Chapter 665

(Senate Bill 54)

AN ACT concerning

~~Insurance – Accountable Care Organizations – Technical Correction~~
Health Insurance – Technical Corrections and Required Conformity With Federal Law

FOR the purpose of correcting ~~an~~ certain incorrect ~~cross–reference~~ cross–references for purposes of certain provisions of law relating to accountable care organizations ~~and~~, incentive–based compensation, and the renewal of certain health benefit plans; altering the triggering events for which certain carriers are required to provide a certain open enrollment period; altering the definition of "small employer" for purposes of certain provisions of law governing the Maryland Health Benefit Exchange; and generally relating to ~~accountable care organizations~~ health insurance and conformity with federal law.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–113(c), 15–1208.2(d), 15–1309(b), and 31–101(z)(1)
Annotated Code of Maryland
(2017 Replacement Volume)

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

Article – Insurance

15–113.

(c) (1) In this subsection, "set of health care practitioners" means:

(i) a group practice;

(ii) a clinically integrated organization established in accordance with Subtitle 19 of this title; or

(iii) an accountable care organization established in accordance with **[**42 U.S.C. § 1899**]** **42 U.S.C. § 1395JJJ** and any applicable federal regulations.

(2) This section does not prohibit a carrier from providing bonuses or other incentive–based compensation to a health care practitioner or a set of health care practitioners if the bonus or other incentive–based compensation:

(i) does not create a disincentive to the provision of medically appropriate or medically necessary health care services; and

(ii) if the carrier is a health maintenance organization, complies with the provisions of § 19–705.1 of the Health – General Article.

(3) A bonus or other incentive–based compensation under this subsection:

(i) if applicable, shall promote the provision of preventive health care services; or

(ii) may reward a health care practitioner or a set of health care practitioners, based on satisfaction of performance measures, if the following is agreed on in writing by the carrier and the health care practitioner or set of health care practitioners:

1. the performance measures;

2. the method for calculating whether the performance measures have been satisfied; and

3. the method by which the health care practitioner or set of health care practitioners may request reconsideration of the calculations by the carrier.

(4) Acceptance of a bonus or other incentive–based compensation under this subsection shall be voluntary.

(5) A carrier may not require a health care practitioner or a set of health care practitioners to participate in the carrier's bonus or incentive–based compensation program as a condition of participation in the carrier's provider network.

(6) A health care practitioner, a set of health care practitioners, a health care practitioner's designee, or a designee of a set of health care practitioners may file a complaint with the Administration regarding a violation of this subsection.

15–1208.2.

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

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

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

(4) A triggering event occurs when:

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

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

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

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

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

[2. gains access to new qualified health plans as a result of a permanent move and either:

A. had minimum essential coverage as described in 26 C.F.R. § 1.5000a–1(b) for 1 or more days during the 60 days before the date of the permanent move; or

B. was living outside the United States or in a United States territory at the time of the permanent move; or

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

(v) an eligible employee or a dependent:

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

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

(vi) for SHOP Exchange health benefit plans:

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

A. unintentional, inadvertent, or erroneous; and

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

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

3. an eligible employee or dependent adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the eligible employee's or dependent's decision to purchase a qualified health plan through the Exchange; or

4. AN ELIGIBLE EMPLOYEE OR DEPENDENT 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;

(vii) an eligible employee or dependent:

1. is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B–2T;

2. is enrolled in minimum essential coverage; and

3. seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;

(viii) an eligible employee or dependent:

1. applies for coverage through the Individual Exchange during the annual open enrollment period or a special enrollment period;

2. is assessed by the Individual Exchange as potentially eligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

3. is determined ineligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program by the Maryland Department of Health either:

A. after open enrollment has ended; or

B. more than 60 days after the qualifying event; **[**or**]**

(ix) an eligible employee or dependent:

1. applies for coverage through the Maryland Medical Assistance Program or the Maryland Children's Health Program during the annual open enrollment period; and

2. is determined ineligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program after open enrollment has ended**; OR**

(X) AN ELIGIBLE EMPLOYEE OR DEPENDENT GAINS ACCESS TO NEW QUALIFIED HEALTH PLANS AS A RESULT OF A PERMANENT MOVE AND EITHER:

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

2. LIVED IN A FOREIGN COUNTRY OR IN A UNITED STATES TERRITORY FOR 1 OR MORE DAYS DURING THE 60 DAYS BEFORE THE DATE OF THE PERMANENT MOVE.

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

(i) voluntary termination of coverage;

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

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

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

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

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

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

(10) If a victim of domestic abuse or spousal abandonment meets the requirements for the triggering event described in paragraph (4)(vii) of this subsection, the victim's dependents may enroll in a qualified health plan at the same time as the victim.

15–1309.

(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**] 45 C.F.R. § 147.106(E)(3)(V)**.

31–101.

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

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

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

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2018.

Approved by the Governor, May 15, 2018.