

Article - Insurance

§31–101.

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

(a–1) “Application counselor” means an individual who holds an Individual Exchange application counselor certification issued under § 31–113(r) of this title.

(a–2) “Application counselor sponsoring entity” or “sponsoring entity” means an entity designated by the Individual Exchange as a sponsoring entity under § 31–113(r) of this title.

(b) “Board” means the Board of Trustees of the Exchange.

(c) “Carrier” means:

(1) an insurer authorized to sell health insurance;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) any other entity providing a plan of health insurance, health benefits, or health services authorized under this article or the Affordable Care Act.

(c–1) “Captive producer” means an insurance producer who:

(1) is licensed in the State and authorized by the Commissioner to sell, solicit, or negotiate health insurance;

(2) receives an authorization and meets the other requirements set forth in § 31–113(n)(2) of this title;

(3) has a current and exclusive appointment with a single carrier; and

(4) receives compensation as a captive producer only from that carrier.

(c–2) “Consolidated Services Center” or “CSC” means the consumer assistance call center established in accordance with the requirement to operate a toll–free hotline under § 1311(d)(4) of the Affordable Care Act and § 31–108(b)(5) of this title.

(d) “Coverage level” means a level of coverage, as defined in § 1302 of the Affordable Care Act and as determined in regulations adopted by the Secretary, for a qualified health plan.

(e) (1) “Exchange” means the Maryland Health Benefit Exchange established as a public corporation under § 31–102 of this title.

(2) “Exchange” includes:

- (i) the Individual Exchange; and
- (ii) the Small Business Health Options Program (SHOP Exchange).

(e-1) (1) “Full-time employee” means an employee who works, on average, at least 30 hours per week.

(2) “Full-time employee” does not include a seasonal employee unless the employee works for the employer on more than 120 days during the taxable year.

(f) “Fund” means the Maryland Health Benefit Exchange Fund established under § 31-107 of this subtitle.

(g) (1) “Health benefit plan” means a policy, contract, certificate, or agreement offered, issued, or delivered by a carrier to an individual or small employer in the State to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(2) “Health benefit plan” does not include:

(i) coverage only for accident or disability insurance or any combination of accident and disability insurance;

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

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers’ compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics; or

(viii) other similar insurance coverage, specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; or

(iii) such other similar limited benefits as are specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act.

(4) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether the benefits are provided under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness;

(ii) group hospital indemnity or other fixed indemnity insurance, if the benefits are payable in a fixed dollar amount per period of time, such as \$100 per day of hospitalization, regardless of the amount of expenses incurred; or

(iii) individual hospital indemnity or other fixed indemnity insurance, if:

1. except as provided in item 4 of this item, the benefits are provided only to individuals who attest in their hospital indemnity or fixed indemnity insurance application that they have other health coverage that is minimum essential coverage, or that they are treated as having minimal essential coverage due to their status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code, 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 4B of this item is deemed to satisfy the attestation requirement;

2. the benefits are paid in a fixed dollar amount per period of hospitalization, illness, or service, regardless of the amount of expenses incurred and of the amount of benefits provided with respect to the event or service under any other health coverage;

3. a notice is displayed prominently in the application materials, in at least 14 point type, that has the following language in capital letters: “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.”;

4. 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."

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

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

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(iii) similar supplemental coverage provided to coverage under a group health plan if:

1. the coverage is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles; and

2. the coverage is not supplemental solely because it becomes secondary or supplemental under a coordination of benefits clause.

(h) "Individual Exchange" means the division of the Exchange that serves the individual health insurance market.

(i) "Individual Exchange navigator" means an individual who:

(1) holds an Individual Exchange navigator certification; and

(2) provides the services described in § 31-113(d)(1) of this title for an Individual Exchange connector entity.

(j) "Individual Exchange navigator certification" means a certificate issued by the Individual Exchange that authorizes an individual to act as an Individual Exchange navigator.

(k) "Individual Exchange connector entity" means a community-based

organization or other entity or a partnership of entities that:

(1) is authorized by the Individual Exchange under § 31–113(f) of this title;
and

(2) employs or engages Individual Exchange navigators to provide the services described in § 31–113(d)(1) of this title.

(l) “Individual Exchange connector entity authorization” means a grant of authority from the Individual Exchange to an Individual Exchange connector entity under § 31–113(f) of this title.

(m) “Insurance producer authorization” means a permit issued by the SHOP Exchange or Individual Exchange to allow an insurance producer to sell qualified plans in the SHOP Exchange or Individual Exchange.

(n) “Managed care organization” has the meaning stated in § 15–101 of the Health – General Article.

(o) “Maryland Health Care Reform Coordinating Council” means the joint executive–legislative council established and expanded by Executive Orders 01.01.2010.07 and 01.01.2011.10.

(o–1) “Minimum essential coverage” has the meaning stated in 26 U.S.C. § 5000A.

(o–2) “Plan year” has the meaning stated in § 15–1201 of this article.

(p) “Qualified dental plan” means a dental plan certified by the Exchange that provides limited scope dental benefits, as described in § 31–108(b)(2) of this title.

(q) “Qualified employer” means a small employer that elects to make its full–time employees and, at the option of the employer, some or all of its part–time employees eligible for one or more qualified health plans offered through the SHOP Exchange, provided that the employer:

(1) has its principal place of business in the State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the State.

(r) “Qualified health plan” means a health benefit plan that has been certified by the Exchange to meet the criteria for certification described in § 1311(c) of the Affordable Care Act and § 31–115 of this title.

(s) “Qualified individual” means an individual, including a minor, who at the time of enrollment:

(1) is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) resides in the State;

(3) is not incarcerated, other than incarceration pending disposition of charges; and

(4) is, and reasonably is expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(t) “Qualified plan” means a:

(1) qualified health plan;

(2) qualified dental plan; and

(3) qualified vision plan.

(u) “Qualified vision plan” means a vision plan certified by the Exchange that provides limited scope vision benefits, as described in § 31–108(b)(3) of this title.

(v) “Secretary” means the Secretary of the federal Department of Health and Human Services.

(w) “SHOP Exchange” means the Small Business Health Options Program authorized under § 31–108(b)(13) of this title.

(x) “SHOP Exchange navigator” means an individual engaged by the SHOP Exchange and authorized by the Commissioner to provide the services described in § 31–112(c)(1) of this title.

(y) “SHOP Exchange navigator license” means a license issued by the Commissioner that authorizes an individual to carry out the functions set forth in § 31–112(c) of this title in the SHOP Exchange.

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

(i) 50 employees for plan years that begin before January 1, 2016;
and

(ii) 100 employees for plan years that begin on or after January 1, 2016, or another number of employees or date as provided under federal law.

(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;

(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.

(aa) “State benchmark plan” means the health benefit plan designated by the State, under regulations adopted by the Secretary, to serve as the standard for the essential health benefits to be offered by:

(1) qualified health plans inside the Exchange;

(2) individual health benefit plans, except grandfathered health plans, as defined in § 1251 of the Affordable Care Act; and

(3) health benefit plans offered to small employers, except grandfathered health plans, as defined in § 1251 of the Affordable Care Act.