HB0123/746788/1

BY: Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 123
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 3, after the first "of" insert "altering the length of a policy term and the information provided in a certain notice for short-term medical insurance procured from a nonadmitted insurer;"; in line 7, after "market;" insert "authorizing the dependents of certain victims to enroll in a certain health plan, at a certain time, under certain circumstances; adding a definition of "short-term limited duration insurance" and"; in line 8, after "market;" insert "altering the scope of certain supplemental coverage under a group health plan; prohibiting a carrier, under certain circumstances, from canceling or refusing to renew an individual health benefit because an eligible individual is entitled to or enrolled in Medicare; requiring an entity that leases employees from certain organizations or coemployers to be treated as a small employer to the extent permitted by federal law; providing that a carrier will not be considered to have elected not to renew certain health benefit plans if the carrier complies with certain federal regulations on guaranteed renewability; altering certain definitions to conform to guaranteed renewability provisions in certain federal regulations;"; strike line 12 in its entirety and substitute:

"Section 3-306.2, 15-137.1, 15-1201(i), 15-1208.2(d), 15-1212(a), 15-1301(l) and (s), 15-1309(a), 15-1401(h), 15-1409(a), and 31-101(g) and (z)";

and after line 14, insert:

"BY adding to
Article – Insurance
Section 15-1212(k), 15-1301(s), 15-1308(h), 15-1309(i), and 15-1409(g)
Annotated Code of Maryland
(2011 Replacement Volume and 2016 Supplement)".

(Over)

AMENDMENT NO. 2

On page 1, after line 17, insert:

"3–306.2.

(a) Subject to subsections (b) through (e) of this section, disability insurance and short–term medical insurance under § 3–302(c) of this subtitle may be procured from a nonadmitted insurer if the coverage procured is in excess of coverage available from, or is not available from, an admitted insurer that writes that particular kind and class of insurance in the State.

(b) Procurement of disability insurance under this section from a nonadmitted insurer is subject to:

(1) the diligent search requirements of §§ 3–306 and 3–306.1 of this subtitle; and

(2) all other requirements of this subtitle.

(c) Procurement of short–term medical insurance under this section from a nonadmitted insurer is subject to:

(1) a policy term that:

(i) **[**may not exceed 11**]** **IS LESS THAN 3** months; and

(ii) may not be extended or renewed;

(2) the provision of written notice to the applicant, on a form approved by the Commissioner:

(i) stating that coverage may be available under the Affordable Care Act without medical underwriting;

(ii) providing contact information for the Maryland Health Benefit Exchange;

(iii) stating that the short–term medical insurance may be available from an admitted insurer;

(iv) stating that similar coverage may be available from an admitted insurer offering travel insurance, as defined in § 10–101 of this article; and

(v) **[**stating that:

1. the short–term medical insurance does not meet the requirements for minimum essential coverage under the Affordable Care Act; and

2. a purchaser of the short–term medical insurance may be subject to tax penalties for not having minimum essential coverage**] DISPLAYING PROMINENTLY IN THE CONTRACT AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT IN THE COVERAGE IN AT LEAST 14 POINT TYPE THE FOLLOWING: "THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES."**;

(3) the diligent search requirements of §§ 3–306 and 3–306.1 of this subtitle; and

(4) all other requirements of this subtitle.

(d) Short–term medical insurance may not be procured from a nonadmitted insurer unless:

(1) the insurance is procured through a qualified surplus lines broker;

(2) if the insurance is offered on a Web site on the Internet, the Web site identifies the qualified surplus lines broker through whom the insurance may be procured; and

(3) the diligent search required under §§ 3–306 and 3–306.1 of this subtitle includes a search of the short–term medical insurance policies offered for sale by admitted insurers.

(e) A short–term medical insurance policy procured from a nonadmitted insurer may not include:

(1) a preexisting condition exclusion, unless the exclusion relates to a condition that was first manifested, treated, or diagnosed before the effective date of the policy; or

(2) a definition of sickness or illness that excludes any sickness or illness that began, existed, or had its origin before the effective date of the policy, unless the sickness or illness was first manifested, treated, or diagnosed before the effective date of the policy.

(f) The Commissioner shall develop and make available on the Administration's Web site a consumer guide on short–term medical insurance that includes information on:

(1) the availability of coverage from admitted insurers; and

(2) the types of coverage and provisions in short–term medical insurance policies that may be important to consumers.".

AMENDMENT NO. 3

On page 3, after line 4, insert:

"15-1201.

(i) (1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits issued by an insurer;

(ii) a nonprofit health service plan contract; or

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

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

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

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

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

(i) accident-only insurance;

(ii) credit health insurance;

(iii) disability income insurance;

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

(v) workers' compensation or similar insurance;

(vi) automobile medical payment insurance;

(vii) the following benefits, if the benefits are provided under a separate policy, certificate, or contract, or are not otherwise an integral part of a small employer health benefit plan:

1. dental benefits;

2. vision benefits; or

3. long-term care insurance as defined in § 18-101 of this article;

(viii) disease-specific insurance if:

1. the benefits are provided under a separate policy, certificate, or contract;

2. there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same employer; and

3. the benefits are paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same employer;

(ix) hospital indemnity or other fixed indemnity insurance if:

1. the benefits are provided under a separate policy, certificate, or contract;

2. there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same employer;

3. the benefits are paid with respect to an event, without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same employer; and

4. the benefits are payable in a fixed dollar amount per period of time, **[**such as $100 per day of hospitalization,**]** regardless of the amount of expenses incurred; or

(x) the following supplemental benefits, if the benefits are provided under a separate policy, certificate, or contract:

1. a Medicare supplement policy as defined in § 15-901 of this title;

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

3. similar supplemental coverage provided to coverage under a group health plan if**[**:

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

B. the coverage is not supplemental solely because it becomes secondary or supplemental under a coordination of benefits clause**] THE COVERAGE QUALIFIES FOR THE EXCEPTION DESCRIBED IN 45 C.F.R. § 146.145(B)(5)(I)(C)**.".

AMENDMENT NO. 4

On page 4, in line 27, strike "or"; and after line 27, insert:

"**3. AN ELIGIBLE EMPLOYEE OR DEPENDENT ADEQUATELY DEMONSTRATES TO THE EXCHANGE THAT A MATERIAL ERROR RELATED TO PLAN BENEFITS, SERVICE AREA, OR PREMIUM INFLUENCED THE ELIGIBLE EMPLOYEE'S OR DEPENDENT'S DECISION TO PURCHASE A QUALIFIED HEALTH PLAN THROUGH THE EXCHANGE; OR**".

AMENDMENT NO. 5

On page 4, strike beginning with "an" in line 28 down through "plan" in line 31 and substitute "**AN ELIGIBLE EMPLOYEE OR DEPENDENT:**

1. IS A VICTIM OF DOMESTIC ABUSE OR SPOUSAL ABANDONMENT, AS DEFINED BY 26 C.F.R. § 1.36B-2T;

2. IS ENROLLED IN MINIMUM ESSENTIAL COVERAGE; AND

3. SEEKS TO ENROLL IN COVERAGE SEPARATE FROM THE PERPETRATOR OF THE ABUSE OR ABANDONMENT;

(VIII) AN ELIGIBLE EMPLOYEE OR DEPENDENT:

1. APPLIES FOR COVERAGE THROUGH THE INDIVIDUAL EXCHANGE DURING THE ANNUAL OPEN ENROLLMENT PERIOD OR A SPECIAL ENROLLMENT PERIOD;

2. IS ASSESSED BY THE INDIVIDUAL EXCHANGE AS POTENTIALLY ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

3. IS DETERMINED INELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE EITHER:

A. AFTER OPEN ENROLLMENT HAS ENDED; OR

B. MORE THAN 60 DAYS AFTER THE QUALIFYING EVENT; OR

(IX) AN ELIGIBLE EMPLOYEE OR DEPENDENT:

1. APPLIES FOR COVERAGE THROUGH THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM DURING THE ANNUAL OPEN ENROLLMENT PERIOD; AND

2. IS DETERMINED INELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM AFTER OPEN ENROLLMENT HAS ENDED".

AMENDMENT NO. 6

On page 5, in line 12, after "eligible employee" insert "**AND A DEPENDENT**".

AMENDMENT NO. 7

On page 5, strike beginning with "A" in line 18 down through "plan" in line 20 and substitute "**IF A VICTIM OF DOMESTIC ABUSE OR SPOUSAL ABANDONMENT MEETS THE REQUIREMENTS FOR THE TRIGGERING EVENT DESCRIBED IN PARAGRAPH (4)(VII) OF THIS SUBSECTION, THE VICTIM'S DEPENDENTS MAY ENROLL IN A QUALIFIED HEALTH PLAN AT THE SAME TIME AS THE VICTIM**".

AMENDMENT NO. 8

On page 5, after line 20, insert:

"15-1212.

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

(2) "Plan" means, with respect to **[**a carrier and**]** a product, the pairing of the health benefits under the product with a particular cost-sharing structure, provider network, and service area.

(3) (i) "Product" means a discrete package of health benefits that **[**a carrier offers**]** **ARE OFFERED** using a particular product network type within a geographic service area.

(ii) "Product" comprises all plans offered within the product.

(4) "Uniform modification of coverage" means a change to a small employer's health benefit plan that**[**:

(i) 1. is made in accordance with a State or federal requirement; and

2. is effective uniformly among small employers with the same product; or

(ii) meets all of the following requirements:

1. the product is offered by the same carrier;

2. the product is offered as the same network type, such as preferred provider, exclusive provider, closed health maintenance organization plan, or health maintenance organization plan with point of service benefits;

3. the product continues to cover at least a majority of the same service area;

4. within the product, each plan has the same cost-sharing structure as before modification, except:

A. for any variation in cost sharing solely related to changes in cost and utilization of medical care; or

B. to maintain the same metal tier level described in § 1302(d) and (e) of the Affordable Care Act;

5. the product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of plus or minus 2 percentage points; and

6. the modification is effective uniformly among small employers with the same product**] MEETS THE CRITERIA STATED IN 45 C.F.R. § 147.106(E)**.

(K) A CARRIER WILL NOT BE CONSIDERED TO HAVE ELECTED NOT TO RENEW ALL HEALTH BENEFIT PLANS THAT ARE ISSUED TO SMALL EMPLOYERS IN THE STATE IF THE CARRIER COMPLIES WITH 45 C.F.R. § 147.106(D)(3).".

AMENDMENT NO. 9

On page 7, in line 24, strike "an employer sponsored plan" and substitute "**A GROUP HEALTH PLAN IF THE COVERAGE QUALIFIES FOR THE EXCEPTION DESCRIBED IN 45 C.F.R. § 146.145(B)(5)(I)(C)**".

AMENDMENT NO. 10

On page 7, after line 24, insert:

"**(S) "SHORT-TERM LIMITED DURATION INSURANCE" HAS THE MEANING STATED IN 45 C.F.R. § 144.103.**

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

AMENDMENT NO. 11

On page 7, before line 25, insert:

"15-1308.

(H) A CARRIER WILL NOT BE CONSIDERED TO HAVE ELECTED NOT TO RENEW ALL INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE IF THE CARRIER COMPLIES WITH 45 C.F.R. § 147.106(D)(3).

15-1309.

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

(2) "Plan" means, with respect to **[**a carrier and**]** a product, the pairing of the health benefits under the product with a particular cost-sharing structure, provider network, and service area.

(3) (i) "Product" means a discrete package of health benefits that **[**a carrier offers**]** **ARE OFFERED** using a particular product network type within a geographic service area.

(ii) "Product" comprises all plans offered within the product.

(4) "Uniform modification of coverage" means a change to a health benefit plan that**[**:

(i) 1. is made in accordance with a State or federal requirement; and

2. is effective uniformly for all individuals with the same product; or

(ii) meets all of the following requirements:

1. the product is offered by the same carrier;

2. the product is offered as the same network type, such as preferred provider, exclusive provider, closed health maintenance organization plan, or health maintenance organization plan with point of service benefits;

3. the product continues to cover at least a majority of the same service area;

4. within the product, each plan has the same cost-sharing structure as before modification, except:

A. for any variation in cost sharing solely related to changes in cost and utilization of medical care; or

B. to maintain the same metal tier level described in § 1302(d) and (e) of the Affordable Care Act;

5. the product provides the same covered benefits, except for any changes in benefits that cumulatively impact the rate for any plan within the product within an allowable variation of plus or minus 2 percentage points; and

6. the modification is effective uniformly for all individuals with the same product**] MEETS THE CRITERIA STATED IN 45 C.F.R. § 147.106(E)**.

(I) A CARRIER MAY NOT CANCEL OR REFUSE TO RENEW AN INDIVIDUAL HEALTH BENEFIT PLAN BECAUSE AN ELIGIBLE INDIVIDUAL IS ENTITLED TO OR ENROLLED IN MEDICARE IF THE ELIGIBLE INDIVIDUAL IS RENEWING COVERAGE UNDER THE SAME POLICY OR CONTRACT OF INSURANCE.

15-1401.

(h) (1) "Health benefit plan" means any:

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

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

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

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

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

1. coverage only for accident or disability income insurance;

2. coverage issued as a supplement to liability insurance;

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

4. workers' compensation or similar insurance;

5. automobile medical payment insurance;

6. credit-only insurance;

7. coverage for on-site medical clinics; and

8. other similar insurance coverage, specified in federal regulations issued under the federal Health Insurance Portability and Accountability

Act, under which benefits for medical care are secondary or incidental to other insurance benefits;

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

1. limited scope dental or vision benefits;

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

3. such other similar, limited benefits as are specified in federal regulations issued under the federal Health Insurance Portability and Accountability Act;

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

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

2. hospital indemnity or other fixed indemnity insurance, if the benefits are payable in a fixed dollar amount per period of time, **[**such as $100 per day of hospitalization,**]** regardless of the amount of expenses incurred; or

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

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

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

3. similar supplemental coverage provided to coverage under an employer sponsored plan if**[**:

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

B. the coverage is not supplemental solely because it becomes secondary or supplemental under a coordination of benefits clause**] THE COVERAGE QUALIFIES FOR THE EXCEPTION DESCRIBED IN 45 C.F.R. § 146.145(B)(5)(I)(C)**.

15-1409.

(a) In this section, "product" means a discrete package of health benefits that **[**a carrier offers**] ARE OFFERED** using a particular product network type within a geographic service area.

(G) A CARRIER WILL NOT BE CONSIDERED TO HAVE ELECTED NOT TO RENEW ALL GROUP HEALTH BENEFIT PLANS IN THE STATE IF THE CARRIER COMPLIES WITH 45 C.F.R. § 147.106(D)(3).".

AMENDMENT NO. 12

On pages 9 and 10, strike beginning with the colon in line 36 on page 9 down through "clause" in line 2 on page 10 and substitute "**THE COVERAGE QUALIFIES FOR THE EXCEPTION DESCRIBED IN 45 C.F.R. § 146.145(B)(5)(I)(C)**".

AMENDMENT NO. 13

On page 10, after line 2, insert:

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

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

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

(2) For purposes of this subsection:

(i) all persons treated as a single employer under § 414(b), (c), **[**(m),**]** or (o) of the Internal Revenue Code shall be treated as a single employer;

(ii) an employer and any predecessor employer shall be treated as a single employer;

(iii) the number of employees of an employer shall be determined by adding:

1. the number of full–time employees; and

2. the number of full–time equivalent employees, which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full–time employees for the month by 120;

(iv) if an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year; **[**and**]**

(v) an employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this title as long as it continuously makes enrollment through the SHOP Exchange available to its employees**; AND**

(VI) TO THE EXTENT PERMITTED BY FEDERAL LAW, AN ENTITY THAT LEASES EMPLOYEES FROM A PROFESSIONAL EMPLOYER ORGANIZATION, COEMPLOYER, OR OTHER ORGANIZATION ENGAGED IN EMPLOYEE LEASING AND THAT OTHERWISE MEETS THE DESCRIPTION IN THIS SECTION SHALL BE TREATED AS A SMALL EMPLOYER.".