Chapter 363

(Senate Bill 556)

AN ACT concerning

Health Insurance – *Selection of State Benchmark Plan and Required* Conformity With Federal Law

FOR the purpose of providing that certain requirements of the federal Patient Protection and Affordable Care Act relating to prescription drug benefits apply to certain coverage offered in certain markets; repealing a certain provision of law providing for the applicability of a certain limitation on certain deductibles for certain health insurance coverage; altering certain provisions of law relating to the provision of benefits for the diagnosis and treatment of a mental illness, an emotional disorder, a drug abuse disorder, or an alcohol abuse disorder to conform to the requirements of the federal Mental Health Parity and Addiction Equity Act; applying the provisions to health maintenance organizations and repealing certain duplicative provisions of law; ~~requiring certain insurers, nonprofit health service plans, and health maintenance organizations to have procedures in place for certain individuals to request an expedited review of a request for coverage of a nonformulary drug or device based on a certain exigent circumstance; requiring the insurers, nonprofit health service plans, and health maintenance organizations to notify certain individuals about the determination made about the request within a certain period of time and, under certain circumstances, to provide coverage of the nonformulary drug or device;~~ altering the definitions of "full–time employee" and "health benefit plan" for purposes of certain provisions of law governing the small group health insurance market; altering the circumstances under which certain health benefit plans are required to allow certain individuals to enroll for certain coverage; altering the circumstances under which a triggering event occurs for an employee or a dependent of an employee covered under a small group health benefit plan; altering the definition of "health benefit plan" and defining the term "grandfathered health plan coverage" for purposes of certain provisions of law governing the individual health insurance market; establishing the circumstances under which a carrier may make a certain uniform modification of coverage for a certain product offered by the carrier in the small group, individual, and large group health insurance markets; establishing the circumstances under which a certain plan that has been modified is considered to be the same plan; repealing certain provisions of law relating to the certification of creditable coverage and the determination and establishment of a period of creditable coverage; repealing a certain provision of law relating to rating certain policy forms; altering the beginning and ending dates of the annual open enrollment period in the individual health insurance market for certain years; establishing and altering certain effective dates of coverage for individuals who enroll in individual health benefit plans during certain open enrollment periods; ~~altering the length of the special open enrollment period that a carrier in the individual health insurance market must~~ requiring certain carriers to provide ~~for each individual who experiences a triggering event and the circumstances under~~

~~which a triggering event occurs~~ certain special enrollment periods; providing that a carrier that offers certain student health plans in the individual health insurance market is not required to take certain actions relating to the plans; providing that a student health plan is not subject to the requirement of a certain risk pool; providing that a student administrative health fee is not considered a cost–sharing requirement with respect to certain services; altering the definition of "health benefit plan" for purposes of certain provisions of law governing the large group health insurance market; altering a certain exception to a requirement relating to the renewal of health benefit plans offered in the large group health insurance market; altering certain limitations on the cancellation or refusal to renew certain health benefit plans; altering the definitions of "full–time employee" and "health benefit plan" and defining the term "minimum essential coverage" for purposes of certain provisions of law governing the Maryland Health Benefit Exchange; *altering the process for selection of the State benchmark plan used to establish certain essential health benefits; requiring the Maryland Insurance Commissioner, in consultation with the Exchange, and instead of the Maryland Health Care Reform Coordinating Council, to select the State benchmark plan; requiring the Commissioner to submit a report to certain legislative committees advising the committees of certain information;* altering and repealing certain definitions; defining certain terms; making certain conforming changes; making this Act an emergency measure; and generally relating to health insurance and *implementation of and required* conformity with federal law.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–137.1, 15–802, 15–831, 15–10A–01(b)(1), 15–1201(h) and (i), 15–1208.1(c), 15–1208.2, 15–1212, 15–1301, 15–1309, 15–1316, 15–1401, 15–1408, 15–1409, 27–210(h), ~~and 31–101(e–1) and (g)~~ 31–101(e–1), (g), and (z)(1), *and 31–116(c) and (d)*
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY repealing
Article – Insurance
Section 15–1310, 15–1311, 15–1312, 15–1403, 15–1404, ~~and~~ 15–1405, *and 31–116(e)*
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY adding to
Article – Insurance
Section 15–1318 ~~and~~, 31–101(o–1) and (o–2), *and 31–116(e)*
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance

Section 31–116(a) and (b)
Annotated Code of Maryland
(2011 Replacement Volume and 2014 Supplement)

BY repealing
Article – Health – General
Section 19–703.1
Annotated Code of Maryland
(2009 Replacement Volume and 2014 Supplement)

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

Article – Insurance

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; **[**and**]**

(20) guaranteed availability of coverage**; AND**

(21) PRESCRIPTION DRUG BENEFIT REQUIREMENTS.

(b) **[**The annual limitation on deductibles for the employer–sponsored plans provision of Title I, Subtitle D of the Affordable Care Act applies to health insurance coverage offered in the small group market, as 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.

(c)**]** The provisions of **[**subsections (a) and (b)**]** **SUBSECTION (A)** of this section do not apply to coverage for excepted benefits, as defined in 45 C.F.R. § 146.145(c).

[(d)**] (C)** The Commissioner may enforce this section under any applicable provisions of this article.

15–802.

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

(2) "Alcohol abuse" has the meaning stated in § 8–101 of the Health – General Article.

(3) "Drug abuse" has the meaning stated in § 8–101 of the Health – General Article.

(4) "GRANDFATHERED HEALTH PLAN COVERAGE" HAS THE MEANING STATED IN 45 C.F.R. § 147.140.

[(4)**] (5)** "Health benefit plan"**:**

(I) FOR A GROUP OR BLANKET PLAN, has the meaning stated in § 15–1401 of this title**; AND**

(II) FOR AN INDIVIDUAL PLAN, HAS THE MEANING STATED IN § 15–1301 OF THIS TITLE.

[(5) "Large employer" means an employer that has more than 50 employees and is not a small employer.**]**

(6) "Managed care system" means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.

(7) "Partial hospitalization" means the provision of medically directed intensive or intermediate short–term treatment:

(i) to an insured, subscriber, or member;

(ii) in a licensed or certified facility or program;

(iii) for mental illness, emotional disorders, drug abuse, or alcohol abuse; and

(iv) for a period of less than 24 hours but more than 4 hours in a day.

(8) "Small employer" **[**means an employer that:

(i) employed an average of at least two, but not more than 50 employees on business days during the preceding calendar year; and

(ii) employs at least two employees on the first day of the plan year**] HAS THE MEANING STATED IN § 31–101 OF THIS ARTICLE**.

(b) **[**This**] WITH THE EXCEPTION OF SMALL EMPLOYER GRANDFATHERED HEALTH PLAN COVERAGE, THIS** section applies to each **[**health insurance policy or contract**] INDIVIDUAL, GROUP, AND BLANKET HEALTH BENEFIT PLAN** that is delivered or issued for delivery in the State **[**to an employer or individual on a group or individual basis and that provides coverage on an expense–incurred basis**] BY AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION**.

(c) A **[**policy or contract**] HEALTH BENEFIT PLAN** subject to this section **[**may not discriminate against**] SHALL PROVIDE AT LEAST THE FOLLOWING BENEFITS FOR**

THE DIAGNOSIS AND TREATMENT OF [an individual with**]** a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder **[**by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses.

(d) It is not discriminatory under subsection (c) of this section if at least the following benefits are provided**]**:

(1) **[**with respect to**]** inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient benefits**[**, the total number of days for which benefits are payable and the terms and conditions that apply to those benefits are at least equal to those that apply to the benefits available under the policy or contract for physical illnesses**]**;

(2) **[**except as provided in item (3) of this subsection and subject to subsection (g) of this section, with respect to benefits for partial hospitalization, at least 60 days of partial hospitalization are covered under the same terms and conditions that apply to the benefits available under the policy or contract for physical illnesses;

(3) for group contracts covering employees of one or more large employers, with respect to benefits for**]** partial hospitalization **[**for the treatment of mental illness, emotional disorders, drug abuse, and alcohol abuse, the greater of:

(i) the same benefits payable under the contract for partial hospitalization for physical illness; or

(ii) at least 60 days of partial hospitalization covered under the same terms and conditions that apply to outpatient treatment of physical illnesses**]** **BENEFITS**;

[(4) except as provided in item (5) of this subsection, with respect to outpatient coverage, other than for inpatient or partial hospitalization services, benefits for covered expenses arising from services, including psychological and neuropsychological testing for diagnostic purposes, provided to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse are at a rate that, after the applicable deductible, is not less than:

(i) 80% for the first five visits in a calendar year or benefit period of not more than 12 months;

(ii) 65% for the 6th through 30th visit in a calendar year or benefit period of not more than 12 months; and

(iii) 50% for the 31st visit and any subsequent visit in a calendar year or benefit period of not more than 12 months;**]** and

[(5)**] (3)** **[**for group contracts covering employees of one or more large employers, benefits for covered**]** outpatient **[**expenses arising from services**]** **BENEFITS**, including all office visits and psychological and neuropsychological testing for diagnostic purposes**[**, provided to treat mental illnesses, emotional disorders, drug abuse, or alcohol abuse are covered under the same terms and conditions that apply to similar benefits available under the contract for physical illnesses**]**.

[(e)**] (D)** (1) The benefits under this section are required only for expenses arising from the treatment of mental illnesses, emotional disorders, drug abuse, or alcohol abuse if, in the professional judgment of health care providers:

(i) the mental illness, emotional disorder, drug abuse, or alcohol abuse is treatable; and

(ii) the treatment is medically necessary.

(2) The benefits required under this section:

(i) shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug abuse, and alcohol abuse;

(ii) shall **[**have the same terms and conditions as the benefits for physical illnesses covered under the policy or contract subject to this section, except as specifically provided in this section**]** **COMPLY WITH 45 C.F.R. § 146.136 (A) THROUGH (D)**; **[**and**]**

(iii) subject to paragraph (3) of this subsection, may be delivered under a managed care system**; AND**

(IV) FOR PARTIAL HOSPITALIZATION UNDER SUBSECTION (C)(2) OF THIS SECTION, MAY NOT BE LESS THAN 60 DAYS.

(3) **[**For group contracts covering employees of one or more large employers, the**]** **THE** benefits required under this section may be delivered under a managed care system only if the benefits for physical illnesses covered under the **[**contract**]** **HEALTH BENEFIT PLAN** are delivered under a managed care system.

(4) **[**For group contracts covering employees of one or more large employers, the**]** **THE** processes, strategies, evidentiary standards, or other factors used to manage the benefits required under this section must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the **[**contract**]** **HEALTH BENEFIT PLAN**.

[(5) Except for the coinsurance requirements under subsection (d)(4) of this section, a policy or contract subject to this section may not have:

(i) separate lifetime maximums for physical illnesses and illnesses covered under this section;

(ii) separate deductibles and coinsurance amounts for physical illnesses and illnesses covered under this section; or

(iii) separate out–of–pocket limits in a benefit period of not more than 12 months for physical illnesses and illnesses covered under this section.

(6) (i) Subject to subparagraph (ii) of this paragraph, any copayments required under a policy or contract subject to this section for benefits for illnesses covered under this section shall be:

1. actuarially equivalent to any coinsurance requirements under this section; or

2. if there are no coinsurance requirements, not greater than any copayment required under the policy or contract for a benefit for a physical illness.

(ii)**] (5)** An insurer **[**or**],** nonprofit health service plan**, OR HEALTH MAINTENANCE ORGANIZATION** may not charge a copayment **FOR METHADONE MAINTENANCE TREATMENT** that is greater than 50% of the daily cost for methadone maintenance treatment.

[(f) An office visit to a physician or other health care provider for medication management:

(1) may not be counted against the number of visits required to be covered as a part of the benefits required under subsection (d)(4) of this section; and

(2) shall be reimbursed under the same terms and conditions as an office visit for a physical illness covered under the policy or contract subject to this section.

(g) This section does not prohibit exceeding the minimum benefits required under subsection (d)(2) or (3) of this section for any partial hospitalization day that is medically necessary and would serve to prevent inpatient hospitalization.

(h)**] (E)** An entity that issues or delivers a **[**policy or contract**] HEALTH BENEFIT PLAN** subject to this section shall provide on its Web site and annually in print to its insureds **OR MEMBERS**:

(1) notice about the benefits required under this section and**[**, if applicable to the policy or contract of the insured,**]** the federal Mental Health Parity and Addiction Equity Act; and

(2) notice that the insured **OR MEMBER** may contact the Administration for further information about the benefits.

[(i)**] (F)** An entity that issues or delivers a **[**policy or contract**] HEALTH BENEFIT PLAN** subject to this section shall:

(1) post a release of information authorization form on its Web site; and

(2) provide a release of information authorization form by standard mail within 10 business days after a request for the form is received.

15–831.

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

(2) "Authorized prescriber" has the meaning stated in § 12–101 of the Health Occupations Article.

~~**(3) "EXIGENT CIRCUMSTANCE" MEANS A CIRCUMSTANCE IN WHICH:**~~

~~**(I) A MEMBER IS SUFFERING FROM A HEALTH CONDITION THAT MAY SERIOUSLY JEOPARDIZE THE MEMBER'S LIFE, HEALTH, OR ABILITY TO REGAIN MAXIMUM FUNCTION; OR**~~

~~**(II) A MEMBER IS UNDERGOING A CURRENT COURSE OF TREATMENT USING A NONFORMULARY DRUG.**~~

[(3)**]** ~~**(4)**~~ "Formulary" means a list of prescription drugs or devices that are covered by an entity subject to this section.

[(4)**]** ~~**(5)**~~ (i) "Member" means an individual entitled to health care benefits for prescription drugs or devices under a policy issued or delivered in the State by an entity subject to this section.

(ii) "Member" includes a subscriber.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices under **INDIVIDUAL, GROUP, OR BLANKET** health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs and devices under **INDIVIDUAL OR GROUP** contracts that are issued or delivered in the State.

(2) An insurer, nonprofit health service plan, or health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefit manager is subject to the requirements of this section.

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(c) Each entity subject to this section that limits its coverage of prescription drugs or devices to those in a formulary shall establish and implement a procedure by which a member may receive a prescription drug or device that is not in the entity's formulary in accordance with this section.

(d) The procedure shall provide for coverage for a prescription drug or device that is not in the formulary if, in the judgment of the authorized prescriber:

(1) there is no equivalent prescription drug or device in the entity's formulary; or

(2) an equivalent prescription drug or device in the entity's formulary:

(i) has been ineffective in treating the disease or condition of the member; or

(ii) has caused or is likely to cause an adverse reaction or other harm to the member.

(e) A decision by an entity subject to this section not to provide access to or coverage of a prescription drug or device in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

~~**(F) AN ENTITY SUBJECT TO THIS SECTION SHALL:**~~

~~**(1) HAVE PROCEDURES IN PLACE FOR A MEMBER, THE MEMBER'S DESIGNEE, OR THE MEMBER'S AUTHORIZED PRESCRIBER TO REQUEST AN EXPEDITED REVIEW OF A REQUEST FOR COVERAGE OF A NONFORMULARY DRUG OR DEVICE BASED ON AN EXIGENT CIRCUMSTANCE; AND**~~

~~(2) WITHIN 24 HOURS AFTER IT RECEIVES AN EXPEDITED REVIEW REQUEST BASED ON AN EXIGENT CIRCUMSTANCE, NOTIFY THE FOLLOWING OF THE ENTITY'S DETERMINATION ABOUT THE REQUEST:~~

~~(I) THE MEMBER OR THE MEMBER'S DESIGNEE; AND~~

~~(II) THE MEMBER'S AUTHORIZED PRESCRIBER.~~

~~(G) AN ENTITY SUBJECT TO THIS SECTION THAT GRANTS AN EXCEPTION BASED ON AN EXIGENT CIRCUMSTANCE SHALL PROVIDE COVERAGE OF THE NONFORMULARY DRUG OR DEVICE FOR THE DURATION OF THE EXIGENCY.~~

15–10A–01.

(b) (1) "Adverse decision" means:

(i) a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

1. a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

2. may result in noncoverage of the health care service; or

(ii) a denial by a carrier of a request by a member for an alternative standard or a waiver of a standard to satisfy the requirements of a **[**bona fide**]** wellness program under § 15–509 of this title.

15–1201.

(h) **(1)** "Full–time employee" means**, WITH RESPECT TO A CALENDAR MONTH,** an employee of a small employer who works, on average, at least 30 hours per week.

(2) "FULL–TIME EMPLOYEE" DOES NOT INCLUDE A SEASONAL EMPLOYEE ~~UNLESS THE EMPLOYEE WORKS FOR THE EMPLOYER ON MORE THAN 120 DAYS DURING THE TAXABLE YEAR~~ AS DEFINED IN FEDERAL LAW.

(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) fixed indemnity insurance;**]**

[(iii)**] (II)** credit health insurance;

[(iv) Medicare supplement policies;

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

(vi) long–term care insurance;**]**

[(vii)**] (III)** disability income insurance;

[(viii)**] (IV)** coverage issued as a supplement to liability insurance;

[(ix)**] (V)** workers' compensation or similar insurance;

[(x) disease–specific insurance;

(xi)**] (VI)** automobile medical payment insurance**[**;

(xii) dental insurance; or

(xiii) vision 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.

15–1208.1.

(c) All small employer health benefit plans shall provide a special enrollment period during which the following individuals may be enrolled under the health benefit plan:

(1) an individual who becomes a dependent of the eligible employee through marriage, birth, adoption, placement for adoption, or placement for foster care;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, placement for adoption, **[**or**]** placement for foster care**, OR THROUGH A CHILD SUPPORT ORDER OR OTHER COURT ORDER**; **[**and**]**

(3) the spouse of an eligible employee at the birth or adoption of a child, **[**or**]** placement of a child for foster care, **OR THROUGH A CHILD SUPPORT ORDER OR OTHER COURT ORDER,** provided the spouse is otherwise eligible for coverage**; AND**

(4) AT THE OPTION OF THE SHOP EXCHANGE, AN ENROLLEE WHO IS THE ELIGIBLE EMPLOYEE OR THE SPOUSE OF THE ELIGIBLE EMPLOYEE, IF:

(I) THE ENROLLEE LOSES A DEPENDENT OR IS NO LONGER CONSIDERED TO BE A DEPENDENT DUE TO DIVORCE OR LEGAL SEPARATION; OR

(II) THE EMPLOYEE OR THE EMPLOYEE'S DEPENDENT DIES.

15–1208.2.

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

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with an eligible employee.

(3) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

(b) (1) A carrier shall establish a standardized annual open enrollment period of at least 30 days for each small employer.

(2) The annual open enrollment period shall occur before the end of the small employer's plan year.

(3) During the annual open enrollment period, each eligible employee of the small employer shall be permitted to:

(i) enroll in a health benefit plan offered by the small employer;

(ii) discontinue enrollment in a health benefit plan offered by the small employer; or

(iii) change enrollment from one health benefit plan offered by the small employer to a different health benefit plan offered by the small employer.

(c) A carrier shall provide an open enrollment period of at least 30 days for each employee who becomes an eligible employee outside the initial or annual open enrollment period.

(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;

[(ii)**] (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; 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;

[(iii) an eligible employee or a dependent is enrolled in an employer–sponsored health benefit plan that is not qualifying coverage in an eligible employer–sponsored plan and is allowed to terminate existing coverage;

(iv)**] (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; ~~[~~or**]**

(VI) ~~DUE TO THE MISCONDUCT ON THE PART OF A NON–EXCHANGE ENTITY PROVIDING ENROLLMENT ASSISTANCE OR CONDUCTING ENROLLMENT ACTIVITIES, AN ELIGIBLE EMPLOYEE OR A DEPENDENT:~~

~~1. WAS NOT ENROLLED IN A QUALIFIED HEALTH PLAN;~~

~~2. WAS NOT ENROLLED IN THE QUALIFIED HEALTH PLAN SELECTED BY THE ELIGIBLE EMPLOYEE; OR~~

~~3. IS NOT RECEIVING ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT OR COST–SHARING REDUCTIONS; OR~~

[~~(v)~~**] (VII)** 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.

(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;

[(i)**] (II)** failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or

[(ii)**] (III)** a rescission authorized under 45 C.F.R. § 147.128.

[(6) If an eligible employee or a dependent meets the requirements for the triggering event described in paragraph (4)(iii) of this subsection, the open enrollment period shall:

(i) apply only to health benefit plans offered by the carrier in the SHOP Exchange; and

(ii) begin at least 60 days before the end of the eligible employee's or dependent's coverage under the employer–sponsored plan.**]**

(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)(v)1**]** ~~**(4)(VII)1**~~ **(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)(v)2**]** ~~**(4)(VII)2**~~ **(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)(iv)**] (4)(V)** of this subsection shall have 60 days from the triggering event to select a health benefit plan.

(e) If an individual enrolls for coverage during one of the open enrollment periods described in this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

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 ~~**METAL TIER LEVEL, AS DESCRIBED IN § 1302(D) AND (E) OF THE AFFORDABLE CARE ACT**~~ **PARTICULAR COST–SHARING STRUCTURE, PROVIDER NETWORK, AND SERVICE AREA.**

(3) (I) "PRODUCT" MEANS A DISCRETE PACKAGE OF HEALTH BENEFITS THAT A CARRIER OFFERS 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.

(B) CHANGES IN BENEFITS MADE IN ACCORDANCE WITH FEDERAL OR STATE REQUIREMENTS ARE NOT SUBJECT TO THE PLUS OR MINUS 2 PERCENTAGE POINTS REFERENCED IN SUBSECTION (A)(4)(II)5 OF THIS SECTION.

(C) THE COMBINATION OF ALL PLANS OFFERED WITH A PRODUCT CONSTITUTES THE TOTAL SERVICE AREA OF THE PRODUCT.

(D) (1) WITH RESPECT TO A PLAN THAT HAS BEEN MODIFIED AT THE TIME OF COVERAGE RENEWAL CONSISTENT WITH THIS SECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN IF:

(I) 1. THE PLAN HAS THE SAME COST–SHARING STRUCTURE AS BEFORE THE MODIFICATION; OR

2. ANY VARIATION IN COST SHARING:

A. IS SOLELY RELATED TO CHANGES IN COST OR UTILIZATION OF MEDICAL CARE; OR

B. IS TO MAINTAIN THE SAME METAL LEVEL DESCRIBED IN § 1302(D) AND (E) OF THE AFFORDABLE CARE ACT;

(II) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME SERVICE AREA; AND

(III) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME PROVIDER NETWORK.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN TO THE EXTENT THAT THE MODIFICATIONS ARE:

(I) MADE UNIFORMLY AND SOLELY AS A RESULT OF A FEDERAL OR STATE REQUIREMENT;

(II) MADE WITHIN A REASONABLE TIME PERIOD AFTER THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT; AND

(III) DIRECTLY RELATED TO THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT.

[(a)**]** ~~**(D)**~~ **(E)** (1) Except as provided in subsections **[**(b), (c), and (d)**]** ~~**(E), (F), AND (G)**~~ **(F), (G), AND (H)** of this section, a carrier shall renew a health benefit plan at the option of the small employer.

(2) On renewal, a carrier may not exclude eligible employees or dependents from a health benefit plan.

(3) (i) A carrier shall mail a notice of renewal to the small employer at least **[**45**]** **60** days before the expiration of a health benefit plan.

(ii) The notice of renewal shall include the dates of the renewal period, the health benefit plan rates, and the terms of coverage under the health benefit plan.

(4) Policies or certificates for hospital or medical benefits issued through a professional employer organization, coemployer, or other organization under this subtitle may, with the consent of the carrier, have a common renewal date.

[(b)**]** ~~**(E)**~~ **(F)** A carrier may cancel or refuse to renew a health benefit plan only:

(1) for nonpayment of premiums;

(2) for fraud or intentional misrepresentation of material fact by the small employer;

(3) for noncompliance with a material plan provision relating to employer contributions or group participation rules;

(4) when the carrier elects not to renew:

(i) all of its health benefit plans that are issued to small employers in the State; or

(ii) the particular **[**health benefit plan**]** **PRODUCT** for all small employers in the State; or

(5) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area**, PROVIDED NOTICE OF THE TERMINATION IS PROVIDED TO EACH SMALL EMPLOYER AND TO EACH EMPLOYEE COVERED UNDER THE HEALTH BENEFIT PLAN AT LEAST 90 CALENDAR DAYS BEFORE THE DATE COVERAGE WILL BE TERMINATED**.

[(c)**]** ~~**(F)**~~ **(G)** When a carrier elects not to renew all health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected small employers and the insurance regulatory authority of each state in which an eligible employee or dependent resides at least 180 days before the effective date of nonrenewal;

(2) shall give notice to the Commissioner at least 30 working days before giving the notice specified in item (1) of this subsection; and

(3) may not write new business for small employers in the State for a period of 5 years beginning on the date of notice to the Commissioner.

[(d)**]** ~~**(G)**~~ **(H)** When a carrier elects not to renew a particular **[**health benefit plan**]** **PRODUCT** for all small employers in the State, the carrier shall:

(1) provide notice of the nonrenewal at least 90 days before the date of the nonrenewal to:

(i) each affected:

1. small employer; and

2. enrolled employee; and

(ii) the Commissioner;

(2) offer to each affected small employer the option to purchase all other health benefit plans currently offered by the carrier in the small group market; and

(3) act uniformly without regard to the claims experience of any affected small employer, or any health status–related factor of any affected individual.

[(e)**]** ~~**(H)**~~ **(I)** Within 7 days after cancellation or nonrenewal of a health benefit plan, the carrier shall send to each enrolled employee written notice of its action.

~~**(I)**~~ **(J) A CARRIER MAY MAKE A UNIFORM MODIFICATION OF COVERAGE FOR A PRODUCT ONLY AT THE TIME OF RENEWAL OF THE HEALTH BENEFIT PLAN.**

15–1301.

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

(b) "Affiliation period" means a period of time beginning on the date of enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee, during which a health maintenance organization does not collect premium, and coverage issued does not become effective.

(c) "Association" or "bona fide association" means an association that:

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

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

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

(4) makes health insurance coverage offered through the association available to all members regardless of any health status–related factor relating to the

members or individuals eligible for coverage and states so clearly in all membership and application materials;

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

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

(d) "Benefit year" means a calendar year in which a health benefit plan provides coverage for health benefits.

(e) "Carrier" means a person that is:

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

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

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

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

(f) "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.

[(g) (1) "Creditable coverage" means coverage of an individual under:

(i) an employer sponsored plan;

(ii) a health benefit plan;

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

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

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

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

(vii) a State health benefits risk pool;

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

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

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

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

[(h)**] (G)** "Eligible individual" means an individual who applies for or is covered under an individual health benefit plan.

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

[(j)**] (I)** "Enrollment date" means the date on which:

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

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

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

(K) "GRANDFATHERED HEALTH PLAN COVERAGE" HAS THE MEANING STATED IN 45 C.F.R. § 147.140.

(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; **[**and

8. other similar insurance coverage, specified in federal regulations issued pursuant to P.L. 104–191, 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 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; **[**and

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

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

~~1.~~ coverage only for a specified disease or illness **IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS**; ~~and~~

~~2.~~ **(IV)** hospital indemnity or other fixed indemnity insurance **IF:**

1. OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS;

~~A.~~ **2. EXCEPT AS PROVIDED IN ITEM ~~D~~ 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;**

~~B.~~ **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;**

~~C.~~ **4. 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**

~~D.~~ **5. ~~FOR HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE CONTRACTS ISSUED BEFORE JANUARY 1, 2015, THE INDIVIDUAL PROVIDES A WRITTEN ATTESTATION ON OR BEFORE OCTOBER 1, 2016, THAT THE INDIVIDUAL HAS OTHER HEALTH COVERAGE THAT IS MINIMUM ESSENTIAL COVERAGE, OR THAT THE INDIVIDUAL IS TREATED AS HAVING 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~~ 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

~~(iv)~~ **(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.

(m) "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

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

(8) disability.

[(n) "High level policy form" means a policy or plan under which the actuarial value of the benefit under the coverage is:

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

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

(o)**] (N)** "Individual Exchange" has the meaning stated in § 31–101 of this article.

[(p)**] (O)** (1) "Individual health benefit plan" means:

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

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

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

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

(r)**] (P)** "Minimum essential coverage" has the meaning stated in 45 C.F.R. § 155.20.

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

[(t)**] (R)** "Qualified health plan" has the meaning stated in § 31–101 of this article.

[(u)**] (S)** "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.

[(v) (1) "Weighted average" means the average actuarial value of the benefits provided by:

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

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

(2) "Weighted average" does not include coverages issued under this subtitle.**]**

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 ~~METAL TIER LEVEL, AS DESCRIBED IN § 1302(D) AND (E) OF THE AFFORDABLE CARE ACT~~ PARTICULAR COST–SHARING STRUCTURE, PROVIDER NETWORK, AND SERVICE AREA.

(3) (I) "PRODUCT" MEANS A DISCRETE PACKAGE OF HEALTH BENEFITS THAT A CARRIER OFFERS 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.

(B) CHANGES IN BENEFITS MADE TO COMPLY WITH FEDERAL OR STATE REQUIREMENTS ARE NOT SUBJECT TO THE PLUS OR MINUS 2 PERCENTAGE POINTS REFERENCED IN SUBSECTION (A)(4)(II)5 OF THIS SECTION.

(C) THE COMBINATION OF ALL PLANS OFFERED WITH A PRODUCT CONSTITUTES THE TOTAL SERVICE AREA OF THE PRODUCT.

(D) (1) WITH RESPECT TO A PLAN THAT HAS BEEN MODIFIED AT THE TIME OF COVERAGE RENEWAL CONSISTENT WITH THIS SECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN IF:

(I) 1. THE PLAN HAS THE SAME COST–SHARING STRUCTURE AS BEFORE THE MODIFICATION; OR

2. ANY VARIATION IN COST SHARING:

A. IS SOLELY RELATED TO CHANGES IN COST OR UTILIZATION OF MEDICAL CARE; OR

B. IS TO MAINTAIN THE SAME METAL LEVEL DESCRIBED IN § 1302(D) AND (E) OF THE AFFORDABLE CARE ACT;

(II) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME SERVICE AREA; AND

(III) THE PLAN CONTINUES TO COVER A MAJORITY OF THE SAME PROVIDER NETWORK.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, THE PLAN SHALL BE CONSIDERED TO BE THE SAME PLAN TO THE EXTENT THAT THE MODIFICATIONS ARE:

(I) MADE UNIFORMLY AND SOLELY AS A RESULT OF A FEDERAL OR STATE REQUIREMENT;

(II) MADE WITHIN A REASONABLE TIME PERIOD AFTER THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT; AND

(III) DIRECTLY RELATED TO THE IMPOSITION OR MODIFICATION OF THE FEDERAL OR STATE REQUIREMENT.

[(a)**]** ~~**(D)**~~ **(E)** Except as provided in subsection **[**(b)**]** ~~**(E)**~~ **(F)** of this section, a carrier shall renew an individual health benefit plan at the option of the eligible individual.

[(b)**]** ~~**(E)**~~ **(F)** A carrier may not cancel or refuse to renew an individual health benefit plan except:

(1) for nonpayment of the required premiums;

(2) where the individual has performed an act or practice that constitutes fraud;

(3) where the individual has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the carrier elects not to renew all of its individual health benefit plans in the State in accordance with this article;

(5) where the individual no longer resides, lives, or works in the service area, provided that**:**

(I) the coverage is terminated under this provision uniformly without regard to any health status–related factor of covered individuals**; AND**

(II) NOTICE OF THE TERMINATION IS PROVIDED TO THE INDIVIDUAL AT LEAST 90 CALENDAR DAYS BEFORE THE DATE COVERAGE WILL BE TERMINATED; or

(6) for individual health benefit plans that are not grandfathered health plans, as defined in 45 C.F.R. § 147.140, where a carrier discontinues offering a particular **[**type of health benefit plan coverage**]** **PRODUCT** in the individual market, if the carrier:

(i) at least 90 days before discontinuation of the **[**coverage**]** **PRODUCT**, provides notice of the discontinuation to each individual provided coverage **[**of this type**]** **UNDER THE PRODUCT**;

(ii) offers each individual provided coverage **[**of this type**]** **UNDER THE PRODUCT** the option to purchase any other individual health benefit plan coverage offered by the carrier for individuals in the State; and

(iii) acts uniformly without regard to any health status–related factor of enrolled individuals or individuals who may become eligible for the coverage.

~~(F)~~ (G) A CARRIER MAY MAKE A UNIFORM MODIFICATION OF COVERAGE FOR A PRODUCT ONLY AT THE TIME OF RENEWAL OF THE HEALTH BENEFIT PLAN.

~~(G)~~ (H) A CARRIER SHALL PROVIDE NOTICE OF RENEWAL OR UNIFORM MODIFICATION OF COVERAGE FOR:

(1) GRANDFATHERED HEALTH PLAN COVERAGE, AT LEAST 60 DAYS BEFORE THE DATE THE COVERAGE WILL BE RENEWED; AND

(2) A HEALTH BENEFIT PLAN THAT IS NOT GRANDFATHERED HEALTH PLAN COVERAGE, BEFORE THE DATE OF THE FIRST DAY OF THE NEXT ANNUAL OPEN ENROLLMENT PERIOD, IN A FORM AND MANNER SPECIFIED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.

[15–1310.

(a) A carrier shall provide written certification of creditable coverage.

(b) The certification of creditable coverage described in subsection (a) of this section shall be provided:

(1) automatically at the time an individual ceases to be covered under the health benefits plan or otherwise becomes covered under a COBRA continuation provision;

(2) in the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under the provision; and

(3) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in item (1) or (2) of this subsection, whichever is later.

(c) The certification may be provided at a time consistent with notices required under any applicable State or federal continuation provision.

(d) The certification shall contain:

(1) written certification of the period of creditable coverage of the individual under the health benefit plan, and the coverage, if applicable, under the applicable State or federal continuation provision; and

(2) the waiting period, if any, imposed with respect to the individual for any coverage under the health benefit plan.

(e) If a group health plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage, then:

(1) upon request of the group health plan, the entity which issued the certification provided by the individual shall promptly disclose to the requesting group health plan, information regarding coverage of classes and categories of health benefits available under the entity's plan or policy; and

(2) the entity may charge the requesting plan for the reasonable cost of disclosing the information.**]**

[15–1311.

(a) In determining a period of creditable coverage, any period that an individual is in a waiting period for coverage under a group health benefit plan or an affiliation period may not be taken into account in determining any period of continuous creditable coverage.

(b) A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period.**]**

[15–1312.

A carrier that issued a high level or low level policy form prior to July 1, 2004, may not charge a rate to eligible individuals under the high level or low level policy form that is greater than 200% of the rate the carrier normally would charge for the same or similar policy forms to other individuals.**]**

15–1316.

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

(2) "Dependent" means an individual who is or who may become eligible for coverage under the terms of a health benefit plan because of a relationship with another individual.

(3) "Qualifying coverage in an eligible employer–sponsored plan" has the meaning stated in 45 C.F.R. § 155.300.

(b) (1) Beginning November 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services, a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.

(2) The annual open enrollment period for 2014 shall begin on November 15, 2014, and extend through January 15, 2015, unless alternative dates are adopted by the federal Department of Health and Human Services.

(3) The annual open enrollment period for years beginning on and after January 1, 2015, shall **[**begin on October 15 and extend through December 7 each year**]** **BE THE DATES ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES**.

(4) During the annual open enrollment period, an individual shall be permitted to:

(i) enroll in a health benefit plan offered by the carrier;

(ii) discontinue enrollment in a health benefit plan offered by the carrier; or

(iii) change enrollment in a health benefit plan offered by the carrier to a different health benefit plan offered by the carrier.

(5) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for 2014, the effective date of coverage shall be:

(i) January 1, 2015, if the application is received by the carrier on or before December 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services; **[**and**]**

(ii) February 1, 2015, if the application is received by the carrier from December 16, 2014, through January 15, 2015, unless an alternative date is adopted by the federal Department of Health and Human Services**; AND**

(III) MARCH 1, 2015, IF THE APPLICATION IS RECEIVED BY THE CARRIER FROM JANUARY 16, 2015, THROUGH FEBRUARY 15, 2015, UNLESS AN ALTERNATIVE DATE IS ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(6) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for years beginning on and after January 1, 2015, the effective date of coverage shall be **[**January 1 of the following calendar year**]** **THE DATE ADOPTED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES**.

(c) ~~(1) A carrier shall provide a special open enrollment period for each individual who experiences a triggering event.~~

~~(2)~~ **[**~~The special open enrollment period shall be for at least 60 days, beginning on the date of the triggering event.~~**] EXCEPT AS PROVIDED IN PARAGRAPHS (3) AND (4) OF THIS SUBSECTION, AN INDIVIDUAL SHALL HAVE 60 DAYS FROM THE DATE OF A TRIGGERING EVENT TO APPLY FOR COVERAGE.**

(3) FOR THE TRIGGERING EVENTS DESCRIBED IN PARAGRAPH (6)(I), (II), AND (III) OF THIS SUBSECTION, THE SPECIAL OPEN ENROLLMENT PERIOD SHALL BEGIN 60 DAYS BEFORE THE TRIGGERING EVENT AND END 60 DAYS AFTER THE TRIGGERING EVENT.

(4) FOR THE TRIGGERING EVENT DESCRIBED IN PARAGRAPH (6)(VII)2 OF THIS SUBSECTION, THE SPECIAL ENROLLMENT PERIOD SHALL BEGIN 60 DAYS BEFORE THE DATE OF LOSS OF ELIGIBILITY FOR QUALIFYING COVERAGE IN AN ELIGIBLE EMPLOYER–SPONSORED PLAN AND END 60 DAYS AFTER THE DATE OF LOSS OF ELIGIBILITY FOR QUALIFYING COVERAGE IN AN ELIGIBLE EMPLOYER–SPONSORED PLAN.

[~~(3)~~**] (5)** ~~During the special open enrollment period, a carrier shall permit an individual who experiences a triggering event to enroll in or change from one health benefit plan offered by the carrier to another health benefit plan offered by the carrier.~~

[~~(4)~~**] (6)** ~~A triggering event occurs when:~~

~~(i) subject to paragraph~~ **[**~~(5)~~**] (7)** ~~of this subsection, an individual or A~~ dependent loses minimum essential coverage;

(II) AN INDIVIDUAL 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 INDIVIDUAL OR DEPENDENT WOULD HAVE PREGNANCY–RELATED COVERAGE;~~

~~(III) AN INDIVIDUAL 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 INDIVIDUAL OR DEPENDENT WOULD HAVE MEDICALLY NEEDY COVERAGE;~~

~~[(ii)] (IV) an individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care;~~

~~[(iii)] (V) an individual's or a dependent's enrollment or nonenrollment in a qualified health plan is, as evaluated and determined by the Individual Exchange:~~

~~1. unintentional, inadvertent, or erroneous; and~~

~~2. the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Individual Exchange or the U.S. Department of Health and Human Services or its instrumentalities;~~

~~[(iv)] (VI) an individual or a dependent who is enrolled in a qualified health plan in the Individual Exchange adequately demonstrates to the Individual Exchange that the qualified health plan in which the individual or dependent is enrolled substantially violated a material provision of the qualified health plan's contract in relation to the individual or dependent;~~

~~[(v)] (VII) 1. an individual or a dependent enrolled in the same health benefit plan is determined newly eligible or newly ineligible for advance payments of federal premium tax credits or has a change in eligibility for federal cost–sharing reductions; or~~

~~2. an individual or a dependent who is enrolled in an eligible employer–sponsored plan is determined newly eligible for advance payments of federal premium tax credits based in part on a finding that the individual is ineligible for qualifying coverage in an eligible employer–sponsored plan in accordance with 26 C.F.R. § 1.36B–2(c)(3), including as a result of the employee's employer discontinuing or changing available coverage within the next 60 days, provided that the individual is allowed to terminate existing coverage;~~

~~[(vi)] (VIII) an individual or a dependent gains access to a new health benefit plan as a result of a permanent move;~~

~~[(vii) the individual or dependent is enrolled in an employer–sponsored health benefit plan that is not qualifying coverage in an eligible employer–sponsored plan and is allowed to terminate existing coverage;~~

~~(viii)~~ **] (IX)** ~~for a health benefit plan offered through the Individual Exchange:~~

~~1. an individual who was not previously a citizen, national, or lawfully present individual becomes a citizen, national, or lawfully present individual; or~~

~~2. an individual or a dependent demonstrates to the Individual Exchange, in accordance with guidelines issued by the U.S. Department of Health and Human Services, that the individual or dependent meets other exceptional circumstances as the Individual Exchange may provide; or~~

~~[(ix)~~ **] (X)** ~~it has been determined by the Exchange that a qualified individual was not enrolled in a qualified health plan, was not enrolled in the qualified health plan selected by the individual, or is eligible for, but is not receiving, advance federal premium tax credits or cost–sharing reductions as a result of misconduct on the part of a non–Exchange entity providing enrollment assistance or conducting enrollment activities.~~

~~[(5)~~ **] (7)** ~~Loss of minimum essential coverage under paragraph~~ **[**~~(4)(i)~~**] (6)(I)** ~~of this subsection does not include~~ **VOLUNTARY TERMINATION OF COVERAGE OR OTHER** ~~loss of coverage due to:~~

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

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

~~(8)~~ VOLUNTARY TERMINATION OF COVERAGE REFERENCED IN PARAGRAPH (7) OF THIS SUBSECTION DOES NOT INCLUDE TERMINATION OF COVERAGE INCIDENTAL TO A VOLUNTARY TERMINATION OF EMPLOYMENT.

~~(9)~~ THE TRIGGERING EVENT DESCRIBED IN PARAGRAPH (6)(III) OF THIS SUBSECTION IS PERMITTED ONLY ONCE PER YEAR PER INDIVIDUAL.

~~[(6)~~ **] (10)** ~~If a triggering event described in paragraph~~ **[**~~(4)(iii)~~**] (6)(V)** ~~of this subsection occurs, the Individual Exchange may take action as may be necessary to correct or eliminate the effects of the error, misrepresentation, or inaction.~~

~~[(7)~~ **] (11)** ~~If a triggering event described in paragraph~~ **[**~~(4)(v)2~~**] (6)(VII)2** ~~of this subsection occurs, a carrier shall permit an individual or a dependent who is enrolled in an employer–sponsored plan and who will lose eligibility for qualifying coverage in an~~

~~eligible employer–sponsored plan within the next 60 days to access the special enrollment period prior to the end of the individual's existing coverage, although the individual is not eligible for advance payment of the federal premium tax credit until the end of the individual's coverage in an eligible employer–sponsored plan.~~

~~[(8) If an individual or a dependent meets the requirements for the triggering event described in paragraph (4)(vii) of this subsection, the special open enrollment period shall begin at least 60 days before the end of the individual's or dependent's coverage under the employer–sponsored plan.]~~

~~(d) An individual who is an Indian, as defined in § 4 of the federal Indian Health Care Improvement Act, may enroll in a health benefit plan in the Individual Exchange or change from one health benefit plan in the Individual Exchange to another health benefit plan in the Individual Exchange one time per month.~~

~~(e) (1) A carrier shall provide a limited open enrollment period for an individual who is enrolled in a noncalendar year individual health benefit plan to enroll in a health benefit plan issued by the carrier.~~

~~(2) The limited enrollment period required by paragraph (1) of this subsection shall:~~

~~(i) begin on the date that is at least 30 calendar days before the date the noncalendar year health benefit plan's policy year ends in 2014; and~~

~~(ii) last at least 60 days~~ **A CARRIER PARTICIPATING IN THE INDIVIDUAL EXCHANGE SHALL PROVIDE THE SPECIAL ENROLLMENT PERIODS SPECIFIED IN 45 C.F.R. § 155.420 FOR INDIVIDUALS WHO PURCHASE COVERAGE THROUGH THE INDIVIDUAL EXCHANGE.**

(D) A CARRIER SHALL PROVIDE THE SPECIAL ENROLLMENT PERIODS SPECIFIED IN 45 C.F.R. § 147.104(B)(2) FOR INDIVIDUALS WHO PURCHASE COVERAGE OUTSIDE THE INDIVIDUAL EXCHANGE.

~~(f)~~ **(E)** If an individual enrolls for coverage during one of the open enrollment or special open enrollment periods described in this section, coverage shall be effective in accordance with the requirements in 45 C.F.R. § 155.420.

~~(g)~~ **(F)**(1) A health maintenance organization may:

(i) limit the individuals who may apply for coverage to those who live or reside in the health maintenance organization's service area; and

(ii) deny coverage to individuals if the health maintenance organization has demonstrated to the Commissioner that:

1. it will not have the capacity to deliver services adequately to any additional individuals because of its obligations to existing enrollees; and

2. it is applying the provisions of this paragraph uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A health maintenance organization that denies coverage to an individual in accordance with paragraph (1) of this subsection may not offer coverage in the individual market within the service area to any individual for a period of 180 days after the date the coverage is denied.

(3) Paragraph (2) of this subsection does not:

(i) limit the health maintenance organization's ability to renew coverage already in force; or

(ii) relieve the health maintenance organization of the responsibility to renew coverage already in force.

~~(h)~~ **(G)** (1) A carrier may deny a health benefit plan to an individual if the carrier has demonstrated to the Commissioner that:

(i) it does not have the financial reserves necessary to offer additional coverage; and

(ii) it is applying the provisions of this paragraph uniformly to all individuals in the individual market in the State without regard to the claims experience of those individuals and their dependents or any health status–related factor relating to the individuals and their dependents.

(2) A carrier that denies a health benefit plan to an individual in the State under paragraph (1) of this subsection may not offer coverage in the individual market before the later of:

(i) the 181st day after the date the carrier denies coverage; and

(ii) the date the carrier demonstrates to the Commissioner that the carrier has sufficient financial reserves to underwrite additional coverage.

(3) Paragraph (2) of this subsection does not:

(i) limit the carrier's ability to renew coverage already in force; or

(ii) relieve the carrier of the responsibility to renew coverage already in force.

(4) Health benefit plans offered after the time period described in paragraph (2) of this subsection are subject to the requirements of this section.

15–1318.

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

(2) "INSTITUTION OF HIGHER EDUCATION" HAS THE MEANING STATED IN THE FEDERAL HIGHER EDUCATION ACT OF 1965.

(3) "STUDENT ADMINISTRATIVE HEALTH FEE" MEANS A FEE CHARGED BY AN INSTITUTION OF HIGHER EDUCATION ON A PERIODIC BASIS TO STUDENTS OF THE INSTITUTION OF HIGHER EDUCATION TO OFFSET THE COST OF PROVIDING HEALTH CARE THROUGH HEALTH CLINICS REGARDLESS OF WHETHER THE STUDENTS UTILIZE THE HEALTH CLINICS OR ENROLL IN STUDENT HEALTH PLAN COVERAGE.

(4) "STUDENT HEALTH PLAN" MEANS AN INDIVIDUAL HEALTH BENEFIT PLAN THAT IS PROVIDED TO STUDENTS ENROLLED IN AN INSTITUTION OF HIGHER EDUCATION AND THEIR DEPENDENTS UNDER A WRITTEN AGREEMENT THAT:

(I) IS BETWEEN THE INSTITUTION OF HIGHER EDUCATION AND A CARRIER;

(II) DOES NOT MAKE COVERAGE UNDER THE HEALTH BENEFIT PLAN AVAILABLE OTHER THAN IN CONNECTION WITH ENROLLMENT AS A STUDENT OR AS A DEPENDENT OF A STUDENT IN THE INSTITUTION OF HIGHER EDUCATION; AND

(III) DOES NOT CONDITION ELIGIBILITY FOR THE HEALTH BENEFIT PLAN ON ANY HEALTH STATUS–RELATED FACTOR RELATING TO A STUDENT OR A DEPENDENT OF A STUDENT.

(B) A CARRIER THAT OFFERS STUDENT HEALTH PLANS IS NOT REQUIRED TO:

(1) ACCEPT INDIVIDUALS WHO ARE NOT:

(I) STUDENTS; OR

(II) DEPENDENTS OF STUDENTS COVERED UNDER THE STUDENT HEALTH PLAN;

(2) ESTABLISH OPEN ENROLLMENT PERIODS;

(3) ESTABLISH EFFECTIVE DATES THAT ARE BASED ON A CALENDAR YEAR;

(4) OFFER HEALTH BENEFIT PLAN CONTRACTS THAT ARE ON A CALENDAR YEAR BASIS; OR

(5) RENEW, OR CONTINUE IN FORCE, COVERAGE FOR INDIVIDUALS WHO ARE NO LONGER STUDENTS OR DEPENDENTS OF STUDENTS.

(C) A STUDENT HEALTH PLAN IS NOT SUBJECT TO THE REQUIREMENT OF A SINGLE RISK POOL UNDER § 1312(C) OF THE AFFORDABLE CARE ACT.

(D) A STUDENT ADMINISTRATIVE HEALTH FEE IS NOT CONSIDERED A COST–SHARING REQUIREMENT WITH RESPECT TO SPECIFIED RECOMMENDED PREVENTIVE SERVICES.

15–1401.

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

(b) **[**"Affiliation period" means a period of time beginning on the date of enrollment and not to exceed 2 months, or 3 months in the case of a late enrollee, during which a health maintenance organization does not collect premium and coverage issued does not become effective.

(c)**]** "Association" or "bona fide association" means, with respect to health insurance coverage offered in this State, an association that:

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

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

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

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

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

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

[(d)**] (C)** "Carrier" means a person that is:

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

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

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

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

[(e)**] (D)** "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.

[(f) (1) "Creditable coverage" means coverage of an individual under:

(i) an employer–sponsored plan;

(ii) a health benefit plan;

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

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

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

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

(vii) a State health benefits risk pool;

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

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

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

(2) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63–day period during all of which the individual was not covered under any creditable coverage.**]**

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

[(h)**] (F)** "Enrollment date" means the date on which:

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

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

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

[(j)**] (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.

[(k)**] (I)** "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

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

(8) disability.

[(l)**] (J)** "Late enrollee" means a member, subscriber, or dependent who enrolls in a group health benefit plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period.

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

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

[(o)**] (M)** "Secretary" means the Secretary of the federal Department of Health and Human Services.

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

[(q)**] (O)** "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.

[15–1403.

(a) A carrier shall provide written certification of creditable coverage in connection with group health benefit plans, including those issued in accordance with Subtitle 12 of this title.

(b) The certification of creditable coverage described in subsection (a) of this section shall be provided:

(1) automatically at the time an individual ceases to be covered under the health benefits plan or otherwise becomes covered under a COBRA continuation provision;

(2) in the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under the provision; and

(3) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in item (1) or (2) of this subsection, whichever is later.

(c) The certification may be provided at a time consistent with notices required under any applicable State or federal continuation provision.

(d) The certification shall contain:

(1) written certification of the period of creditable coverage of the individual under the health benefit plan, and the coverage, if applicable, under the applicable State or federal continuation provision; and

(2) the waiting period, if any, imposed with respect to the individual for any coverage under the health benefit plan.

(e) If a group health plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage, then:

(1) on request of the group health plan, the entity that issued the certification provided by the individual promptly shall disclose to the requesting group health plan, information regarding coverage of classes and categories of health benefits available under the entity's plan or policy; and

(2) the entity may charge the requesting plan for the reasonable cost of disclosing the information.**]**

[15–1404.

(a) In determining a period of creditable coverage, any period that an individual is in a waiting period for any coverage under a group health benefit plan or an affiliation period may not be taken into account in determining any period of continuous creditable coverage.

(b) Except as provided in subsection (c) of this section, a carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(c) (1) A carrier may elect to reduce the period of any preexisting condition provision based on coverage of benefits within any class or category of benefits specified by the Secretary by regulation.

(2) Any election made under this section shall be made on a uniform basis for all covered individuals.

(3) A carrier that makes an election under this section shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within that class or category.

(d) A carrier that makes an election under subsection (c) of this section shall:

(1) prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the carrier has made this election; and

(2) include in the statement a description of the effect of the election on the member or subscriber.**]**

[15–1405.

An individual shall establish the individual's period of creditable coverage by presenting the certificate described in § 15–1403 of this subtitle.**]**

15–1408.

A carrier shall renew group health benefit plans at the option of the policyholder or plan sponsor, except in any of the following cases:

(1) for nonpayment of the required premium;

(2) where the policyholder or plan sponsor has performed an act or practice that constitutes fraud;

(3) where the policyholder or plan sponsor has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the policyholder or plan sponsor has failed to comply with a material plan provision relating the employer contributions or group participation rules;

(5) where the carrier elects not to renew all group health benefit plans in the State;

(6) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area**, PROVIDED NOTICE OF THE NONRENEWAL IS PROVIDED TO EACH EMPLOYER AND TO EACH EMPLOYEE COVERED UNDER THE HEALTH BENEFIT PLAN AT LEAST 90 DAYS BEFORE THE DATE COVERAGE WILL BE TERMINATED**;

(7) in the case of a carrier that offers coverage only through one or more bona fide associations, when the membership of an employer in the association ceases and nonrenewal under this item is applied uniformly without regard to any health status–related factor relating to any covered individual; or

(8) the carrier makes an election under § 15–1409 of this subtitle.

15–1409.

(A) IN THIS SECTION, "PRODUCT" MEANS A DISCRETE PACKAGE OF HEALTH BENEFITS THAT A CARRIER OFFERS USING A PARTICULAR PRODUCT NETWORK TYPE WITHIN A GEOGRAPHIC SERVICE AREA.

[(a)**] (B)** A carrier that elects not to renew all of a particular **[**type of coverage or policy form**] PRODUCT** in the State shall:

(1) provide notice of the nonrenewal at least 90 days before the date of the nonrenewal to each affected:

(i) policyholder;

(ii) plan sponsor;

(iii) participant; and

(iv) beneficiary;

(2) offer to each affected plan sponsor the option to purchase any other health insurance coverage currently being offered by the carrier; and

(3) act uniformly without regard to the claims experience of any affected plan sponsor, or any health status–related factor of any affected individual.

[(b)**] (C)** A carrier may elect not to renew all group health benefit plans in the State.

[(c)**] (D)** When a carrier elects not to renew all group health benefit plans in the State, the carrier:

(1) shall give notice of its decision to the affected individuals at least 180 days before the effective date of nonrenewal;

(2) at least 30 working days before that notice, shall give notice to the Commissioner; and

(3) may not write new business for groups in the State for a 5–year period beginning on the date of notice to the Commissioner.

[(d)**] (E)** A health maintenance organization need not offer coverage to an individual who does not live, reside, or work within the health maintenance organization's approved service areas.

(F) A CARRIER MAY MAKE A UNIFORM MODIFICATION OF COVERAGE FOR A PRODUCT ONLY AT THE TIME OF RENEWAL OF A HEALTH BENEFIT PLAN.

27–210.

(h) (1) In this subsection, **[**"bona fide wellness**] "WELLNESS** program" **[**has the meaning stated in**] MEANS A PROGRAM THAT:**

(I) MEETS THE REQUIREMENTS OF A PARTICIPATORY WELLNESS PROGRAM OR A HEALTH–CONTINGENT WELLNESS PROGRAM UNDER § 15–509 of this article**; AND**

(II) IS PROVIDED AS A BENEFIT OUTSIDE OF THE HEALTH INSURANCE OR HEALTH MAINTENANCE ORGANIZATION CONTRACT.

(2) It is not discrimination or a rebate for a carrier to provide reasonable incentives to an individual who is an insured, a subscriber, or a member for participation in a **[**bona fide**]** wellness program offered by the carrier **[**in accordance with § 15–509 of this article**]**.

(3) Any incentive offered for participation in a **[**bona fide**]** wellness program:

(i) shall be reasonably related to the **[**bona fide**]** wellness program; and

(ii) may not have a value that exceeds any limit established in regulations adopted by the Commissioner.

(4) The Commissioner shall adopt regulations to implement the provisions of this subsection.

31–101.

(e–1) **(1)** "Full–time employee" means an employee who works, on average, at least 30 hours per week.

(2) "FULL–TIME EMPLOYEE" DOES NOT INCLUDE A SEASONAL EMPLOYEE UNLESS THE EMPLOYEE WORKS FOR THE EMPLOYER ON MORE THAN 120 DAYS DURING THE TAXABLE YEAR.

(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; **[**or**]**

(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 5B 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;

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.";

4. ~~FOR HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE CONTRACTS ISSUED BEFORE JANUARY 1, 2015, THE INDIVIDUAL PROVIDES A WRITTEN ATTESTATION ON OR BEFORE OCTOBER 1, 2016, THAT THE INDIVIDUAL HAS OTHER HEALTH COVERAGE THAT IS MINIMUM ESSENTIAL COVERAGE, OR THAT THE INDIVIDUAL IS TREATED AS HAVING 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~~ 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.

(O–1) "MINIMUM ESSENTIAL COVERAGE" HAS THE MEANING STATED IN 26 U.S.C. § 5000A.

(O–2) "PLAN YEAR" HAS THE MEANING STATED IN § 15–1201 OF THIS ARTICLE.

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

(i) 50 employees **[**if the preceding calendar year ended on or before**]** **FOR PLAN YEARS THAT BEGIN BEFORE** January 1, 2016; and

(ii) 100 employees **[**if the preceding calendar year ended after**]** **FOR PLAN YEARS THAT BEGIN ON OR AFTER** January 1, 2016**, OR ANOTHER NUMBER OF EMPLOYEES OR DATE AS PROVIDED UNDER FEDERAL LAW**.

31–116.

(a) The essential health benefits required under § 1302(a) of the Affordable Care Act:

(1) shall be the benefits in the State benchmark plan, selected in accordance with this section; and

(2) notwithstanding any other benefits mandated by State law, shall be the benefits required in:

(i) subject to subsection (f) of this section, all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange; and

(ii) subject to § 31–115(c) of this title, all qualified health plans offered in the Exchange.

(b) In selecting the State benchmark plan, the State seeks to:

(1) balance comprehensiveness of benefits with plan affordability to promote optimal access to care for all residents of the State;

(2) accommodate to the extent practicable the diverse health needs across the diverse populations within the State; and

(3) ensure the benefit of input from the stakeholders and the public.

(c) (1) The State benchmark plan, ***FOR 2017 AND UNTIL THE SECRETARY REQUIRES THAT A NEW BENCHMARK PLAN BE SELECTED,*** *shall be selected by the* ***[****Maryland Health Care Reform Coordinating Council****]*** ***COMMISSIONER, IN CONSULTATION WITH THE EXCHANGE:***

(I) BASED ON ENROLLMENT FOR THE FIRST QUARTER OF 2014, FROM THE LARGEST HEALTH PLAN BY ENROLLMENT IN ANY OF THE THREE LARGEST SMALL GROUP INSURANCE PRODUCTS BY ENROLLMENT IN THE STATE'S SMALL GROUP MARKET; AND

(II) *through an open, transparent, and inclusive process****, WHICH SHALL INCLUDE AT LEAST ONE PUBLIC HEARING AND AN OPPORTUNITY FOR PUBLIC COMMENT****.*

(2) ***[****Any action of the Council may be taken only by the affirmative vote of at least nine members of the Maryland Health Care Reform Coordinating Council.*

*(3)***]** *In selecting the State benchmark plan, the* **[***Maryland Health Care Reform Coordinating Council***]** ***COMMISSIONER, IN CONSULTATION WITH THE EXCHANGE,*** *may exclude****, CONSISTENT WITH APPLICABLE FEDERAL REGULATIONS****:*

(i) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(ii) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(d) In selecting the State benchmark plan, the **[***Maryland Health Care Reform Coordinating Council shall:*

(1) obtain guidance necessary to:

(i) determine the 10 health benefit plans deemed eligible by the Secretary to be the State benchmark plan; and

(ii) conduct a comparative analysis of the benefits of each plan;

(2) solicit the input of stakeholders in the State, including members of the General Assembly and members of the public, by:

(i) appointing and consulting with an advisory group made up of a diverse and representative cross–section of stakeholders, including:

1. individuals with knowledge of and expertise in advocating for consumers representing lower income, racial, ethnic, or other minorities, individuals with chronic diseases and other disabilities, and vulnerable populations;

2. public health researchers and other academic experts with relevant knowledge and background, including knowledge and background relating to disparities and the health needs of diverse populations; and

3. carriers, health care providers, and other industry representatives with knowledge and expertise relevant to health plan benefits and design;

(ii) to the extent practicable, appointing individuals to the advisory group who reflect the gender, racial, ethnic, and geographic diversity of the State; and

(iii) establishing a mechanism for members of the General Assembly and members of the public to:

1. be kept informed by electronic mail; and

2. provide comment; and

(3)] ***COMMISSIONER, IN CONSULTATION WITH THE EXCHANGE, SHALL:***

(1) *select a plan that complies with all requirements of this title and the Affordable Care Act, the federal Mental Health Parity and Addiction Equity Act of 2008, and any other federal laws, regulations, policies, or guidance applicable to state benchmark plans and essential health benefits****;***

(2) FOR INDIVIDUAL HEALTH BENEFIT PLANS, REQUIRE THAT THE HEALTH BENEFIT PLANS INCLUDE ANY MANDATED BENEFITS THAT WERE REQUIRED IN INDIVIDUAL HEALTH BENEFIT PLANS BEFORE DECEMBER 31, 2011, IF THE BENEFITS ARE NOT INCLUDED IN THE SELECTED BENCHMARK PLAN; AND

(3) IF THE SELECTED STATE BENCHMARK PLAN DOES NOT COMPLY WITH ANY FEDERAL BENEFIT REQUIREMENT, SUPPLEMENT THE REQUIRED BENEFITS, TO THE EXTENT PERMITTED BY FEDERAL LAW, WITH BENEFITS SIMILAR TO THOSE CHOSEN BY THE MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL IN 2012*.*

[*(e) On or before September 30, 2012, the Maryland Health Care Reform Coordinating Council shall select the State benchmark plan for coverage beginning January 1, 2014.****]***

(E) WITHIN 10 DAYS AFTER SELECTING THE STATE BENCHMARK PLAN, THE COMMISSIONER SHALL SUBMIT A REPORT, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE ADVISING THE COMMITTEES OF THE COMMISSIONER'S SELECTION AND THE PROCESS USED IN MAKING THE SELECTION.

Article – Health – General

[19–703.1.

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

(2) "Alcohol abuse" has the meaning stated in § 8–101 of this article.

(3) "Drug abuse" has the meaning stated in § 8–101 of this article.

(4) "Health benefit plan" has the meaning stated in § 15–1401 of the Insurance Article.

(5) "Large employer" means an employer that has more than 50 employees and is not a small employer.

(6) "Managed care system" means a method that a carrier uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(7) "Partial hospitalization" means the provision of medically directed intensive or intermediate short–term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a member or subscriber in a licensed or certified facility or program.

(8) "Small employer" means an employer that:

(i) Employed an average of at least two, but not more than 50 employees on business days during the preceding calendar year; and

(ii) Employs at least two employees on the first day of the plan year.

(b) (1) Subject to the provisions of this section, each contract or certificate issued to a member or subscriber by a health maintenance organization that provides health benefits and services for diseases may not discriminate against any person with a mental illness, emotional disorder or a drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions as provided for covered benefits offered under the contract or certificate for the treatment of physical illness.

(2) It shall not be considered to be discriminatory under paragraph (1) of this subsection if at least the following benefits are provided:

(i) With respect to inpatient benefits provided in a licensed or certified facility, which shall include hospital inpatient benefits, the total number of days for which benefits are payable shall be at least equal to the same terms and conditions that apply to the benefits available under the contract or certificate for physical illness;

(ii) Except as provided in item (iii) of this paragraph and subject to subsection (e) of this section, with respect to benefits for partial hospitalization, at least 60 days of partial hospitalization shall be covered under the same terms and conditions that apply to the benefit available under the contract or certificate for physical illness;

(iii) For group contracts covering employees of one or more large employers, with respect to benefits for partial hospitalization for the treatment of mental illness, emotional disorders, drug abuse, and alcohol abuse, the greater of:

1. The same benefits payable under the contract for partial hospitalization for physical illness; or

2. At least 60 days of partial hospitalization covered under the same terms and conditions that apply to outpatient treatment of physical illnesses;

(iv) Except as provided in item (v) of this paragraph, with respect to outpatient coverage, other than for inpatient or partial hospitalization services, benefits for covered expenses arising from services, including psychological and neuropsychological testing for diagnostic purposes, that are rendered to treat mental illness, emotional disorders, drug abuse, and alcohol abuse shall be at a rate that is, after the applicable deductible, not less than:

1. 80 percent for the first 5 visits in any calendar year or benefit period of not more than 12 months;

2. 65 percent for the 6th through 30th visit in any calendar year or benefit period of not more than 12 months; and

3. 50 percent for the 31st visit and any visit after the 31st visit in any calendar year or benefit period of not more than 12 months; and

(v) For group contracts covering employees of one or more large employers, benefits for covered outpatient expenses arising from services, including all office visits and psychological and neuropsychological testing for diagnostic purposes, that are rendered to treat mental illness, emotional disorders, drug abuse, and alcohol abuse shall be covered under the same terms and conditions that apply to similar benefits available under the contract for physical illness.

(c) (1) The benefits under this section shall be required only for expenses arising for treatment of mental illnesses, emotional disorders, drug abuse, and alcohol abuse that in the professional judgment of practitioners is medically necessary and treatable.

(2) The benefits required under this section shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug abuse, and alcohol abuse.

(3) Subject to paragraph (4) of this subsection, the benefits required under this section may be delivered under a managed care system.

(4) For group contracts covering employees of one or more large employers, the benefits required under this section may be delivered under a managed care system

only if the benefits for physical illnesses covered under the contract are delivered under a managed care system.

(5) For group contracts covering employees of one or more large employers, the processes, strategies, evidentiary standards, or other factors used to manage the benefits required under this section must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the contract.

(6) Except as specifically provided in this section, benefits for illnesses covered by this section and the benefits for physical illnesses covered under a contract or certificate shall have the same terms and conditions.

(7) Except for the coinsurance provisions in subsection (b)(2)(iv) of this section, a contract or certificate that is subject to this section may not have:

(i) Separate lifetime maximums for physical illnesses and illnesses covered under this section;

(ii) Separate deductibles and coinsurance amounts for physical illnesses and illnesses covered under this section; or

(iii) Separate out–of–pocket limits in a benefit period of not more than 12 months for physical illnesses and illnesses covered under this section.

(8) (i) Subject to subparagraph (ii) of this paragraph, any copayments required under a contract or certificate for benefits for illnesses covered under this section shall be:

1. Actuarially equivalent to any coinsurance requirements under this section; or

2. Where there are no coinsurance requirements, not greater than a copayment required for a benefit under the contract or a certificate for a physical illness.

(ii) A health maintenance organization may not charge a copayment that is greater than 50% of the daily cost for methadone maintenance treatment.

(d) An office visit to a physician or other health care provider for the purpose of medication management may not be counted against the number of visits required to be covered as a part of the benefits required under subsection (b)(2)(iv) of this section and shall be reimbursed under the same terms and conditions as an office visit for physical illnesses covered under the contract or certificate.

(e) Nothing in this section shall be construed to prohibit exceeding the minimum benefits required under subsection (b)(2)(ii) or (iii) of this section for any partial hospitalization day that is medically necessary and would serve to prevent inpatient hospitalization.

(f) A health maintenance organization shall provide on its Web site and annually in print to its members:

(1) Notice about the benefits required under this section and, if applicable to the contract of the member, the federal Mental Health Parity and Addiction Equity Act; and

(2) Notice that the member may contact the Maryland Insurance Administration for further information about the benefits.

(g) A health maintenance organization shall:

(1) Post a release of information authorization form on its Web site; and

(2) Provide a release of information authorization form by standard mail within 10 business days after a request for the form is received.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, May 12, 2015.