HOUSE BILL 361

C3 3lr0105

By: **Chair, Health and Government Operations Committee (By Request – Departmental – Insurance Administration, Maryland)**
Introduced and read first time: January 25, 2013
Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Conformity with Federal Patient Protection and**
3 **Affordable Care Act**

4 FOR the purpose of establishing certain fees for an initial SHOP Exchange navigator
5 license, a license renewal, and a license reinstatement; providing that certain
6 provisions of the federal Patient Protection and Affordable Care Act relating to
7 annual limitations on cost sharing and deductibles and to child–only plan
8 offerings apply to certain coverage in certain insurance markets; altering the
9 definition of "child dependent" for purposes of certain provisions of law that
10 require certain policies and contracts to provide certain health insurance
11 coverage and benefits to child dependents; providing that certain provisions of
12 law relating to preexisting condition provisions apply to certain carriers for
13 health benefit plan years that begin before a certain date; providing that certain
14 provisions of law relating to exclusionary riders apply to individual health
15 benefit plans issued or delivered in the State before a certain date; repealing a
16 requirement that the Maryland Insurance Commissioner transmit certain
17 information to the Maryland Health Care Commission on or before a certain
18 date each year; repealing certain disclosure requirements for certain
19 out–of–state association contracts; conforming the definition of "small employer"
20 for purposes of provisions of law governing the small group insurance market to
21 the definition used in provisions of law governing the Maryland Health Benefit
22 Exchange; prohibiting certain carriers from imposing a minimum participation
23 requirement for a qualified employer under certain circumstances; providing
24 that certain provisions of law relating to the Comprehensive Standard Health
25 Benefit Plan offered in the small group insurance market apply only to certain
26 plans beginning on a certain date; providing that certain special enrollment
27 periods apply to certain eligible employees; altering the circumstances under
28 which a carrier must allow a certain employee or dependent to enroll for
29 coverage under a certain health benefit plan; altering the minimum number of
30 days in a certain special enrollment period; altering the time at which certain

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets**]** indicate matter deleted from existing law.

1 coverage becomes effective; requiring certain carriers to establish a
2 standardized annual open enrollment period for each small employer in the
3 small group insurance market; specifying the minimum number of days in the
4 annual open enrollment period and when it must occur; specifying the actions
5 an eligible employee of the small employer must be permitted to take during the
6 annual open enrollment period; requiring certain carriers to provide a certain
7 open enrollment period for an employee who becomes an eligible employee
8 outside the initial or annual open enrollment period; requiring certain carriers
9 to provide certain open enrollment periods for individuals who experience
10 certain triggering events; altering the requirements a small employer must
11 meet to be covered under a health benefit plan offered by a carrier in the small
12 group insurance market; providing that certain provisions of law relating to
13 increasing access to care choices or lowering the cost–sharing arrangement in
14 the Standard Health Benefit Plan apply only to certain grandfathered health
15 plans beginning on a certain date; altering the scope of certain provisions of law
16 governing carriers that offer health benefit plans to individuals in the State;
17 requiring certain qualified health plans issued on or after a certain date by
18 certain carriers to include a certain grace period provision; requiring and
19 authorizing the carriers to take certain actions during the grace period;
20 requiring certain carriers that sell certain health benefit plans to individuals in
21 the State to establish a certain annual enrollment period; specifying the actions
22 an individual must be permitted to take during the annual open enrollment
23 period; specifying the effective date of coverage for an individual who enrolls in
24 a health benefit plan during the annual open enrollment period; authorizing
25 certain individuals to enroll in a health benefit plan or change from one health
26 benefit plan in the Individual Exchange to another health benefit plan in the
27 Individual Exchange a certain number of times per month; providing that the
28 guaranteed issuance of coverage provision of the Affordable Care Act applies to
29 each health benefit plan with a plan year that begins on or after a certain date;
30 authorizing the Commissioner to deny a SHOP Exchange navigator license
31 under certain circumstances; requiring carriers in the small group insurance
32 market to set premium rates for the entire plan year for each small employer;
33 requiring a carrier that sells health benefit plans to individuals in the State to
34 establish a certain initial open enrollment period; requiring the carrier to accept
35 all applicants who apply during the initial open enrollment period; specifying
36 when coverage for an applicant must begin; repealing the termination date of
37 certain provisions of law relating to health insurance policies for certain
38 self–employed individuals in the small group insurance market; altering certain
39 definitions; defining certain terms; making conforming changes; providing for
40 the effective dates of this Act; and generally relating to health insurance and
41 implementation of the federal Patient Protection and Affordable Care Act.

42 BY repealing and reenacting, with amendments,
43 Article – Insurance
44 Section 2–112(a)(6), 15–137.1, 15–418, 15–508, 15–508.1, 15–605(f) and (g),
45 15–1105, 15–1201, 15–1206, 15–1208.1, 15–1209, 15–1213,
46 15–1301, 15–1302, and 31–112(e)(1)

1 Annotated Code of Maryland
2 (2011 Replacement Volume and 2012 Supplement)

3 BY repealing
4 Article – Insurance
5 Section 15–605(e) and 15–1203
6 Annotated Code of Maryland
7 (2011 Replacement Volume and 2012 Supplement)

8 BY adding to
9 Article – Insurance
10 Section 15–1207(h), 15–1208.2, 15–1315, 15–1316, 15–1317, and 15–1410
11 Annotated Code of Maryland
12 (2011 Replacement Volume and 2012 Supplement)

13 BY adding to
14 Article – Insurance
15 Section 15–1205(h)
16 Annotated Code of Maryland
17 (2011 Replacement Volume and 2012 Supplement)
18 (As enacted by Chapter 152 of the Acts of the General Assembly of 2012)

19 BY repealing and reenacting, without amendments,
20 Chapter 347 of the Acts of the General Assembly of 2005, as amended by
21 Chapter 59 of the Acts of the General Assembly of 2007
22 Section 2

23 BY repealing and reenacting, with amendments,
24 Chapter 347 of the Acts of the General Assembly of 2005, as amended by
25 Chapter 76 of the Acts of the General Assembly of 2008 and Chapter 104
26 of the Acts of the General Assembly of 2011
27 Section 4

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

30 **Article – Insurance**

31 2–112.

32 (a) Fees for the following certificates, licenses, and services shall be collected
33 in advance by the Commissioner, and shall be paid by the appropriate persons to the
34 Commissioner:

35 (6) fees for licenses:

36 (i) public adjuster license:

1 1. fee for initial license within 1 year of renewal $25

2 2. fee for initial license over 1 year from renewal $50

3 3. biennial renewal fee $50

4 (ii) adviser license:

5 1. fee for initial license within 1 year of renewal $100

6 2. fee for initial license over 1 year from renewal $200

7 3. biennial renewal fee $200

8 (iii) insurance producer license:

9 1. fee for initial license $54

10 2. biennial renewal fee $54

11 **(IV) SHOP EXCHANGE NAVIGATOR LICENSE:**

12 **1. FEE FOR INITIAL LICENSE $54**

13 **2. BIENNIAL RENEWAL FEE $54**

14 **3. FEE FOR REINSTATEMENT OF LICENSE $100**

15 **[**(iv)**] (V)** application fee $25

16 15–137.1.

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

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

24 (2) preexisting condition exclusions;

25 (3) policy rescissions;

1 (4) bona fide wellness programs;

2 (5) lifetime limits;

3 (6) annual limits for essential benefits;

4 (7) waiting periods;

5 (8) designation of primary care providers;

6 (9) access to obstetrical and gynecological services;

7 (10) emergency services;

8 (11) summary of benefits and coverage explanation;

9 (12) minimum loss ratio requirements and premium rebates; **[**and**]**

10 (13) disclosure of information**;**

11 **(14) ANNUAL LIMITATIONS ON COST SHARING; AND**

12 **(15) CHILD–ONLY PLAN OFFERINGS IN THE INDIVIDUAL MARKET**.

13 **(B) THE ANNUAL LIMITATION ON DEDUCTIBLES FOR THE**
14 **EMPLOYER–SPONSORED PLANS PROVISION OF TITLE I, SUBTITLE D OF THE**
15 **AFFORDABLE CARE ACT APPLIES TO HEALTH INSURANCE COVERAGE OFFERED**
16 **IN THE SMALL GROUP MARKET, AS DEFINED IN THE FEDERAL PUBLIC HEALTH**
17 **SERVICE ACT, ISSUED OR DELIVERED IN THE STATE BY AN AUTHORIZED**
18 **INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE**
19 **ORGANIZATION.**

20 **[**(b)**] (C)** The provisions of **[**subsection**] SUBSECTIONS** (a) **AND (B)** of this
21 section do not apply to coverage for excepted benefits, as defined in 45 C.F.R. §
22 146.145(c).

23 **[**(c)**] (D)** The Commissioner may enforce this section under any applicable
24 provisions of this article.

25 15–418.

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

27 (2) "Carrier" means:

28 (i) an insurer;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization.

(3) "Child dependent" means an individual who:

(i) is:

1. the **[**natural child, stepchild, adopted child, or**]** grandchild of the insured; **OR**

2. **[**a child placed with the insured for legal adoption; or

3.**]** a child who is entitled to dependent coverage under § 15–403.1 of this subtitle;

(ii) **[**is a dependent of the insured as that term is used in 26 U.S.C. §§ 104, 105, and 106, and any regulations adopted under those sections;

(iii)**]** is unmarried; and

[(iv)**]** **(III)** is under the age of 25 years.

(b) (1) This section applies to:

(i) each policy of individual or group health insurance that is issued in the State;

(ii) each contract that is issued in the State by a nonprofit health service plan; and

(iii) each contract that is issued in the State by a health maintenance organization.

(2) Notwithstanding paragraph (1) of this subsection, this section does not apply to:

(i) a contract covering one or more, or any combination of the following:

1. coverage only for loss caused by an accident;

2. disability coverage;

3. credit–only insurance; or

1 4. long–term care coverage; or

2 (ii) the following benefits if they are provided under a separate
3 contract:

4 1. dental coverage;

5 2. vision coverage;

6 3. Medicare supplement insurance;

7 4. coverage limited to benefits for a specified disease or
8 diseases;

9 5. travel accident or sickness coverage; and

10 6. fixed indemnity limited benefit insurance that does
11 not provide benefits on an expense incurred basis.

12 (c) Each policy or contract subject to this section that provides coverage for
13 dependents shall:

14 (1) include coverage for a child dependent;

15 (2) provide the same health insurance benefits to a child dependent
16 that are available to any other covered dependent; and

17 (3) provide health insurance benefits to a child dependent at the same
18 rate or premium applicable to any other covered dependent.

19 (d) This section does not limit or alter any right to dependent coverage or to
20 the continuation of coverage that is otherwise provided for in this article.

21 15–508.

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

23 (2) "Carrier" has the meaning stated in § 15–1301 of this title.

24 (3) "Enrollment date" has the meaning stated in § 15–1301 of this
25 title.

26 **(4) "PLAN YEAR" MEANS A CALENDAR YEAR OR OTHER**
27 **CONSECUTIVE 12–MONTH PERIOD DURING WHICH A HEALTH BENEFIT PLAN**
28 **PROVIDES COVERAGE FOR HEALTH BENEFITS.**

1 [(4)] **(5)** "Policy or certificate" means any group or blanket health
2 insurance contract or policy that is issued or delivered in the State by an insurer or
3 nonprofit health service plan that provides hospital, medical, or surgical benefits on an
4 expense–incurred basis.

5 [(5)] **(6)** "Preexisting condition provision" has the meaning stated in
6 § 15–1301 of this title.

7 [(6)] **(7)** "Late enrollee" has the meaning stated in § 15–1401 of this
8 title.

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

11 **(2) THIS SECTION APPLIES TO CARRIERS FOR PLAN YEARS THAT**
12 **BEGIN BEFORE JANUARY 1, 2014.**

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

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

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

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

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

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

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

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

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

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

4 15–508.1.

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

6 (2) "Carrier" means an insurer or a nonprofit health service plan.

7 (3) "Creditable coverage" has the meaning stated in § 15–1301 of this
8 title.

9 (4) "Exclusionary rider" means an endorsement to an individual
10 health benefit plan that excludes benefits for one or more named conditions that are
11 discovered by a carrier during the underwriting process.

12 (5) "Health benefit plan" has the meaning stated in § 15–1301 of this
13 title.

14 (6) "Individual health benefit plan" means a health benefit plan issued
15 by a carrier that insures:

16 (i) only one individual; or

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

19 **(B) THIS SECTION APPLIES TO INDIVIDUAL HEALTH BENEFIT PLANS**
20 **THAT ARE ISSUED OR DELIVERED IN THE STATE BEFORE JANUARY 1, 2014.**

21 **[**(b)**] (C)** A carrier may not attach an exclusionary rider to an individual
22 health benefit plan unless the carrier obtains the prior written consent of the
23 policyholder.

24 **[**(c)**] (D)** Except as provided in subsection **[**(d)**] (E)** of this section, a carrier
25 may impose a preexisting condition exclusion or limitation on an individual for a
26 condition that was not discovered during the underwriting process for an individual
27 health benefit plan only if the exclusion or limitation:

28 (1) relates to a condition of the individual, regardless of its cause, for
29 which medical advice, diagnosis, care, or treatment was recommended or received
30 within the 12–month period immediately preceding the effective date of the
31 individual's coverage;

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

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

[(d)**] (E)** (1) Subject to paragraph (2) of this subsection, a carrier may not impose a preexisting condition exclusion or limitation on an individual who, as of the last day of the 30–day period beginning with the date of the individual's birth, is covered under any creditable coverage.

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

15–605.

[(e) (1) On or before May 1 of each year, the Commissioner shall transmit to the Maryland Health Care Commission any information it needs to evaluate the Comprehensive Standard Health Benefit Plan as required under § 15–1207 of this title.

(2) The information provided by the Commissioner shall be specified in regulations adopted by the Commissioner in consultation with the Maryland Health Care Commission.**]**

[(f)**] (E)** (1) (i) On or before March 1 of each year, unless, for good cause shown, the Commissioner extends the time for a reasonable period, each managed care organization shall file with the Commissioner a report that shows the financial condition of the managed care organization on the last day of the preceding calendar year and any other information that the Commissioner requires by bulletin or regulation.

(ii) At any time, the Commissioner may require a managed care organization to file an interim statement containing the information that the Commissioner considers necessary.

(iii) The annual and interim reports shall be filed in a form required by the Commissioner.

(2) (i) Except as provided in paragraph (3) of this subsection on or before June 1 of each year, each managed care organization shall file with the Commissioner an audited financial report for the preceding calendar year.

(ii) The audited financial report shall:

1 1. be filed in a form required by the Commissioner; and

2 2. be certified by an audit of an independent certified
3 public accountant.

4 (3) With 90 days' advance notice, the Commissioner may require a
5 managed care organization to file an audited financial report earlier than the date
6 specified in paragraph (2) of this subsection.

7 **[**(g)**]** **(F)** Each financial report filed under this section is a public record.

8 15–1105.

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

10 (2) "Carrier" means:

11 (i) an insurer; or

12 (ii) a nonprofit health service plan.

13 (3) "Eligible individual" means a Maryland resident who has
14 membership in an association.

15 (4) "Evidence of individual insurability" means medical or other
16 information that indicates health status, used to determine whether coverage of an
17 individual is to be:

18 (i) issued or denied; or

19 (ii) issued with or without an exclusionary rider.

20 (5) "Health benefit plan" has the meaning stated in § 15–1301 of this
21 title.

22 (6) "Health status–related factor" has the meaning stated in § 15–1201
23 of this title.

24 (7) "Individual health insurance contract" means a health benefit plan
25 that is issued or delivered in the State to an individual.

26 (8) "Member" means an eligible individual who purchases coverage
27 under an out–of–state association contract.

28 (9) "Out–of–state association contract" means a health benefit plan
29 that is issued or delivered to an association outside the State.

(b) This section applies to a carrier that requires evidence of individual insurability for coverage under an out–of–state association contract.

(c) A carrier shall disclose to a Maryland resident applying for coverage under an out–of–state association contract:

(1) that coverage is conditioned on membership in the association that holds the out–of–state association contract;

(2) all costs related to joining and maintaining membership in the association;

(3) that membership fees or dues are in addition to the premium for coverage under the out–of–state association contract;

(4) that the terms and conditions of coverage under the out–of–state association contract are determined by the association and the carrier; **AND**

(5) **[**the mandated benefits required under Subtitle 8 of this title that are not included in the out–of–state association contract;

(6) that the Maryland resident may purchase an individual health benefit plan that includes the mandated benefits under Subtitle 8 of this title that are not included in the out–of–state association contract from a carrier licensed and authorized to do business in the State;

(7) that benefits offered under the out–of–state association contract are not regulated by the Commissioner; and

(8)**]** that the terms and conditions of coverage under the out–of–state association contract may be changed by agreement of the association and the carrier without the consent of a member.

(d) (1) The Commissioner may require a carrier that offers coverage under an out–of–state association contract to report, on or before March 1 of each year, the number of Maryland residents covered in the preceding calendar year under the out–of–state association contract.

(2) The data required under paragraph (1) of this subsection shall be reported in a manner determined by the Commissioner.

(e) If a carrier collects membership fees or dues on behalf of an association, the carrier shall disclose on the enrollment application for an out–of–state association contract that the carrier bills and collects membership fees and dues on behalf of the association.

15–1201.

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

2 (b) "Board" means the Board of Directors of the Pool established under §
3 15–1216 of this subtitle.

4 (c) "Carrier" means a person that:

5 (1) offers health benefit plans in the State covering eligible employees
6 of small employers; and

7 (2) is:

8 (i) an authorized insurer that provides health insurance in the
9 State;

10 (ii) a nonprofit health service plan that is licensed to operate in
11 the State;

12 (iii) a health maintenance organization that is licensed to
13 operate in the State; or

14 (iv) any other person or organization that provides health
15 benefit plans subject to State insurance regulation.

16 (d) "Commission" means the Maryland Health Care Commission established
17 under Title 19, Subtitle 1 of the Health – General Article.

18 **[**(e) (1) "Eligible employee" means:

19 (i) an individual who:

20 1. is an employee, partner of a partnership, or
21 independent contractor who is included as an employee under a health benefit plan;
22 and

23 2. works on a full–time basis and has a normal
24 workweek of at least 30 hours; or

25 (ii) a sole employee of a nonprofit organization that has been
26 determined by the Internal Revenue Service to be exempt from taxation under §
27 501(c)(3), (4), or (6) of the Internal Revenue Code who:

28 1. has a normal workweek of at least 20 hours; and

29 2. is not covered under a public or private plan for
30 health insurance or other health benefit arrangement.

1 (2) "Eligible employee" does not include an individual who works:

2 (i) on a temporary or substitute basis; or

3 (ii) except for an individual described in paragraph (1)(ii) of this
4 subsection, for less than 30 hours in a normal workweek.**]**

5 **(E) "COVERAGE LEVEL" HAS THE MEANING STATED IN § 31–101 OF**
6 **THIS ARTICLE.**

7 **(F) (1) "ELIGIBLE EMPLOYEE" MEANS AN EMPLOYEE WHO IS**
8 **OFFERED COVERAGE UNDER A HEALTH BENEFIT PLAN BY A SMALL EMPLOYER.**

9 **(2) "ELIGIBLE EMPLOYEE", AT THE OPTION OF THE SMALL**
10 **EMPLOYER, MAY INCLUDE:**

11 **(I) ONLY FULL–TIME EMPLOYEES; OR**

12 **(II) FULL–TIME EMPLOYEES AND PART–TIME EMPLOYEES.**

13 **(G) "EMPLOYEE" MEANS AN INDIVIDUAL WHO IS EMPLOYED BY A SMALL**
14 **EMPLOYER.**

15 **(H) "FULL–TIME EMPLOYEE" MEANS AN EMPLOYEE OF A SMALL**
16 **EMPLOYER WHO HAS A NORMAL WORKWEEK OF AT LEAST 30 HOURS.**

17 **[**(f)**] (I)** (1) "Health benefit plan" means:

18 (i) a policy or certificate for hospital or medical benefits;

19 (ii) a nonprofit health service plan; or

20 (iii) a health maintenance organization subscriber or group
21 master contract.

22 (2) "Health benefit plan" includes a policy or certificate for hospital or
23 medical benefits that covers residents of this State who are eligible employees and
24 that is issued through:

25 (i) a multiple employer trust or association located in this State
26 or another state; or

27 (ii) a professional employer organization, coemployer, or other
28 organization located in this State or another state that engages in employee leasing.

1 (3) "Health benefit plan" does not include:

2 (i) accident–only insurance;

3 (ii) fixed indemnity insurance;

4 (iii) credit health insurance;

5 (iv) Medicare supplement policies;

6 (v) Civilian Health and Medical Program of the Uniformed
7 Services (CHAMPUS) supplement policies;

8 (vi) long–term care insurance;

9 (vii) disability income insurance;

10 (viii) coverage issued as a supplement to liability insurance;

11 (ix) workers' compensation or similar insurance;

12 (x) disease–specific insurance;

13 (xi) automobile medical payment insurance;

14 (xii) dental insurance; or

15 (xiii) vision insurance.

16 **[**(g)**] (J)** "Health status–related factor" means a factor related to:

17 (1) health status;

18 (2) medical condition;

19 (3) claims experience;

20 (4) receipt of health care;

21 (5) medical history;

22 (6) genetic information;

23 (7) evidence of insurability including conditions arising out of acts of
24 domestic violence; or

1 (8) disability.

2 [(h)] **(K)** "Late enrollee" means an eligible employee or dependent who
3 requests enrollment in a health benefit plan after the initial enrollment period
4 provided under the health benefit plan.

5 **(L) "MINIMUM ESSENTIAL COVERAGE" HAS THE MEANING STATED IN**
6 **45 C.F.R. § 155.20.**

7 **(M) "PART–TIME EMPLOYEE" MEANS AN EMPLOYEE OF A SMALL**
8 **EMPLOYER WHO:**

9 **(1) HAS A NORMAL WORKWEEK OF AT LEAST 17.5 HOURS; AND**

10 **(2) IS NOT A FULL–TIME EMPLOYEE.**

11 **(N) "PLAN YEAR" MEANS A CALENDAR YEAR OR OTHER CONSECUTIVE**
12 **12–MONTH PERIOD DURING WHICH A HEALTH BENEFIT PLAN PROVIDES**
13 **COVERAGE FOR HEALTH CARE SERVICES.**

14 [(i)] **(O)** "Pool" means the Maryland Small Employer Health Reinsurance
15 Pool established under this subtitle.

16 [(j)] **(P)** "Preexisting condition" means:

17 (1) a condition existing during a specified period immediately
18 preceding the effective date of coverage, that would have caused an ordinarily prudent
19 person to seek medical advice, diagnosis, care, or treatment; or

20 (2) a condition for which medical advice, diagnosis, care, or treatment
21 was recommended or received during a specified period immediately preceding the
22 effective date of coverage.

23 [(k)] **(Q)** "Preexisting condition provision" means a provision in a health
24 benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or
25 services related to a preexisting condition.

26 **(R) "QUALIFIED EMPLOYER" HAS THE MEANING STATED IN § 31–101 OF**
27 **THIS ARTICLE.**

28 **(S) "QUALIFIED HEALTH PLAN" HAS THE MEANING STATED IN § 31–101**
29 **OF THIS ARTICLE.**

30 [(l)] **(T)** "Reinsuring carrier" means a carrier that participates in the Pool.

1 [(m)] **(U)** "Risk–assuming carrier" means a carrier that does not participate
2 in the Pool.

3 **(V) "SHOP EXCHANGE" HAS THE MEANING STATED IN § 31–101 OF**
4 **THIS ARTICLE.**

5 [(n)] **(W)** "Small employer" [means:

6 (1) an employer described in § 15–1203 of this subtitle; or

7 (2) an entity that leases employees from a professional employer
8 organization, coemployer, or other organization engaged in employee leasing and that
9 otherwise meets the description of § 15–1203 of this subtitle] **HAS THE MEANING**
10 **STATED IN § 31–101 OF THIS ARTICLE**.

11 [(o)] **(X)** "Special enrollment period" means a period during which a group
12 health plan shall permit certain individuals who are eligible for coverage, but not
13 enrolled, to enroll for coverage under the terms of the group health benefit plan.

14 [(p)] **(Y)** "Standard Plan" means the Comprehensive Standard Health
15 Benefit Plan adopted by the Commission in accordance with § 15–1207 of this subtitle
16 and Title 19, Subtitle 1 of the Health – General Article.

17 [(q)] **(Z)** (1) "Wellness program" means a program or activity that:

18 (i) is designed to improve health status and reduce health care
19 costs; and

20 (ii) complies with guidelines developed by the Commission.

21 (2) "Wellness program" includes programs and activities for:

22 (i) smoking cessation;

23 (ii) reduction of alcohol misuse;

24 (iii) weight reduction;

25 (iv) nutrition education; and

26 (v) automobile and motorcycle safety.

27 [(r)] **(AA)** "Wellness benefit" means a benefit that:

28 (1) includes a bona fide wellness program as defined in § 15–509 of
29 this title; and

(2) complies with regulations adopted by the Commission.

[15–1203.

(a) A small employer under this subtitle is a person that meets the criteria specified in any subsection of this section.

(b) (1) A person is considered a small employer under this subtitle if the person:

(i) is an employer that on at least 50% of its working days during the preceding calendar quarter, employed at least two but not more than 50 eligible employees, the majority of whom are employed in the State; and

(ii) is a person actively engaged in business or is the governing body of:

1. a charter home–rule county established under Article XI–A of the Maryland Constitution;

2. a code home–rule county established under Article XI–F of the Maryland Constitution;

3. a commission county established or operating under Article 25 of the Code; or

4. a municipal corporation established or operating under Article XI–E of the Maryland Constitution.

(2) Notwithstanding paragraph (1)(i) of this subsection:

(i) a person is considered a small employer under this subtitle if the employer did not exist during the preceding calendar year but on at least 50% of the working days during its first year the employer employs at least two but not more than 50 eligible employees and otherwise satisfies the conditions of paragraph (1)(i) of this subsection; and

(ii) if the federal Employee Retirement Income Security Act (ERISA) is amended to exclude employee groups under a specific size, this subtitle shall apply to any employee group size that is excluded from that Act.

(3) In determining the group size specified under paragraph (1)(i) of this subsection:

(i) companies that are affiliated companies or that are eligible to file a consolidated federal income tax return shall be considered one employer; and

1 (ii) an employee may not be counted who is a part–time
2 employee as described in § 15–1210(a)(2) of this subtitle.

3 (4) A carrier may request documentation to verify that a person meets
4 the criteria under this subsection to be considered a small employer under this
5 subtitle.

6 (5) Notwithstanding paragraph (1)(i) of this subsection, a person is
7 considered to continue to be a small employer under this subtitle if the person met the
8 conditions of paragraph (1)(i) of this subsection and purchased a health benefit plan in
9 accordance with this subtitle, and subsequently eliminated all but one employee.

10 (c) A person is considered a small employer under this subtitle if the person
11 is a nonprofit organization that has been determined by the Internal Revenue Service
12 to be exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code
13 and has at least one eligible employee.]

14 15–1206.

15 (a) (1) A carrier may not arbitrarily transfer a small employer
16 involuntarily into or out of a health benefit plan.

17 (2) A carrier may not offer to transfer a small employer into or out of a
18 health benefit plan unless the offer to transfer is made to all small employers with
19 similar risk adjustment factors.

20 (b) A carrier shall make a reasonable disclosure in its solicitation and sales
21 materials of:

22 (1) the provisions that relate to the carrier's right to change premium
23 rates, including any factors that may affect the changes in premium rates;

24 (2) the provisions that relate to renewability of policies and contracts;

25 (3) the provisions that relate to preexisting conditions; and

26 (4) the provisions of § 15–1209 of this subtitle that require an
27 employer to make dependent coverage available to eligible employees but do not
28 require the employer to make a contribution to the premium payments for that
29 dependent coverage.

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

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

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

(i) those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under the Standard Plan; or

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

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

(5) A CARRIER MAY NOT IMPOSE A MINIMUM PARTICIPATION REQUIREMENT FOR A QUALIFIED EMPLOYER IF THE QUALIFIED EMPLOYER DESIGNATES A COVERAGE LEVEL WITHIN WHICH ITS EMPLOYEES MAY CHOOSE ANY QUALIFIED HEALTH PLAN IN THE SHOP EXCHANGE, AS PROVIDED FOR IN § 31–111(C)(1) OF THIS ARTICLE.

(d) (1) On or before March 15 of each year, each carrier shall file an actuarial certification with the Commissioner.

(2) The actuarial certification shall be written in a form that the Commissioner approves, by a member of the American Academy of Actuaries or another person acceptable to the Commissioner and shall state that the carrier is in compliance with this subtitle and has followed the rating practices imposed under § 15–1205 of this subtitle.

(3) The actuarial certification shall be based on an examination that includes a review of appropriate records and actuarial assumptions and methods used by the carrier.

(e) (1) To indicate compliance with subsections (b) and (c)(1) of this section and § 15–1205(e) of this subtitle, a carrier shall maintain information and documentation that is satisfactory to the Commissioner.

(2) A carrier shall:

(i) retain all information and documentation required under this subtitle at its principal place of business for a period of 5 years; and

(ii) make the information and documentation available to the Commissioner on request.

(f) A carrier may not implement a producer commission schedule that varies the amount of a commission based on the size of a small employer group unless the variation:

(1) is inversely related to the size of the small employer group;

(2) applies to the cumulative premium paid over a specific period of time, is uniformly applied, and is inversely related to the cumulative premium paid during the period of time; or

(3) is established by a contract between the carrier and each outside producer, and the carrier:

(i) specifies in the contract the group size to which the variation applies;

(ii) directs the outside producer to refer small employers of the specified size to an employee of the carrier who is a licensed producer or to a company affiliated with the carrier through common ownership within an insurance holding company; and

(iii) pays a commission to the employee producer described in item (ii) of this item.

(g) (1) A licensed insurance producer, in connection with the sale, solicitation, or negotiation of a health benefit plan to a small employer, shall:

(i) provide information to the small employer about wellness benefits; and

(ii) advise the small employer to consult a tax advisor about the tax advantages of a payroll deduction plan under § 125 of the Internal Revenue Code.

(2) The information shall be provided:

(i) whenever the employer purchases or renews a health benefit plan; and

(ii) on request.

(h) (1) In accordance with regulations adopted by the Commissioner, a licensed insurance producer may provide to a small employer information about the

1 Maryland Medical Assistance Program and the Maryland Children's Health Program
2 for the small employer to distribute to its employees during the enrollment period.

3 (2) The information provided under paragraph (1) of this subsection
4 shall be restricted to general information about the Maryland Medical Assistance
5 Program and the Maryland Children's Health Program, including:

6 (i) income eligibility thresholds; and

7 (ii) application instructions.

8 15–1207.

9 **(H) BEGINNING JANUARY 1, 2014, THIS SECTION APPLIES ONLY TO**
10 **GRANDFATHERED HEALTH PLANS AS DEFINED IN § 1251 OF THE AFFORDABLE**
11 **CARE ACT.**

12 15–1208.1.

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

15 (b) If the small employer elects under § 15–1210(a)(3) of this subtitle to offer
16 coverage to all of its **ELIGIBLE** employees who are covered under another public or
17 private plan of health insurance or another health benefit arrangement, a carrier shall
18 allow an **ELIGIBLE** employee or dependent who is eligible, but not enrolled, for
19 coverage under the terms of the employer's health benefit plan to enroll for coverage
20 under the terms of the plan if:

21 (1) the **ELIGIBLE** employee or dependent was covered under an
22 employer–sponsored plan or group health benefit plan at the time coverage was
23 previously offered to the employee or dependent;

24 (2) the **ELIGIBLE** employee states in writing, at the time coverage was
25 previously offered, that coverage under an employer–sponsored plan or group health
26 benefit plan was the reason for declining enrollment, but only if the plan sponsor or
27 carrier requires the statement and provides the employee with notice of the
28 requirement;

29 (3) the **ELIGIBLE** employee's or dependent's coverage described in
30 item (1) of this subsection:

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

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

(4) under the terms of the plan, the **ELIGIBLE** employee requests enrollment not later than **[**30**]** **60** days after:

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

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

(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, or placement for adoption;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, or placement for adoption; and

(3) the spouse of an eligible employee at the birth or adoption of a child, provided the spouse is otherwise eligible for coverage.

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

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

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

(e) The special enrollment period under subsection (c) of this section shall be a period of not less than **[**31**]** **60** days and shall begin on the later of:

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

(2) the date of the marriage, birth, adoption, or placement for adoption, whichever is applicable.

(f) If an eligible employee enrolls any of the individuals described in subsection (c) of this section during the first **[**31**]** **60** days of the special enrollment period, the coverage shall become effective as follows:

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

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

(3) in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption, whichever occurs first.

15–1208.2.

(A) (1) A CARRIER SHALL ESTABLISH A STANDARDIZED ANNUAL OPEN ENROLLMENT PERIOD OF AT LEAST 30 DAYS FOR EACH SMALL EMPLOYER.

(2) THE ANNUAL OPEN ENROLLMENT PERIOD SHALL OCCUR BEFORE THE END OF THE SMALL EMPLOYER'S PLAN YEAR.

(3) DURING THE ANNUAL OPEN ENROLLMENT PERIOD, EACH ELIGIBLE EMPLOYEE OF THE SMALL EMPLOYER SHALL BE PERMITTED TO:

(I) ENROLL IN A HEALTH BENEFIT PLAN OFFERED BY THE SMALL EMPLOYER;

(II) DISCONTINUE ENROLLMENT IN A HEALTH BENEFIT PLAN OFFERED BY THE SMALL EMPLOYER; OR

(III) CHANGE ENROLLMENT FROM ONE HEALTH BENEFIT PLAN OFFERED BY THE SMALL EMPLOYER TO A DIFFERENT HEALTH BENEFIT PLAN OFFERED BY THE SMALL EMPLOYER.

(B) A CARRIER SHALL PROVIDE AN OPEN ENROLLMENT PERIOD OF AT LEAST 30 DAYS FOR EACH EMPLOYEE WHO BECOMES AN ELIGIBLE EMPLOYEE OUTSIDE THE INITIAL OR ANNUAL OPEN ENROLLMENT PERIOD.

(C) (1) A CARRIER SHALL PROVIDE AN OPEN ENROLLMENT PERIOD FOR EACH INDIVIDUAL WHO EXPERIENCES A TRIGGERING EVENT DESCRIBED IN PARAGRAPH (4) OF THIS SUBSECTION.

(2) THE OPEN ENROLLMENT PERIOD SHALL BE FOR AT LEAST 60 DAYS, BEGINNING ON THE DATE OF THE TRIGGERING EVENT.

(3) DURING THE OPEN ENROLLMENT PERIOD FOR AN INDIVIDUAL WHO EXPERIENCES A TRIGGERING EVENT, A CARRIER SHALL PERMIT THE

1 **INDIVIDUAL TO ENROLL IN OR CHANGE FROM ONE HEALTH BENEFIT PLAN**
2 **OFFERED BY THE SMALL EMPLOYER TO ANOTHER HEALTH BENEFIT PLAN**
3 **OFFERED BY THE SMALL EMPLOYER.**

4 **(4) A TRIGGERING EVENT OCCURS WHEN:**

5 **(I) SUBJECT TO PARAGRAPH (5) OF THIS SUBSECTION, AN**
6 **ELIGIBLE EMPLOYEE OR DEPENDENT LOSES MINIMUM ESSENTIAL COVERAGE;**
7 **OR**

8 **(II) AN ELIGIBLE EMPLOYEE WHO IS ENROLLED IN A**
9 **QUALIFIED HEALTH PLAN IN THE SHOP EXCHANGE:**

10 **1. ADEQUATELY DEMONSTRATES TO THE SHOP**
11 **EXCHANGE THAT THE QUALIFIED HEALTH PLAN IN WHICH THE ELIGIBLE**
12 **EMPLOYEE IS ENROLLED SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF**
13 **THE QUALIFIED HEALTH PLAN'S CONTRACT IN RELATION TO THE ELIGIBLE**
14 **EMPLOYEE;**

15 **2. GAINS ACCESS TO NEW QUALIFIED HEALTH PLANS**
16 **AS A RESULT OF A PERMANENT MOVE; OR**

17 **3. DEMONSTRATES TO THE SHOP EXCHANGE, IN**
18 **ACCORDANCE WITH GUIDELINES ISSUED BY THE FEDERAL DEPARTMENT OF**
19 **HEALTH AND HUMAN SERVICES, THAT THE ELIGIBLE EMPLOYEE MEETS OTHER**
20 **EXCEPTIONAL CIRCUMSTANCES AS THE SHOP EXCHANGE MAY PROVIDE.**

21 **(5) LOSS OF MINIMUM ESSENTIAL COVERAGE UNDER**
22 **PARAGRAPH (4)(I) OF THIS SUBSECTION DOES NOT INCLUDE LOSS OF**
23 **COVERAGE DUE TO:**

24 **(I) FAILURE TO PAY PREMIUMS ON A TIMELY BASIS,**
25 **INCLUDING COBRA PREMIUMS PRIOR TO EXPIRATION OF COBRA COVERAGE;**
26 **OR**

27 **(II) A RESCISSION AUTHORIZED UNDER 45 C.F.R. § 147.128.**

28 15–1209.

29 (a) This section does not apply to any insurance enumerated in [§
30 15–1201(f)(3)(i) through (xiii)] **§ 15–1201(I)(3)(I) THROUGH (XIII)** of this subtitle.

31 (b) A carrier shall issue its health benefit plans to each small employer that
32 meets the requirements of this section.

1 (c) (1) Nothing in this subsection requires a small employer to contribute
2 to the premium payments for coverage of a dependent of an eligible employee.

3 (2) To be covered under a health benefit plan offered by a carrier, a
4 small employer shall:

5 (i) elect to be covered;

6 (ii) agree to pay the premiums;

7 (iii) agree to offer coverage to any dependent of an eligible
8 employee when coverage is sought by the eligible employee, in accordance with
9 provisions governing late enrollees and any other provisions of this subtitle that apply
10 to coverage;

11 (iv) agree to collect payments for premiums through payroll
12 deductions for coverage of eligible employees and dependents and transmit those
13 payments to the carrier **OR THE SHOP EXCHANGE, AS APPLICABLE**; and

14 (v) satisfy other reasonable provisions of the health benefit plan
15 as approved by the Commissioner.

16 (d) (1) In determining whether a small employer satisfies the
17 requirements of this section, a carrier shall apply its requirements uniformly among
18 all small employers with the same number of eligible employees who apply for or
19 receive coverage from the carrier, including a requirement that a minimum percentage
20 of eligible employees of the small employer participate in the health benefit plan.

21 (2) A carrier may vary application of minimum participation of eligible
22 employees only by the size of the group of the small employer.

23 (e) A carrier may not require a small employer to contribute to payment of
24 premiums for a health benefit plan.

25 15–1213.

26 (a) This section does not apply to any insurance enumerated in **[**§
27 15–1201(f)(3)(i) through (xiii)**]** **§ 15–1201(I)(3)(I) THROUGH (XIII)** of this subtitle.

28 (b) Each benefit offered in addition to the Standard Plan that increases
29 access to care choices or lowers the cost–sharing arrangement in the Standard Plan is
30 subject to all of the provisions of this subtitle applicable to the Standard Plan,
31 including:

32 (1) guaranteed issuance;

1 (2) guaranteed renewal; and

2 (3) adjusted community rating.

3 (c) (1) Each benefit offered in addition to the Standard Plan that
4 increases the type of services available or the frequency of services is not subject to
5 guaranteed issuance but is subject to all other provisions of this subtitle applicable to
6 the Standard Plan, including:

7 (i) guaranteed renewal; and

8 (ii) adjusted community rating.

9 (2) For each additional benefit offered under this subsection, a carrier
10 shall accept or reject the application of the entire group.

11 (3) The Commissioner may prohibit a carrier from offering an
12 additional benefit under this subsection if the Commissioner finds that the additional
13 benefit will be sold in conjunction with the Standard Plan in a manner designed to
14 promote risk selection or underwriting practices otherwise prohibited by this subtitle.

15 (d) (1) A benefit offered in addition to the Standard Plan to lower the
16 cost–sharing arrangement in the Standard Plan in accordance with § 15–301.1 of the
17 Health – General Article is subject to:

18 (i) guaranteed issuance;

19 (ii) guaranteed renewal; and

20 (iii) adjusted community rating.

21 (2) A carrier that offers a benefit under this subsection shall be
22 required to guarantee issuance and guarantee renewal of the additional benefit only to
23 employers who are participating in the MCHP private option plan established under §
24 15–301.1 of the Health – General Article.

25 **(E) BEGINNING JANUARY 1, 2014, THIS SECTION APPLIES ONLY TO**
26 **GRANDFATHERED HEALTH PLANS AS DEFINED IN § 1251 OF THE AFFORDABLE**
27 **CARE ACT.**

28 15–1301.

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

30 (b) "Affiliation period" means a period of time beginning on the date of
31 enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee,

1 during which a health maintenance organization does not collect premium, and
2 coverage issued does not become effective.

3 (c) “Association” or “bona fide association” means an association that:

4 (1) has been actively in existence for at least 5 years;

5 (2) has been formed and maintained in good faith for purposes other
6 than obtaining insurance and does not condition membership on the purchase of
7 association–sponsored insurance;

8 (3) does not condition membership in the association on any health
9 status–related factor relating to an individual, and states so clearly in all membership
10 and application materials;

11 (4) makes health insurance coverage offered through the association
12 available to all members regardless of any health status–related factor relating to the
13 members or individuals eligible for coverage and states so clearly in all membership
14 and application materials;

15 (5) does not make health insurance coverage offered through the
16 association available other than in connection with membership in the association,
17 and states so clearly in all marketing and application materials; and

18 (6) provides and annually updates information necessary for the
19 Commissioner to determine whether or not the association meets the definition of
20 bona fide association before qualifying as an association under this subtitle.

21 **(D) “BENEFIT YEAR” MEANS A CALENDAR YEAR IN WHICH A HEALTH**
22 **BENEFIT PLAN PROVIDES COVERAGE FOR HEALTH BENEFITS.**

23 **[**(d)**] (E)** “Carrier” means a person that is:

24 (1) an insurer that holds a certificate of authority in the State and
25 provides health insurance in the State;

26 (2) a health maintenance organization that is licensed to operate in
27 the State;

28 (3) a nonprofit health service plan that is licensed to operate in the
29 State; or

30 (4) any other person or organization that provides health benefit plans
31 subject to State insurance regulation.

1 **[**(e)**] (F)** “Church plan” means a plan as defined under § 3(33) of the
2 Employee Retirement Income Security Act of 1974.

3 **[**(f)**] (G)** (1) “Creditable coverage” means coverage of an individual
4 under:

5 (i) an employer sponsored plan;

6 (ii) a health benefit plan;

7 (iii) Part A or Part B of Title XVIII of the Social Security Act;

8 (iv) Title XIX or Title XXI of the Social Security Act, other than
9 coverage consisting solely of benefits under § 1928 of that Act;

10 (v) Chapter 55 of Title 10 of the United States Code;

11 (vi) a medical care program of the Indian Health Service or of a
12 tribal organization;

13 (vii) a State health benefits risk pool;

14 (viii) a health plan offered under the Federal Employees Health
15 Benefits Program (FEHBP), Title 5, Chapter 89 of the United States Code;

16 (ix) a public health plan as defined by federal regulations
17 authorized by the Public Health Service Act, § 2701(c)(1)(i), as amended by P.L.
18 104–191; or

19 (x) a health benefit plan under § 5(e) of the Peace Corps Act, 22
20 U.S.C. 2504(e).

21 (2) A period of creditable coverage shall not be counted, with respect to
22 enrollment of an individual under a health benefit plan or an employer sponsored
23 plan, if, after such period and before the enrollment date, there was a 63–day period
24 during all of which the individual was not covered under any creditable coverage.

25 **[**(g)**] (H)** “Eligible individual” means an individual:

26 (1) (i) for whom, as of the date on which the individual seeks
27 coverage under this subtitle, the aggregate of the periods of creditable coverage is 18
28 or more months; and

29 (ii) whose most recent prior creditable coverage was under an
30 employer sponsored plan, governmental plan, church plan, or health benefit plan
31 offered in connection with any of these plans;

(2) who is not eligible for coverage under:

(i) an employer sponsored plan;

(ii) Part A or Part B of Title XVIII of the Social Security Act; or

(iii) a State plan under Title XIX of the Social Security Act;

(3) who does not have coverage under a health benefit plan;

(4) who has not had the most recent prior creditable coverage described in paragraph (1)(ii) of this subsection terminated for nonpayment of premiums or fraud by the individual; and

(5) who, if the individual has been offered the option of continuation coverage under a State or federal continuation provision:

(i) has elected that coverage; and

(ii) has exhausted that coverage.

[(h)**] (I)** "Employer sponsored plan" means an employee welfare benefit plan that provides medical care to employees or their dependents, and is not subject to State regulation in accordance with the federal Employee Retirement Income Security Act of 1974.

[(i)**] (J)** "Enrollment date" means the date on which:

(1) an individual enrolls in a health benefit plan; or

(2) the first day of the waiting period before which the individual may enroll.

[(j)**] (K)** "Governmental plan" means a plan as defined in § 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

[(k)**] (L)** (1) "Health benefit plan" means a:

(i) hospital or medical policy or certificate, including those issued under multiple employer trusts or associations located in Maryland or any other state covering Maryland residents;

(ii) policy, contract, or certificate issued by a nonprofit health service plan that covers Maryland residents; or

(iii) health maintenance organization subscriber or group master contract.

1 (2) "Health benefit plan" does not include:

2 (i) one or more, or any combination of the following:

3 1. coverage only for accident or disability income
4 insurance;

5 2. coverage issued as a supplement to liability
6 insurance;

7 3. liability insurance, including general liability
8 insurance and automobile liability insurance;

9 4. workers' compensation or similar insurance;

10 5. automobile medical payment insurance;

11 6. credit–only insurance;

12 7. coverage for on–site medical clinics; and

13 8. other similar insurance coverage, specified in federal
14 regulations issued pursuant to P.L. 104–191, under which benefits for medical care are
15 secondary or incidental to other insurance benefits;

16 (ii) the following benefits if they are provided under a separate
17 policy, certificate, or contract of insurance or are otherwise not an integral part of a
18 plan:

19 1. limited scope dental or vision benefits;

20 2. benefits for long–term care, nursing home care, home
21 health care, community–based care, or any combination of these benefits; and

22 3. such other similar, limited benefits as are specified in
23 federal regulations issued pursuant to P.L. 104–191;

24 (iii) the following benefits if offered as independent,
25 noncoordinated benefits:

26 1. coverage only for a specified disease or illness; and

27 2. hospital indemnity or other fixed indemnity
28 insurance; or

1 (iv) the following benefits if offered as a separate insurance
2 policy:

3 1. Medicare supplemental health insurance (as defined
4 under § 1882(g)(1) of the Social Security Act);

5 2. coverage supplemental to the coverage provided under
6 Chapter 55 of Title 10, United States Code; and

7 3. similar supplemental coverage provided to coverage
8 under an employer sponsored plan.

9 **[**(l)**] (M)** "Health status–related factor" means a factor related to:

10 (1) health status;

11 (2) medical condition;

12 (3) claims experience;

13 (4) receipt of health care;

14 (5) medical history;

15 (6) genetic information;

16 (7) evidence of insurability including conditions arising out of acts of
17 domestic violence; or

18 (8) disability.

19 **[**(m)**] (N)** "High level policy form" means a policy or plan under which the
20 actuarial value of the benefit under the coverage is:

21 (1) at least 15% greater than the actuarial value of the low level policy
22 form coverage offered by the carrier in this State; and

23 (2) at least 100% but not greater than 120% of the weighted average.

24 **(O) "INDIVIDUAL EXCHANGE" HAS THE MEANING STATED IN § 31–101**
25 **OF THIS ARTICLE.**

26 **[**(n)**] (P)** (1) "Individual health benefit plan" means:

27 (i) a health benefit plan other than a converted policy or a
28 professional association plan for eligible individuals and their dependents; and

1 (ii) a certificate issued to an eligible individual that evidences
2 coverage under a policy or contract issued to a trust or association or other similar
3 group of individuals, regardless of the situs of delivery of the policy or contract, if the
4 eligible individual pays the premium and is not being covered under the policy or
5 contract under either federal or State continuation of benefits provisions.

6 (2) "Individual health benefit plan" does not include short–term
7 limited duration insurance.

8 **[**(o)**] (Q)** "Low level policy form" means a policy or plan under which the
9 actuarial value of the benefit under the coverage is at least 85% but not greater than
10 100% of the weighted average.

11 **(R) "MINIMUM ESSENTIAL COVERAGE" HAS THE MEANING STATED IN**
12 **45 C.F.R. § 155.20.**

13 **[**(p)**] (S)** "Preexisting condition" means a condition that was present before
14 the date of enrollment for coverage, whether or not any medical advice, diagnosis,
15 care, or treatment was recommended or received before that date.

16 **(T) "QUALIFIED HEALTH PLAN" HAS THE MEANING STATED IN § 31–101**
17 **OF THIS ARTICLE.**

18 **[**(q)**] (U)** "Waiting period" means the period of time that must pass before an
19 individual is eligible to be covered for benefits under the terms of a group health
20 benefit plan.

21 **[**(r)**] (V)** (1) "Weighted average" means the average actuarial value of
22 the benefits provided by:

23 (i) all the health insurance coverages issued by the carrier in
24 this State in the individual market during the previous calendar year, weighted by
25 enrollment for the different coverages; or

26 (ii) all the health insurance coverages issued by all carriers in
27 this State in the individual market, if the data are available, during the previous
28 calendar year, weighted by enrollment for the different coverages.

29 (2) "Weighted average" does not include coverages issued under this
30 subtitle.

31 15–1302.

32 (a) This subtitle applies to all carriers that offer health benefit plans to
33 individuals in the State.

(b) This subtitle does not apply to a carrier that offers only conversion policies as required by law.

(c) This subtitle does not apply to a carrier that offers health insurance coverage only in connection with group health plans [or through one or more bona fide associations, or both].

15–1315.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "INDIVIDUAL EXCHANGE" HAS THE MEANING STATED IN § 31–101 OF THIS ARTICLE.

(3) "QUALIFIED HEALTH PLAN" HAS THE MEANING STATED IN § 31–101 OF THIS ARTICLE.

(4) "QUALIFIED INDIVIDUAL" HAS THE MEANING STATED IN § 31–101 OF THIS ARTICLE.

(B) THIS SECTION APPLIES TO A QUALIFIED HEALTH PLAN THAT IS ISSUED ON OR AFTER JANUARY 1, 2014, BY A CARRIER THROUGH THE INDIVIDUAL EXCHANGE.

(C) A QUALIFIED HEALTH PLAN SUBJECT TO THIS SECTION SHALL INCLUDE A GRACE PERIOD PROVISION APPLICABLE TO A QUALIFIED INDIVIDUAL WHO:

(1) IS RECEIVING ADVANCE PAYMENTS OF FEDERAL PREMIUM TAX CREDITS; AND

(2) HAS PAID AT LEAST 1 FULL MONTH'S PREMIUM DURING THE BENEFIT YEAR.

(D) THE GRACE PERIOD PROVISION SHALL:

(1) PROVIDE A GRACE PERIOD OF 3 CONSECUTIVE MONTHS; AND

(2) BE IN ADDITION TO ANY OTHER GRACE PERIOD PROVISION REQUIRED BY ANY OTHER APPLICABLE STATE LAW.

1 (E) DURING THE GRACE PERIOD, A CARRIER THAT ISSUES A QUALIFIED
2 HEALTH PLAN SUBJECT TO THIS SECTION:

3 (1) SHALL PAY ALL APPROPRIATE CLAIMS FOR SERVICES
4 RENDERED TO THE QUALIFIED INDIVIDUAL DURING THE FIRST MONTH OF THE
5 GRACE PERIOD;

6 (2) MAY PEND CLAIMS FOR SERVICES RENDERED TO THE
7 QUALIFIED INDIVIDUAL IN THE SECOND AND THIRD MONTHS OF THE GRACE
8 PERIOD;

9 (3) SHALL NOTIFY THE FEDERAL DEPARTMENT OF HEALTH AND
10 HUMAN SERVICES THAT THE QUALIFIED INDIVIDUAL IS IN THE GRACE PERIOD;
11 AND

12 (4) SHALL NOTIFY PROVIDERS OF THE POSSIBILITY THAT CLAIMS
13 MAY BE DENIED WHEN A QUALIFIED INDIVIDUAL IS IN THE SECOND AND THIRD
14 MONTHS OF THE GRACE PERIOD.

15 **15–1316.**

16 (A) (1) BEGINNING OCTOBER 15, 2014, A CARRIER THAT SELLS
17 HEALTH BENEFIT PLANS TO INDIVIDUALS IN THE STATE SHALL ESTABLISH AN
18 ANNUAL OPEN ENROLLMENT PERIOD.

19 (2) THE ANNUAL OPEN ENROLLMENT PERIOD SHALL BEGIN ON
20 OCTOBER 15 AND EXTEND THROUGH DECEMBER 7 EACH YEAR.

21 (3) DURING THE ANNUAL OPEN ENROLLMENT PERIOD, AN
22 INDIVIDUAL SHALL BE PERMITTED TO:

23 (I) ENROLL IN A HEALTH BENEFIT PLAN OFFERED BY THE
24 CARRIER;

25 (II) DISCONTINUE ENROLLMENT IN A HEALTH BENEFIT
26 PLAN OFFERED BY THE CARRIER; OR

27 (III) CHANGE ENROLLMENT IN A HEALTH BENEFIT PLAN
28 OFFERED BY THE CARRIER TO A DIFFERENT HEALTH BENEFIT PLAN OFFERED
29 BY THE CARRIER.

30 (4) IF AN INDIVIDUAL ENROLLS IN A HEALTH BENEFIT PLAN
31 OFFERED BY THE CARRIER DURING THE ANNUAL OPEN ENROLLMENT PERIOD,

THE EFFECTIVE DATE OF COVERAGE SHALL BE JANUARY 1 OF THE FOLLOWING CALENDAR YEAR.

(B) (1) A CARRIER SHALL PROVIDE A SPECIAL OPEN ENROLLMENT PERIOD FOR EACH INDIVIDUAL WHO EXPERIENCES A TRIGGERING EVENT.

(2) THE SPECIAL OPEN ENROLLMENT PERIOD SHALL BE FOR AT LEAST 60 DAYS, BEGINNING ON THE DATE OF THE TRIGGERING EVENT.

(3) DURING THE SPECIAL OPEN ENROLLMENT PERIOD, A CARRIER SHALL PERMIT AN INDIVIDUAL WHO EXPERIENCES A TRIGGERING EVENT TO ENROLL IN OR CHANGE FROM ONE HEALTH BENEFIT PLAN OFFERED BY THE CARRIER TO ANOTHER HEALTH BENEFIT PLAN OFFERED BY THE CARRIER.

(4) A TRIGGERING EVENT OCCURS WHEN:

(I) SUBJECT TO PARAGRAPH (5) OF THIS SUBSECTION, AN INDIVIDUAL OR DEPENDENT LOSES MINIMUM ESSENTIAL COVERAGE;

(II) AN INDIVIDUAL GAINS A DEPENDENT OR BECOMES A DEPENDENT THROUGH MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION; OR

(III) FOR A HEALTH BENEFIT PLAN OFFERED THROUGH THE INDIVIDUAL EXCHANGE:

1. AN INDIVIDUAL WHO WAS NOT PREVIOUSLY A CITIZEN, NATIONAL, OR LAWFULLY PRESENT INDIVIDUAL BECOMES A CITIZEN, NATIONAL, OR LAWFULLY PRESENT INDIVIDUAL;

2. AN INDIVIDUAL'S ENROLLMENT OR NONENROLLMENT IN A QUALIFIED HEALTH PLAN IS, AS EVALUATED AND DETERMINED BY THE INDIVIDUAL EXCHANGE:

A. UNINTENTIONAL, INADVERTENT, OR ERRONEOUS; AND

B. THE RESULT OF THE ERROR, MISREPRESENTATION, OR INACTION OF AN OFFICER, EMPLOYEE, OR AGENT OF THE INDIVIDUAL EXCHANGE OR THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES OR ITS INSTRUMENTALITIES;

1 **3. AN INDIVIDUAL WHO IS ENROLLED IN A**
2 **QUALIFIED HEALTH PLAN IN THE INDIVIDUAL EXCHANGE ADEQUATELY**
3 **DEMONSTRATES TO THE INDIVIDUAL EXCHANGE THAT THE QUALIFIED HEALTH**
4 **PLAN IN WHICH THE INDIVIDUAL IS ENROLLED SUBSTANTIALLY VIOLATED A**
5 **MATERIAL PROVISION OF THE QUALIFIED HEALTH PLAN'S CONTRACT IN**
6 **RELATION TO THE INDIVIDUAL;**

7 **4. AN INDIVIDUAL IS DETERMINED NEWLY ELIGIBLE**
8 **OR NEWLY INELIGIBLE FOR ADVANCE PAYMENTS OF FEDERAL PREMIUM TAX**
9 **CREDITS OR HAS A CHANGE IN ELIGIBILITY FOR FEDERAL COST–SHARING**
10 **REDUCTIONS, REGARDLESS OF WHETHER THE INDIVIDUAL IS ALREADY**
11 **ENROLLED IN A QUALIFIED HEALTH PLAN;**

12 **5. AN INDIVIDUAL GAINS ACCESS TO NEW QUALIFIED**
13 **HEALTH PLANS AS A RESULT OF A PERMANENT MOVE; OR**

14 **6. AN INDIVIDUAL DEMONSTRATES TO THE**
15 **INDIVIDUAL EXCHANGE, IN ACCORDANCE WITH GUIDELINES ISSUED BY THE**
16 **FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, THAT THE**
17 **INDIVIDUAL MEETS OTHER EXCEPTIONAL CIRCUMSTANCES AS THE INDIVIDUAL**
18 **EXCHANGE MAY PROVIDE.**

19 **(5) LOSS OF MINIMUM ESSENTIAL COVERAGE UNDER**
20 **PARAGRAPH (4)(I) OF THIS SUBSECTION DOES NOT INCLUDE LOSS OF**
21 **COVERAGE DUE TO:**

22 **(I) FAILURE TO PAY PREMIUMS ON A TIMELY BASIS,**
23 **INCLUDING COBRA PREMIUMS PRIOR TO EXPIRATION OF COBRA COVERAGE;**
24 **OR**

25 **(II) A RESCISSION AUTHORIZED UNDER 45 C.F.R. § 147.128.**

26 **(6) IF A TRIGGERING EVENT DESCRIBED IN PARAGRAPH (4)(III)2**
27 **OF THIS SUBSECTION OCCURS, THE INDIVIDUAL EXCHANGE MAY TAKE ACTION**
28 **AS MAY BE NECESSARY TO CORRECT OR ELIMINATE THE EFFECTS OF THE**
29 **ERROR, MISREPRESENTATION, OR INACTION.**

30 **(7) IF A TRIGGERING EVENT DESCRIBED IN PARAGRAPH (4)(III)4**
31 **OF THIS SUBSECTION OCCURS, A CARRIER SHALL PERMIT AN INDIVIDUAL,**
32 **WHOSE EXISTING COVERAGE THROUGH AN EMPLOYER–SPONSORED PLAN WILL**
33 **NO LONGER BE AFFORDABLE OR PROVIDE MINIMUM VALUE FOR THE UPCOMING**
34 **PLAN YEAR OF THE INDIVIDUAL'S EMPLOYER, TO ACCESS THE SPECIAL**

1 **ENROLLMENT PERIOD BEFORE THE END OF THE INDIVIDUAL'S COVERAGE**
2 **THROUGH THE EMPLOYER–SPONSORED PLAN.**

3 **(C) AN INDIVIDUAL WHO IS AN INDIAN, AS DEFINED IN § 4 OF THE**
4 **FEDERAL INDIAN HEALTH CARE IMPROVEMENT ACT, MAY ENROLL IN A**
5 **HEALTH BENEFIT PLAN OR CHANGE FROM ONE HEALTH BENEFIT PLAN IN THE**
6 **INDIVIDUAL EXCHANGE TO ANOTHER HEALTH BENEFIT PLAN IN THE**
7 **INDIVIDUAL EXCHANGE ONE TIME PER MONTH.**

8 **15–1410.**

9 **(A) IN THIS SECTION, "PLAN YEAR" HAS THE MEANING STATED IN §**
10 **15–1201 OF THIS TITLE.**

11 **(B) THE GUARANTEED ISSUANCE OF COVERAGE PROVISION IN TITLE I,**
12 **SUBTITLE C OF THE AFFORDABLE CARE ACT APPLIES TO EACH HEALTH**
13 **BENEFIT PLAN WITH A PLAN YEAR THAT BEGINS ON OR AFTER JANUARY 1,**
14 **2014.**

15 31–112.

16 (e) (1) The Commissioner may **DENY,** suspend, revoke, or refuse to renew
17 or reinstate a SHOP Exchange navigator license after notice and opportunity for a
18 hearing under §§ 2–210 through 2–214 of this article, if the licensee:

19 (i) has willfully violated this article or any regulation adopted
20 under this article;

21 (ii) has intentionally misrepresented or concealed a material
22 fact in the application for the license;

23 (iii) has obtained the license by misrepresentation, concealment,
24 or other fraud;

25 (iv) has engaged in fraudulent or dishonest practices in
26 conducting activities under the license;

27 (v) has misappropriated, converted, or unlawfully withheld
28 money in conducting activities under the license;

29 (vi) has failed or refused to pay over on demand money that
30 belongs to a person entitled to the money;

31 (vii) has willfully and materially misrepresented the provisions of
32 a qualified plan;

(viii) has been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust;

(ix) has failed an examination required by this article or regulations adopted under this article;

(x) has forged another's name on an application for a qualified plan or on any other document in conducting activities under the license;

(xi) has otherwise shown a lack of trustworthiness or competence to act as a SHOP Exchange navigator; or

(xii) has willfully failed to comply with or violated a proper order or subpoena of the Commissioner.

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.**]**

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

Article – Insurance

15–1205.

(H) A CARRIER SHALL SET PREMIUM RATES FOR THE ENTIRE PLAN YEAR FOR EACH SMALL EMPLOYER.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–1317.

(A) A CARRIER THAT SELLS HEALTH BENEFIT PLANS TO INDIVIDUALS IN THE STATE SHALL ESTABLISH AN INITIAL OPEN ENROLLMENT PERIOD THAT BEGINS OCTOBER 1, 2013, AND EXTENDS THROUGH MARCH 31, 2014.

(B) A CARRIER SHALL ACCEPT ALL APPLICANTS WHO APPLY FOR COVERAGE DURING THE INITIAL OPEN ENROLLMENT PERIOD.

(C) IF AN APPLICATION IS RECEIVED BY A CARRIER DURING THE INITIAL OPEN ENROLLMENT PERIOD, COVERAGE FOR THE APPLICANT SHALL BEGIN NO LATER THAN:

(1) JANUARY 1, 2014, IF THE APPLICATION IS RECEIVED ON OR BEFORE DECEMBER 15, 2013;

(2) THE FIRST DAY OF THE FOLLOWING MONTH, IF THE APPLICATION IS RECEIVED BETWEEN THE FIRST AND FIFTEENTH DAY, INCLUSIVE, OF JANUARY, FEBRUARY, OR MARCH; AND

(3) THE FIRST DAY OF THE SECOND FOLLOWING MONTH, IF THE APPLICATION IS RECEIVED BETWEEN THE SIXTEENTH DAY AND THE LAST DAY, INCLUSIVE, OF DECEMBER, JANUARY, FEBRUARY, OR MARCH.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2014.

1 SECTION 5. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall
2 take effect January 1, 2014, the effective date of Section 2 of Chapter 152 of the Acts of
3 the General Assembly of 2012. If the effective date of Section 2 of Chapter 152 is
4 amended, Section 2 of this Act shall take effect on the taking effect of Section 2 of
5 Chapter 152.

6 SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in
7 Sections 4 and 5 of this Act, this Act shall take effect October 1, 2013.