HB0361/396585/1

BY: Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 361
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, after "with" insert "and Implementation of"; in line 7, strike "and to" and substitute a comma; in line 8, after "offerings" insert ", 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"; in line 15, after "date;" insert "altering the limits on incentives for certain wellness programs;"; in line 18, after "year;" insert "providing for 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;"; and in line 23, after "employer" insert "or a small employer group".

On pages 1 and 2, strike beginning with "altering" in line 27 on page 1 down through "effective;" in line 1 on page 2.

On page 2, in line 16, after "State;" insert "adding an exception to the prohibition on canceling or refusing to renew an individual health benefit plan where a carrier discontinues offering a particular type of health insurance coverage, under certain circumstances;"; in line 27, after "month;" insert "requiring a carrier to provide a limited open enrollment period for certain individuals; requiring coverage for certain individuals to be effective in accordance with certain federal requirements; authorizing a health maintenance organization to establish a certain limit and to deny coverage to individuals under certain circumstances; prohibiting a health maintenance organization that denies coverage under certain circumstances from offering coverage in the individual market within a certain area for a certain period of time; authorizing a carrier to deny a health benefit plan to an individual under certain circumstances; prohibiting a carrier that denies a health benefit plan to an individual from offering coverage in the individual market for a certain period of time; providing that the

(Over)

prohibition on health maintenance organizations and carriers offering coverage in the individual market does not limit the ability to renew certain coverage or relieve certain responsibility;"; in line 44, after "15-508.1," insert "15-509(b),"; in the same line, after "(g)," insert "15-1005(c),"; and in line 46, after "15-1302," insert "15-1309(b)(5) and (6), 31-101(z),".

On page 3, in line 10, after "15-1208.2," insert "15-1309(b)(7),"; in the same line, strike "and"; and in the same line, after "15-1410" insert ", and 31-101(e-1)".

AMENDMENT NO. 2

On page 4, after line 15 insert:

"SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance".

On page 5, in line 11, strike "**AND**"; and in line 12, after "**MARKET**" insert "**;**

(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".

AMENDMENT NO. 3

On page 10, after line 12, insert:

"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 **[**20%**]** **30%** 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 **[**20%**]** **30%** 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.".

On page 11, after line 7, insert:

"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.".

AMENDMENT NO. 4

On page 14, in line 16, strike "**HAS A NORMAL WORKWEEK OF**" and substitute "**WORKS, ON AVERAGE,**"; and in the same line, after "**HOURS**" insert "**PER WEEK**".

On page 20, after line 19, insert:

"**(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.**".

On page 23, in lines 7, 27, and 32, in each instance, strike the brackets; and in the same lines, in each instance, strike "**60**".

On page 24, after line 7, insert:

"**(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.";

and in lines 8, 21, and 24, strike "**(A)**", "**(B)**", and "**(C)**", respectively, and substitute "**(B)**", "**(C)**", and "**(D)**", respectively.

On page 25, in line 7, strike "**OR**"; in lines 8, 12, 14, and 19, in each instance, after "**EMPLOYEE**" insert "**OR A DEPENDENT**"; in line 20, after "**PROVIDE**" insert "**;**

(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";

and after line 27, insert:

"**(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.".

AMENDMENT NO. 5

On page 34, after line 5, insert:

"15–1309.

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

(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) 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**; OR**

(7) 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.".

AMENDMENT NO. 6

On page 35, after line 15, insert:

"**(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.";

and in line 16, strike "**(A)**" and substitute "**(B)**".

On page 36, in line 3, strike "**(B)**" and substitute "**(C)**"; in line 17, strike "**OR**"; after line 17, insert:

"**(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";

in line 18, strike "**(III)**" and substitute "**(VIII)**"; in line 22, after "**INDIVIDUAL;**" insert "**OR**"; and strike in their entirety lines 23 through 31, inclusive.

On page 37, strike in their entirety lines 1 through 13, inclusive; in line 14, strike "**6.**" and substitute "**2.**"; in lines 14 and 31, in each instance, after

"**INDIVIDUAL**" insert "**OR A DEPENDENT**"; in line 16, strike "**FEDERAL**" and substitute "**U.S.**"; in line 17, after "**INDIVIDUAL**" insert "**OR DEPENDENT**"; in line 26, strike "**(4)(III)2**" and substitute "**(4)(III)**"; in line 30, strike "**(4)(III)4**" and substitute "**(4)(V)**"; and in line 34, after "**SPECIAL**" insert "**OPEN**".

On page 38, after line 2, insert:

"**(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.**";

in line 3, strike "**(C)**" and substitute "**(D)**"; in line 5, after the first "**PLAN**" insert "**IN THE INDIVIDUAL EXCHANGE**"; and after line 7, insert:

"**(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.".

AMENDMENT NO. 7

On page 38, after line 14, insert:

"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) **[**all employees shall be counted, including part–time employees and employees who are not eligible for coverage through the employer**]** **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.".

AMENDMENT NO. 8

On page 39, strike in their entirety lines 11 through 33, inclusive.

On page 40, after line 26, insert:

"Chapter 347 of the Acts of 2005, as amended by Chapter 59 of the Acts of 2007

SECTION 2. AND BE IT FURTHER ENACTED, That each individual enrolled on September 30, 2005 in a health benefit plan offered by a carrier under Title 15, Subtitle 12 of the Insurance Article may at the option of the enrollee remain covered under any policy issued by the carrier to small employers and selected by the enrollee at renewal, subject to the termination provisions under § 15–1212(b) of the Insurance Article, provided the enrollee continues to:

(1) work and reside in the State; and

(2) is a self–employed individual organized as a sole proprietorship or in any other legally recognized manner that a self–employed individual may organize:

(i) a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

(ii) who has filed the appropriate Internal Revenue form or forms and schedule for the previous taxable year; and

(iii) for whom a copy of the appropriate Internal Revenue form or forms and schedule has been filed with the carrier.

Chapter 347 of the Acts of 2005, as amended by Chapter 76 of the Acts of 2008 and Chapter 104 of the Acts of 2011

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2005. **[**Sections 1 and 2 of this Act shall remain effective for a period of 8 years and 3 months and, at the end of December 31, 2013, with no further action required by the General Assembly, Sections 1 and 2 of this Act shall be abrogated and of no further force and effect.**]**".

AMENDMENT NO. 9

On page 40, in lines 1, 7, and 27, strike "2.", "3.", and "4.", respectively, and substitute "3.", "4.", and "5.", respectively; and in line 27, strike "1" and substitute "2".

On page 41, in lines 1 and 6, strike "5." and "6.", respectively, and substitute "6." and "7.", respectively; in line 1, strike "2" and substitute "3"; in line 4, strike the first "2" and substitute "3"; in line 7, strike "4 and 5" and substitute "5 and 6"; and in the same line, strike "October" and substitute "June".