



Report of the Maryland
Health Insurance Coverage
Protection Commission

Annapolis, Maryland
December 2020

**Report of the
Maryland Health Insurance Coverage
Protection Commission**

Annapolis, Maryland

December 2020

Contributing Staff

Writers

Jennifer B. Chasse

Lisa J. Simpson

For further information concerning this document contact:

Library and Information Services
Office of Policy Analysis
Department of Legislative Services
90 State Circle
Annapolis, Maryland 21401

Baltimore Area: 410-946-5400 • Washington Area: 301-970-5400

Other Areas: 1-800-492-7122, Extension 5400

TTY: 410-946-5401 • 301-970-5401

TTY users may also use the Maryland Relay Service
to contact the General Assembly.

Email: libr@mlis.state.md.us

Home Page: <http://mgaleg.maryland.gov>

The Department of Legislative Services does not discriminate on the basis of age, ancestry, color, creed, marital status, national origin, race, religion, gender, gender identity, sexual orientation, or disability in the admission or access to its programs, services, or activities. The Department's Information Officer has been designated to coordinate compliance with the nondiscrimination requirements contained in Section 35.107 of the Department of Justice regulations. Requests for assistance should be directed to the Information Officer at the telephone numbers shown above.



THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401-1991

December 31, 2020

The Honorable Bill Ferguson
President of the Senate
H-107 State House
Annapolis, Maryland 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
101 State House
Annapolis, Maryland 21401-1991

Dear President Ferguson and Speaker Jones:

The Maryland Health Insurance Coverage Protection Commission respectfully submits its fourth annual report containing a summary of the commission's activities during the 2020 interim.

This has been an unprecedented year due to the global COVID-19 pandemic, which has resulted in significant morbidity and mortality, as well as substantial job loss and associated loss of employer-sponsored health insurance both nationally and in Maryland. During the 2020 interim, the commission held two meetings, which included presentations on Maryland's State Reinsurance Program, how other states fund their share of reinsurance programs, options for connecting unemployed individuals with health insurance coverage, proposals for a State-based individual market subsidy, and the impact of COVID-19 on enrollment in the Maryland Health Benefit Exchange.

We wish to thank the commission members, the commission staff, and the many individuals who briefed the commission for their support of the commission's work.

Sincerely,

Brian J. Feldman

Senator Brian J. Feldman
Senate Chair

Joseline A. Peña-Melnyk

Delegate Joseline A. Peña-Melnyk
House Chair

BJF:JAP/LJS:JBC/kkh

Enclosure

**Maryland Health Insurance Coverage
Protection Commission
2020 Membership**

**Senator Brian J. Feldman, Senate Chair
Delegate Joseline A. Peña-Melnyk, House Chair**

Senators

Delores G. Kelley
Chris West

Delegates

Bonnie Cullison
Kirill Reznik

Nonlegislative Members

Bob Atlas
David Cooney
Vincent DeMarco
Lori Doyle
Jamal Lee
Robert R. Neall
Marco Priolo
Carolyn A. Quattrochi
Deborah R. Rivkin
Dr. Stephen Rockower
Allison W. Taylor
Sanford Walters

Staff

Jennifer B. Chasse
Lisa J. Simpson

Agency Staff

Laura Goodman
Michael Paddy
Webster Ye

Contents

Transmittal Letter.....	iii
Membership Roster.....	v
Chapter 1. Introduction.....	1
The Maryland Health Insurance Coverage Protection Commission.....	1
State Actions to Stabilize the Individual Health Insurance Market.....	2
State Reinsurance Program.....	2
Maryland Health Benefit Exchange Affordability Workgroup.....	3
Maryland Easy Enrollment Health Insurance Program.....	4
The Impact of COVID-19.....	4
Update on Legal Challenges to the ACA.....	5
Chapter 2. Work of the Commission.....	7
Agenda and Presentations.....	7
September Meeting.....	7
State Reinsurance Program.....	7
Funding States’ Share of Reinsurance Programs.....	8
Linking Laid-off Workers with Health Insurance.....	8
Additional Information on Linking Unemployment Insurance Claimants with Health Insurance.....	10
December Meeting.....	11
State-based Individual Market Subsidy Program Report.....	11
Impact of COVID-19 on Enrollment.....	13
Chapter 3. Recommendations.....	15
Required Findings and Recommendations.....	15
The Need for and Components of Additional Section 1332 Waivers.....	15
Tabled Options for Stabilizing the Individual Markets.....	16
Additional Information Requested on Medicaid Buy-in.....	16
Subsidies That Supplement Premium Tax Credit or Cost-sharing Reductions.....	17
Potential State-based Individual Health Insurance Mandate.....	18
State Reinsurance Program.....	18
Additional Recommendations.....	19
Connecting laid-off Workers with Health Coverage.....	19
Appendix 1.....	21
Appendix 2.....	27
Appendix 3.....	45
Appendix 4.....	69

Chapter 1. Introduction

The Maryland Health Insurance Coverage Protection Commission

Both in response to and in anticipation of efforts at the federal level to repeal and replace the Patient Protection and Affordable Care Act (ACA), Chapter 17 of 2017 (**Appendix 1**) established the Maryland Health Insurance Coverage Protection Commission. Section 2 of Chapters 37 and 38 of 2018 altered the membership and charge of the commission (**Appendix 2**). Chapters 417 and 418 of 2019 required the commission to establish a workgroup and extended the termination date of the commission (**Appendix 3**), and Chapters 597 and 598 of 2019 further altered the commission's charge (**Appendix 4**).

The commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program (MCHP), Medicare, and the Maryland All-payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. The commission will terminate on June 30, 2023.

The commission consists of (1) three members of the Senate; (2) three members of the House of Delegates; (3) the Secretary of Health (or designee); (4) the Maryland Insurance Commissioner (or designee); (5) the Attorney General (or designee); (6) one representative of the Maryland Hospital Association; (7) one representative of a managed care organization; (8) one consumer; (9) one representative of a health insurance carrier; (10) one representative who is an employer; (11) one representative of the nursing home industry; (12) one representative of the Maryland State Medical Society, also known as MedChi; (13) one representative of behavioral health care providers; (14) two members of the public; and (15) one representative of a group model health maintenance organization that participates in the individual market.

The duties of the commission encompass a requirement for a study that includes (1) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and the economy of the State resulting from changes to the ACA, Medicaid, MCHP, Medicare, or the Maryland All-payer Model; (2) an estimate of the costs of such adverse effects and the resulting loss of health coverage; (3) an examination of measures that may prevent or mitigate such adverse effects and the resulting loss of health coverage; and (4) recommendations for laws that may be warranted to minimize such adverse effects and assist residents in obtaining and maintaining affordable health coverage. The commission may hold public meetings across the State to carry out its duties and convene workgroups to solicit input from stakeholders.

More specifically, the commission is required to study and make recommendations for individual and group health insurance market stability, including:

- the need for and components of one or more Section 1332 waivers;

- whether to pursue a standard plan design that limits cost-sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or cost-sharing reductions;
- whether to adopt a State-based individual health insurance mandate, and how to use payments collected from individuals who do not maintain minimum essential coverage including use of the payments to assist individuals in purchasing health insurance; and
- whether the State Reinsurance Program should be extended after calendar 2023 and, if so, how it will be funded.

By December 31 each year, the commission must submit a report on its findings and recommendations to the General Assembly and the Governor. This report is the fourth annual report of the commission.

State Actions to Stabilize the Individual Health Insurance Market

In response to recommendations by the commission, emergency legislation was enacted to adopt measures to stabilize Maryland's individual market.

State Reinsurance Program

Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to submit an application for a State Innovation Waiver under Section 1332 of the ACA to establish a State reinsurance program and seek federal pass-through funding (federal funding that would have been provided to Maryland residents in the form of federal tax credits in the absence of the program). In August 2018, the federal government approved the waiver, which is valid through 2023. The program, which began on January 1, 2019, provides reimbursement to carriers in the individual market that incur certain total annual claims cost on a per individual basis. Carriers are reimbursed for 80% of claims between \$20,000 and \$250,000. Payments to carriers are made after the plan year ends and all costs have been recorded and reconciled.

The reinsurance program is funded by a combination of assessment revenues and federal pass-through funds. Originally, the revenues came from a 2.75% assessment on specified health insurance carriers to recoup the aggregate amount of the health insurance provider fee that would have been assessed under the ACA for calendar 2019 but was temporarily suspended for that year by action at the federal level. Chapters 597 and 598 extended the assessment through 2023 to provide additional funding for the program; however, for calendar 2020 through 2023, the assessment will be 1.0%.

When the program was established, MHBE initially overestimated the amount of total funding required. Since that time, federal pass-through funding has been greater than anticipated and, based on updated actuarial assumptions and actual experience, program expenditures have been lower than forecast. For example, for calendar 2019, estimated costs were \$462 million, but final actual costs were \$353 million. Thus, even with the potential impact of COVID-19 on enrollment and expenditures, available funding from the assessment will likely last longer than anticipated or may be available to fund other activities to further stabilize the individual market.

For calendar 2019, individual market premium rates approved by the Maryland Insurance Administration (MIA), reflecting the anticipated impact of the reinsurance program, declined by 13.2% overall. For calendar 2020 and 2021, approved rates fell an additional 10.3% and 11.9%, respectively. As a result of the success of the reinsurance program, a third carrier, UnitedHealthcare, will join CareFirst BlueCross BlueShield and Kaiser Permanente in the individual exchange in calendar 2021. However, although premiums have decreased for the third year in a row, they remain high with average premiums costing 10% of the median income for a household of four. Deductibles and out-of-pocket (OOP) expenses for calendar 2021 remain the same as calendar 2020 but range from \$4,000 to \$7,900 for bronze plans, \$2,250 to \$6,000 for silver plans (the most commonly purchased plan), and \$0 to \$1,750 for gold plans. Affordability is particularly an issue for individuals who do not receive a federal advanced premium tax credit (APTC).

Maryland Health Benefit Exchange Affordability Workgroup

To address these issues, MHBE established an affordability workgroup to develop recommendations to reduce OOP costs and maximize affordability. The workgroup found that the reinsurance program has helped stabilize the individual market and provide insurance to individuals with chronic illnesses that would not otherwise be able to obtain insurance. The workgroup also found that young adults aged 19 to 34 represent the largest group of the remaining uninsured. Thus, the workgroup recommended continuing the reinsurance program and considering a young adult subsidy, which may require Maryland to apply for another federal waiver. Chapters 104 and 105 of 2020 required MHBE to study an individual subsidy program and report to the General Assembly by December 1, 2020.

Maryland Easy Enrollment Health Insurance Program

In an effort to reach the remaining uninsured and streamline the process for enrolling in coverage, Chapters 423 and 424 of 2019 established the Maryland Easy Enrollment Health Insurance Program to facilitate health insurance enrollment for uninsured Marylanders. The program allows an uninsured individual to elect on their State income tax return to authorize the Comptroller to share information with MHBE in order to determine the individual's eligibility for insurance affordability programs. MHBE assists in enrolling these individuals in Medicaid or health insurance.

The Comptroller's Office, MHBE, the Maryland Department of Health (MDH), and other stakeholders collaborated to operationalize the program for the 2019 tax filing season. For phase I of the program, limited data fields were added to the State income tax return to allow tax filers to indicate whether any members of their household were uninsured and whether they authorized the Comptroller to share relevant information with MHBE. The Comptroller's Office sent data for applicable tax filers to MHBE, and MHBE notified eligible tax filers that they may enroll in coverage through a special enrollment period (SEP). MHBE, the Comptroller's Office, and MDH are targeting launch of phase II of the program in early 2022, for tax year 2021, with the goal of simplifying the enrollment process for interested individuals.

Overall, of the 60,645 individuals on tax year 2019 returns who expressed interest in health care coverage, 53,146 were determined eligible for the Easy Enrollment SEP, meaning that they had a Maryland address and were not already enrolled in Medicaid or a qualified health plan (QHP). Of those 53,146 eligible individuals, 9,131 (17.2%) applied for coverage, and 4,015 (7.6%) enrolled. The majority (75.9%) of individuals who enrolled were eligible for Medicaid coverage. Of those enrolling in QHPs, 87.0% were eligible for financial assistance. Individuals residing in Anne Arundel, Baltimore, Montgomery, and Prince George's, counties and Baltimore City accounted for almost 70% of all enrollments. Individuals aged 18 to 34 accounted for 38.4% of all enrollments.

The Impact of COVID-19

On March 5, 2020, the Governor declared a State of Emergency and the existence of a catastrophic health emergency to deploy resources and implement the emergency powers of the Governor to control and prevent the spread of COVID-19. Emergency legislation, Chapters 13 and 14 of 2020 (the COVID-19 Public Health Emergency Protection Act) authorized the Governor, for the duration of the emergency, to take actions relating to health insurance, Medicaid, retailer profits, employer actions, and personnel at State health care facilities as a result of the State of Emergency and catastrophic health emergency relating to COVID-19. More specifically, the Acts authorized the Governor to (1) facilitate access to health care and the provision of that care and (2) mitigate costs to individuals for COVID-19 diagnosis and treatment, including by prohibiting cost-sharing by health insurance carriers for COVID-19 testing, ordering MDH to cover the cost of testing if not paid for by a carrier or another third party, and requiring carriers to cover a

COVID-19 immunization (if and when available) without cost-sharing. The Acts also authorized the Governor to establish or waive telehealth protocols and order MDH to reimburse certain Medicaid telehealth services for COVID-19 patients. Additionally, the Acts authorized the development and implementation of orders to minimize disruption in enrollment in health insurance and Medicaid and to facilitate reimbursement for services relating to COVID-19.

MIA has adopted several sets of emergency regulations and bulletins related to the pandemic, including requiring carriers to (1) waive any cost-sharing for any visit to diagnose or test for COVID-19, regardless of the setting of the testing; (2) waive any cost-sharing for laboratory fees to diagnose or test for COVID-19; (3) waive any cost-sharing for vaccination for COVID-19, when a vaccine becomes available; (4) evaluate a request to use an out-of-network provider to perform diagnostic testing of COVID-19; and (5) consider an adverse decision on a request for coverage of diagnostic services for COVID-19 an emergency case for which an expedited grievance procedure is required. The emergency regulations do not apply to Medicare supplement policies. Additionally, the Insurance Commissioner has issued bulletins prohibiting the cancellation or nonrenewal of individual health policies for nonpayment of a premium as part of the State's overall response to COVID-19.

In an effort to prioritize health and safety, MHBE opened a new Coronavirus SEP, running from March 16, 2020, through December 15, 2020, for any uninsured Marylander to apply for coverage. As of December 6, 2020, 97,759 individuals have enrolled in coverage through the SEP. Of these enrollees, 67% qualified for Medicaid, 23% enrolled in a QHP with an APTC, and 10% enrolled in a QHP without assistance.

Update on Legal Challenges to the ACA

In *Texas v. United States*, 20 states filed suit in the U.S. District Court, Northern District of Texas arguing that the ACA, as amended by the Tax Cuts and Jobs Act of 2017 (which eliminated the tax penalty of the individual mandate), is no longer constitutional without a tax penalty. In December 2018, Judge Reed C. O'Connor ruled in favor of the plaintiffs, concluding that the mandate is no longer permissible under Congress's taxing power and is thus unconstitutional. The judge found the individual mandate to be "essential" to and inseparable from the ACA and declared the entire law invalid. On appeal, the Fifth Circuit Court of Appeals affirmed the District Court opinion that Congress does not have constitutional authority to enforce the mandate. However, the circuit court did not affirm the District Court's determination that the individual mandate is not severable. Instead, the circuit court remanded the severability issue to the District Court. The Supreme Court heard oral arguments in the case, now known as *California v. Texas*, on November 10, 2020. Issues before the Supreme Court include (1) whether Texas and the individual plaintiffs have standing; (2) if so, whether the individual mandate is unconstitutional; (3) if unconstitutional, whether the rest of the ACA can survive; and (4) if the entire ACA is held invalid, whether the entire law should be unenforceable nationwide or whether it should be unenforceable only to the extent that provisions injure individual plaintiffs. The Supreme Court is expected to deliver its decision in spring 2021.

An October 2020 Urban Institute report estimated that, should the ACA be overturned, an additional 21.1 million people will become uninsured nationally. Medicaid and Children's Health Insurance Program coverage will decline by 15.5 million, 9.3 million people will lose income-related subsidies such as the APTC and cost-sharing reductions, the number of individuals with private nongroup insurance will decline by 27%, and federal spending on health care will fall by \$152 billion per year in 2022. Furthermore, available private nongroup coverage will likely cover fewer benefits, require more OOP spending, and be less accessible to people with current or past health problems because of the elimination of guaranteed issue and modified community rating rules. In Maryland, an estimated 395,000 people will become uninsured (an increase of 95%), Maryland will lose an estimated \$3.7 billion in federal funding for marketplace subsidies, Medicaid and MCHP, and health care spending by public and private insurers and households is estimated to decline by \$3.3 billion.

To protect against the possibility that the ACA might be overturned, Chapters 620 and 621 of 2020 established nondiscrimination provisions and codified the consumer protection provisions of the ACA, including protections for individuals with preexisting conditions, which were previously only specified in Maryland law through cross-references. The Acts generally apply to any health benefit plan offered in the small group, individual, or large group markets with specified exceptions for grandfathered plans. Although the Acts will give Marylanders the option to retain coverage without the substantial federal subsidies provided under the ACA, many Marylanders could find insurance unaffordable.

Chapter 2. Work of the Commission

Agenda and Presentations

During the course of the 2020 interim, the Maryland Health Insurance Coverage Protection Commission held two virtual meetings that were live streamed to the public. Below is a summary of information as it was presented to the commission at the commission meetings. Accordingly, there may be some variation in figures referenced by presenters due to their drawing upon differing sources of information for their presentations. The views expressed by the presenters do not necessarily reflect the views of the commission or its members.

September Meeting

On September 14, 2020, during its first meeting, the commission received an update on the State Reinsurance Program, a presentation on how other states fund their share of reinsurance programs, and options for linking laid-off workers with health insurance.

State Reinsurance Program

Ms. Michele Eberle and Ms. Johanna Fabian-Marks, the Executive Director of the Maryland Health Benefit Exchange (MHBE) and the Director of Policy and Plan Management for MHBE, respectively, updated the commission on the State Reinsurance Program. As a result of the program, average premium rates have returned to pre-2018 levels, with monthly premiums decreasing an average of 10% for 2020 and 13% for 2019. Lower premiums have contributed to increased enrollment in the individual market, allowed enrollees to upgrade to higher value plans with lower cost-sharing, and led to UnitedHealthcare announcing that it would rejoin the individual market for plan year 2021.

State regulations require MHBE to estimate parameters for the program (including attachment point, coinsurance rate, and cap) by April 1 of the calendar year immediately before the applicable plan year and finalize the parameters by December 31. For the first three years of the program, the parameters have remained the same with carriers being reimbursed for 80% of claims between \$20,000 and \$250,000. Maryland's reinsurance program is unique in its application of a dampening factor, which accounts for the interaction of the program and the federal risk adjustment program (a market stabilization program that moves money from lower risk carriers to higher risk carriers to help balance premiums). The dampening factor, which has decreased from 0.8 in 2019 to 0.760 in 2021, is intended to ensure that a carrier does not receive double payments under both programs.

For 2019, the program cost a total of just under \$353 million below original estimates, which caused MHBE's actuaries to reduce future estimated costs for 2020 through 2023. Costs are

projected to grow to \$478 million in total funds by 2023. Federal funding for the program was \$373 million in 2019 and \$447 million in 2020. MHBE anticipates receiving more federal funding than the actual cost of the program, which is fairly unique nationally. The program is estimated to result in a reduction in individual market premiums of 25.7% in 2020 and 29.1% in 2023. Enrollment growth is anticipated to continue to grow in 2021 to an estimated 224,909 enrollees.

State regulations require all carriers participating in the program to submit an annual report describing carrier activities to manage the costs and utilization of enrollees whose claims are reimbursed under the program. Carrier reports will collect targeted information on diabetes, behavioral health, asthma, and pregnancy/childbirth as well as information on common diagnoses among enrollees whose claims were reimbursed under the program. Reports on 2019 data were due October 30, 2020.

Funding States' Share of Reinsurance Programs

Ms. Jennifer B. Chasse, Principal Policy Analyst with the Department of Legislative Services, provided a presentation on the funding of states' share of reinsurance programs. As of September 2020, 14 states had approved reinsurance programs, including newly approved programs in New Hampshire and Pennsylvania, which will begin in 2021. There is great variation among the size and scope of programs as well as the annual cost, which ranges from \$14.7 million in Rhode Island to \$377.8 million in Maryland (the largest program). Costs differ based on numerous factors, including enrollment, attachment point, cap, coinsurance percentage, the amount of federal pass-through funding, and the risk pool being insured in each state's individual marketplace.

All state reinsurance programs are designed to use a combination of state funding and federal pass-through funding. Even if federal funding exceeds the cost of the program from year-to-year, the state must have a designated source of funding for the program. The most common state funding sources are insurer assessments (nine states), general fund appropriations (four states), former high-risk pool/special fund transfers (two states), state individual mandate penalty revenues (two states), and savings from switching from a federal exchange to a state-based exchange (two states).

Linking Laid-off Workers with Health Insurance

Millions of Americans lost employment due to the COVID-19 pandemic. According to the Commonwealth Fund, as of June 2020, 7.7 million Americans lost jobs with employer-sponsored insurance (ESI) as a result of the pandemic. Experts project that unemployment and the number of uninsured will continue to rise as job losses become permanent and temporary policies such as grace periods granted to those unable to pay their monthly insurance premiums expire.

Mr. Stan Dorn, Director of the National Center for Coverage Innovation at Families USA, provided a presentation on options for Maryland to provide health insurance to laid-off workers

and their families. Mr. Dorn presented Census Bureau data (as of July 2020) that showed that one-third (33%) of all uninsured adults were receiving unemployment insurance (UI) and that 81% lived in a household that experienced reduced employment income since mid-March 2020. The majority of uninsured adults were people of color, the vast majority did not have a college degree, and most were earning less than \$50,000 per year even prior to the COVID-19 pandemic.

Mr. Dorn described that the United States has had limited past success in enrolling laid-off workers in health insurance, likely due to the trauma of job loss, and the need for individuals to meet survival needs such as food and rent. However, there has been some success. Federal health coverage tax credits for trade-displaced workers initially did not have a significant effect (reaching only 10% to 20% of eligible individuals), but in areas where unions and state agencies completed paperwork on behalf of enrollees and proactively worked to solve problems, coverage rates increased to more than 50%. In 2020, Kentucky's UI agency gave the state's Medicaid agency contact information for UI claimants. The Medicaid agency then sent emails to claimants and invited them to complete a simple application form. When claimants opened the email without completing the application form, the agency called the claimant and helped them fill out the form over the telephone. Under this initiative, more than 130,000 adults gained Medicaid coverage in Kentucky from March to June 2020, a larger increase than any other state.

Mr. Dorn described several options for Maryland to pursue that would link laid-off workers with health insurance. First, Maryland could pursue a similar approach to Kentucky (proactive individual contact), which can be done quickly with little effort from UI, but with high health administrative costs (federal COVID relief funds may be used or a federal Medicaid administrative match of up to 75%). Second, Maryland could use an approach similar to the Easy Enrollment program, a check box on the UI form with simple income attestation and household information to start Medicaid eligibility. This information could be collected on the follow-up UI form. This would require some administrative costs and there would be more work for the Maryland Department of Labor (MDL) (*i.e.*, modifying forms, data interface). Third, Maryland could present health enrollment options while UI claimants are on hold on the telephone (*i.e.*, push a button to be connected to someone who can enroll you in health insurance). California uses an off-the-shelf software program called On Demand, billed as the "Uber for health insurance," which follows up with individuals who express interest in enrolling. Finally, Maryland could provide information about how to access health insurance to UI claimants. This could be done quickly with low health administrative costs and little effort from UI but is potentially less effective. Mr. Dorn noted that, unfortunately, information alone is often not enough and people who have lost their job often need help signing up for coverage.

Mr. Michael Harrison, Policy Director at MDL, responded to Mr. Dorn's presentation. Mr. Harrison noted that UI is 100% federally funded program using a tax paid by employers, which requires Maryland UI to strictly abide by federal laws. Thus, no federal funds may be used to promote a State program, which limits options for supporting direct linkage to MHBE. MDL can provide links on its website and is happy to look into options.

Ms. Eberle commented that MHBE has an excellent relationship with MDL and has been working with them to get information about coverage options to UI claimants even prior to the COVID-19 pandemic. Ms. Eberle remarked that the agencies should continue to work together to pursue options to ensure all Marylanders have access to coverage.

Additional Information on Linking Unemployment Insurance Claimants with Health Insurance

According to the National Academy of State Health Policy, at least four other states have taken action to connect recently unemployed individuals who have lost ESI with coverage. New Jersey has coordinated with its Department of Labor to include a link to the exchange website within the Department of Labor's consumer portal so that individuals are reminded of their health coverage options when they check the status of their unemployment claims. Colorado has purchased targeted advertisements to reach those who search for Consolidated Omnibus Budget Reconciliation Act so that consumers can compare cost and coverage options across programs. The Washington Health Benefit Exchange is telling consumers, "Filing for unemployment benefits? Visit the exchange to stay covered" to remind them to seek a new form of coverage after losing their ESI. Nevada includes informational pamphlets about open enrollment in direct mailers sent to individuals who have filed for unemployment. In addition, the state's Department of Unemployment will share open enrollment information on its social media and web pages.

On October 16, 2020, the Maryland Attorney General's COVID-19 Access to Justice Task Force sent correspondence to the Maryland Secretary of Labor, the Secretary of Health, and the Executive Director of MHBE requesting:

a robust, three-step response to help the recently unemployed obtain healthcare coverage: First, building on Maryland's early success with the Easy Enrollment Program, the Department should, as quickly as possible, incorporate a health insurance check box into applications for unemployment insurance. A mandatory question on the application should seek the applicant's response to whether the applicant wants information from their unemployment application shared with the Maryland Health Benefit Exchange assistance in obtaining free or low-cost health insurance. The Department would then share that information with MHBE, which would follow up with the applicant. Second, ensure that MHBE has the resources to follow up and provide individual assistance to laid-off workers and their families by proactively reaching out, filling out paperwork, and walking them through the process. Third, launch a robust communications campaign, starting immediately and continuing until the economy recovers, that informs the public about the availability of free or low-cost health insurance for people who lose their jobs or experience income loss. The campaign should direct them to visit the Maryland Health Connection website for further information about how to obtain free or low-cost health insurance.

December Meeting

On December 8, 2020, during its second virtual meeting, the commission received a briefing on MHBE's State-based Individual Market Subsidy Program Report and the impact of COVID-19 on enrollment in the exchange, before engaging in a discussion on potential recommendations.

State-based Individual Market Subsidy Program Report

Ms. Eberle and Ms. Fabian-Marks presented MHBE's State-based Individual Market Subsidy Program Report.

Chapters 104 and 105 of 2020 required MHBE to submit a report to the Senate Finance and House Health and Government Operations committees on the potential design, implementation, and effects of establishing State-based, individual market health insurance subsidies in Maryland as well as an analysis of the appropriate allocation of available funding between subsidies and reinsurance. MHBE worked with Lewis & Ellis Actuarial Consultants, in consultation with the Maryland Insurance Administration, to model the design and impact of State subsidies on the populations targeted, the individual market overall, and the reinsurance program. Lewis & Ellis produced a report detailing their evaluation, which MHBE published for public comment in October 2020. To gather additional feedback on the proposed subsidy designs, MHBE formed an individual subsidy workgroup that met virtually on a weekly basis from October 7, 2020 to November 12, 2020. On December 1, 2020, MHBE submitted the required report, which incorporates the Lewis & Ellis analysis, public comments, and the workgroup report.

Ms. Fabian-Marks described how the State Reinsurance Program has successfully reduced premiums in the individual exchange. Monthly premiums are down an average of 11.9% for 2021 and more than 30% compared to 2018. In 2021, Maryland's lowest cost plans will be about 20% to 30% below U.S. averages, depending on metal level. However, Ms. Fabian-Marks noted that the benefits of the reinsurance program are primarily felt by households earning more than 300% of the federal poverty level (FPL), and particularly households earning more than 400% FPL (about \$51,000 for an individual or \$105,000 for a family of four) that earn too much to qualify for federal advanced premium tax credits (APTC). Because of the way that the federal subsidy structure works, reductions in premiums resulting from the reinsurance program are not typically felt by individuals at lower incomes. As a result, the reinsurance program is not an effective way to reduce premiums for individuals at lower incomes or to target subsidies toward specific populations, such as young adults.

Ms. Fabian-Marks described Maryland's remaining uninsured population (pre-COVID-19) as comprising about 156,000 uninsured adults who do not qualify for Medicaid and are lawfully present. This represents the target population for a potential State-based subsidy. Of this group, young adults are most likely to be uninsured (67,200; 43% of total). A majority of the uninsured

also have incomes below 400% FPL. Two potential target populations for a State-based subsidy are young adults and households with incomes between 400% and 600% FPL.

MHBE's 2019 Affordability Work Group recommended that a subsidy be targeted to young adults, which comprise the largest group of uninsured, lawfully present adults ineligible for Medicaid by age. Adding this population to the market could further stabilize the market and reduce premiums for all enrollees. In a 2019 survey, about 70% of uninsured Maryland young adults said that they would like to have health insurance, but 76% said that it is difficult to afford.

The second potential target population for a State-based subsidy, households with incomes between 400% and 600% FPL, was also discussed by the 2019 Affordability Work Group. The federal subsidy cliff at 400% FPL can result in a big jump in net premium for people just over 400% FPL. This primarily impacts middle-income, older adults. For example, a couple age 55 to 64 with a household income between 400% and 600% FPL can see their premium jump 177% compared to a couple of the same age with a household income between 300% and 400% FPL.

MHBE modeled multiple subsidy scenarios for both potential target populations. Regarding young adults, eight scenarios were modelled, resulting in estimated increases in enrollment of between 500 and 21,000 new participants to the market. On average, a State subsidy for young adults would reduce premiums for subsidized enrollees by between 12% and 60% compared to a federal APTC only (equating to \$20 to \$130 per month). The cost of young adult subsidies would range from \$6 million to \$64 million per year depending on the subsidy provided. Should the State receive a federal waiver, State costs could be offset by federal pass-through funding of between \$400,000 and \$12 million depending on the subsidy provided. Overall, individual market premiums could be reduced by between 0.10% and 3.5% by a young adult subsidy.

Regarding subsidies for individuals with household incomes between 400% and 600% FPL, three scenarios were modelled resulting in estimated increases in enrollment of between 2,300 and 8,900 new participants to the market. This is primarily because this type of subsidy largely impacts older adults who are already more likely to have insurance. On average, a State subsidy for individuals with incomes between 400% and 600% FPL would reduce premiums for subsidized enrollees by between 5% and 20% (equating to \$33 to \$121 per month). The cost of these subsidies would range from \$17 million to \$69 million, depending on the subsidy provided. Should the State receive a federal waiver, State costs could be offset by federal pass-through funding of between \$3 million and \$10 million, depending on the subsidy provided. Overall, individual market premiums could be reduced by between 0.10% and 0.5% by a subsidy for individuals with incomes between 400% and 600% FPL.

There are two potential funding sources for a State-based subsidy – federal pass-through funding and the State health insurance provider fee. Ms. Fabian-Marks notes that it would be ideal to use federal funding, but there is sufficient State funding available since the federal pass-through funding for reinsurance has exceeded costs.

MHBE's individual subsidy workgroup made a total of seven recommendations, including that (1) MHBE target subsidies at young adults, with subsidies phasing out to age 40; (2) MHBE target subsidies at young adults with incomes up to 400% FPL; (3) of the subsidy designs presented, the Age Adjustment Subsidy Enhancement; linear interpolation to age 40 (AASE; LI to 40) best met the framework goals; and (4) MHBE later explore a subsidy targeting those with incomes at 400% to 600% FPL and explore including young adults in the subsidy design. Subsidy design AASE; LI-40 would provide a subsidy to individuals age 18 to 39, is estimated to increase MHBE enrollment by 20,900 by 2024, and would cost \$64 million in 2024. This cost could potentially be offset by up to \$12 million in federal pass-through funding and could reduce individual market premiums for all by 3.5%,

Ms. Fabian-Marks described that a young adult subsidy could meaningfully reduce the uninsured rate among young adults, further stabilize the risk pool, and potentially reduce premiums for all enrollees. Implementing a State subsidy program is not projected to impact the reinsurance program. If MHBE is authorized to implement a State subsidy program, it would be prudent to pursue amendment of the existing reinsurance waiver to enable MHBE to put surplus federal pass-through funding toward the subsidy program. However, federal approval of such an amendment is uncertain. Given the novel nature of a State subsidy program, the legislature may want to consider a pilot program of approximately two to three years to allow MHBE to gather enough credible data to refine longer-term projections of program costs.

Impact of COVID-19 on Enrollment

Ms. Fabian-Marks also provided an update on the impact of COVID-19 on MHBE enrollment. MHBE launched a COVID-19 special enrollment period from March 15, 2020, through December 15, 2020. Any uninsured Marylander can enroll in coverage and does not need to have a qualifying event, such as moving or marriage. Through December 6, 2020, 97,759 individuals have enrolled (67% Medicaid, 23% qualified health plan (QHP) with an APTC, and 10% a QHP without assistance). Overall, as of October 31, 2020, MHBE QHP enrollment was up 18% year-over-year.

Chapter 3. Recommendations

Required Findings and Recommendations

In its 2020 annual report, the Maryland Health Insurance Coverage Protection Commission must make recommendations for individual and group health insurance market stability, including:

- the need for and components of one or more Section 1332 waivers;
- whether to pursue a standard plan design that limits cost-sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or cost-sharing reductions;
- whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance; and
- whether the State Reinsurance Program should be extended after calendar 2023 and, if so, how it will be funded.

The Need for and Components of Additional Section 1332 Waivers

Section 1332 of the federal Patient Protection and Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver (now also referred to as a State Relief and Empowerment Waiver) to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. Under such a waiver, states may waive specified ACA requirements while still providing access to quality health care that is at least as comprehensive and affordable and covers a comparable number of residents as would be covered absent a waiver, without increasing the federal deficit. A Section 1332 waiver may waive ACA standards including qualified health plan establishment, consumer choice and insurance competition, advanced premium tax credits (APTC), and cost-sharing reduction plans. Under a Section 1332 waiver, a state may receive federal funding

that would have been provided to the state in the form of APTCs or other federal funding in the absence of the state innovation for which the waiver is granted. The application process is robust, and a state must provide significant data, actuarial analyses and certifications, a detailed 10-year budget plan, analysis of the impact of the waiver on health insurance coverage, and a detailed implementation plan and timeline. Waivers can be approved for up to 5 years and can be renewed.

Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to submit an application for a Section 1332 waiver to establish a State Reinsurance Program and seek federal pass-through funding. The federal government approved the waiver in August 2018. The waiver is approved through 2023. Under the waiver, Maryland is able to use federal pass-through funds to provide additional funding for the program.

Maryland may need to apply for a new Section 1332 waiver or amend the waiver obtained for the reinsurance program to implement additional options to stabilize the individual market. For instance, if Maryland moves forward with establishing a State-based individual market subsidy program, a determination will need to be made as to whether implementation requires federal approval. In particular, if the State seeks federal funds to implement the program, a Section 1332 waiver will be required.

Tabled Options for Stabilizing the Individual Market

During the 2019 interim, the commission declined to further pursue three options for stabilizing the individual market: (1) merging the individual and small group markets; (2) establishing a standard plan; and (3) establishing a basic health program. The commission considered the recommendations of the MHBE Board of Trustees against merging the markets and the Wakely Consulting Group report, which noted that merging the markets would lessen the effect of the State Reinsurance Program. Based on the recommendations and report, the commission did not to pursue the option of merging the markets. MHBE established a standardized benefit design workgroup in 2017. Commissioners considered the findings of the workgroup and whether a standardized benefit design would benefit Maryland consumers with only two carriers in the individual market. The commission was uncertain how a standardized benefit design would affect deductibles and premiums in the individual market and did not request additional information on the option of establishing a standardized benefit design. Section 1331 of the ACA authorizes states to create a basic health program. Two states have offered basic health plans but have experienced funding shortages. The commission did not opt to pursue establishing a basic health program in Maryland at this time.

Additional Information Requested on Medicaid Buy-in

In its 2019 report, the commission requested additional information before making a recommendation on whether to establish a Medicaid buy-in option. There are several options to structure and finance Medicaid buy-in plans, and the commission suggested that a consultant could help determine what option would be most beneficial to Maryland consumers. Unfortunately,

budget constraints did not allow the commission to request a study. Should the fiscal 2021 budget allow, the commission would like to request a study on pursuing a Medicaid buy-in, similar to the studies conducted for Colorado and New Mexico in 2018.

Subsidies That Supplement Premium Tax Credits or Cost-sharing Reductions

At its December 2020 meeting, the commission received a presentation on MHBE's State-based Individual Market Subsidy Program Report. MHBE's individual subsidy workgroup recommended that MHBE target subsidies at young adults with incomes up to 400% of the federal poverty level, with subsidies phasing out to age 40. Such a subsidy is projected to reduce the uninsured rate among young adults, further stabilize the risk pool, and potentially reduce premiums for all enrollees.

MHBE suggested that the program could be funded with surplus funds in the MHBE Fund generated by the annual health insurance provider fee and federal pass-through funds. Surplus funds generated from the annual health insurance provider fee are projected to exceed the cost of the State-based individual market subsidy recommended by the workgroup. In addition, federal funding under the current Section 1332 waiver for the reinsurance program is projected to exceed the cost of the reinsurance program and could be sufficient to finance a subsidy program for three to seven years. State legislation is required to use any surplus funds that are earmarked in statute for the State Reinsurance Program and an amendment to the Section 1332 waiver for the reinsurance program is required to use the federal-pass through funds.

The health insurance provider fee and the reinsurance program are scheduled to terminate in 2023. As an alternative to implementing a permanent program for individual subsidies, the workgroup report recommended establishing a pilot program so that additional data can be collected to refine the long-term costs of the subsidy program and the State Reinsurance Program. The fees generated from the health insurer provider fee could support a pilot of two to three years, and the pilot program could provide sufficient data to pursue a waiver to gain federal pass-through funding for both the individual market subsidy program and the reinsurance program. Both programs could be renewed in 2023.

The commission supports the recommendations of the individual subsidy workgroup for MHBE to pursue a young adult subsidy. Further, the commission supports the establishment of the subsidy as a pilot program of two to three years, with MHBE reporting back to the General Assembly and the commission on the impact and long-term cost of such a subsidy. The commission cautions that funding for the reinsurance program should not be jeopardized as a result of funding individual subsidies. The reinsurance program has substantially reduced individual market premiums and stabilized the market, and the commission believes that its continuation is necessary to continue improving access to affordable healthcare.

Potential State-based Individual Health Insurance Mandate

The commission received several briefings on the impact of individual mandates and the implementation of individual responsibility fees at the federal and state levels. In the 2018 commission report, the commission found that a State-based individual mandate could take several forms. Maryland could adopt a mandate that mirrors the federal individual mandate as did New Jersey. Alternatively, the report found that Maryland could adopt a down payment plan in which the uninsured could elect to turn their penalty payment into a down payment to buy insurance.

In response to the commission's findings, Chapters 423 and 424 of 2019 established the Maryland Easy Enrollment Health Insurance Program. The Acts also require MHBE to establish a Maryland Easy Enrollment Health Insurance Program Advisory Workgroup to provide ongoing advice regarding implementation of the program. By December 31, 2022, the advisory workgroup must report to the General Assembly on (1) the effectiveness of the program; (2) recommendations as to whether implementing an individual responsibility amount or implementing automatic enrollment of individuals in a qualified health plan in the individual market is feasible and in the best interest of the State; and (3) if so, the dollar amount of the individual responsibility amount and whether the State should provide an individual the option of obtaining health insurance instead of paying the individual responsibility amount.

The commission therefore defers making a recommendation on whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage until the advisory workgroup has submitted its report in 2022.

State Reinsurance Program

The State Reinsurance Program, which began January 1, 2019, and is the largest reinsurance program in the nation, has been a successful tool for stabilizing Maryland's individual health insurance market. As a result of the program, average premium rates have returned to pre-2018 levels, with monthly premiums decreasing an average of 10% for 2020 and 13% for 2019. Lower premiums have contributed to increased enrollment in the individual market, allowed enrollees to upgrade to higher value plans with lower cost-sharing, and led to UnitedHealthcare announcing it would rejoin the individual market for plan year 2021. Program costs have come in below those initially estimated and federal pass-through funding has exceeded the actual costs of the program leading to a surplus of available funding. Enrollment growth is anticipated to continue to grow in 2021 to an estimated 224,909 enrollees.

The federal terms and conditions of the Section 1332 waiver for the program require MHBE "to ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in MHBE's waiver application." Chapters 37 and 38 of 2018 established a one-time State health plan assessment to be collected in 2019 to help fund the

reinsurance program. The State assessment was modeled on Section 9010 of the ACA, which imposed a federal assessment of approximate 2.75% on the premiums for specified entity's that provide health insurance and was suspended by the federal government in 2019. Subsequent to the approval of Maryland's Section 1332 waiver, the Section 9010 assessment was repealed for calendar years beginning after December 31, 2020. Meanwhile, Chapters 597 and 598 of 2019 extended the State assessment through 2023 and reduced it to 1%. The 1% assessment is estimated to collect approximately \$112 million to \$125 million per year and ensures that Maryland has consistent funding to support the reinsurance program and access to federal pass-through funding.

Based on the success of the program and its dependence on continued State funding, at this time, the commission supports the State Reinsurance Program because of its proven success and recommends that the program be extended past 2023. In light of the dependence of the program on State funding, a majority of the commissioners also support extending the duration of the assessment past 2023 at an amount sufficient to continue the program as it currently exists.

Additional Recommendations

Connecting Laid-off Workers with Health Coverage

As a result of the COVID-19 pandemic, millions of Americans lost employment. According to the Commonwealth Fund as of June 2020, 7.7 million Americans lost jobs with employer-sponsored insurance, and experts project that unemployment and the number of uninsured will continue to rise. There are many options for Maryland to pursue that would help link unemployed and laid-off workers with health care coverage. At its September 2020 meeting, the commission was briefed on options to link laid-off workers with health coverage. Options included (1) proactive contact of unemployment insurance (UI) claimants by MHBE based on information provided from the Maryland Department of Labor (MDL); (2) an approach similar to the Maryland Easy Enrollment Health Insurance Program in which a check box on the UI form would indicate whether the applicant wishes to be contacted by MHBE; (3) the automatic transfer by telephone or electronic link of UI claimants from MDL to MHBE for the purpose of possible enrollment in health insurance options; or (4) providing information about how to access health insurance to UI claimants.

In October 2020, the Maryland Attorney General's COVID-19 Access to Justice Task Force sent correspondence to MDL, the Maryland Department of Health, and MHBE requesting "a robust, three-step response to help the recently unemployed obtain healthcare coverage." As of the final commission meeting, the Attorney General had not received a response, although, MHBE indicated one is forthcoming.

Based on what is possible under federal law, the commission recommends that MHBE and MDL continue to work together to find a way to establish a means to connect unemployment insurance claimants with health insurance coverage options to ensure that individuals have support

in obtaining needed health insurance coverage. Although not specifically mentioned or endorsed during the discussion of commission recommendations at the December 8 meeting, some commissioners have expressed strong support for recommending that (1) MHBE and MDL, as soon as practicable and as allowed under federal law, create a checkbox on appropriate UI forms similar to the one used on individual tax forms for the Maryland Easy Enrollment Health Insurance Program (MEEHIP) and (2) the General Assembly enact legislation during the 2021 session requiring MHBE and MDL to establish a program similar to MEEHIP that utilizes a checkbox on appropriate UI forms to connect UI applicants to health insurance coverage.

Appendix 1

LAWRENCE J. HOGAN, JR., Governor

Ch. 17

Chapter 17

(Senate Bill 571)

AN ACT concerning

Maryland Health Insurance Coverage Protection Act

FOR the purpose of establishing the Maryland Health Insurance Coverage Protection Commission; providing for the composition, ~~chair~~ cochairs, and staffing of the Commission; prohibiting a member of the Commission from receiving certain compensation, but authorizing the reimbursement of certain expenses; requiring the Commission to ~~study~~ monitor and assess the impact of certain changes to certain laws and programs and make recommendations regarding certain matters; requiring the duties of the Commission to include a certain study; authorizing the Commission to hold public meetings across the State for a certain purpose; authorizing the Commission to convene certain workgroups; requiring the Commission to report its findings and recommendations to the Governor and the General Assembly on or before a certain date each year; providing for the termination of this Act; defining a certain term; and generally relating to the Maryland Health Insurance Coverage Protection Commission.

Preamble

WHEREAS, The Congressional Budget Office estimates that a repeal of the Patient Protection and Affordable Care Act (ACA) may result in 22 million individuals becoming uninsured in the United States; and

WHEREAS, With a health insurance market collapse potentially resulting from a repeal of the ACA, an additional 7.3 million individuals could lose insurance coverage, leading to a total of nearly 30 million individuals losing health care coverage nationwide; and

WHEREAS, In Maryland, more than 350,000 people may become uninsured in the aftermath of a repeal of the ACA; and

WHEREAS, A repeal or weakening of the ACA, Medicaid, or Medicare could more than double the number of individuals without health insurance by 2019; and

WHEREAS, One in five of the nonelderly population in the State could become uninsured, which would be more individuals uninsured than before the implementation of the ACA in 2009; and

WHEREAS, About 12.9 million individuals in the United States could lose Medicaid or Children's Health Insurance Program coverage as a result of a repeal or weakening of the ACA or Medicaid, including more than 200,000 individuals in our State; and

WHEREAS, A repeal or weakening of the ACA, Medicaid, or Medicare ~~would~~ could disproportionately affect working and retired individuals and families; and

WHEREAS, Millions of American seniors, including ~~hundreds of~~ thousands of Maryland seniors, could see their prescription drug costs rise substantially as a result of a repeal or weakening of the ACA or Medicare; and

WHEREAS, It is prudent for Maryland to study and develop a plan to mitigate these negative effects of a repeal or weakening of the ACA, Medicaid, or Medicare, address economic impacts, help save lives, and protect public health by recommending and implementing solutions to this broad-scale loss of health coverage; and

WHEREAS, The United States Congress should not diminish any of the benefits of the ACA, Medicaid, or Medicare; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
That:

(a) In this section, “ACA” means the federal Patient Protection and Affordable Care Act.

(b) There is a Maryland Health Insurance Coverage Protection Commission.

(c) The Commission consists of the following members:

(1) ~~two~~ three members of the Senate of Maryland, appointed by the President of the Senate;

(2) ~~two~~ three members of the House of Delegates, appointed by the Speaker of the House;

(3) the Secretary of Health and Mental Hygiene, or the Secretary’s designee;

(4) the Maryland Insurance Commissioner, or the Commissioner’s designee; and

(5) the Attorney General, or the Attorney General’s designee; and

~~(5) (6) five the following members of the public, appointed jointly by the President of the Senate and the Speaker of the House;~~

~~(i) one representative of a hospital, appointed jointly by the President of the Senate and the Speaker of the House;~~

(i) one representative of the Maryland Hospital Association;

(ii) one representative of a managed care organization, appointed jointly by the President of the Senate and the Speaker of the House;

(iii) one consumer of health care services, appointed jointly by the President of the Senate and the Speaker of the House;

~~(iv) one representative of a health insurance carrier, appointed by the Governor;~~

~~(iv) one representative of a nonprofit health service plan that has continuously offered plans in all jurisdictions and in all fully insured markets in the State both before and after the enactment of the ACA, appointed by the Governor~~ health insurance carrier, appointed jointly by the President of the Senate and the Speaker of the House;

(v) one representative who is an employer, appointed by the Governor;

(vi) one representative of the nursing home industry, appointed by the Governor; and

(vii) one representative of MedChi;

(viii) one representative of behavioral health providers, appointed jointly by the President of the Senate and the Speaker of the House; and

~~(vii)~~ (ix) two members of the public:

1. one of whom shall be appointed jointly by the President of the Senate and the Speaker of the House; and

2. one of whom shall be appointed by the Governor.

(d) ~~The chair of the Commission shall be designated jointly by the~~ President of the Senate and the Speaker of the House of Delegates shall designate a member who is a Senator and a member who is a Delegate, respectively, to serve as cochairs of the Commission.

(e) The Department of Legislative Services, the Department of Health and Mental Hygiene, and the Maryland Insurance Administration jointly shall provide staff for the Commission.

(f) A member of the Commission:

(1) may not receive compensation as a member of the Commission; but

(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) (1) The Commission shall:

(i) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, and Medicare Medicare, and the Maryland All-Payer Model;

~~(i)~~ (ii) conduct a study to assess the impact of potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, and Medicare Medicare, and the Maryland All-Payer Model; and

~~(ii)~~ (iii) provide recommendations for State and local action to protect access of residents of the State to affordable health coverage.

(2) The ~~study conducted~~ duties of the Commission under paragraph (1) of this subsection shall include a study that includes:

(i) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model;

(ii) an estimate of the costs to the State and State residents of adverse effects from ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model and the resulting loss of health coverage;

(iii) an examination of measures that may prevent or mitigate the adverse effects of ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model and the resulting loss of health coverage on the residents, public health, and economy of the State; and

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model; and

2. will assist residents in obtaining and maintaining affordable health coverage.

(h) The Commission may:

(1) hold public meetings across the State to ~~conduct the study~~ carry out the duties of the Commission; and

(2) convene workgroups to solicit input from stakeholders.

(i) On or before December 31, ~~2017~~ each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017. It shall remain effective for a period of ~~1 year~~ 3 years and 1 month and, at the end of June 30, ~~2018~~ 2020, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Enacted under Article II, § 17(b) of the Maryland Constitution, April 6, 2017.

Appendix 2

LAWRENCE J. HOGAN, JR., Governor

Ch. 37

Chapter 37

(House Bill 1782)

AN ACT concerning

**Health Insurance – ~~Health Care Access Program – Establishment~~ Individual Market Stabilization
(Maryland Health Care Access Act of 2018)**

FOR the purpose of ~~requiring the State Health Services Cost Review Commission, for a certain fiscal year, to assess on each hospital a certain fee for a certain purpose; prohibiting the State Health Services Cost Review Commission from raising certain hospital rates as part of a certain update factor to offset the fee; prohibiting the fee from exceeding a certain percentage of certain revenue; requiring each hospital to remit the fee to the Maryland Health Benefit Exchange Fund; requiring a carrier to pay a certain assessment on certain premiums under certain circumstances beginning on a certain date; requiring the assessment to be in addition to certain taxes and certain penalties or actions; requiring certain health insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations to pay, in a certain calendar year, a certain additional assessment for a certain purpose; providing for the distribution of the assessments; altering the purpose, contents, and authorized use of the Maryland Health Benefit Exchange Fund; requiring that certain funds be used in a certain manner; repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state-specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the authority of the Exchange to establish a State Reinsurance Program; requiring the Exchange to establish a Health Care Access Program to provide reinsurance to certain carriers; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made from certain sources; requiring that, beginning on a certain date and under certain circumstances, certain State funding for the reinsurance of the individual market through the Program be contingent on the Centers for Medicare and Medicaid Services approving a waiver under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; authorizing the Exchange and the Maryland Insurance Commissioner to submit a waiver under a certain provision of federal law in accordance with the recommendations of the Maryland Health Insurance Coverage Protection Commission; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; requiring, beginning on a certain date, an individual to maintain certain coverage for certain individuals; requiring that an individual pay a certain penalty under certain circumstances; requiring that the penalty be in addition to a certain State income tax and included with a certain income tax return; requiring that certain individuals be jointly liable for the penalty under certain circumstances; establishing the amount of the penalty; exempting an individual who qualifies for a~~

~~certain exemption under federal law from being assessed the penalty; requiring an individual to indicate certain information on a certain income tax return; requiring the Comptroller to distribute certain revenues from the penalty to a certain fund for certain purposes; defining certain terms; repealing certain provisions of law rendered obsolete by certain provisions of this Act; requiring the Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group market stability; requiring the Maryland Health Insurance Coverage Protection Commission to engage an independent actuarial firm to assist in its study; requiring the Maryland Health Insurance Coverage Protection Commission, on or before a certain date, to report certain findings and recommendations to the Governor and the General Assembly requiring certain health insurers, nonprofit health service plans, health maintenance organizations, ~~and~~ dental plan organizations, fraternal benefit organizations, managed care organizations, and certain other persons to be subject to a certain assessment in a certain year; establishing the purpose and providing for the distribution of the assessment; establishing that certain provisions of law that apply to certain small employer health benefit plans apply to health benefit plans offered by certain entities; altering the definition of “short-term limited duration insurance” as it relates to certain provisions of law governing individual health benefit plans; altering the membership of the Maryland Health Insurance Coverage Protection Commission; requiring the Commission to study and make recommendations for individual and group health insurance market stability; requiring the Commission to engage an independent actuarial firm to assist in a certain study; requiring the Commission to include its findings and recommendations from a certain study in a certain report; making this Act an emergency measure; and generally relating to health insurance.~~

~~BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–214(d)
Annotated Code of Maryland
(2015 Replacement Volume and 2017 Supplement)~~

BY adding to
Article – Insurance
Section 6–102.1, ~~6–102.2, 31–117, and 31–117.1~~
Annotated Code of Maryland
(2017 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section ~~31–107~~ 15–1202 and 15–1301(s)
Annotated Code of Maryland
(2017 Replacement Volume)

~~BY repealing~~

~~Article — Insurance
Section 31 — 117
Annotated Code of Maryland
(2017 Replacement Volume)~~

~~BY adding to
Article — Tax — General
Section 10 — 102.2
Annotated Code of Maryland
(2016 Replacement Volume and 2017 Supplement)~~

BY repealing and reenacting, without amendments,
Chapter 17 of the Acts of the General Assembly of 2017
Section 1(b) and (g)

BY repealing and reenacting, with amendments,
Chapter 17 of the Acts of the General Assembly of 2017
Section 1(c)(6)(viii) and (ix), (h), and (i)

BY adding to
Chapter 17 of the Acts of the General Assembly of 2017
Section 1(c)(6)(x) and ~~(xi)~~ and (h)

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

~~Article — Health — General~~

~~19 — 214.~~

~~(d) (1) Each year, the Commission shall assess a uniform, broad-based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly.~~

~~(2) (i) 1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue.~~

~~2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15 — 701 of this article.~~

~~(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.~~

~~(3) (i) Funds generated from the assessment under this subsection may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008.~~

~~(ii) Any funds remaining after the expenditure of funds under subparagraph (i) of this paragraph has been made may be used for the general operations of the Medicaid program.~~

~~(4) (i) IN ADDITION TO THE RATES IMPOSED UNDER PARAGRAPH (1) OF THIS SUBSECTION AND SUBJECT TO SUBPARAGRAPHS (ii) AND (iii) OF THIS PARAGRAPH, FOR FISCAL YEAR 2019, THE COMMISSION SHALL ASSESS A UNIFORM, BROAD BASED AND REASONABLE FEE ON EACH HOSPITAL FOR THE PURPOSE OF SUPPORTING THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~

~~(ii) THE COMMISSION MAY NOT RAISE HOSPITAL RATES AS PART OF THE ANNUAL UPDATE FACTOR FOR FISCAL YEAR 2019 TO OFFSET THE FEE ASSESSED UNDER SUBPARAGRAPH (i) OF THIS PARAGRAPH.~~

~~(iii) THE FEE ASSESSED UNDER SUBPARAGRAPH (i) OF THIS PARAGRAPH MAY NOT EXCEED 0.5% OF EACH HOSPITAL'S NET PATIENT REVENUE.~~

~~(iv) EACH HOSPITAL SHALL REMIT THE FEE ASSESSED UNDER SUBPARAGRAPH (i) OF THIS PARAGRAPH TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THE INSURANCE ARTICLE.~~

Article - Insurance

6-102.1.

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

~~(2) "CARRIER" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(3) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(B) (1) BEGINNING JANUARY 1, 2019, A CARRIER SHALL PAY AN ASSESSMENT OF 3% ON THE CARRIER'S NEW AND RENEWAL GROSS DIRECT PREMIUMS IF THE CARRIER FAILS TO OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE IN ACCORDANCE WITH TITLE 15, SUBTITLE 13 OF THIS ARTICLE.~~

~~(2) THE ASSESSMENT PAYABLE BY A CARRIER UNDER THIS SECTION SHALL BE BASED ON THE CARRIER'S PREMIUMS IN ANY MARKET SEGMENT:~~

~~(I) ALLOCABLE TO THE STATE; AND~~

~~(II) WRITTEN DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.~~

~~(C) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, BEGINNING JANUARY 1, 2019, THE ASSESSMENT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE DISTRIBUTED ANNUALLY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE FOR THE SOLE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31-117 OF THIS ARTICLE.~~

~~(D) THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE IN ADDITION TO:~~

~~(1) TAXES OWED BY THE CARRIER UNDER ANY OTHER PROVISION OF LAW; AND~~

~~(2) ANY PENALTIES IMPOSED OR ACTIONS TAKEN BY THE COMMISSIONER IN RESPONSE TO THE CARRIER'S FAILURE TO COMPLY WITH THIS ARTICLE.~~

~~6-102.2.~~

(A) THIS SECTION APPLIES TO:

(1) A HEALTH AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, A DENTAL PLAN ORGANIZATION, A FRATERNAL BENEFIT ORGANIZATION, AND ANY OTHER PERSON SUBJECT TO REGULATION BY THE STATE THAT PROVIDES A HEALTH BENEFIT PLAN REGULATED PRODUCT THAT:

(I) IS SUBJECT TO THE FEE UNDER § 9010 OF THE AFFORDABLE CARE ACT; AND

(II) MAY BE SUBJECT TO AN ASSESSMENT BY THE STATE; AND

(2) A MANAGED CARE ORGANIZATION AUTHORIZED UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE.

(B) THE PURPOSE OF THIS SECTION IS TO RECOUP THE AGGREGATE AMOUNT OF THE HEALTH INSURANCE PROVIDER FEE THAT OTHERWISE WOULD HAVE BEEN ASSESSED UNDER § 9010 OF THE AFFORDABLE CARE ACT THAT IS ATTRIBUTABLE TO STATE HEALTH RISK FOR CALENDAR YEAR 2019 AS A BRIDGE TO STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.

(C) (1) IN CALENDAR YEAR 2019, IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 2.75% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6-102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR CALENDAR YEAR 2018.

(2) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE DISTRIBUTED BY THE COMMISSIONER TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE.

15-1202.

(a) This subtitle applies only to a health benefit plan that:

(1) covers eligible employees of small employers in the State; and

(2) is issued or renewed on or after July 1, 1994, if:

(i) any part of the premium or benefits is paid by or on behalf of the small employer;

(ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;

(iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or

(iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.

(b) A carrier is subject to the requirements of § 15-1403 of this title in connection with health benefit plans issued under this subtitle.

(C) THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN OFFERED BY AN ASSOCIATION, A PROFESSIONAL ~~EMPLOYEE~~ EMPLOYER ORGANIZATION, OR ANY

OTHER ENTITY, INCLUDING A PLAN ISSUED UNDER THE LAWS OF ANOTHER STATE, IF THE HEALTH BENEFIT PLAN COVERS ELIGIBLE EMPLOYEES OF ONE OR MORE SMALL EMPLOYERS AND MEETS THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION.

15-1301.

(s) "Short-term limited duration insurance" [has the meaning stated in 45 C.F.R. § 144.103] MEANS HEALTH INSURANCE COVERAGE PROVIDED UNDER A POLICY OR CONTRACT WITH A CARRIER AND THAT:

(1) HAS A POLICY TERM THAT IS LESS THAN 3 MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE POLICY OR CONTRACT;

(2) MAY NOT BE EXTENDED OR RENEWED;

(3) APPLIES THE SAME UNDERWRITING STANDARDS TO ALL APPLICANTS REGARDLESS OF WHETHER THEY HAVE PREVIOUSLY BEEN COVERED BY SHORT-TERM LIMITED DURATION INSURANCE; AND

(4) CONTAINS THE NOTICE REQUIRED BY FEDERAL LAW PROMINENTLY DISPLAYED IN THE CONTRACT AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT.

~~31-107.~~

~~(a) There is a Maryland Health Benefit Exchange Fund.~~

~~(b) (1) The purpose of the Fund is to:~~

~~(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; and~~

~~(ii) provide funding for the establishment and operation of the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(2) The operation and administration of the Exchange and the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM may include functions delegated by the Exchange to a third party under law or by contract.~~

~~(c) The Exchange shall administer the Fund.~~

~~(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.~~

~~(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.~~

~~(e) The Fund consists of:~~

~~(1) any user fees or other assessments collected by the Exchange;~~

~~(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6-103.2 of this article;~~

~~(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;~~

~~(4) ASSESSMENTS COLLECTED BY THE COMMISSIONER UNDER §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(5) ASSESSMENTS REMITTED IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(6) PENALTIES COLLECTED BY THE COMPTROLLER UNDER § 10-102.2 OF THE TAX GENERAL ARTICLE;~~

~~[(4)] (7) income from investments made on behalf of the Fund;~~

~~[(5)] (8) interest on deposits or investments of money in the Fund;~~

~~[(6)] (9) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;~~

~~[(7)] (10) money donated to the Fund;~~

~~[(8)] (11) money awarded to the Fund through grants; and~~

~~[(9)] (12) any other money from any other source accepted for the benefit of the Fund.~~

~~(f) The Fund may be used only:~~

~~(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; and~~

~~(2) for the establishment and operation of the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM.~~

~~(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.~~

~~(3) Funds received from the distribution of the premium tax under § 6-103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.~~

~~[(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program.]~~

~~(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM:~~

~~(I) ASSESSMENTS DISTRIBUTED TO THE FUND IN ACCORDANCE WITH §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(II) ASSESSMENTS REMITTED TO THE FUND IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(III) PENALTIES DISTRIBUTED TO THE FUND IN ACCORDANCE WITH § 10-102.2 OF THE TAX GENERAL ARTICLE; AND~~

~~(IV) ANY FUNDS THAT THE STATE RECEIVES FROM THE FEDERAL GOVERNMENT UNDER ANY FEDERALLY SPONSORED OR DEVELOPED PROGRAM TO PROMOTE OR ENHANCE STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.~~

~~(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:~~

~~(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or~~

~~(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.~~

~~(2) Notwithstanding § 7-304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6-103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the~~

~~premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.~~

~~(3) If operating expenses of the Exchange may be charged to either State or non-State fund sources, the non-State funds shall be charged before State funds are charged.~~

~~(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.~~

~~(2) Any investment earnings of the Fund shall be credited to the Fund.~~

~~(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.~~

~~(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.~~

~~§ 11-117.~~

~~(a) The Exchange, with the approval of the Commissioner, shall implement or oversee the implementation of the state-specific requirements of §§ 1341 and 1343 of the Affordable Care Act relating to transitional reinsurance and risk adjustment.~~

~~(b) The Exchange may not assume responsibility for the program corridors for health benefit plans in the Individual Exchange and the SHOP Exchange established under § 1342 of the Affordable Care Act.~~

~~(c) (1) In compliance with § 1341 of the Affordable Care Act, the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, shall operate or oversee the operation of a transitional reinsurance program in accordance with regulations adopted by the Secretary for coverage years 2014 through 2016.~~

~~(2) As required by the Affordable Care Act and regulations adopted by the Secretary, the transitional reinsurance program shall be designed to protect carriers that offer individual health benefit plans inside and outside the Exchange against excessive health care expenses incurred by high-risk individuals.~~

~~(3) (i) The Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, may establish a State Reinsurance Program to take effect on or after January 1, 2014.~~

~~(ii) The purpose of the State Reinsurance Program is to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the Exchange.~~

~~(iii) The Exchange shall use funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, to fund the State Reinsurance Program.~~

~~(d) (1) In compliance with § 1343 of the Affordable Care Act, the Exchange, with the approval of the Commissioner, shall operate or oversee the operation of a risk adjustment program designed to:~~

~~(i) reduce the incentive for carriers to manage their risk by seeking to enroll individuals with a lower than average health risk;~~

~~(ii) increase the incentive for carriers to enhance the quality and cost-effectiveness of their enrollees' health care services; and~~

~~(iii) require appropriate adjustments among all health benefit plans in the individual and small group markets inside and outside the Exchange to compensate for the enrollment of high-risk individuals.~~

~~(2) Beginning in 2014, the Exchange, with the approval of the Commissioner, shall strongly consider using the federal model adopted by the Secretary in the operation of the State's risk adjustment program.]~~

~~31-117.~~

~~(A) THE EXCHANGE SHALL ESTABLISH A HEALTH CARE ACCESS PROGRAM TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.~~

~~(B) THE HEALTH CARE ACCESS PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH-RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.~~

~~(C) BEGINNING JANUARY 1, 2020, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM MAY BE MADE FROM:~~

~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~

~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

~~(D) BEGINNING JANUARY 1, 2020, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVING A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(E) THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.~~

~~31-117.1.~~

~~(A) THE EXCHANGE AND THE COMMISSIONER MAY SUBMIT A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT IN ACCORDANCE WITH THE RECOMMENDATIONS OF THE MARYLAND HEALTH INSURANCE COVERAGE PROTECTION COMMISSION ESTABLISHED UNDER CHAPTER 17 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2017.~~

~~(B) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2019 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~Article Tax General~~

~~10-102.2.~~

~~(A) THIS SECTION DOES NOT APPLY TO A NONRESIDENT, INCLUDING A NONRESIDENT SPOUSE AND A NONRESIDENT DEPENDENT.~~

~~(B) BEGINNING JANUARY 1, 2019, AN INDIVIDUAL SHALL MAINTAIN FOR THE INDIVIDUAL, AND FOR EACH DEPENDENT OF THE INDIVIDUAL, MINIMUM ESSENTIAL COVERAGE, AS DEFINED IN § 15-1301 OF THE INSURANCE ARTICLE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION AND EXCEPT AS PROVIDED UNDER SUBSECTION (E) OF THIS SECTION, AN INDIVIDUAL SHALL PAY A PENALTY IN THE AMOUNT DETERMINED UNDER SUBSECTION (D) OF THIS SECTION IF THE INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR 3 OR MORE MONTHS OF THE TAXABLE YEAR.~~

~~(2) ANY PENALTY IMPOSED UNDER THIS SUBSECTION FOR ANY MONTH IN WHICH AN INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE:~~

~~(i) IN ADDITION TO THE STATE INCOME TAX UNDER § 10-105(A) OF THIS SUBTITLE; AND~~

~~(ii) INCLUDED WITH THE STATE INCOME TAX RETURN FOR THE INDIVIDUAL UNDER SUBTITLE 8 OF THIS TITLE FOR THE TAXABLE YEAR THAT~~

~~INCLUDES THE MONTHS IN WHICH COVERAGE WAS NOT MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION.~~

~~(3) IF AN INDIVIDUAL WHO IS SUBJECT TO A PENALTY UNDER THIS SECTION FILES A JOINT STATE INCOME TAX RETURN UNDER § 10-807 OF THIS TITLE, THE INDIVIDUAL AND THE INDIVIDUAL'S SPOUSE SHALL BE JOINTLY LIABLE FOR THE PENALTY.~~

~~(D) THE AMOUNT OF THE PENALTY IMPOSED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE EQUAL TO THE GREATER OF:~~

~~(1) 2.5% OF THE SUM OF THE INDIVIDUAL'S FEDERAL MODIFIED ADJUSTED GROSS INCOME, AS DEFINED IN 42 U.S.C. § 1395R, AND THE FEDERAL MODIFIED ADJUSTED GROSS INCOME OF ALL INDIVIDUALS CLAIMED ON THE INDIVIDUAL'S INCOME TAX RETURN; OR~~

~~(2) THE FOLLOWING FLAT RATES PER INDIVIDUAL, ADJUSTED ANNUALLY FOR INFLATION:~~

~~(I) \$695 PER ADULT; AND~~

~~(II) \$347.50 PER CHILD UNDER 18 YEARS OLD.~~

~~(E) AN INDIVIDUAL MAY NOT BE ASSESSED A PENALTY UNDER SUBSECTION (C) OF THIS SECTION IF THE INDIVIDUAL QUALIFIES FOR AN EXEMPTION UNDER 26 U.S.C. § 5000A(E).~~

~~(F) AN INDIVIDUAL SHALL INDICATE ON THE INCOME TAX RETURN FOR THE INDIVIDUAL, IN THE FORM REQUIRED BY THE COMPTROLLER, WHETHER MINIMUM ESSENTIAL COVERAGE WAS MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR:~~

~~(1) THE INDIVIDUAL;~~

~~(2) THE INDIVIDUAL'S SPOUSE IN THE CASE OF A MARRIED COUPLE;~~

~~AND~~

~~(3) EACH DEPENDENT CHILD OF THE INDIVIDUAL, IF ANY.~~

~~(G) NOTWITHSTANDING § 2-609 OF THIS ARTICLE, AFTER DEDUCTING A REASONABLE AMOUNT FOR ADMINISTRATIVE COSTS, THE COMPTROLLER SHALL DISTRIBUTE THE REVENUES FROM THE PENALTY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~

~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) (1) The Maryland Health Insurance Coverage Protection Commission, established under Chapter 17 of the Acts of the General Assembly of 2017, shall study and make recommendations for individual and group health insurance market stability, including:~~

~~(i) the components of a waiver under § 1332 of the Affordable Care Act to ensure market stability;~~

~~(ii) whether to pursue a standard plan design that limits cost sharing;~~

~~(iii) whether to merge the individual and small group health insurance markets in the State for rating purposes;~~

~~(iv) whether to pursue a Basic Health Program; and~~

~~(v) whether to pursue a Medicaid buy-in program for the individual market.~~

~~(2) The Maryland Health Insurance Coverage Protection Commission shall engage an independent actuarial firm to assist in its study under this subsection.~~

~~(b) On or before October 1, 2018, the Maryland Health Insurance Coverage Protection Commission shall issue a report on its findings and recommendations, including any legislative proposals, under subsection (a) of this section to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Health Benefit Exchange shall adopt the regulations required under § 31-117 of the Insurance Article, as enacted by Section 1 of this Act, on or before January 1, 2019.~~

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Chapter 17 of the Acts of 2017

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(b) There is a Maryland Health Insurance Coverage Protection Commission.

(c) The Commission consists of the following members:

(6) the following members:

(viii) one representative of behavioral health providers, appointed jointly by the President of the Senate and the Speaker of the House; [and]

(ix) two members of the public:

1. one of whom shall be appointed jointly by the President of the Senate and the Speaker of the House; and

2. one of whom shall be appointed by the Governor; AND

(X) ONE REPRESENTATIVE OF A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION THAT PARTICIPATES IN THE INDIVIDUAL MARKET, APPOINTED BY THE GOVERNOR; AND

~~(XI) ONE REPRESENTATIVE OF THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND, TO BE APPOINTED JOINTLY BY THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE.~~

(g) (1) The Commission shall:

(i) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model;

(ii) assess the impact of potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model; and

(iii) provide recommendations for State and local action to protect access of residents of the State to affordable health coverage.

(2) The duties of the Commission under paragraph (1) of this subsection shall include a study that includes:

(i) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All-Payer Model;

(ii) an estimate of the costs to the State and State residents of adverse effects from changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, or the Maryland All-Payer Model and the resulting loss of health coverage;

(iii) an examination of measures that may prevent or mitigate the adverse effects of changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model and the resulting loss of health coverage on the residents, public health, and economy of the State; and

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model; and

2. will assist residents in obtaining and maintaining affordable health coverage.

(H) (1) THE COMMISSION SHALL STUDY AND MAKE RECOMMENDATIONS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE MARKET STABILITY, INCLUDING:

(I) THE COMPONENTS OF ONE OR MORE WAIVERS UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ENSURE MARKET STABILITY THAT MAY BE SUBMITTED BY THE STATE;

(II) WHETHER TO PURSUE A STANDARD PLAN DESIGN THAT LIMITS COST SHARING;

(III) WHETHER TO MERGE THE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS IN THE STATE FOR RATING PURPOSES;

(IV) WHETHER TO PURSUE A BASIC HEALTH PROGRAM;

(V) WHETHER TO PURSUE A MEDICAID BUY–IN PROGRAM FOR THE INDIVIDUAL MARKET;

(VI) WHETHER TO PROVIDE SUBSIDIES THAT SUPPLEMENT PREMIUM TAX CREDITS OR COST–SHARING REDUCTIONS DESCRIBED IN § 1402(C) OF THE AFFORDABLE CARE ACT; AND

(VII) WHETHER TO ADOPT A STATE–BASED INDIVIDUAL HEALTH INSURANCE MANDATE AND HOW TO USE PAYMENTS COLLECTED FROM INDIVIDUALS WHO DO NOT MAINTAIN MINIMUM ESSENTIAL COVERAGE, INCLUDING USE OF THE PAYMENTS TO ASSIST INDIVIDUALS IN PURCHASING HEALTH INSURANCE.

(2) THE COMMISSION SHALL ENGAGE AN INDEPENDENT ACTUARIAL FIRM TO ASSIST IN ITS STUDY UNDER THIS SUBSECTION.

(3) THE COMMISSION SHALL INCLUDE ITS FINDINGS AND RECOMMENDATIONS FROM THE STUDY REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (J) OF THIS SECTION.

[(h)] (I) The Commission may:

(1) hold public meetings across the State to carry out the duties of the Commission; and

(2) convene workgroups to solicit input from stakeholders.

[(i)] (J) On or before December 31 each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION ~~4~~ 3. 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, April 10, 2018.

Appendix 3

LAWRENCE J. HOGAN, JR., Governor

Ch. 417

Chapter 417

(Senate Bill 868)

AN ACT concerning

Health Insurance – Consumer Protections and Maryland Health Insurance Coverage Protection Commission

FOR the purpose of ~~making a certain finding and declaration of the General Assembly; repealing certain provisions of law applying certain provisions of the federal Affordable Care Act to certain health insurance coverage issued or delivered in the State by certain insurers, nonprofit health service plans, or health maintenance organizations; prohibiting certain carriers from excluding or limiting certain benefits or denying coverage under certain circumstances; prohibiting certain carriers from establishing certain rules for eligibility based on health status factors; authorizing certain carriers offering an individual plan to determine a premium rate based on certain factors; prohibiting certain premium rates from varying by more than a certain ratio; requiring certain carriers to provide coverage to certain children until the child is a certain age; prohibiting certain carriers from rescinding a certain health benefit plan once the insured individual is covered under the plan; prohibiting certain carriers from establishing lifetime and annual limits on the dollar value of benefits for any insured individual; prohibiting carriers of a group plan from applying a certain waiting period for eligibility for coverage; requiring certain carriers to allow certain individuals to designate a certain provider as a primary care provider under certain circumstances; requiring a carrier to treat the provision and ordering of certain obstetrical and gynecological care by a certain provider as the authorization of a primary care provider; prohibiting certain carriers from requiring certain authorization or referrals of certain care or services; requiring certain health care providers to comply with certain policies and procedures of a carrier; requiring certain carriers to provide certain coverage for emergency services in a certain manner under certain circumstances; requiring the Maryland Insurance Commissioner to adopt regulations to develop certain standards for use by certain carriers to compile and provide to consumers a certain summary of benefits and coverage explanations; requiring certain carriers to provide a certain summary of benefits and coverage explanation to certain applicants and insured individuals at certain times; authorizing certain carriers to provide a certain summary of benefits and coverage explanation in certain forms; requiring certain carriers to provide certain notification of certain modifications under certain circumstances; establishing a certain penalty; requiring certain carriers to submit a certain report to the Commissioner in certain years; requiring certain carriers to provide a certain rebate to each insured individual based on certain ratios in certain years; requiring the Commissioner to take certain action regarding premiums; requiring a carrier to disclose certain information to insured individuals in a certain manner; requiring certain carriers that offer certain plans to offer certain plans to individuals under a certain age; authorizing certain carriers to offer a certain catastrophic plan under certain circumstances; requiring the Commissioner to adopt regulations to establish~~

~~certain limitations on cost sharing for certain health benefit plans and for prescription drug benefit requirements for certain health benefit plans; making conforming changes; requiring the Maryland Health Insurance Coverage Protection Commission to establish a certain workgroup; requiring that the workgroup include certain members; specifying the duties of the workgroup; requiring the Commission to report to the General Assembly on or before a certain date; altering the date on which the Commission is required to submit a certain report; extending the termination date for the Maryland Health Insurance Coverage Protection Commission; providing for the application and construction of certain provisions of this Act; stating the intent of the General Assembly; defining certain terms; and generally relating to consumer protections for health insurance and the Maryland Health Insurance Coverage Protection Commission.~~

BY repealing and reenacting, with amendments,
 Article – Insurance
 Section 15–137.1
 Annotated Code of Maryland
 (2017 Replacement Volume and 2018 Supplement)

~~BY adding to
 Article – Insurance
 Section 15–1A–01 through 15–1A–17 to be under the new subtitle “Subtitle 1A–
 Consumer Protections”
 Annotated Code of Maryland
 (2017 Replacement Volume and 2018 Supplement)~~

~~BY repealing and reenacting, with amendments,
 Article – Insurance
 Section 15–1205(a) and (g) and 15–1406
 Annotated Code of Maryland
 (2017 Replacement Volume and 2018 Supplement)~~

BY repealing and reenacting, without amendments,
 Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37
 and 38 of the Acts of the General Assembly of 2018
 Section 1(b)

BY repealing and reenacting, with amendments,
 Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37
 and 38 of the Acts of the General Assembly of 2018
 Section 1(h)(3), (i), and (j) and 2

BY adding to
 Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37
 and 38 of the Acts of the General Assembly of 2018
 Section 1(i)

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.

~~(A)~~ **(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.

~~(b)~~ **(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.

~~(e)~~ **(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 OPERATE IN THE STATE; OR**~~

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

~~(C) "GROUP PLAN" MEANS A SMALL GROUP PLAN OR A LARGE GROUP PLAN.~~

~~(D) "HEALTH BENEFIT PLAN" MEANS AN INDIVIDUAL PLAN, A SMALL GROUP PLAN, OR A LARGE GROUP PLAN.~~

~~(E) "INDIVIDUAL PLAN" MEANS A HEALTH BENEFIT PLAN AS DEFINED IN § 15-1301 OF THIS TITLE.~~

~~(F) "INSURED INDIVIDUAL" MEANS AN INSURED, AN ENROLLEE, A SUBSCRIBER, A POLICY HOLDER, A PARTICIPANT, OR A BENEFICIARY.~~

~~(G) "LARGE GROUP PLAN" MEANS A HEALTH BENEFIT PLAN AS DEFINED IN § 15-1401 OF THIS TITLE.~~

~~(H) "SMALL GROUP PLAN" MEANS A HEALTH BENEFIT PLAN AS DEFINED IN IN § 15-1201 OF THIS TITLE.~~

~~15-1A-02.~~

~~EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, THIS SUBTITLE APPLIES ONLY TO CARRIERS THAT OFFER HEALTH BENEFIT PLANS 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.~~

~~15-1A-03.~~

~~(A) A CARRIER MAY NOT:~~

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

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

~~(B) THE PROHIBITION IN SUBSECTION (A) OF THIS SECTION APPLIES WHETHER OR NOT:~~

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

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

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

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

~~15-1A-04.~~

~~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 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.~~

~~15-1A-05.~~

~~(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, A CARRIER OFFERING AN INDIVIDUAL PLAN MAY DETERMINE A PREMIUM RATE BASED ON:~~

~~(1) AGE;~~

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

~~(I) THE BALTIMORE METROPOLITAN AREA;~~

~~(II) THE DISTRICT OF COLUMBIA METROPOLITAN AREA;~~

~~(III) WESTERN MARYLAND; AND~~

~~(IV) EASTERN AND SOUTHERN MARYLAND;~~

~~(3) WHETHER THE PLAN COVERS AN INDIVIDUAL OR FAMILY; AND~~

~~(4) TOBACCO USE.~~

~~(B) (1) A PREMIUM RATE BASED ON AGE MAY NOT VARY BY A RATIO OF MORE THAN 3 TO 1 FOR ADULTS.~~

~~(2) A PREMIUM RATE BASED ON TOBACCO USE MAY NOT VARY BY A RATIO OF MORE THAN 1.5 TO 1.~~

~~15-1A-06.~~

~~(A) A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN THAT PROVIDES COVERAGE TO A DEPENDENT CHILD SHALL CONTINUE TO MAKE THE COVERAGE AVAILABLE FOR THE CHILD UNTIL THE CHILD IS 26 YEARS OF AGE.~~

~~(B) THIS SECTION MAY NOT BE CONSTRUED TO REQUIRE A CARRIER TO ISSUE A HEALTH BENEFIT PLAN TO A CHILD OF A CHILD RECEIVING DEPENDENT COVERAGE.~~

~~15-1A-07.~~

~~(A) (1) IN THIS SECTION, "RESCIND" MEANS TO CANCEL OR DISCONTINUE COVERAGE UNDER A HEALTH BENEFIT PLAN WITH RETROACTIVE EFFECT.~~

~~(2) "RESCIND" DOES NOT INCLUDE:~~

~~(i) THE CANCELLATION OR DISCONTINUATION OF A HEALTH BENEFIT PLAN IF THE CANCELLATION OR DISCONTINUATION OF THE HEALTH BENEFIT PLAN:~~

~~1. HAS ONLY A PROSPECTIVE EFFECT; OR~~

~~2. IS EFFECTIVE RETROACTIVELY TO THE EXTENT THE RETROACTIVE EFFECT IS ATTRIBUTABLE TO A FAILURE OF TIMELY PAYMENT OF REQUIRED PREMIUMS OR CONTRIBUTIONS TOWARDS THE COST OF COVERAGE; OR~~

~~(H) THE CANCELLATION OR DISCONTINUATION OF A HEALTH BENEFIT PLAN THAT COVERS ACTIVE EMPLOYEES AND, IF APPLICABLE, DEPENDENTS AND THOSE COVERED UNDER CONTINUATION COVERAGE PROVISIONS, IF:~~

~~1. THE EMPLOYEE DOES NOT PAY A PREMIUM FOR COVERAGE AFTER TERMINATION OF EMPLOYMENT; AND~~

~~2. THE CANCELLATION OR DISCONTINUATION OF THE HEALTH BENEFIT PLAN IS EFFECTIVE RETROACTIVELY BACK TO THE DATE OF TERMINATION OF EMPLOYMENT DUE TO A DELAY IN ADMINISTRATIVE RECORD KEEPING.~~

~~(B) THIS SECTION DOES NOT APPLY TO AN INSURED INDIVIDUAL WHO:~~

~~(1) HAS PERFORMED AN ACT THAT CONSTITUTES FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT AS PROHIBITED BY THE TERMS OF THE HEALTH BENEFIT PLAN; OR~~

~~(2) HAS RECEIVED PRIOR NOTICE OF A DECISION TO RESCIND A HEALTH BENEFIT.~~

~~(C) A CARRIER MAY NOT RESCIND A HEALTH BENEFIT PLAN WITH RESPECT TO AN INSURED INDIVIDUAL ONCE THE INSURED INDIVIDUAL IS COVERED UNDER THE PLAN.~~

~~15-1A-08.~~

~~(A) A CARRIER MAY NOT ESTABLISH LIFETIME LIMITS OR ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR ANY INSURED INDIVIDUAL.~~

~~(B) TO THE EXTENT THAT LIMITS ARE OTHERWISE AUTHORIZED UNDER FEDERAL OR STATE LAW, 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 IN THE STATE BENCHMARK PLAN SELECTED IN ACCORDANCE WITH § 31-116 OF THIS ARTICLE.~~

~~15-1A-09.~~

~~A CARRIER OFFERING A GROUP PLAN MAY NOT APPLY A WAITING PERIOD OF MORE THAN 90 DAYS THAT MUST PASS BEFORE AN INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE TERMS OF THE GROUP PLAN.~~

~~15-1A-10.~~

~~(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 A HEALTH BENEFIT PLAN.~~

~~(H) 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 OBSTETRIC OR GYNECOLOGIC CARE; AND~~
- ~~2. REQUIRES THE DESIGNATION BY AN INSURED INDIVIDUAL OF A PARTICIPATING PRIMARY CARE PROVIDER.~~

~~(H) THIS SUBSECTION MAY NOT BE CONSTRUED TO:~~

- ~~1. WAIVE ANY EXCLUSIONS OF COVERAGE UNDER THE TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN WITH RESPECT TO COVERAGE OF OBSTETRICAL OR GYNECOLOGICAL CARE; OR~~
- ~~2. PROHIBIT A CARRIER FROM REQUIRING THAT THE OBSTETRICAL OR GYNECOLOGICAL PROVIDER NOTIFY THE PRIMARY CARE PROVIDER OR CARRIER FOR AN INSURED INDIVIDUAL WHO IS FEMALE OF TREATMENT DECISIONS.~~

~~(2) A CARRIER SHALL TREAT THE PROVISION OF OBSTETRICAL AND GYNECOLOGICAL CARE AND THE ORDERING OF RELATED OBSTETRICAL AND GYNECOLOGICAL ITEMS AND SERVICES BY A PARTICIPATING HEALTH CARE~~

~~PROVIDER WHO SPECIALIZES IN OBSTETRICS OR GYNECOLOGY AS THE AUTHORIZATION OF THE PRIMARY CARE PROVIDER.~~

~~(3) A CARRIER MAY NOT REQUIRE AUTHORIZATION OR REFERRAL BY ANY PERSON, INCLUDING THE PRIMARY CARE PROVIDER FOR THE INSURED INDIVIDUAL, FOR AN INSURED INDIVIDUAL WHO IS FEMALE AND WHO SEEKS COVERAGE FOR OBSTETRICAL OR GYNECOLOGICAL CARE PROVIDED BY A PARTICIPATING HEALTH CARE PROVIDER WHO SPECIALIZES IN OBSTETRICS OR GYNECOLOGY.~~

~~(4) A HEALTH CARE PROVIDER WHO PROVIDES OBSTETRICAL OR GYNECOLOGICAL CARE IN ACCORDANCE WITH THIS SUBSECTION SHALL COMPLY WITH A CARRIER'S POLICIES AND PROCEDURES.~~

~~15-1A-11.~~

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

~~(2) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION THAT MANIFESTS ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED BY A PRUDENT LAYPERSON, WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, TO RESULT IN:~~

- ~~(I) PLACING THE PATIENT'S HEALTH IN SERIOUS JEOPARDY;~~
- ~~(II) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR~~
- ~~(III) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.~~

~~(3) "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY MEDICAL CONDITION:~~

~~(I) A MEDICAL SCREENING EXAMINATION THAT IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE AN EMERGENCY MEDICAL CONDITION; OR~~

~~(II) ANY OTHER EXAMINATION OR TREATMENT WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL THAT IS NECESSARY TO STABILIZE THE PATIENT.~~

~~(B) IF A CARRIER COVERS ANY BENEFITS FOR EMERGENCY SERVICES TO TREAT EMERGENCY MEDICAL CONDITIONS IN AN EMERGENCY DEPARTMENT OF A HOSPITAL, THE CARRIER:~~

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

~~(2) SHALL PROVIDE COVERAGE FOR THE EMERGENCY SERVICES REGARDLESS OF WHETHER THE HEALTH CARE PROVIDER FURNISHING THE EMERGENCY SERVICES HAS A CONTRACTUAL RELATIONSHIP WITH THE CARRIER TO FURNISH EMERGENCY SERVICES.~~

~~(C) IF A HEALTH CARE PROVIDER OF EMERGENCY SERVICES DOES NOT HAVE A CONTRACTUAL RELATIONSHIP WITH THE CARRIER TO FURNISH EMERGENCY SERVICES, THE CARRIER:~~

~~(1) MAY NOT IMPOSE ANY LIMITATION ON COVERAGE THAT WOULD BE MORE RESTRICTIVE THAN LIMITATIONS IMPOSED ON COVERAGE FOR EMERGENCY SERVICES FURNISHED BY A PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER; AND~~

~~(2) SHALL REQUIRE THE SAME COST SHARING AMOUNTS OR RATES AS WOULD APPLY IF THE EMERGENCY SERVICES WERE FURNISHED BY A PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER.~~

~~15-1A-12.~~

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

~~(2) "INSURANCE RELATED TERMS" MEANS:~~

~~(I) PREMIUM;~~

~~(II) DEDUCTIBLE;~~

~~(III) CO-INSURANCE;~~

~~(IV) CO-PAYMENT;~~

~~(V) OUT-OF-POCKET LIMIT;~~

~~(VI) PREFERRED PROVIDER;~~

~~(VII) NONPREFERRED PROVIDER;~~

~~(VIII) OUT-OF-NETWORK CO-PAYMENTS;~~

~~(IX) USUAL, CUSTOMARY, AND REASONABLE FEES;~~

~~(X) EXCLUDED SERVICES;~~

~~(XI) GRIEVANCE AND APPEALS; AND~~

~~(XII) ANY OTHER TERM THE COMMISSIONER DETERMINES IS IMPORTANT TO DEFINE SO THAT A CONSUMER MAY COMPARE HEALTH BENEFIT PLANS AND UNDERSTAND THE TERMS OF THE CONSUMER'S COVERAGE.~~

~~(3) "MEDICAL TERMS" MEANS:~~

~~(I) HOSPITALIZATION;~~

~~(II) HOSPITAL OUTPATIENT CARE;~~

~~(III) EMERGENCY ROOM CARE;~~

~~(IV) PHYSICIAN SERVICES;~~

~~(V) PRESCRIPTION DRUG COVERAGE;~~

~~(VI) DURABLE MEDICAL EQUIPMENT;~~

~~(VII) HOME HEALTH CARE;~~

~~(VIII) SKILLED NURSING CARE;~~

~~(IX) REHABILITATION SERVICES;~~

~~(X) HOSPICE SERVICES;~~

~~(XI) EMERGENCY MEDICAL TRANSPORTATION; AND~~

~~(XII) ANY OTHER TERMS THE COMMISSIONER DETERMINES ARE IMPORTANT TO DEFINE SO THAT A CONSUMER MAY COMPARE THE MEDICAL BENEFITS OFFERED BY HEALTH BENEFIT PLANS AND UNDERSTAND THE EXTENT OF AND EXCEPTIONS TO THOSE MEDICAL BENEFITS.~~

~~(B) (1) THE COMMISSIONER SHALL ADOPT REGULATIONS TO DEVELOP STANDARDS FOR USE BY A CARRIER TO COMPILE AND PROVIDE TO CONSUMERS A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION THAT ACCURATELY DESCRIBES THE BENEFITS AND COVERAGE UNDER THE APPLICABLE HEALTH BENEFIT PLAN.~~

~~(2) IN DEVELOPING THE STANDARDS UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COMMISSIONER SHALL CONSULT WITH THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.~~

~~(C) THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION SHALL ENSURE THAT THE SUMMARY OF BENEFITS AND COVERAGE:~~

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

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

~~(D) THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION SHALL INCLUDE:~~

~~(1) UNIFORM DEFINITIONS OF STANDARD INSURANCE RELATED TERMS AND MEDICAL TERMS SO THAT CONSUMERS MAY COMPARE HEALTH BENEFIT PLANS AND UNDERSTAND THE TERMS OF AND EXCEPTIONS TO COVERAGE;~~

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

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

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

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

~~(4) THE RENEWABILITY AND CONTINUATION OF COVERAGE PROVISIONS;~~

~~(5) A COVERAGE FACTS LABEL THAT INCLUDES EXAMPLES TO ILLUSTRATE COMMON BENEFITS SCENARIOS BASED ON RECOGNIZED CLINICAL PRACTICE GUIDELINES, INCLUDING PREGNANCY AND SERIOUS OR CHRONIC MEDICAL CONDITIONS AND RELATED COST SHARING REQUIREMENTS;~~

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

~~(7) A STATEMENT THAT:~~

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

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

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

~~(E) AS APPROPRIATE, THE COMMISSIONER SHALL PERIODICALLY REVIEW AND UPDATE THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION.~~

~~(F) (1) EACH CARRIER SHALL PROVIDE A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION THAT COMPLIES WITH THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION BY THE COMMISSIONER TO:~~

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

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

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

~~(G) EXCEPT AS OTHERWISE PROVIDED IN THIS ARTICLE, IF A CARRIER MAKES ANY MATERIAL MODIFICATION IN ANY OF THE TERMS OF THE PLAN OR COVERAGE INVOLVED THAT IS NOT REFLECTED IN THE MOST RECENTLY PROVIDED SUMMARY OF BENEFITS AND COVERAGE EXPLANATION, THE CARRIER SHALL~~

~~PROVIDE NOTICE OF THE MODIFICATION TO INSURED INDIVIDUALS NO LATER THAN 60 DAYS BEFORE THE EFFECTIVE DATE OF THE MODIFICATION.~~

~~(H) (1) A CARRIER THAT WILLFULLY FAILS TO PROVIDE THE INFORMATION REQUIRED UNDER THIS SECTION SHALL BE SUBJECT TO A FINE OF NOT MORE THAN \$1,000 FOR EACH FAILURE.~~

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

~~15-1A-13.~~

~~(A) THIS SECTION APPLIES ONLY TO HEALTH BENEFIT PLAN YEARS IN WHICH THE FEDERAL GOVERNMENT DOES NOT COLLECT A COMPARABLE REPORT OR DETERMINE ANNUAL REBATE AMOUNTS.~~

~~(B) (1) FOR EACH HEALTH BENEFIT PLAN YEAR, A CARRIER SHALL SUBMIT TO THE COMMISSIONER A REPORT CONCERNING THE RATIO OF:~~

~~(I) INCURRED LOSS OR INCURRED CLAIMS PLUS LOSS ADJUSTMENT EXPENSE OR CHANGE IN CONTRACT RESERVES, INCLUDING:~~

~~1. REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO INSURED INDIVIDUALS UNDER THE PLAN; AND~~

~~2. ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY;~~
~~AND~~

~~(II) EARNED PREMIUMS CALCULATED AS THE TOTAL OF PREMIUM REVENUE:~~

~~1. AFTER ACCOUNTING FOR COLLECTIONS OR RECEIPTS FOR RISK ADJUSTMENT AND RISK CORRIDORS AND PAYMENTS OF REINSURANCE; AND~~

~~2. EXCLUDING FEDERAL AND STATE TAXES AND LICENSING OR REGULATORY FEES.~~

~~(2) THE REPORT SHALL:~~

~~(I) SPECIFY THE AMOUNT SPENT ON:~~

~~1. TOTAL REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES;~~

~~2. TOTAL COST OF ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY; AND~~

~~3. ALL OTHER NONCLAIMS COSTS; AND~~

~~(H) INCLUDE AN EXPLANATION OF THE NATURE OF THE COSTS SPECIFIED UNDER ITEM (I) OF THIS PARAGRAPH.~~

~~(3) THE COMMISSIONER SHALL MAKE REPORTS RECEIVED UNDER THIS SUBSECTION AVAILABLE TO THE PUBLIC ON THE ADMINISTRATION'S WEBSITE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, FOR EACH HEALTH BENEFIT PLAN YEAR, A CARRIER SHALL PROVIDE AN ANNUAL REBATE TO EACH INSURED INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN ON A PRO RATA BASIS, IF THE AVERAGE OF THE RATIOS REPORTED IN EACH OF THE IMMEDIATELY PRECEDING 3 YEARS IS LESS THAN:~~

~~(I) WITH RESPECT TO A LARGE GROUP PLAN, 85% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS; OR~~

~~(II) WITH RESPECT TO A SMALL GROUP PLAN OR AN INDIVIDUAL HEALTH BENEFIT PLAN, 80% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS.~~

~~(2) IF THE COMMISSIONER DETERMINES THAT THE APPLICATION OF THE RATIOS ESTABLISHED IN PARAGRAPH (1) OF THIS SUBSECTION MAY DESTABILIZE A MARKET FOR HEALTH BENEFIT PLANS, THE COMMISSIONER MAY DETERMINE A LOWER PERCENTAGE.~~

~~(3) THE TOTAL AMOUNT OF AN ANNUAL REBATE REQUIRED UNDER THIS SUBSECTION SHALL BE IN AN AMOUNT EQUAL TO THE AMOUNT OF THE RATIO DETERMINED UNDER SUBSECTION (A) OF THIS SECTION IF THE RATIO EXCEEDS THE PERCENTAGES ESTABLISHED IN ACCORDANCE WITH PARAGRAPHS (1) AND (2) OF THIS SUBSECTION.~~

~~(4) IN DETERMINING THE PERCENTAGES UNDER PARAGRAPHS (1) AND (2) OF THIS SUBSECTION, THE COMMISSIONER SHALL SEEK TO ENSURE ADEQUATE PARTICIPATION BY CARRIERS, COMPETITION IN THE HEALTH INSURANCE MARKETS IN THE STATE, AND VALUE FOR CONSUMERS SO THAT PREMIUMS ARE USED FOR CLINICAL SERVICES AND QUALITY IMPROVEMENTS.~~

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

~~(B) A CARRIER SHALL DISCLOSE TO AN INSURED INDIVIDUAL OR EMPLOYER, AS APPLICABLE, OF 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 INSURED 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 INSURED INDIVIDUAL OR EMPLOYER.~~

~~15-1A-15.~~

~~EACH CARRIER THAT OFFERS A HEALTH BENEFIT PLAN SHALL OFFER AN IDENTICAL HEALTH BENEFIT PLAN IN WHICH THE ONLY INSURED INDIVIDUALS ARE INDIVIDUALS UNDER THE AGE OF 21 YEARS, AS OF THE BEGINNING OF A HEALTH BENEFIT PLAN YEAR.~~

~~15-1A-16.~~

~~A CARRIER MAY OFFER A CATASTROPHIC PLAN IN THE INDIVIDUAL MARKET IF:~~

~~(1) THE PLAN IS ONLY OFFERED TO INDIVIDUALS WHO:~~

~~(I) ARE UNDER THE AGE OF 30 YEARS BEFORE THE BEGINNING OF THE PLAN YEAR; OR~~

~~(II) HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AFFORDABILITY EXEMPTION AS DETERMINED IN REGULATION BY THE COMMISSIONER; AND~~

~~(2) THE PLAN COVERS:~~

- ~~(I) AMBULATORY PATIENT SERVICES;~~
- ~~(II) EMERGENCY SERVICES;~~
- ~~(III) HOSPITALIZATION;~~
- ~~(IV) MATERNITY AND NEWBORN CARE;~~
- ~~(V) BEHAVIORAL HEALTH SERVICES;~~
- ~~(VI) PRESCRIPTION DRUGS;~~
- ~~(VII) REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES;~~
- ~~(VIII) LABORATORY SERVICES;~~
- ~~(IX) PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT;~~
- ~~(X) PEDIATRIC SERVICES, INCLUDING ORAL AND VISON CARE;~~
- ~~(XI) AT LEAST THREE PRIMARY CARE VISITS PER PLAN YEAR.~~

~~15-1A-17.~~

~~THE COMMISSIONER SHALL ADOPT REGULATIONS:~~

- ~~(1) TO ESTABLISH ANNUAL LIMITATIONS ON COST SHARING FOR HEALTH BENEFIT PLANS; AND~~
- ~~(2) FOR PRESCRIPTION DRUG BENEFIT REQUIREMENTS FOR HEALTH BENEFIT PLANS.~~

~~15-1205.~~

- ~~(a) (1) This subsection applies to a carrier with respect to any health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act.~~
- ~~(2) In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that~~

~~health benefit plan without regard to any factor not specifically authorized under this subsection or subsection (g) of this section.~~

~~(3) A carrier may adjust the community rate only for:~~

~~(i) age; AND~~

~~(ii) geography based on the following contiguous areas of the State:~~

~~1. the Baltimore metropolitan area;~~

~~2. the District of Columbia metropolitan area;~~

~~3. Western Maryland; and~~

~~4. Eastern and Southern Maryland; and~~

~~(iii) health status, as provided in subsection (g) of this section];~~

~~(4) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.~~

~~(5) (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph (3) of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.~~

~~(ii) A discount offered under subparagraph (i) of this paragraph shall be:~~

~~1. applied to reduce the rate otherwise payable by the small employer;~~

~~2. actuarially justified;~~

~~3. offered uniformly to all small employers; and~~

~~4. approved by the Commissioner.~~

~~(g) (1) [A carrier may adjust the community rate for a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, for health status only if a small employer has not offered a health benefit plan issued under this subtitle to its employees in the 12 months prior to the initial enrollment of the small employer in the health benefit plan.~~

~~(2) (i) Based on the adjustment allowed under paragraph (1) of this subsection, in addition to the adjustments allowed under subsection (d)(1) of this section, a carrier may charge:~~

~~1. in the first year of enrollment, a rate that is 10% above or below the community rate;~~

~~2. in the second year of enrollment, a rate that is 5% above or below the community rate; and~~

~~3. in the third year of enrollment, a rate that is 2% above or below the community rate.~~

~~(ii) A carrier may not make any adjustment for health status in the community rate of a health benefit plan issued under this subtitle after the third year of enrollment of a small employer in the health benefit plan.~~

~~(3) For a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, a carrier may use health statements, in a form approved by the Commissioner, and health screenings to establish an adjustment to the community rate for health status as provided in this subsection.~~

~~(4) A] FOR A HEALTH BENEFIT PLAN THAT IS A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT, A carrier may not limit coverage offered by the carrier, or refuse to issue a health benefit plan to any small employer that meets the requirements of this subtitle, based on a health status related factor.~~

~~[(5)] (2) It is an unfair trade practice for a carrier knowingly to provide coverage to a small employer that discriminates against an employee or applicant for employment, based on the health status of the employee or applicant or a dependent of the employee or applicant, with respect to participation in a health benefit plan sponsored by the small employer.~~

~~15-1406.~~

~~[(a) A carrier may not establish rules for eligibility of an individual to enroll under a group health benefit plan based on any health status related factor.~~

~~(b) Subsection (a) of this section does not:~~

~~(1) require a carrier to provide particular benefits other than those provided under the terms of the particular health benefit plan; or~~

~~(2) prevent a carrier from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the health benefit plan.~~

~~(e) Rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for enrollment.]~~

~~[(d)] (A) A carrier shall allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of a group health benefit plan to enroll for coverage under the terms of the plan if:~~

~~(1) the employee or dependent was covered under an employer sponsored plan or group health benefit plan at the time coverage was previously offered to the employee or dependent;~~

~~(2) the employee states in writing, at the time coverage was previously offered, that coverage under an employer sponsored plan or group health benefit plan was the reason for declining enrollment, but only if the plan sponsor or issuer requires the statement and provides the employee with notice of the requirement;~~

~~(3) the employee's or dependent's coverage described in item (1) of this subsection:~~

~~(i) was under a COBRA continuation provision, and the coverage under that provision was exhausted; or~~

~~(ii) was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and~~

~~(4) under the terms of the plan, the employee requests enrollment not later than 30 days after:~~

~~(i) the date of exhaustion of coverage described in item (3)(i) of this subsection; or~~

~~(ii) termination of coverage or termination of employer contributions described in item (3)(ii) of this subsection.~~

~~[(e)] (B) A carrier shall allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of a group health benefit plan to enroll for coverage under the terms of the plan if the employee or dependent requests enrollment within 30 days after the employee or dependent is determined to be eligible for coverage under the MCHP private option plan in accordance with § 15-301.1 of the Health General Article.~~

**Chapter 17 of the Acts of 2017, as amended by Chapters 37 and 38 of the Acts of
2018**

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,
That:

(b) There is a Maryland Health Insurance Coverage Protection Commission.

(h) (3) The Commission shall include its findings and recommendations from the study required under paragraph (1) of this subsection in the annual report submitted by the Commission on or before December 31, [2019] 2020, under subsection [(j)](K) of this section.

(1) (1) THE COMMISSION SHALL ESTABLISH A WORKGROUP TO CARRY OUT THE FINDING AND DECLARATION OF THE GENERAL ASSEMBLY 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.

(2) THE WORKGROUP SHALL INCLUDE MEMBERS WHO REPRESENT NONPROFIT AND FOR-PROFIT CARRIERS, CONSUMERS, AND PROVIDERS.

(3) THE WORKGROUP SHALL:

(I) MONITOR THE APPEAL OF THE DECISION OF THE U.S. DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS IN TEXAS V. UNITED STATES REGARDING THE ACA AND THE IMPLICATIONS OF THE DECISION FOR THE STATE;

(II) MONITOR THE ENFORCEMENT OF THE AFFORDABLE CARE ACT BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND

(III) DETERMINE THE MOST EFFECTIVE MANNER OF ENSURING THAT MARYLAND CONSUMERS CAN OBTAIN AND RETAIN QUALITY HEALTH INSURANCE INDEPENDENT OF ANY ACTION OR INACTION ON THE PART OF THE FEDERAL GOVERNMENT OR ANY CHANGES TO FEDERAL LAW OR ITS INTERPRETATION.

(4) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSION SHALL INCLUDE THE FINDINGS OF THE WORKGROUP IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (K) OF THIS SECTION.

[(i)] (J) The Commission may:

- (1) hold public meetings across the State to carry out the duties of the Commission; and
- (2) convene workgroups to solicit input from stakeholders.

[(j)] (K) On or before December 31 each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017. It shall remain effective for a period of **[3] 6** years and 1 month and, at the end of June 30, **[2020] 2023**, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

~~SECTION 2. AND BE IT FURTHER ENACTED, That it is the intent of the General Assembly 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 Act.~~

SECTION ~~2.~~ 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~July~~ June 1, 2019.

Approved by the Governor, May 13, 2019.

Appendix 4

LAWRENCE J. HOGAN, JR., Governor

Ch. 597

Chapter 597

(House Bill 258)

AN ACT concerning

Health Insurance – Individual Market Stabilization – Provider Fee

FOR the purpose of clarifying that certain provisions of law apply to managed care organizations; requiring a managed care organization to pay a certain fee on a certain basis in certain calendar years; altering the purpose of certain provisions of law requiring that certain entities be subject to a certain assessment on all amounts used to calculate a certain premium tax liability or the amount of the entity's premium tax exemption value; requiring that certain entities be subject to certain assessments for in certain calendar years in which the federal government makes an assessment and for certain calendar years in which the federal government does not make an assessment under a certain provision of federal law; ; clarifying that certain assessments are for insurance products that are subject to a certain provision of federal law and may be subject to an assessment by the State; requiring that the calculation of the assessment be made without regard to certain threshold limits or a certain partial exclusion of net premiums; making a conforming change; providing for the application of certain provisions of law; requiring the Maryland Health Insurance Coverage Protection Commission to study a certain matter; providing that certain provisions of this Act apply to stand-alone dental plan carriers and stand-alone vision plan carriers; providing for the termination of a certain provision of this Act, subject to a certain contingency; requiring the Maryland Insurance Commissioner to forward a copy of a certain notice to the Department of Legislative Services within a certain period of time and notify certain carriers; making a certain provision of this Act subject to a certain contingency; and generally relating to the stabilization of the individual market and the health insurance provider fee.

BY adding to

Article – Health – General
Section 15–102.3(g)
Annotated Code of Maryland
(2015 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance
Section 6–102.1
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, without amendments,

Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37
and 38 of the Acts of the General Assembly of 2018
Section 1(b)

BY repealing and reenacting, with amendments,

Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37
and 38 of the Acts of the General Assembly of 2018
Section 1(h)(1)

BY repealing and reenacting, with amendments,

Article – Insurance
Section 6–102.1(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

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

Article – Health – General

15–102.3.

**(G) (1) THE PROVISIONS OF § 6–102.1 OF THE INSURANCE ARTICLE
APPLY TO MANAGED CARE ORGANIZATIONS.**

**(2) FOR EACH CALENDAR YEAR THAT THE INSURANCE
COMMISSIONER ASSESSES A HEALTH INSURANCE PROVIDER FEE UNDER § 6–102.1
OF THE INSURANCE ARTICLE, A MANAGED CARE ORGANIZATION SHALL PAY THE FEE
ON A QUARTERLY BASIS IN ACCORDANCE WITH A SCHEDULE ADOPTED BY THE
INSURANCE COMMISSIONER.**

Article – Insurance

6–102.1.

(a) This section applies to:

(1) an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the State that provides a product that:

- (i) is subject to ~~the fee under~~ § 9010 of the Affordable Care Act; and
- (ii) may be subject to an assessment by the State; and

(2) a managed care organization authorized under Title 15, Subtitle 1 of the Health – General Article.

(b) The purpose of this section is to [recoup the aggregate amount of the] **ASSIST IN THE STABILIZATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET BY ASSESSING A** health insurance provider fee [that otherwise would have been assessed under § 9010 of the Affordable Care Act] that is attributable to State health risk for calendar year 2019 ~~[as a bridge to stability in the individual health insurance market]~~ **AND EACH CALENDAR YEAR THEREAFTER YEARS 2019 THROUGH 2023, BOTH INCLUSIVE, AS PROVIDED FOR UNDER SUBSECTION (C) OF THIS SECTION.**

(c) (1) ~~[In] FOR A~~ calendar year ~~[2019] IN WHICH THE FEDERAL GOVERNMENT DOES NOT MAKE AN ASSESSMENT UNDER § 9010 OF THE AFFORDABLE CARE ACT~~, in addition to the amounts otherwise due under this subtitle, an entity subject to this section shall be subject to an assessment of 2.75% on all amounts used to calculate the entity's premium tax liability under § 6-102 of this subtitle or the amount of the entity's premium tax exemption value for ~~THE IMMEDIATELY PRECEDING~~ calendar year ~~[2018]~~.

(2) ~~FOR A CALENDAR YEAR IN WHICH THE FEDERAL GOVERNMENT MAKES AN ASSESSMENT UNDER § 9010 OF THE AFFORDABLE CARE ACT IN CALENDAR YEARS 2020 THROUGH 2023, BOTH INCLUSIVE~~, IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 1% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6-102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(3) THE ASSESSMENTS REQUIRED IN PARAGRAPHS (1) AND (2) OF THIS SUBSECTION ARE FOR PRODUCTS THAT:

(I) ARE SUBJECT TO § 9010 OF THE AFFORDABLE CARE ACT;

AND

(II) MAY BE SUBJECT TO AN ASSESSMENT BY THE STATE.

(4) THE CALCULATION OF THE ASSESSMENTS REQUIRED UNDER PARAGRAPHS (1) AND (2) OF THIS SUBSECTION SHALL BE MADE WITHOUT REGARD TO:

(I) THE THRESHOLD LIMITS ESTABLISHED IN § 9010(B)(2)(A) OF THE AFFORDABLE CARE ACT; OR

(II) THE PARTIAL EXCLUSION OF NET PREMIUMS PROVIDED FOR IN § 9010(B)(2)(B) OF THE AFFORDABLE CARE ACT.

[(2)] (D) Notwithstanding § 2–114 of this article, the assessment required under this section shall be distributed by the Commissioner to the Maryland Health Benefit Exchange Fund established under § 31–107 of this article.

Chapter 17 of the Acts of 2017, as amended by Chapters 37 and 38 of the Acts of 2018

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

That:

(b) There is a Maryland Health Insurance Coverage Protection Commission.

(h) (1) The Commission shall study and make recommendations for individual and group health insurance market stability, including:

(i) the components of one or more waivers under § 1332 of the Affordable Care Act to ensure market stability that may be submitted by the State;

(ii) whether to pursue a standard plan design that limits cost sharing;

(iii) whether to merge the individual and small group health insurance markets in the State for rating purposes;

(iv) whether to pursue a Basic Health Program;

(v) whether to pursue a Medicaid buy-in program for the individual market;

(vi) whether to provide subsidies that supplement premium tax credits or cost-sharing reductions described in § 1402(c) of the Affordable Care Act; [and]

(vii) whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance; AND

(VIII) WHETHER THE STATE REINSURANCE PROGRAM SHOULD BE EXTENDED AFTER CALENDAR YEAR 2023 AND, IF SO, HOW IT WILL BE FUNDED.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

6–102.1.

(a) **(1)** This section applies to:

[(1)] (I) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the State that provides a product that:

[(i)] 1. is subject to the fee under § 9010 of the Affordable Care Act; and

[(ii)] 2. may be subject to an assessment by the State; and

[(2)] (II) a managed care organization authorized under Title 15, Subtitle 1 of the Health – General Article.

(2) THIS SECTION DOES NOT APPLY TO A STAND-ALONE DENTAL PLAN CARRIER OR A STAND-ALONE VISION PLAN CARRIER.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The assessment established under § 6-102.1 of the Insurance Article, as enacted by Section 2 1 of this Act, shall apply to stand-alone dental plan carriers and stand-alone vision plan carriers.

(b) If the federal government confirms that under the rules that implement § 1903 of the Social Security Act, which requires health care related taxes to be broad-based and uniform in order to apply to Medicaid providers, such as managed care organizations, that the State can impose a 1% assessment on Medicaid managed care organizations if it is imposing that fee on all commercial health insurance plans except dental and vision, subsection (a) of this section, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

(c) If the Maryland Insurance Commissioner receives notice of the confirmation described in subsection (b) of this section, within 5 days after receiving notice of the confirmation, the Commissioner shall:

(1) forward a copy of the notice to the Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401; and

(2) notify each stand-alone dental plan carrier and stand-alone vision plan carrier.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect contingent on the termination of Section 3(a) of this Act.

SECTION ~~2~~ 5. AND BE IT FURTHER ENACTED, That, subject to Section 4 of this Act, this Act shall take effect October 1, 2019.

Enacted under Article II, § 17(c) of the Maryland Constitution, May 25, 2019.