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

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Required Conformity With Federal Law**

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

10 BY repealing and reenacting, with amendments,
11 Article – Insurance
12 Section 15–137.1, 15–1208.2(d), 15–1301(l), and 31–101(g)
13 Annotated Code of Maryland
14 (2011 Replacement Volume and 2016 Supplement)

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

17 **Article – Insurance**

18 15–137.1.

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

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

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

2 (2) preexisting condition exclusions;

3 (3) policy rescissions;

4 (4) bona fide wellness programs;

5 (5) lifetime limits;

6 (6) annual limits for essential benefits;

7 (7) waiting periods;

8 (8) designation of primary care providers;

9 (9) access to obstetrical and gynecological services;

10 (10) emergency services;

11 (11) summary of benefits and coverage explanation;

12 (12) minimum loss ratio requirements and premium rebates;

13 (13) disclosure of information;

14 (14) annual limitations on cost sharing;

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

16 (16) minimum benefit requirements for catastrophic plans;

17 (17) health insurance premium rates;

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

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

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

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

23 **(22) PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE**
24 **MANAGEMENT**.

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

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

5 15–1208.2.

6 (d) (1) A carrier shall provide an open enrollment period for each individual
7 who experiences a triggering event described in paragraph (4) of this subsection.

8 (2) The open enrollment period shall be for at least 30 days, beginning on
9 the date of the triggering event.

10 (3) During the open enrollment period for an individual who experiences a
11 triggering event, a carrier shall permit the individual to enroll in or change from one health
12 benefit plan offered by the small employer to another health benefit plan offered by the
13 small employer.

14 (4) A triggering event occurs when:

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

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

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

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

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

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

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

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

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

10 (v) an eligible employee or a dependent:

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

14 2. becomes eligible for assistance, with respect to coverage
15 under the SHOP Exchange, under a Medicaid plan or state child health plan, including any
16 waiver or demonstration project conducted under or in relation to a Medicaid plan or a state
17 child health plan;

18 (vi) for SHOP Exchange health benefit plans:

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

21 A. unintentional, inadvertent, or erroneous; and

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

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

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

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

1 (i) voluntary termination of coverage;

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

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

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

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

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

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

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

21 15–1301.

22 (l) (1) "Health benefit plan" means a:

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

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

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

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

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

32 1. coverage only for accident or disability income insurance;

1 2. coverage issued as a supplement to liability insurance;

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

4 4. workers' compensation or similar insurance;

5 5. automobile medical payment insurance;

6 6. credit–only insurance; and

7 7. coverage for on–site medical clinics;

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

10 1. limited scope dental or vision benefits; and

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

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

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

16 1. offered as independent, noncoordinated benefits;

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

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

29 **[**4.**] 3.** a notice is displayed prominently in the application
30 materials, in at least 14 point type, that has the following language in capital letters: "This
31 is a supplement to health insurance and is not a substitute for major medical coverage.

1 Lack of major medical coverage (or other minimum essential coverage) may result in an
2 additional payment with your taxes."; [and

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

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

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

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

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

23 3. similar supplemental coverage provided to coverage under
24 an employer sponsored plan.

25 31–101.

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

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

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

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

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

1 (iv) workers' compensation or similar insurance;

2 (v) automobile medical payment insurance;

3 (vi) credit–only insurance;

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

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

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

12 (i) limited scope dental or vision benefits;

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

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

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

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

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

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

30 1. **[**except as provided in item 4 of this item, the benefits are
31 provided only to individuals who attest in their hospital indemnity or fixed indemnity
32 insurance application that they have other health coverage that is minimum essential
33 coverage, or that they are treated as having minimal essential coverage due to their status
34 as a bona fide resident of any possession of the United States under § 5000A(f)(4)(b) of the

1 Internal Revenue Code, provided that if an application is not required as part of the renewal
2 process, the continued payment of premiums by the individual after receipt of the notice
3 described in item 4B of this item is deemed to satisfy the attestation requirement;

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

8 **[**3.**] 2.** a notice is displayed prominently in the application
9 materials, in at least 14 point type, that has the following language in capital letters: "This
10 is a supplement to health insurance and is not a substitute for major medical coverage.
11 Lack of major medical coverage (or other minimum essential coverage) may result in an
12 additional payment with your taxes."**[**;

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

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

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

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

32 (ii) coverage supplemental to the coverage provided under Chapter
33 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed
34 Services (CHAMPUS)); or

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

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

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

3 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June
4 1, 2017.