HOUSE BILL 123

C3 7lr0069

By: **Chair, Health and Government Operations Committee (By Request – Departmental – Maryland Insurance Administration)**
Introduced and read first time: January 18, 2017
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 16, 2017

CHAPTER _____

AN ACT concerning

Health Insurance – Required Conformity With Federal Law

FOR the purpose of <u>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;</u> making certain provisions of the federal Patient Protection and Affordable Care Act relating to preventive and wellness services and chronic disease management applicable to certain coverage offered in certain markets; altering certain provisions of law relating to certain special enrollment periods in the small employer health insurance market; <u>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</u> altering the definition of "health benefit plan" for the individual health insurance market; <u>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;</u> and generally relating to health insurance and conformity with federal law.

BY repealing and reenacting, with amendments,

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
<u>Underlining</u> indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Article – Insurance
~~Section 15–137.1, 15–1208.2(d), 15–1301(l), and 31–101(g)~~
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)
Annotated Code of Maryland
(2011 Replacement Volume and 2016 Supplement)

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)

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

Article – Insurance

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.

15–137.1.

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

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

(2) preexisting condition exclusions;

(3) policy rescissions;

(4) bona fide wellness programs;

(5) lifetime limits;

(6) annual limits for essential benefits;

(7) waiting periods;

(8) designation of primary care providers;

(9) access to obstetrical and gynecological services;

(10) emergency services;

(11) summary of benefits and coverage explanation;

(12) minimum loss ratio requirements and premium rebates;

(13) disclosure of information;

(14) annual limitations on cost sharing;

(15) child–only plan offerings in the individual market;

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

(18) coverage for individuals participating in approved clinical trials;

(19) contract requirements for stand–alone dental plans sold on the Maryland Health Benefit Exchange;

(20) guaranteed availability of coverage; **[**and**]**

(21) prescription drug benefit requirements**; AND**

(22) PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT.

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

(c) The Commissioner may enforce this section under any applicable provisions of this article.

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)**.

15–1208.2.

(d) (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 30 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 individual to enroll in or change from one health benefit plan offered by the small employer to another health benefit plan offered by the small employer.

(4) A triggering event occurs when:

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

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

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

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

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

2. gains access to new qualified health plans as a result of a permanent move **AND EITHER:**

A. HAD MINIMUM ESSENTIAL COVERAGE AS DESCRIBED IN 26 C.F.R. § 1.5000A–1(B) FOR 1 OR MORE DAYS DURING THE 60 DAYS BEFORE THE DATE OF THE PERMANENT MOVE; OR

B. WAS LIVING OUTSIDE THE UNITED STATES OR IN A UNITED STATES TERRITORY AT THE TIME OF THE PERMANENT MOVE; or

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

(v) an eligible employee or a dependent:

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

2. becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid plan or state child health plan, including any

waiver or demonstration project conducted under or in relation to a Medicaid plan or a state child health plan;

(vi) for SHOP Exchange health benefit plans:

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

A. unintentional, inadvertent, or erroneous; and

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

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

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

(vii) ~~an eligible employee or a dependent has a loss of coverage under a noncalendar year group health benefit plan or individual health benefit plan, even if the eligible employee or dependent has the option to renew the coverage under the individual or group health benefit plan~~ **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.

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

(i) voluntary termination of coverage;

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

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

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

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

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

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

(10) ~~A loss of coverage under a health benefit plan described in paragraph (4)(vii) of this subsection is considered to be the last day of the plan or policy year of the health benefit plan~~ **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**.

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).

15–1301.

(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.

(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; and

7. coverage for on–site medical clinics;

(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 a plan:

1. limited scope dental or vision benefits; and

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

(iii) coverage only for a specified disease or illness if offered as independent, noncoordinated benefits;

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

1. offered as independent, noncoordinated benefits;

2. **[**except as provided in item 5 of this item, the benefits are provided only to individuals who attest in their hospital indemnity or fixed indemnity insurance application that they have other health coverage that is minimum essential coverage, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code, provided that if an application is not required as part of the renewal process, the continued payment of premiums by the individual after receipt of the notice described in item 5B of this item is deemed to satisfy the attestation requirement;

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

[4.**] 3.** a notice is displayed prominently in the application materials, in at least 14 point type, that has the following language in capital letters: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes."; **[**and

5. A. for hospital indemnity insurance or other fixed indemnity insurance contracts issued before May 1, 2015, that require an application as part of the renewal process, the individual provides, on or before October 1, 2016, a written attestation on the application that the individual has other health insurance coverage that is minimum essential coverage, or that the individual is deemed to have minimum essential

coverage due to the individual's status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code; or

B. for hospital indemnity or other fixed indemnity insurance contracts issued before May 1, 2015, that do not require an application as part of the renewal process, the issuer sends no later than the first renewal of the contract that occurs on or after October 1, 2016, a notice, in at least 14 point type, to the individual that includes the following language: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes. This insurance will remain in force as long as you continue to pay your premiums.";**]** or

(v) 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~~ **A GROUP HEALTH PLAN IF THE COVERAGE QUALIFIES FOR THE EXCEPTION DESCRIBED IN 45 C.F.R. § 146.145(B)(5)(I)(C)**.

(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.

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).

31–101.

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

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

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

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit–only insurance;

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

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

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

(i) limited scope dental or vision benefits;

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

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

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

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

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

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

1. **[**except as provided in item 4 of this item, the benefits are provided only to individuals who attest in their hospital indemnity or fixed indemnity insurance application that they have other health coverage that is minimum essential coverage, or that they are treated as having minimal essential coverage due to their status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code, provided that if an application is not required as part of the renewal process, the continued payment of premiums by the individual after receipt of the notice described in item 4B of this item is deemed to satisfy the attestation requirement;

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

[3.**] 2.** a notice is displayed prominently in the application materials, in at least 14 point type, that has the following language in capital letters: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes."**[**;

4. A. for hospital indemnity insurance or other fixed indemnity insurance contracts issued before May 1, 2015, that require an application as part of the renewal process, the individual provides, on or before October 1, 2016, a written attestation on the application that the individual has other health insurance coverage that is minimum essential coverage, or that the individual is deemed to have minimum essential coverage due to the individual's status as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the Internal Revenue Code; or

B. for hospital indemnity or other fixed indemnity insurance contracts issued before May 1, 2015, that do not require an application as part of the renewal process, the issuer sends no later than the first renewal of the contract that occurs on or after October 1, 2016, a notice, in at least 14 point type, to the individual that includes the following language: "This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes. This insurance will remain in force as long as you continue to pay your premiums."**]**.

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

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

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

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

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

~~2. the coverage is not supplemental solely because it becomes secondary or supplemental under a coordination of benefits clause~~ **THE COVERAGE QUALIFIES FOR THE EXCEPTION DESCRIBED IN 45 C.F.R. § 146.145(B)(5)(I)(C)**.

(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.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.