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By: **Leave Blank (By Request – Departmental – Maryland Insurance Administration)**

A BILL ENTITLED

AN ACT concerning

Health Insurance – Required Conformity With Federal Law

FOR the purpose of 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; altering the definition of "health benefit plan" for the individual health insurance market; and generally relating to health insurance and conformity with federal law.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–137.1, 15–1208.2(d), 15–1301(l), and 31–101(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

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

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.

15–1208.2.

(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

(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.

(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 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.

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.

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.

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