

SENATE BILL 872

C3

EMERGENCY BILL

0lr2455
CF HB 959

By: **Senators Feldman, Guzzone, Hester, Klausmeier, Lam, Lee, and Rosapepe**

Introduced and read first time: February 3, 2020

Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Consumer Protections**

3 FOR the purpose of authorizing the Maryland Insurance Commissioner to enforce certain
4 provisions of law under certain applicable powers; requiring the Commissioner to
5 adopt certain regulations under certain circumstances that are consistent with
6 certain federal regulations, rules, and guidance and that establish certain criteria,
7 certain standards, a certain definition, a certain calculation, certain reporting,
8 certain rebate requirements, certain limitations, and certain requirements;
9 prohibiting certain carriers from excluding or limiting certain benefits or denying
10 certain coverage because a certain health condition was present before or on a certain
11 date; prohibiting certain carriers from establishing certain rules for eligibility based
12 on certain health status–related factors; prohibiting certain carriers from requiring
13 certain individuals to pay a certain premium or contribution on the basis of certain
14 health status–related factors; authorizing certain carriers to determine certain
15 premium rates based on certain factors under certain circumstances; requiring
16 certain carriers that provide certain coverage of a child to continue to make certain
17 coverage available until the child is a certain age; prohibiting certain carriers from
18 establishing certain rules for eligibility for coverage of a certain child; requiring
19 certain carriers to accept certain employers and individuals that apply for certain
20 health benefit plans subject to certain provisions of law and except under certain
21 circumstances; providing that certain carriers must provide certain coverage without
22 imposing certain cost–sharing requirements for certain items, services,
23 immunizations, preventive care, and screenings except under certain circumstances;
24 prohibiting certain carriers from establishing certain lifetime limits or annual limits
25 on the dollar value of certain benefits except under certain circumstances;
26 prohibiting certain carriers from applying certain waiting periods before certain
27 coverage becomes effective for certain individuals; requiring certain carriers to allow
28 certain insured individuals to designate certain primary care providers under certain
29 circumstances; requiring certain carriers to treat certain actions by certain providers
30 as care authorized by certain providers; prohibiting certain carriers from requiring
31 authorization or referral by certain persons for an insured individual who seeks

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 certain coverage; requiring certain providers to comply with certain policies and
2 procedures; prohibiting certain carriers from requiring certain individuals from
3 obtaining certain authorization for certain emergency services; requiring certain
4 carriers to provide certain coverage and certain reimbursement for emergency
5 services under certain circumstances; requiring certain carriers to compile and
6 provide consumers a summary of benefits and coverage explanation that includes
7 certain information; requiring the Commissioner to adopt certain regulations in
8 consultation with the Maryland Health Benefits Exchange; requiring the
9 Commissioner to review and update certain standards in a certain manner under
10 certain circumstances; requiring certain carriers to provide a certain notice to certain
11 insured individuals not later than a certain number of days before a certain date;
12 requiring the Maryland Insurance Administration to levy a certain fine for a certain
13 violation; requiring the Commissioner to adopt certain regulations; establishing
14 certain medical loss ratios for certain markets; requiring certain carriers to comply
15 with certain requirements for calculating certain medical loss ratios and related
16 reporting and rebate requirements; requiring certain carriers to disclose certain
17 information to certain individuals or employers under certain circumstances;
18 authorizing certain carriers to offer certain catastrophic plans to certain individuals
19 under certain circumstances; requiring the Exchange to adopt certain regulations
20 under certain circumstances that are consistent with certain federal laws,
21 regulations, rules, and guidance and that establish a process for issuing certain
22 hardship exemptions and affordability exemptions; establishing certain
23 requirements for certain catastrophic plans; requiring certain carriers to comply
24 with certain annual limitations on cost-sharing for certain essential health benefits
25 covered under certain health benefit plans except under certain circumstances;
26 providing that certain plans must be considered to provide certain prescription drug
27 benefits if the plan complies with certain provisions of federal law or certain
28 regulations; prohibiting certain carriers from rescinding certain health benefit plan
29 coverage unless certain requirements are met; prohibiting certain carriers from
30 refusing, withholding from, or denying certain coverage to certain persons based on
31 certain factors under certain circumstances; requiring the Commission on Civil
32 Rights to enforce certain provisions of this Act; requiring the Administration, the
33 Health Education and Advocacy Unit of the Office of the Attorney General, and the
34 Exchange to monitor certain federal statutes and regulations for a certain purpose
35 and submit a certain annual report to certain committees of the General Assembly
36 on or before a certain date of certain years; providing certain legislative history and
37 intent of the General Assembly; defining certain terms; providing for the application
38 of this Act; making this Act an emergency measure; and generally relating to health
39 insurance and consumer protections.

40 BY repealing

41 Article – Insurance

42 Section 15–137.1

43 Annotated Code of Maryland

44 (2017 Replacement Volume and 2019 Supplement)

45 BY adding to

Article – Insurance

Section 15–1A–01 through 15–1A–22 to be under the new subtitle “Subtitle 1A. Consumer Protections”

Annotated Code of Maryland

(2017 Replacement Volume and 2019 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) The General Assembly finds and declares that it is in the public interest to ensure that the health care protections established by the federal Affordable Care Act continue to protect Maryland residents in light of continued threats to the federal Affordable Care Act.

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

- (1) coverage of children up to the age of 26 years;
- (2) preexisting condition exclusions;
- (3) policy rescissions;
- (4) bona fide wellness programs;
- (5) lifetime limits;
- (6) annual limits for essential benefits;
- (7) waiting periods;
- (8) designation of primary care providers;
- (9) access to obstetrical and gynecological services;
- (10) emergency services;
- (11) summary of benefits and coverage explanation;

(12) minimum loss ratio requirements and premium rebates;

(13) disclosure of information;

(14) annual limitations on cost sharing;

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

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

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

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

(20) guaranteed availability of coverage;

(21) prescription drug benefit requirements; and

(22) preventive and wellness services and chronic disease management.

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

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

SUBTITLE 1A. CONSUMER PROTECTIONS.

15-1A-01.

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

(B) “CARRIER” MEANS:

(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

1 OPERATE IN THE STATE; OR

2 (4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH
3 BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

4 (C) "CHILD" MEANS:

5 (1) A NATURAL CHILD, A STEPCHILD, A FOSTER CHILD, OR AN
6 ADOPTED CHILD OF THE INSURED; OR

7 (2) A CHILD PLACED WITH THE INSURED FOR LEGAL ADOPTION.

8 (D) "ESSENTIAL HEALTH BENEFIT" MEANS A HEALTH BENEFIT THAT:

9 (1) MEETS THE CRITERIA ESTABLISHED UNDER § 1302(B) OF THE
10 AFFORDABLE CARE ACT; OR

11 (2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN
12 § 15-1A-04 OF THIS SUBTITLE, MEETS THE CRITERIA ESTABLISHED BY THE
13 ADOPTED REGULATIONS.

14 (E) "GRANDFATHERED PLAN" MEANS A HEALTH BENEFIT PLAN THAT:

15 (1) MEETS THE CRITERIA ESTABLISHED UNDER 45 C.F.R. § 147.140
16 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS
17 WERE IN EFFECT DECEMBER 1, 2019; OR

18 (2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN
19 § 15-1A-03 OF THE SUBTITLE, MEETS THE CRITERIA ESTABLISHED BY THE
20 ADOPTED REGULATIONS.

21 (F) "GROUP PLAN" MEANS A SMALL GROUP PLAN OR A LARGE GROUP PLAN.

22 (G) "HEALTH BENEFIT PLAN" MEANS AN INDIVIDUAL PLAN, A SMALL GROUP
23 PLAN, OR A LARGE GROUP PLAN.

24 (H) "INDIVIDUAL PLAN" MEANS AN INDIVIDUAL HEALTH BENEFIT PLAN AS
25 DEFINED IN § 15-1301(O) OF THIS TITLE.

26 (I) "INSURED INDIVIDUAL" MEANS:

27 (1) AN INSURED, AN ENROLLEE, A SUBSCRIBER, A PARTICIPANT, A
28 MEMBER, OR A BENEFICIARY OF A HEALTH BENEFIT PLAN; OR

1 **(2) ANY COVERED DEPENDENT OF A HEALTH BENEFIT PLAN.**

2 **(J) “LARGE GROUP PLAN” MEANS A HEALTH BENEFIT PLAN AS DEFINED IN**
3 **§ 15–1401 OF THIS TITLE.**

4 **(K) “SMALL GROUP PLAN” MEANS A HEALTH BENEFIT PLAN AS DEFINED IN**
5 **§ 15–1201 OF THIS TITLE.**

6 **15–1A–02.**

7 **(A) THE COMMISSIONER MAY ENFORCE:**

8 **(1) THE PROVISIONS OF THIS SUBTITLE; AND**

9 **(2) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW, THE**
10 **FOLLOWING PROVISIONS OF TITLE 1, SUBTITLES A, C, AND D OF THE AFFORDABLE**
11 **CARE ACT AS THEY APPLY TO INDIVIDUAL HEALTH INSURANCE COVERAGE AND**
12 **HEALTH INSURANCE COVERAGE OFFERED IN THE SMALL GROUP AND LARGE GROUP**
13 **MARKETS AS THOSE TERMS ARE DEFINED IN THE FEDERAL PUBLIC HEALTH**
14 **SERVICE ACT, ISSUED OR DELIVERED IN THE STATE BY AN AUTHORIZED INSURER,**
15 **NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION:**

16 **(I) COVERAGE OF CHILDREN UP TO THE AGE OF 26 YEARS;**

17 **(II) PREEXISTING CONDITION EXCLUSIONS;**

18 **(III) POLICY RESCISSIONS;**

19 **(IV) BONA FIDE WELLNESS PROGRAMS;**

20 **(V) LIFETIME LIMITS;**

21 **(VI) ANNUAL LIMITS FOR ESSENTIAL BENEFITS;**

22 **(VII) WAITING PERIODS;**

23 **(VIII) DESIGNATION OF PRIMARY CARE PROVIDERS;**

24 **(IX) ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES;**

25 **(X) EMERGENCY SERVICES;**

(XI) SUMMARY OF BENEFITS AND COVERAGE EXPLANATION;

(XII) MINIMUM LOSS RATIO REQUIREMENTS AND PREMIUM
REBATES;

(XIII) DISCLOSURE OF INFORMATION;

(XIV) ANNUAL LIMITATIONS ON COST-SHARING;

(XV) CHILD-ONLY PLAN OFFERINGS IN THE INDIVIDUAL
MARKET;

(XVI) MINIMUM BENEFIT REQUIREMENTS FOR CATASTROPHIC
PLANS;

(XVII) HEALTH INSURANCE PREMIUM RATES;

(XVIII) COVERAGE FOR INDIVIDUALS PARTICIPATING IN
APPROVED CLINICAL TRIALS;

(XIX) CONTRACT REQUIREMENTS FOR STAND-ALONE DENTAL
PLANS SOLD ON THE MARYLAND HEALTH BENEFIT EXCHANGE;

(XX) GUARANTEED AVAILABILITY OF COVERAGE;

(XXI) PRESCRIPTION DRUG BENEFIT REQUIREMENTS; AND

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

(B) THE COMMISSIONER MAY ENFORCE THE PROVISIONS IDENTIFIED
UNDER SUBSECTION (A) OF THIS SECTION UNDER ANY APPLICABLE POWERS
GRANTED TO THE COMMISSIONER UNDER THIS ARTICLE.

15-1A-03.

(A) FOR PURPOSES OF THIS SUBTITLE, TO THE EXTENT NECESSARY, THE
COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(1) ESTABLISH CRITERIA THAT A HEALTH BENEFIT PLAN MUST MEET
TO BE CONSIDERED A GRANDFATHERED PLAN; AND

(2) ARE CONSISTENT WITH 45 C.F.R. § 147.140 AND ANY

CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

(B) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE AND SUBJECT TO SUBSECTION (C) OF THIS SECTION, THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN THAT IS OFFERED BY A CARRIER IN THE STATE WITHIN THE SCOPE OF:

(1) SUBTITLE 12 OF THIS TITLE;

(2) SUBTITLE 13 OF THIS TITLE; OR

(3) SUBTITLE 14 OF THIS TITLE.

(C) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE PROVISIONS OF THIS SUBTITLE DO NOT APPLY TO A GRANDFATHERED PLAN.

(2) (I) THE FOLLOWING PROVISIONS APPLY TO ALL GRANDFATHERED PLANS:

1. THE PROVISIONS OF § 15-1A-08 OF THIS SUBTITLE RELATED TO HEALTH BENEFIT PLANS THAT PROVIDE DEPENDENT COVERAGE OF A CHILD;

2. THE PROVISIONS OF § 15-1A-11 OF THIS SUBTITLE RELATED TO THE PROHIBITION ON ESTABLISHING LIFETIME LIMITS ON THE DOLLAR VALUE OF BENEFITS;

3. THE PROVISIONS OF § 15-1A-12 OF THIS SUBTITLE RELATED TO WAITING PERIODS;

4. THE PROVISIONS OF § 15-1A-15 OF THIS SUBTITLE RELATED TO SUMMARY OF BENEFITS AND COVERAGE REQUIREMENTS;

5. THE PROVISIONS OF § 15-1A-16 OF THIS SUBTITLE RELATED TO MEDICAL LOSS RATIO AND CORRESPONDING REPORTING AND REBATE REQUIREMENTS; AND

6. THE PROVISIONS OF § 15-1A-21 OF THIS SUBTITLE RELATED TO RESCISSION OF A HEALTH BENEFIT PLAN.

(II) THE FOLLOWING PROVISIONS APPLY TO ALL GRANDFATHERED PLANS EXCEPT GRANDFATHERED PLANS THAT ARE INDIVIDUAL

1 PLANS:

2 1. THE PROVISIONS OF § 15-1A-05 OF THIS SUBTITLE
3 RELATED TO PREEXISTING CONDITION EXCLUSIONS; AND

4 2. THE PROVISIONS OF § 15-1A-11 OF THIS SUBTITLE
5 RELATED TO THE PROHIBITION ON ESTABLISHING ANNUAL LIMITS ON THE DOLLAR
6 VALUE OF BENEFITS.

7 15-1A-04.

8 FOR PURPOSES OF THIS SUBTITLE, TO THE EXTENT NECESSARY, THE
9 COMMISSIONER SHALL ADOPT REGULATIONS THAT:

10 (1) ESTABLISH CRITERIA THAT A HEALTH BENEFIT PLAN MUST MEET
11 TO BE CONSIDERED A HEALTH BENEFIT PLAN THAT COVERS ESSENTIAL HEALTH
12 BENEFITS; AND

13 (2) ARE CONSISTENT WITH 45 C.F.R. PART 156 SUBPART B AND ANY
14 CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN
15 EFFECT DECEMBER 1, 2019.

16 15-1A-05.

17 (A) THIS SECTION APPLIES TO ALL GRANDFATHERED PLANS EXCEPT
18 GRANDFATHERED PLANS THAT ARE INDIVIDUAL PLANS AND TO EVERY HEALTH
19 BENEFIT PLAN THAT IS NOT A GRANDFATHERED PLAN.

20 (B) A CARRIER MAY NOT:

21 (1) EXCLUDE OR LIMIT BENEFITS BECAUSE A HEALTH CONDITION
22 WAS PRESENT BEFORE THE EFFECTIVE DATE OF COVERAGE; OR

23 (2) DENY COVERAGE BECAUSE A HEALTH CONDITION WAS PRESENT
24 BEFORE OR ON THE DATE OF DENIAL.

25 (C) THE PROHIBITION IN SUBSECTION (B) OF THIS SECTION APPLIES
26 WHETHER OR NOT:

27 (1) ANY MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS
28 RECOMMENDED OR RECEIVED FOR THE CONDITION; OR

29 (2) THE HEALTH CONDITION WAS IDENTIFIED AS A RESULT OF:

(I) A PRE-ENROLLMENT QUESTIONNAIRE OR PHYSICAL EXAMINATION GIVEN TO AN INDIVIDUAL; OR

(II) A REVIEW OF RECORDS RELATING TO THE PRE-ENROLLMENT PERIOD.

15-1A-06.

(A) A CARRIER MAY NOT ESTABLISH RULES FOR ELIGIBILITY, INCLUDING CONTINUED ELIGIBILITY, FOR ENROLLMENT OF AN INDIVIDUAL INTO A HEALTH BENEFIT PLAN BASED ON HEALTH STATUS-RELATED FACTORS, INCLUDING:

(1) HEALTH CONDITION;

(2) CLAIMS EXPERIENCE;

(3) RECEIPT OF HEALTH CARE;

(4) MEDICAL HISTORY;

(5) GENETIC INFORMATION;

(6) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE; OR

(7) DISABILITY.

(B) A CARRIER MAY NOT REQUIRE AN INDIVIDUAL, AS A CONDITION OF ENROLLMENT OR CONTINUED ENROLLMENT IN A HEALTH BENEFIT PLAN, TO PAY A PREMIUM OR CONTRIBUTION THAT IS GREATER THAN THE PREMIUM OR CONTRIBUTION FOR A SIMILARLY SITUATED INDIVIDUAL ENROLLED IN THE HEALTH BENEFIT PLAN ON THE BASIS OF ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE INDIVIDUAL OR TO AN INDIVIDUAL ENROLLED UNDER THE HEALTH BENEFIT PLAN AS A DEPENDENT OF THE INDIVIDUAL.

15-1A-07.

(A) (1) THIS SECTION MAY NOT BE CONSTRUED TO LIMIT THE AUTHORITY OF THE COMMISSIONER TO CONDUCT A HEALTH BENEFIT PLAN PREMIUM RATE REVIEW UNDER TITLE 11, SUBTITLE 6 OF THIS ARTICLE.

(2) THIS SECTION APPLIES ONLY TO A CARRIER OFFERING AN

1 INDIVIDUAL PLAN AND, SUBJECT TO § 15–1205 OF THIS TITLE, A CARRIER OFFERING
2 A SMALL GROUP PLAN.

3 (B) A CARRIER MAY DETERMINE A PREMIUM RATE BASED ON:

4 (1) SUBJECT TO SUBSECTION (C) OF THIS SECTION, AGE;

5 (2) GEOGRAPHY BASED ON THE FOLLOWING CONTIGUOUS AREAS OF
6 THE STATE:

7 (I) THE BALTIMORE METROPOLITAN AREA;

8 (II) THE DISTRICT OF COLUMBIA METROPOLITAN AREA;

9 (III) WESTERN MARYLAND; AND

10 (IV) EASTERN MARYLAND AND SOUTHERN MARYLAND;

11 (3) SUBJECT TO SUBSECTION (D) OF THIS SECTION, WHETHER THE
12 PLAN COVERS AN INDIVIDUAL OR A FAMILY; AND

13 (4) SUBJECT TO SUBSECTION (E) OF THIS SECTION, TOBACCO USE.

14 (C) (1) IN THIS SUBSECTION, “AGE” MEANS AN INDIVIDUAL’S AGE AS OF
15 THE DATE OF ISSUANCE OR RENEWAL OF A HEALTH BENEFIT PLAN.

16 (2) FOR INDIVIDUALS WHO ARE 21 YEARS OF AGE OR OLDER, A
17 PREMIUM RATE BASED ON AGE:

18 (I) MAY NOT VARY BY MORE THAN A RATIO OF 3 TO 1 FOR
19 ADULTS;

20 (II) SHALL PROVIDE FOR 1–YEAR AGE BANDS FOR INDIVIDUALS
21 AT LEAST 21 YEARS OLD AND UNDER THE AGE OF 64 YEARS; AND

22 (III) SHALL PROVIDE FOR A SINGLE AGE BAND FOR INDIVIDUALS
23 AT LEAST 64 YEARS OLD.

24 (3) FOR INDIVIDUALS WHO ARE UNDER THE AGE OF 21 YEARS, A
25 PREMIUM RATE BASED ON AGE SHALL:

26 (I) BE ACTUARIALLY JUSTIFIED AND CONSISTENT WITH THE
27 UNIFORM AGE RATING CURVE ESTABLISHED IN ACCORDANCE WITH PARAGRAPH (4)

1 OF THIS SUBSECTION;

2 (II) PROVIDE FOR A SINGLE AGE BAND FOR INDIVIDUALS UNDER
3 THE AGE OF 15 YEARS; AND

4 (III) PROVIDE FOR 1-YEAR AGE BANDS FOR INDIVIDUALS AT
5 LEAST 15 YEARS OLD AND UNDER THE AGE OF 20 YEARS.

6 (4) THE UNIFORM AGE RATING CURVE REQUIRED UNDER
7 PARAGRAPH (3)(I) OF THIS SUBSECTION MAY BE ESTABLISHED BY THE
8 COMMISSIONER IN THE INDIVIDUAL MARKET, SMALL GROUP MARKET, OR BOTH
9 MARKETS.

10 (D) (1) A RATING VARIATION FOR A HEALTH BENEFIT PLAN THAT
11 PROVIDES COVERAGE FOR A FAMILY SHALL BE APPLIED BASED ON THE PORTION OF
12 THE PREMIUM ATTRIBUTABLE TO EACH FAMILY MEMBER COVERED.

13 (2) (I) SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, A
14 PREMIUM FOR A HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE FOR A FAMILY
15 SHALL BE DETERMINED BY SUMMING THE PREMIUMS FOR EACH INDIVIDUAL FAMILY
16 MEMBER.

17 (II) FOR A HEALTH BENEFIT PLAN THAT PROVIDES FAMILY
18 COVERAGE FOR INDIVIDUALS UNDER THE AGE OF 21 YEARS, THE SUM SHALL
19 INCLUDE NOT MORE THAN THE PREMIUMS FOR THE THREE OLDEST INDIVIDUALS
20 UNDER THE AGE OF 21 YEARS.

21 (E) A PREMIUM RATE BASED ON TOBACCO USE MAY NOT VARY BY MORE
22 THAN A RATIO OF 1.5 TO 1.

23 15-1A-08.

24 (A) A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN, INCLUDING A
25 GRANDFATHERED PLAN, THAT PROVIDES FOR DEPENDENT COVERAGE OF A CHILD
26 SHALL CONTINUE TO MAKE THE COVERAGE AVAILABLE FOR THE CHILD UNTIL THE
27 CHILD IS 26 YEARS OLD.

28 (B) A CARRIER MAY NOT ESTABLISH RULES FOR ELIGIBILITY, INCLUDING
29 CONTINUED ELIGIBILITY, FOR COVERAGE OF A CHILD UNDER THE AGE OF 26 YEARS
30 BASED ON ANY FACTOR OTHER THAN THE RELATIONSHIP BETWEEN THE CHILD AND
31 THE INSURED.

32 15-1A-09.

1 (A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) THROUGH (D) OF THIS
2 SECTION, A CARRIER SHALL ACCEPT EVERY EMPLOYER AND INDIVIDUAL IN THE
3 STATE THAT APPLIES FOR A HEALTH BENEFIT PLAN, SUBJECT TO THE FOLLOWING
4 PROVISIONS OF THIS ARTICLE:

5 (1) SUBTITLE 4 OF THIS TITLE;

6 (2) §§ 15-1206(C), 15-1208.1, 15-1208.2, 15-1209, AND 15-1210 OF
7 THIS TITLE;

8 (3) §§ 15-1316 AND 15-1318 OF THIS TITLE; AND

9 (4) §§ 15-1406 AND 15-1406.1 OF THIS TITLE.

10 (B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A
11 CARRIER MAY RESTRICT ENROLLMENT TO OPEN OR SPECIAL ENROLLMENT
12 PERIODS.

13 (2) A CARRIER THAT OFFERS A LARGE GROUP PLAN SHALL ALLOW AN
14 EMPLOYER ELIGIBLE TO PURCHASE A LARGE GROUP PLAN TO PURCHASE A LARGE
15 GROUP PLAN AT ANY TIME DURING THE YEAR.

16 (C) IF A CARRIER USES A NETWORK FOR A HEALTH BENEFIT PLAN UNDER
17 WHICH THE FINANCING AND DELIVERY OF MEDICAL CARE ARE PROVIDED, IN WHOLE
18 OR IN PART, THROUGH A DEFINED SET OF PROVIDERS UNDER CONTRACT WITH THE
19 CARRIER, THE CARRIER:

20 (1) (I) MAY LIMIT THE EMPLOYERS THAT MAY APPLY FOR
21 COVERAGE TO EMPLOYERS OF ELIGIBLE INDIVIDUALS WHO LIVE, WORK, OR RESIDE
22 IN THE SERVICE AREA FOR THE NETWORK; AND

23 (II) IF THE CARRIER IS A HEALTH MAINTENANCE
24 ORGANIZATION, MAY LIMIT THE INDIVIDUALS WHO MAY APPLY FOR COVERAGE IN
25 THE INDIVIDUAL MARKET TO THOSE WHO LIVE OR RESIDE IN THE SERVICE AREA
26 FOR THE NETWORK; OR

27 (2) MAY DENY COVERAGE WITHIN A SERVICE AREA IF THE CARRIER:

28 (I) DEMONSTRATES TO THE COMMISSIONER THAT:

29 1. THE CARRIER DOES NOT HAVE THE CAPACITY TO
30 DELIVER ADEQUATE SERVICES TO ADDITIONAL ENROLLEES OF GROUPS OR

1 ADDITIONAL INDIVIDUALS BECAUSE OF ITS OBLIGATIONS TO EXISTING GROUP
2 CONTRACT HOLDERS AND ENROLLEES; AND

3 2. THE CARRIER APPLIES THE DENIAL OF COVERAGE
4 UNIFORMLY TO ALL EMPLOYERS AND INDIVIDUALS WITHOUT REGARD TO THE
5 CLAIMS EXPERIENCE OR ANY HEALTH STATUS-RELATED FACTOR; AND

6 (II) DOES NOT OFFER COVERAGE WITHIN THE SERVICE AREA
7 FOR AT LEAST 180 DAYS AFTER THE DATE THE CARRIER DENIED COVERAGE IN THE
8 SERVICE AREA.

9 (D) A CARRIER MAY DENY COVERAGE IF THE CARRIER:

10 (1) DEMONSTRATES TO THE COMMISSIONER THAT:

11 (I) THE CARRIER DOES NOT HAVE THE FINANCIAL RESERVES
12 NECESSARY TO UNDERWRITE ADDITIONAL COVERAGE; AND

13 (II) THE CARRIER APPLIES THE DENIAL OF COVERAGE
14 UNIFORMLY TO ALL EMPLOYERS AND INDIVIDUALS WITHOUT REGARD TO THE
15 CLAIMS EXPERIENCE OR ANY HEALTH STATUS-RELATED FACTOR; AND

16 (2) UNLESS A LATER DATE IS OTHERWISE AUTHORIZED BY THE
17 COMMISSIONER, DOES NOT OFFER THE DENIED COVERAGE FOR AT LEAST 180 DAYS
18 AFTER THE DATE THE CARRIER DENIED THE COVERAGE.

19 15-1A-10.

20 (A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C) OF THIS SECTION, A
21 CARRIER SHALL PROVIDE COVERAGE FOR AND MAY NOT IMPOSE ANY
22 COST-SHARING REQUIREMENTS, INCLUDING COPAYMENTS, COINSURANCE, OR
23 DEDUCTIBLES FOR:

24 (1) EVIDENCE-BASED ITEMS OR SERVICES THAT HAVE IN EFFECT A
25 RATING OF A OR B IN THE CURRENT RECOMMENDATIONS OF THE UNITED STATES
26 PREVENTIVE SERVICES TASK FORCE WITH RESPECT TO THE INDIVIDUAL
27 INVOLVED;

28 (2) IMMUNIZATIONS FOR ROUTINE USE IN CHILDREN, ADOLESCENTS,
29 AND ADULTS THAT HAVE IN EFFECT A RECOMMENDATION FROM THE ADVISORY
30 COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE
31 CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED, IF THE
32 RECOMMENDATION:

1 (I) HAS BEEN ADOPTED BY THE DIRECTOR OF THE CENTERS
2 FOR DISEASE CONTROL AND PREVENTION; AND

3 (II) IS LISTED ON THE IMMUNIZATION SCHEDULES OF THE
4 CENTERS FOR DISEASE CONTROL AND PREVENTION FOR ROUTINE USE;

5 (3) WITH RESPECT TO INFANTS, CHILDREN, AND ADOLESCENTS,
6 EVIDENCE-INFORMED PREVENTIVE CARE AND SCREENINGS PROVIDED FOR IN
7 COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND
8 SERVICES ADMINISTRATION; AND

9 (4) WITH RESPECT TO WOMEN:

10 (I) EXCEPT AS PROVIDED IN ITEM (II) OF THIS ITEM,
11 PREVENTIVE CARE AND SCREENINGS AS PROVIDED FOR IN COMPREHENSIVE
12 GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES
13 ADMINISTRATION FOR PURPOSES OF § 2713(A)(4) OF THE FEDERAL PUBLIC
14 HEALTH SERVICE ACT; AND

15 (II) SUBJECT TO §§ 15-826 AND 15-826.1 OF THIS TITLE,
16 CONTRACEPTIVE COVERAGE AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES
17 SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR
18 PURPOSES OF § 2713(A)(4) OF THE FEDERAL PUBLIC HEALTH SERVICE ACT.

19 (B) TO THE EXTENT THAT COST-SHARING IS OTHERWISE ALLOWED UNDER
20 FEDERAL OR STATE LAW, A HEALTH BENEFIT PLAN THAT USES A NETWORK OF
21 PROVIDERS MAY IMPOSE COST-SHARING REQUIREMENTS ON THE COVERAGE
22 DESCRIBED IN SUBSECTION (A) OF THIS SECTION FOR ITEMS OR SERVICES
23 DELIVERED BY AN OUT-OF-NETWORK PROVIDER.

24 (C) THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT A CARRIER FROM
25 PROVIDING COVERAGE FOR SERVICES IN ADDITION TO THOSE RECOMMENDED BY
26 THE UNITED STATES PREVENTIVE SERVICES TASK FORCE OR TO DENY COVERAGE
27 FOR SERVICES THAT ARE NOT RECOMMENDED BY THE TASK FORCE.

28 15-1A-11.

29 (A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C) OF THIS SECTION, A
30 CARRIER THAT OFFERS A HEALTH BENEFIT PLAN, INCLUDING A GRANDFATHERED
31 PLAN, MAY NOT ESTABLISH LIFETIME LIMITS OR ANNUAL LIMITS ON THE DOLLAR
32 VALUE OF BENEFITS FOR ANY INSURED INDIVIDUAL.

(B) TO THE EXTENT THAT LIMITS ARE OTHERWISE AUTHORIZED UNDER FEDERAL OR STATE LAW, A CARRIER MAY ESTABLISH ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR AN INSURED INDIVIDUAL FOR A GRANDFATHERED PLAN THAT IS AN INDIVIDUAL PLAN.

(C) THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT A CARRIER FROM PLACING ANNUAL OR LIFETIME PER BENEFICIARY LIMITS ON SPECIFIC COVERED BENEFITS THAT ARE NOT ESSENTIAL HEALTH BENEFITS.

15-1A-12.

A CARRIER OFFERING A GROUP PLAN, INCLUDING A GRANDFATHERED PLAN, MAY NOT APPLY A WAITING PERIOD OF MORE THAN 90 DAYS THAT MUST PASS BEFORE COVERAGE BECOMES EFFECTIVE FOR AN INDIVIDUAL WHO IS OTHERWISE ELIGIBLE FOR THE GROUP PLAN.

15-1A-13.

(A) IF A CARRIER REQUIRES OR PROVIDES FOR THE DESIGNATION OF A PARTICIPATING PRIMARY CARE PROVIDER FOR AN INSURED INDIVIDUAL, THE CARRIER SHALL ALLOW EACH INSURED INDIVIDUAL TO DESIGNATE ANY PARTICIPATING PRIMARY CARE PROVIDER IF THE PROVIDER IS AVAILABLE TO ACCEPT THE INSURED INDIVIDUAL.

(B) (1) (I) THIS SUBSECTION APPLIES ONLY TO AN INDIVIDUAL WHO HAS A CHILD WHO IS AN INSURED INDIVIDUAL UNDER THE INDIVIDUAL'S HEALTH BENEFIT PLAN.

(II) THIS SUBSECTION MAY NOT BE CONSTRUED TO WAIVE ANY EXCLUSIONS OF COVERAGE UNDER THE TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN WITH RESPECT TO COVERAGE OF PEDIATRIC CARE.

(2) IF A CARRIER REQUIRES OR PROVIDES FOR THE DESIGNATION OF A PARTICIPATING PRIMARY CARE PROVIDER FOR A CHILD, THE CARRIER SHALL ALLOW THE INDIVIDUAL TO DESIGNATE ANY PARTICIPATING PHYSICIAN WHO SPECIALIZES IN PEDIATRICS AS THE CHILD'S PRIMARY CARE PROVIDER IF THE PROVIDER IS AVAILABLE TO ACCEPT THE CHILD.

(C) (1) (I) THIS SUBSECTION APPLIES ONLY TO A CARRIER THAT:

1. PROVIDES COVERAGE FOR OBSTETRICAL OR GYNECOLOGICAL CARE; AND

1 **2. REQUIRES THE DESIGNATION BY AN INSURED**
2 **INDIVIDUAL OF A PARTICIPATING PRIMARY CARE PROVIDER.**

3 **(II) THIS SUBSECTION MAY NOT BE CONSTRUED TO:**

4 **1. WAIVE ANY EXCLUSIONS OF COVERAGE UNDER THE**
5 **TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN WITH RESPECT TO COVERAGE**
6 **OF OBSTETRICAL OR GYNECOLOGICAL CARE; OR**

7 **2. PROHIBIT A CARRIER FROM REQUIRING THAT THE**
8 **OBSTETRICAL OR GYNECOLOGICAL PROVIDER NOTIFY THE PRIMARY CARE**
9 **PROVIDER OR CARRIER FOR AN INSURED INDIVIDUAL OF TREATMENT DECISIONS.**

10 **(2) A CARRIER SHALL TREAT THE PROVISION OF OBSTETRICAL AND**
11 **GYNECOLOGICAL CARE AND THE ORDERING OF RELATED OBSTETRICAL AND**
12 **GYNECOLOGICAL ITEMS AND SERVICES BY A PARTICIPATING HEALTH CARE**
13 **PROVIDER THAT SPECIALIZES IN OBSTETRICS OR GYNECOLOGY AS CARE**
14 **AUTHORIZED BY THE PRIMARY CARE PROVIDER FOR THE INSURED INDIVIDUAL.**

15 **(3) A CARRIER MAY NOT REQUIRE AUTHORIZATION OR REFERRAL BY**
16 **ANY PERSON, INCLUDING THE PRIMARY CARE PROVIDER FOR THE INSURED**
17 **INDIVIDUAL, FOR AN INSURED INDIVIDUAL WHO SEEKS COVERAGE FOR**
18 **OBSTETRICAL OR GYNECOLOGICAL CARE PROVIDED BY A PARTICIPATING HEALTH**
19 **CARE PROVIDER WHO SPECIALIZES IN OBSTETRICS OR GYNECOLOGY.**

20 **(4) A HEALTH CARE PROVIDER THAT PROVIDES OBSTETRICAL OR**
21 **GYNECOLOGICAL CARE SHALL COMPLY WITH A CARRIER'S POLICIES AND**
22 **PROCEDURES.**

23 **15-1A-14.**

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

26 **(2) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL**
27 **CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUCH SEVERITY,**
28 **INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION**
29 **COULD REASONABLY BE EXPECTED BY A PRUDENT LAYPERSON, WHO POSSESSES AN**
30 **AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, TO RESULT IN A CONDITION**
31 **DESCRIBED IN § 1867(E)(1) OF THE SOCIAL SECURITY ACT.**

32 **(3) "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN**
33 **EMERGENCY MEDICAL CONDITION:**

1 **(I) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE**
2 **CAPABILITY OF THE EMERGENCY DEPARTMENT OF A FACILITY, INCLUDING**
3 **ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT**
4 **TO EVALUATE AN EMERGENCY MEDICAL CONDITION; OR**

5 **(II) ANY OTHER EXAMINATION OR TREATMENT WITHIN THE**
6 **CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE FACILITY THAT IS**
7 **NECESSARY TO STABILIZE THE PATIENT.**

8 **(B) IF A CARRIER PROVIDES OR COVERS ANY BENEFITS FOR EMERGENCY**
9 **SERVICES IN AN EMERGENCY DEPARTMENT OF A FACILITY, THE CARRIER:**

10 **(1) MAY NOT REQUIRE AN INSURED INDIVIDUAL TO OBTAIN PRIOR**
11 **AUTHORIZATION FOR THE EMERGENCY SERVICES; AND**

12 **(2) SHALL PROVIDE COVERAGE FOR THE EMERGENCY SERVICES**
13 **REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER PROVIDING THE**
14 **EMERGENCY SERVICES HAS A CONTRACTUAL RELATIONSHIP WITH THE CARRIER TO**
15 **FURNISH EMERGENCY SERVICES.**

16 **(C) IF A HEALTH CARE PROVIDER OF EMERGENCY SERVICES DOES NOT**
17 **HAVE A CONTRACTUAL RELATIONSHIP WITH THE CARRIER TO PROVIDE EMERGENCY**
18 **SERVICES, THE CARRIER:**

19 **(1) MAY NOT IMPOSE ANY ADMINISTRATIVE REQUIREMENT OR**
20 **LIMITATION ON COVERAGE THAT WOULD BE MORE RESTRICTIVE THAN**
21 **ADMINISTRATIVE REQUIREMENTS OR LIMITATIONS IMPOSED ON COVERAGE FOR**
22 **EMERGENCY SERVICES FURNISHED BY A HEALTH CARE PROVIDER WITH A**
23 **CONTRACTUAL RELATIONSHIP WITH THE CARRIER;**

24 **(2) SUBJECT TO § 14-205.2 OF THIS ARTICLE AND § 19-710.1 OF**
25 **THE HEALTH – GENERAL ARTICLE, MAY NOT IMPOSE ANY COST-SHARING AMOUNT**
26 **GREATER THAN THE AMOUNT IMPOSED FOR EMERGENCY SERVICES FURNISHED BY**
27 **A HEALTH CARE PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE**
28 **CARRIER; AND**

29 **(3) SHALL REIMBURSE THE HEALTH CARE PROVIDER AT THE**
30 **REIMBURSEMENT RATE SPECIFIED IN SUBSECTION (D) OF THIS SECTION.**

31 **(D) EXCEPT AS PROVIDED IN § 14-205.2 OF THIS ARTICLE AND § 19-710.1**
32 **OF THE HEALTH – GENERAL ARTICLE, A CARRIER SHALL REIMBURSE A HEALTH**
33 **CARE PROVIDER OF EMERGENCY SERVICES THAT DOES NOT HAVE A CONTRACTUAL**

RELATIONSHIP WITH THE CARRIER THE GREATER OF:

(1) THE MEDIAN AMOUNT NEGOTIATED WITH IN-NETWORK PROVIDERS FOR THE EMERGENCY SERVICE, EXCLUDING ANY IN-NETWORK COPAYMENT OR COINSURANCE;

(2) THE AMOUNT FOR THE EMERGENCY SERVICE CALCULATED USING THE SAME METHOD THE HEALTH BENEFIT PLAN GENERALLY USES TO DETERMINE PAYMENTS FOR OUT-OF-NETWORK SERVICES, EXCLUDING ANY IN-NETWORK COPAYMENT OR COINSURANCE, WITHOUT REDUCTION FOR OUT-OF-NETWORK COST-SHARING THAT GENERALLY APPLIES UNDER THE HEALTH BENEFIT PLAN; OR

(3) THE AMOUNT THAT WOULD BE PAID UNDER MEDICARE PART A OR PART B FOR THE EMERGENCY SERVICE, EXCLUDING ANY IN-NETWORK COPAYMENT OR COINSURANCE.

15-1A-15.

(A) THIS SECTION APPLIES TO ALL GRANDFATHERED PLANS AND TO EVERY HEALTH BENEFIT PLAN THAT IS NOT A GRANDFATHERED PLAN.

(B) (1) A CARRIER SHALL COMPILE AND PROVIDE TO CONSUMERS A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION THAT:

(I) ACCURATELY DESCRIBES THE BENEFITS AND COVERAGE UNDER THE APPLICABLE HEALTH BENEFIT PLAN; AND

(II) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, COMPLIES WITH THE STANDARDS UNDER 45 C.F.R. § 147.200.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION, A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION SHALL COMPLY WITH THE STANDARDS IN THE ADOPTED REGULATIONS.

(C) TO THE EXTENT NECESSARY, THE COMMISSIONER, IN CONSULTATION WITH THE MARYLAND HEALTH BENEFIT EXCHANGE, SHALL ADOPT REGULATIONS THAT:

(1) ESTABLISH STANDARDS FOR THE SUMMARY OF BENEFITS AND COVERAGE; AND

(2) ARE CONSISTENT WITH 45 C.F.R. § 147.200 AND ANY

CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT DECEMBER 1, 2019.

(D) THE SUMMARY OF BENEFITS AND COVERAGE SHALL BE PRESENTED:

(1) IN A UNIFORM FORMAT THAT DOES NOT EXCEED FOUR PAGES IN LENGTH AND DOES NOT INCLUDE PRINT SMALLER THAN 12 POINT TYPE; AND

(2) IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE MANNER THAT USES TERMINOLOGY UNDERSTANDABLE BY THE AVERAGE INSURED INDIVIDUAL.

(E) THE STANDARDS DEVELOPED UNDER SUBSECTION (C) OF THIS SECTION SHALL INCLUDE:

(1) UNIFORM DEFINITIONS OF STANDARD INSURANCE-RELATED TERMS AND MEDICAL TERMS SO CONSUMERS MAY COMPARE HEALTH BENEFIT PLANS AND UNDERSTAND THE TERMS OF AND EXCEPTIONS TO COVERAGE, INCLUDING:

(I) PREMIUM;

(II) DEDUCTIBLE;

(III) COINSURANCE;

(IV) COPAYMENT;

(V) OUT-OF-POCKET LIMIT;

(VI) PREFERRED PROVIDER;

(VII) NONPREFERRED PROVIDER;

(VIII) OUT-OF-NETWORK COPAYMENTS;

(IX) USUAL, CUSTOMARY, AND REASONABLE FEES;

(X) EXCLUDED SERVICES;

(XI) GRIEVANCE AND APPEALS;

(XII) HOSPITALIZATION;

1 (XIII) HOSPITAL OUTPATIENT CARE;

2 (XIV) EMERGENCY ROOM CARE;

3 (XV) PHYSICIAN SERVICES;

4 (XVI) PRESCRIPTION DRUG COVERAGE;

5 (XVII) DURABLE MEDICAL EQUIPMENT;

6 (XVIII) HOME HEALTH CARE;

7 (XIX) SKILLED NURSING CARE;

8 (XX) REHABILITATION SERVICES;

9 (XXI) HOSPICE SERVICES;

10 (XXII) EMERGENCY MEDICAL TRANSPORTATION; AND

11 (XXIII) ANY OTHER TERMS THE COMMISSIONER DETERMINES
12 ARE IMPORTANT TO DEFINE SO A CONSUMER MAY COMPARE THE MEDICAL
13 BENEFITS OFFERED BY HEALTH BENEFIT PLANS AND UNDERSTAND THE EXTENT OF
14 AND EXCEPTIONS TO THOSE MEDICAL BENEFITS;

15 (2) A DESCRIPTION OF THE COVERAGE OF A HEALTH BENEFIT PLAN,
16 INCLUDING COST-SHARING FOR:

17 (I) EACH OF THE CATEGORIES OF THE ESSENTIAL HEALTH
18 BENEFITS IN THE STATE BENCHMARK PLAN SELECTED IN ACCORDANCE WITH §
19 31-116 OF THIS ARTICLE; AND

20 (II) OTHER BENEFITS, AS IDENTIFIED BY THE COMMISSIONER;

21 (3) THE EXCEPTIONS, REDUCTIONS, AND LIMITATIONS ON
22 COVERAGE;

23 (4) THE RENEWABILITY AND CONTINUATION OF COVERAGE
24 PROVISIONS;

25 (5) A COVERAGE FACTS LABEL THAT INCLUDES EXAMPLES TO
26 ILLUSTRATE COMMON BENEFITS SCENARIOS BASED ON RECOGNIZED CLINICAL
27 PRACTICE GUIDELINES, INCLUDING PREGNANCY AND SERIOUS OR CHRONIC

1 MEDICAL CONDITIONS AND RELATED COST-SHARING REQUIREMENTS;

2 (6) A STATEMENT OF WHETHER THE HEALTH BENEFIT PLAN ENSURES
3 THAT THE PLAN OR COVERAGE SHARE OF THE TOTAL ALLOWED COSTS OF BENEFITS
4 PROVIDED UNDER THE PLAN OR COVERAGE IS NOT LESS THAN 60% OF THE COSTS;

5 (7) A STATEMENT THAT:

6 (I) THE SUMMARY OF BENEFITS IS AN OUTLINE OF THE HEALTH
7 BENEFIT PLAN; AND

8 (II) THE LANGUAGE OF THE HEALTH BENEFIT PLAN SHOULD BE
9 CONSULTED TO DETERMINE THE GOVERNING CONTRACTUAL PROVISIONS; AND

10 (8) A CONTACT NUMBER FOR THE CONSUMER TO CALL WITH
11 ADDITIONAL QUESTIONS AND A WEBSITE WHERE A COPY OF THE ACTUAL HEALTH
12 BENEFIT PLAN CAN BE REVIEWED AND OBTAINED.

13 (F) AS APPROPRIATE, THE COMMISSIONER, IN CONSULTATION WITH THE
14 MARYLAND HEALTH BENEFIT EXCHANGE, SHALL PERIODICALLY REVIEW AND
15 UPDATE THE STANDARDS DEVELOPED UNDER SUBSECTION (C) OF THIS SECTION.

16 (G) (1) EACH CARRIER SHALL PROVIDE A SUMMARY OF BENEFITS AND
17 COVERAGE EXPLANATION THAT COMPLIES WITH THE STANDARDS DEVELOPED
18 UNDER SUBSECTION (C) OF THIS SECTION BY THE COMMISSIONER TO:

19 (I) AN APPLICANT AT THE TIME OF APPLICATION; AND

20 (II) AN INSURED INDIVIDUAL BEFORE THE TIME OF
21 ENROLLMENT OR REENROLLMENT, AS APPLICABLE.

22 (2) A CARRIER MAY PROVIDE A SUMMARY OF BENEFITS AND
23 COVERAGE EXPLANATION AS REQUIRED UNDER PARAGRAPH (1) OF THIS
24 SUBSECTION IN PAPER OR ELECTRONIC FORM.

25 (H) EXCEPT AS OTHERWISE PROVIDED IN THIS ARTICLE, IF A CARRIER
26 MAKES ANY MATERIAL MODIFICATION IN ANY OF THE TERMS OF THE PLAN OR
27 COVERAGE INVOLVED THAT IS NOT REFLECTED IN THE MOST RECENTLY PROVIDED
28 SUMMARY OF BENEFITS AND COVERAGE EXPLANATION, THE CARRIER SHALL
29 PROVIDE NOTICE OF THE MODIFICATION TO INSURED INDIVIDUALS NOT LATER
30 THAN 60 DAYS BEFORE THE EFFECTIVE DATE OF THE MODIFICATION.

(1) (1) THE MARYLAND INSURANCE ADMINISTRATION SHALL LEVY A FINE OF NOT MORE THAN \$1,000 AGAINST A CARRIER THAT WILLFULLY FAILS TO PROVIDE THE INFORMATION REQUIRED UNDER THIS SECTION.

(2) A FAILURE WITH RESPECT TO EACH INSURED INDIVIDUAL SHALL CONSTITUTE A SEPARATE OFFENSE FOR PURPOSES OF THIS SUBSECTION.

15-1A-16.

(A) (1) FOR PURPOSES OF THIS SECTION, “MEDICAL LOSS RATIO”:

(I) HAS THE MEANING ESTABLISHED IN 45 C.F.R. § 158.221; OR

(II) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION, HAS THE MEANING ESTABLISHED BY THE ADOPTED REGULATIONS.

(2) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(I) ESTABLISH A DEFINITION FOR “MEDICAL LOSS RATIO”; AND

(II) ARE CONSISTENT WITH 45 C.F.R. § 158.221 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

(B) THIS SECTION APPLIES TO ALL GRANDFATHERED PLANS AND TO EVERY HEALTH BENEFIT PLAN THAT IS NOT A GRANDFATHERED PLAN.

(C) THE MINIMUM ACCEPTABLE MEDICAL LOSS RATIO IS:

(1) FOR THE LARGE GROUP MARKET, 85% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS; AND

(2) FOR THE SMALL GROUP MARKET AND INDIVIDUAL MARKET, 80% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS.

(D) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, EACH CARRIER SHALL COMPLY WITH THE REQUIREMENTS FOR CALCULATING MEDICAL LOSS RATIOS AND RELATED REPORTING AND REBATE REQUIREMENTS ESTABLISHED IN 45 C.F.R. PART 158 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (E) OF THIS SECTION, EACH CARRIER SHALL COMPLY WITH THE REQUIREMENTS IN THE ADOPTED REGULATIONS.

(E) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(1) ESTABLISH REQUIREMENTS FOR CALCULATING MEDICAL LOSS RATIOS AND RELATED REPORTING AND REBATE REQUIREMENTS; AND

(2) ARE CONSISTENT WITH 45 C.F.R. PART 158 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

15-1A-17.

(A) (1) THIS SECTION MAY NOT BE CONSTRUED TO REQUIRE A CARRIER TO DISCLOSE INFORMATION THAT IS PROPRIETARY AND TRADE SECRET INFORMATION UNDER APPLICABLE LAW.

(2) THIS SECTION APPLIES ONLY TO CARRIERS OFFERING AN INDIVIDUAL PLAN OR A SMALL GROUP PLAN.

(B) A CARRIER SHALL DISCLOSE TO AN INDIVIDUAL OR EMPLOYER, AS APPLICABLE, THE FOLLOWING INFORMATION:

(1) THE CARRIER'S RIGHT TO CHANGE PREMIUM RATES AND THE FACTORS THAT MAY AFFECT CHANGES IN PREMIUM RATES; AND

(2) THE BENEFITS AND PREMIUMS AVAILABLE UNDER ALL HEALTH BENEFIT PLANS FOR WHICH THE EMPLOYER OR INDIVIDUAL IS QUALIFIED.

(C) THE CARRIER SHALL MAKE THE DISCLOSURE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION:

(1) AS PART OF ITS SOLICITATION AND SALES MATERIAL; OR

(2) IF THE INFORMATION IS REQUESTED BY THE INDIVIDUAL OR EMPLOYER.

(D) INFORMATION DISCLOSED IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION SHALL BE:

1 (1) PROVIDED IN A MANNER DETERMINED TO BE UNDERSTANDABLE
2 BY THE AVERAGE EMPLOYER OR INDIVIDUAL; AND

3 (2) SUFFICIENT TO REASONABLY INFORM THE EMPLOYER OR
4 INDIVIDUAL OF THE EMPLOYER'S OR INDIVIDUAL'S RIGHTS AND OBLIGATIONS
5 UNDER THE HEALTH BENEFIT PLAN.

6 15-1A-18.

7 (A) A CARRIER MAY OFFER A CATASTROPHIC PLAN IN THE INDIVIDUAL
8 MARKET IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SECTION.

9 (B) A CATASTROPHIC PLAN MAY BE OFFERED ONLY TO INDIVIDUALS WHO:

10 (1) ARE UNDER THE AGE OF 30 YEARS BEFORE THE BEGINNING OF
11 THE PLAN YEAR; OR

12 (2) HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AN
13 AFFORDABILITY EXEMPTION AS REQUIRED IN SUBSECTION (C) OF THIS SECTION.

14 (C) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION,
15 TO BE OFFERED A CATASTROPHIC PLAN, AN INDIVIDUAL SHALL HOLD
16 CERTIFICATION FOR A HARDSHIP EXEMPTION OR AN AFFORDABILITY EXEMPTION
17 UNDER 42 U.S.C. § 5000A.

18 (2) IF THE MARYLAND HEALTH BENEFIT EXCHANGE ADOPTS
19 REGULATIONS AS DESCRIBED UNDER SUBSECTION (D) OF THIS SECTION, AN
20 INDIVIDUAL SHALL HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AN
21 AFFORDABILITY EXEMPTION UNDER THE REGULATIONS ADOPTED BY THE
22 EXCHANGE.

23 (D) TO THE EXTENT NECESSARY, THE MARYLAND HEALTH BENEFIT
24 EXCHANGE SHALL ADOPT REGULATIONS THAT:

25 (1) ESTABLISH A PROCESS FOR ISSUING HARDSHIP EXEMPTIONS AND
26 AFFORDABILITY EXEMPTIONS; AND

27 (2) ARE CONSISTENT WITH 42 U.S.C. § 5000A AND ANY
28 CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN
29 EFFECT DECEMBER 1, 2019.

(E) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A CATASTROPHIC PLAN SHALL PROVIDE COVERAGE FOR ESSENTIAL HEALTH BENEFITS.

(2) A CATASTROPHIC PLAN SHALL REQUIRE A DEDUCTIBLE THAT:

(I) IS EQUAL TO THE ANNUAL LIMIT ON COST-SHARING DESCRIBED IN § 15-1A-19 OF THIS SUBTITLE;

(II) APPLIES TO ESSENTIAL HEALTH BENEFITS;

(III) DOES NOT APPLY TO AT LEAST THREE PRIMARY CARE VISITS EACH PLAN YEAR; AND

(IV) DOES NOT APPLY TO ANY COVERED BENEFITS FOR WHICH A DEDUCTIBLE IS PROHIBITED UNDER THIS TITLE.

15-1A-19.

(A) (1) IN THIS SECTION, "COST-SHARING" MEANS ANY EXPENDITURE REQUIRED BY OR ON BEHALF OF AN INSURED INDIVIDUAL WITH RESPECT TO ESSENTIAL HEALTH BENEFITS.

(2) "COST-SHARING" INCLUDES:

(I) DEDUCTIBLES, COINSURANCE, COPAYMENTS, OR SIMILAR CHARGES; AND

(II) ANY OTHER EXPENDITURE REQUIRED OF AN INSURED INDIVIDUAL THAT IS A QUALIFIED MEDICAL EXPENSE, AS DEFINED IN 26 U.S.C. § 223(D)(2), WITH RESPECT TO ESSENTIAL HEALTH BENEFITS COVERED UNDER THE PLAN.

(3) "COST-SHARING" DOES NOT INCLUDE PREMIUMS, BALANCE BILLING AMOUNTS FOR NONNETWORK PROVIDERS, OR SPENDING FOR NONCOVERED SERVICES.

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, EACH CARRIER SHALL COMPLY WITH ANNUAL LIMITATIONS ON COST-SHARING FOR ESSENTIAL HEALTH BENEFITS COVERED UNDER HEALTH BENEFIT PLANS AS ESTABLISHED BY 45 C.F.R. § 156.130.

1 **(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN**
2 **SUBSECTION (C) OF THIS SECTION, EACH CARRIER SHALL COMPLY WITH THE**
3 **ADOPTED REGULATIONS.**

4 **(C) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT**
5 **REGULATIONS THAT:**

6 **(1) ESTABLISH ANNUAL LIMITATIONS ON COST-SHARING; AND**

7 **(2) ARE CONSISTENT WITH 45 C.F.R. § 156.130 AND ANY**
8 **CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN**
9 **EFFECT DECEMBER 1, 2019.**

10 **15-1A-20.**

11 **(A) (1) THIS SECTION APPLIES ONLY TO INDIVIDUAL PLANS AND SMALL**
12 **GROUP PLANS.**

13 **(2) THE REQUIREMENTS IN THIS SECTION ARE IN ADDITION TO AND**
14 **NOT IN SUBSTITUTION OF ANY OTHER REQUIREMENTS OF LAW RELATED TO**
15 **PRESCRIPTION DRUG BENEFITS.**

16 **(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION,**
17 **AN INDIVIDUAL PLAN OR A SMALL GROUP PLAN SHALL BE CONSIDERED TO PROVIDE**
18 **PRESCRIPTION DRUG ESSENTIAL HEALTH BENEFITS ONLY IF THE INDIVIDUAL PLAN**
19 **OR SMALL GROUP PLAN COMPLIES WITH 45 C.F.R. § 156.122.**

20 **(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN**
21 **SUBSECTION (C) OF THIS SECTION, AN INDIVIDUAL PLAN OR A SMALL GROUP PLAN**
22 **SHALL BE CONSIDERED TO PROVIDE PRESCRIPTION DRUG ESSENTIAL HEALTH**
23 **BENEFITS ONLY IF THE INDIVIDUAL PLAN OR SMALL GROUP PLAN COMPLIES WITH**
24 **THE REGULATIONS ADOPTED BY THE COMMISSIONER.**

25 **(C) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT**
26 **REGULATIONS THAT:**

27 **(1) ESTABLISH CRITERIA TO DETERMINE WHETHER AN INDIVIDUAL**
28 **PLAN OR A SMALL GROUP PLAN PROVIDES PRESCRIPTION DRUG ESSENTIAL HEALTH**
29 **BENEFIT COVERAGE; AND**

30 **(2) ARE CONSISTENT WITH 45 C.F.R. § 156.122 AND ANY**
31 **CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN**
32 **EFFECT DECEMBER 1, 2019.**

1 15-1A-21.

2 (A) THIS SECTION APPLIES TO ALL GRANDFATHERED PLANS AND TO EVERY
3 HEALTH BENEFIT PLAN THAT IS NOT A GRANDFATHERED PLAN.

4 (B) (1) SUBJECT TO § 15-1106 OF THIS TITLE, A CARRIER MAY NOT
5 RESCIND THE COVERAGE UNDER A HEALTH BENEFIT PLAN UNLESS:

6 (I) THE INSURED INDIVIDUAL PERFORMS AN ACT, A PRACTICE,
7 OR AN OMISSION THAT CONSTITUTES FRAUD OR MAKES A MISREPRESENTATION OF
8 MATERIAL FACT AS PROHIBITED BY THE HEALTH BENEFIT PLAN; AND

9 (II) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS
10 SUBSECTION, THE CARRIER COMPLIES WITH 45 C.F.R. § 147.128.

11 (2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN
12 SUBSECTION (C) OF THIS SECTION, A CARRIER THAT RESCINDS THE COVERAGE
13 UNDER A HEALTH BENEFIT PLAN IN ACCORDANCE WITH SUBSECTION (B) OF THIS
14 SECTION SHALL COMPLY WITH THE ADOPTED REGULATIONS.

15 (C) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT
16 REGULATIONS THAT:

17 (1) ESTABLISH REQUIREMENTS THAT A CARRIER SHALL COMPLY
18 WITH TO RESCIND COVERAGE UNDER SUBSECTION (B) OF THIS SECTION; AND

19 (2) ARE CONSISTENT WITH 45 C.F.R. § 147.128 AND ANY FEDERAL
20 RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

21 15-1A-22.

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

24 (2) "GENDER IDENTITY" HAS THE MEANING STATED IN § 20-101 OF
25 THE STATE GOVERNMENT ARTICLE.

26 (3) "SEXUAL ORIENTATION" HAS THE MEANING STATED IN § 20-101
27 OF THE STATE GOVERNMENT ARTICLE.

28 (B) THIS SECTION DOES NOT PROHIBIT A CARRIER FROM REFUSING,
29 WITHHOLDING, OR DENYING COVERAGE UNDER A HEALTH BENEFIT PLAN TO ANY

1 INDIVIDUAL FOR FAILURE TO CONFORM TO THE USUAL AND REGULAR
2 REQUIREMENTS, STANDARDS, AND REGULATIONS OF THE CARRIER, UNLESS THE
3 DENIAL IS BASED ON DISCRIMINATION ON THE GROUNDS OF RACE, SEX, COLOR,
4 CREED, NATIONAL ORIGIN, MARITAL STATUS, SEXUAL ORIENTATION, AGE, GENDER
5 IDENTITY, OR DISABILITY.

6 (C) A CARRIER MAY NOT REFUSE, WITHHOLD, OR DENY ANY INDIVIDUAL
7 COVERAGE UNDER A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER OR
8 OTHERWISE DISCRIMINATE AGAINST ANY INDIVIDUAL BECAUSE OF THE
9 INDIVIDUAL'S RACE, SEX, CREED, COLOR, NATIONAL ORIGIN, MARITAL STATUS,
10 SEXUAL ORIENTATION, AGE, GENDER IDENTITY, OR DISABILITY.

11 (D) THE COMMISSION ON CIVIL RIGHTS SHALL ENFORCE THE PROVISIONS
12 OF THIS SECTION AS PROVIDED FOR IN § 2-202 OF THIS ARTICLE.

13 SECTION 2. AND BE IT FURTHER ENACTED, That the Maryland Insurance
14 Administration, the Health Education and Advocacy Unit of the Office of the Attorney
15 General, and the Maryland Health Benefit Exchange:

16 (1) shall monitor federal statutes and regulations to determine whether
17 provisions of the federal Affordable Care Act or corresponding regulations are repealed or
18 amended to the benefit or detriment of Maryland consumers; and

19 (2) on or before December 31 each year until 2024, in accordance with §
20 2-1257 of the State Government Article, submit a joint report to the Senate Finance
21 Committee and the House Health and Government Operations Committee on:

22 (i) any repeals or amendments determined to be a benefit or
23 detriment to Maryland consumers; and

24 (ii) recommendations for legislation the General Assembly should
25 enact to address the repeals or amendments.

26 SECTION 3. AND BE IT FURTHER ENACTED, That:

27 (a) The General Assembly, in Chapters 3 and 4 of the Acts of the General
28 Assembly of 2011, enacted the list of protections in § 15-137.1 of the Insurance Article to
29 protect Maryland residents approximately 1 year after the Patient Protection and
30 Affordable Care Act (ACA) was passed and approximately 1 year before the United States
31 Supreme Court upheld the majority of the ACA in *National Federation of Independent*
32 *Business v. Sebelius*.

33 (b) The General Assembly, regardless of whether the ACA was found to be
34 constitutional, intended for the protections listed in § 15-137.1 of the Insurance Article, as
35 enacted by Chapters 3 and 4 of the Acts of the General Assembly of 2011 and as amended
36 thereafter, to apply to individual health insurance coverage and health insurance coverage

1 offered in the small group and large group markets issued or delivered in the State by an
2 authorized insurer, nonprofit health service plan, or health maintenance organization.

3 (c) The General Assembly, in Chapters 3 and 4 of the Acts of the General
4 Assembly of 2011 and in yearly conformity bills thereafter consistent with the General
5 Assembly's intent, repealed some provisions of Maryland law that provided the same or
6 similar protections as the ACA and used cross-references to the ACA as a stylistic drafting
7 choice for the purpose of maintaining consistency between State and federal law.

8 (d) In recent years, the federal government has reduced the shared responsibility
9 payment for individuals failing to demonstrate health insurance coverage to \$0, has taken
10 regulatory action to minimize the protections provided to Americans by the ACA, and, after
11 refusing to defend the ACA, has asserted, in the context of *Texas v. United States*, that 26
12 U.S.C. § 5000(A), the minimum essential coverage requirement, is unconstitutional and
13 that the remainder of the ACA is inseverable.

14 (e) Moving the provisions in § 15–137.1 of the Insurance Article to §
15 15–1A–02 of the Insurance Article and supplementing the cross-references to the ACA with
16 the codification of specific statutory language in Title 15, Subtitle 1A of the Insurance
17 Article, as enacted by Section 1 of this Act, further implements the continuing intent of the
18 General Assembly to ensure that Maryland residents benefit from the consumer
19 protections.

20 SECTION 4. AND BE IT FURTHER ENACTED, That this Act is an emergency
21 measure, is necessary for the immediate preservation of the public health or safety, has
22 been passed by a yea and nay vote supported by three-fifths of all the members elected to
23 each of the two Houses of the General Assembly, and shall take effect from the date it is
24 enacted.