marriage, birth, adoption, placement for adoption, [or]  
13 placement for foster care, **CHILD SUPPORT ORDER OR OTHER COURT ORDER, DIVORCE,**  
14 **LEGAL SEPARATION, OR DEATH,** whichever is applicable.

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

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

20 (2) in the case of a dependent's birth, as of the date of the dependent's birth;

21 (3) in the case of a dependent's adoption or placement for adoption, the date  
22 of adoption or placement for adoption, whichever occurs first; [and]

23 (4) in the case of a dependent's placement for foster care, the date of  
24 placement; **AND**

25 **(5) IN THE CASE OF A DEPENDENT ADDED DUE TO A CHILD SUPPORT**  
26 **ORDER OR ANY OTHER COURT ORDER:**

27 **(I) THE DATE THE CHILD SUPPORT ORDER OR OTHER COURT**  
28 **ORDER IS EFFECTIVE; OR**

1                   **(II) FOR SHOP EXCHANGE PLANS, IF THE SHOP EXCHANGE**  
2 **PERMITS THE ELIGIBLE EMPLOYEE TO SELECT AN EFFECTIVE DATE BASED ON THE**  
3 **DATE THE APPLICATION IS RECEIVED BY THE SHOP EXCHANGE:**

4                   **1. THE FIRST DAY OF THE MONTH FOLLOWING RECEIPT**  
5 **OF THE APPLICATION, IF THE APPLICATION IS RECEIVED BETWEEN THE FIRST AND**  
6 **FIFTEENTH DAY, INCLUSIVE, OF THE MONTH; AND**

7                   **2. THE FIRST DAY OF THE SECOND MONTH FOLLOWING**  
8 **RECEIPT OF THE APPLICATION, IF THE APPLICATION IS RECEIVED BETWEEN THE**  
9 **SIXTEENTH AND THE LAST DAY, INCLUSIVE, OF THE MONTH.**

10           **(G) IF THE SHOP EXCHANGE PERMITS THE SPECIAL ENROLLMENT**  
11 **PERIODS DESCRIBED IN SUBSECTION (C)(4) OF THIS SECTION, THE COVERAGE**  
12 **SHALL BECOME EFFECTIVE AS FOLLOWS:**

13                   **(1) FOR SPECIAL ENROLLMENT PERIODS IN THE SHOP EXCHANGE**  
14 **DUE TO DEATH OF THE EMPLOYEE OR DEPENDENT:**

15                   **(I) THE FIRST DAY OF THE MONTH FOLLOWING PLAN**  
16 **SELECTION; OR**

17                   **(II) IF THE SHOP EXCHANGE PERMITS THE ELIGIBLE**  
18 **EMPLOYEE TO SELECT AN EFFECTIVE DATE BASED ON THE DATE THE APPLICATION**  
19 **IS RECEIVED BY THE SHOP EXCHANGE:**

20                   **1. THE FIRST DAY OF THE MONTH FOLLOWING RECEIPT**  
21 **OF THE APPLICATION, IF THE APPLICATION IS RECEIVED BETWEEN THE FIRST AND**  
22 **FIFTEENTH DAY, INCLUSIVE, OF THE MONTH; AND**

23                   **2. THE FIRST DAY OF THE SECOND MONTH FOLLOWING**  
24 **RECEIPT OF THE APPLICATION, IF THE APPLICATION IS RECEIVED BETWEEN THE**  
25 **SIXTEENTH AND THE LAST DAY, INCLUSIVE, OF THE MONTH; AND**

26                   **(2) FOR SPECIAL ENROLLMENT PERIODS IN THE SHOP EXCHANGE**  
27 **DUE TO DIVORCE OR LEGAL SEPARATION, IF THE APPLICATION IS RECEIVED BY THE**  
28 **SHOP EXCHANGE:**

29                   **(I) BETWEEN THE FIRST AND FIFTEENTH DAY, INCLUSIVE, OF**  
30 **THE MONTH, THE FIRST DAY OF THE MONTH FOLLOWING RECEIPT OF THE**  
31 **APPLICATION; AND**

1                   **(II) BETWEEN THE SIXTEENTH AND THE LAST DAY, INCLUSIVE,**  
2 **OF THE MONTH, THE FIRST DAY OF THE SECOND MONTH FOLLOWING RECEIPT OF**  
3 **THE APPLICATION.**

4 15–1208.2.

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

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

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

13           (4)   A triggering event occurs when:

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

16                   (ii)   an eligible employee or a dependent loses pregnancy–related  
17 coverage described under § 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security  
18 Act, which is considered to occur on the last day the eligible employee or dependent would  
19 have pregnancy–related coverage;

20                   (iii)   an eligible employee or a dependent loses medically needy  
21 coverage as described under § 1902(a)(10)(C) of the Social Security Act, which is considered  
22 to occur on the last day the eligible employee or dependent would have medically needy  
23 coverage;

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

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

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

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

1 (v) an eligible employee or a dependent:

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

5 2. becomes eligible for assistance, with respect to coverage  
6 under the SHOP Exchange, under a Medicaid plan or state child health plan, including any  
7 waiver or demonstration project conducted under or in relation to a Medicaid plan or a state  
8 child health plan; [or]

9 (vi) for SHOP Exchange health benefit plans:

10 1. an eligible employee's or a dependent's enrollment or  
11 nonenrollment in a qualified health plan is, as evaluated and determined by the Exchange:

12 A. unintentional, inadvertent, or erroneous; and

13 B. the result of the error, misrepresentation, misconduct, or  
14 inaction of an officer, employee, or agent of the Exchange or the federal Department of  
15 Health and Human Services, or its instrumentalities, or a non-Exchange entity providing  
16 enrollment assistance or conducting enrollment activities; or

17 2. an eligible employee is an Indian as defined in § 4 of the  
18 federal Indian Health Care Improvement Act; OR

19 **(VII) AN ELIGIBLE EMPLOYEE OR A DEPENDENT HAS A LOSS OF**  
20 **COVERAGE UNDER A NONCALENDAR YEAR GROUP HEALTH BENEFIT PLAN OR**  
21 **INDIVIDUAL HEALTH BENEFIT PLAN, EVEN IF THE ELIGIBLE EMPLOYEE OR**  
22 **DEPENDENT HAS THE OPTION TO RENEW THE COVERAGE UNDER THE INDIVIDUAL**  
23 **OR GROUP HEALTH BENEFIT PLAN.**

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

26 (i) voluntary termination of coverage;

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

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

30 (6) The triggering event described in paragraph (4)(iii) of this subsection is  
31 permitted only once per year per individual.

1           (7) If an eligible employee or a dependent meets the requirements for the  
2 triggering event described in paragraph (4)(vi)1 of this subsection, the Exchange may take  
3 any action necessary to correct or eliminate the effects of the error, misrepresentation, or  
4 inaction.

5           (8) If an eligible employee meets the requirements for the triggering event  
6 described in paragraph (4)(vi)2 of this subsection, the eligible employee may enroll in a  
7 qualified health plan or change from one qualified health plan to another one time per  
8 month.

9           (9) An eligible employee or a dependent who meets the requirements for  
10 the triggering event described in paragraph (4)(v) of this subsection shall have 60 days from  
11 the triggering event to select a health benefit plan.

12           **(10) A LOSS OF COVERAGE UNDER A HEALTH BENEFIT PLAN**  
13 **DESCRIBED IN PARAGRAPH (4)(VII) OF THIS SUBSECTION IS CONSIDERED TO BE THE**  
14 **LAST DAY OF THE PLAN OR POLICY YEAR OF THE HEALTH BENEFIT PLAN.**

15           SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June  
16 1, 2016.