Report of the Maryland Health Insurance Coverage Protection Commission

DEPARTMENT OF LEGISLATIVE SERVICES 2019

Report of the Maryland Health Insurance Coverage Protection Commission

Annapolis, Maryland

December 2019

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THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401-1991

December 31, 2019

The Honorable Thomas V. Mike Miller, Jr.
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 Miller and Speaker Jones:

The Maryland Health Insurance Coverage Protection Commission respectfully submits its third report containing a summary of the commission's activities during the 2019 interim.

The commission held three informative meetings to monitor potential and actual federal changes relating to the federal Patient Protection and Affordable Care Act and to assess the impact of such changes. The briefings received by the commission included presentations on the preexisting condition protections implemented in other states, cost-sharing trends in health insurance, affordability issues, Medicaid buy-in programs, and health insurance coverage reforms in Massachusetts.

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,

Senator Brian J. Feldman
Senate Chair

Delegate Joseline A. Peña-Melnyk
House Chair

BJF:JAP/LJS:JBC/kkh

Enclosure

Maryland Health Insurance Coverage Protection Commission
2019 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
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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, 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 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 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.

Chapters 417 and 418 created the Health Insurance Consumer Protections Workgroup. The purpose of the workgroup was 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 ACA] continue to protect Maryland residents in light of continued threats to the ACA." The findings and recommendations of the workgroup can be found in **Appendix 5**.

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 third annual report of the commission.

State Actions to Stabilize the Individual Health Insurance Market

State Reinsurance Program

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

costs on a per individual basis. Carriers are reimbursed for 80% of claims between $20,000 and $250,000. Payments to carriers will be 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. Revenues come 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 reinsurance program was established, MHBE estimated that total funding would be $1.1 billion for calendar 2019 through 2021, including $365 million in State funds from the one-time assessment and $730 million in federal pass-through funds. MHBE advises that program costs are now estimated to be less than anticipated. For calendar 2019, estimated costs of $462 million have been revised to $370 million, though final costs will be not be determined until all 2019 claims are accrued. For calendar 2020, estimated costs of $459 million are now anticipated to be $400 million. These revised estimates suggest that funding will last longer than initially 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 an average 13.2%. For calendar 2020, approved rates fell an additional 10.3%. Although premiums have decreased for the second year in a row, they remain high, and deductibles and out-of-pocket expenses continue to increase. In calendar 2020, deductibles will 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 an advanced premium tax credit. To address these issues, MIA conducted a report on health insurance cost-sharing trends, and MHBE established a workgroup to study affordability of health care in Maryland.

Maryland Easy Enrollment Health Insurance Program

Following presentations made to the commission in 2018, 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 will assist in enrolling uninsured individuals in Medicaid or subsidized or unsubsidized health insurance. Phase 1 of the program is anticipated to begin with the filing of tax year 2019 State income tax returns in early 2020.

Chapter 2. Work of the Commission

Agenda and Presentations

During the course of the 2019 interim, the Maryland Health Insurance Coverage Protection Commission held three meetings. 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.

August Meeting

On August 21, 2019, during its first meeting, the commission received information on the Maryland Easy Enrollment Health Insurance Program (MEEHIP), the Health Insurance Consumer Protections Workgroup, and preexisting condition protections implemented in other states. The commission also reviewed and discussed options to stabilize the individual market that were presented to the commission in 2017 and 2018.

Maryland Easy Enrollment Health Insurance Program

During the 2019 session, the General Assembly passed legislation establishing the MEEHIP to allow an uninsured individual to elect on their State income tax return to authorize the Office of the Comptroller to share information with the Maryland Health Benefit Exchange (MHBE) in order to determine the individual's eligibility for insurance affordability programs. MHBE and the Office of the Comptroller briefed the commission on progress made in implementing the MEEHIP.

Ms. Heather Forsyth, Director of Consumer Assistance at MHBE, advised the commission that the MEEHIP will be available in part for the 2019 tax year. In discussions with the Office of the Comptroller, MHBE determined that it was not administratively feasible to roll the entire program out this year; however, the agencies will implement as much as possible. In Phase 1 of implementation (available for tax year 2019), the system will provide preliminary eligibility determinations. The system will generate a personalized notice to everyone who checks the box on the tax form. The notice will include information about the individual's likely eligibility status and advise the individual about how to access assistance on finding a health insurance. MHBE is also preparing training materials for their consumer assistance workers and has privacy protections in place.

There will be a 30-day "tax time" special enrollment period for individuals enrolling in private insurance. The special enrollment period will begin when an individual receives their notice of eligibility. The notice will include the date on which the individual's special enrollment period will end. MHBE also noted that individuals can enroll in Medicaid year round, so no special enrollment period is needed for individuals who seek Medicaid or Maryland Children's Health Program enrollment.

MHBE advised the commission that they will be collecting data on (1) the number of consumers who check the checkoff box; (2) the number of consumers who follow-up with MHBE; and (3) the number who enroll in health insurance. This data will be made available to the General Assembly.

Ms. Deborah Gorman, Deputy Director of the Revenue Administration Division at the Office of the Comptroller, provided a draft copy of the MEEHIP tax forms. Individuals will use the checkoff boxes on Maryland Form 502 to indicate whether they have insurance and, if not, whether they authorize the Comptroller to share information from their tax return with MHBE. Individuals may use Maryland From 502B to provide information about dependents. Ms. Gorman also indicated that MHBE has set up a landing page, linked from the tax instructions, where individuals can get more information about health insurance options.

Ms. Jessica Grau, Health Policy Analyst at MHBE, provided information on the Maryland Easy Enrollment Workgroup. The workgroup is comprised of 22 members, chosen from 55 applicants. Ms. Grau also announced that the workgroup's first meeting would be held in September.

Health Insurance Consumer Protections Workgroup

Delegate Joseline A. Peña-Melnyk provided an update on the Health Insurance Consumer Protections Workgroup. This workgroup was created by Chapters 417 and 418 (House Bill 697 and Senate Bill 868) of 2019. The workgroup is comprised of members of the commission and held an organizational meeting in late July. The group will meet four times during the interim to review House Bill 697 and Senate Bill 868, as introduced, and make recommendations for legislation that would codify the Patient Protection and Affordable Care Act's (ACA) consumer protections in Maryland law. Meetings will be open to the public, and video recordings of the meetings will be published on the Department of Legislative Services (DLS) website. The workgroup will provide its report to the commission at the December 17 meeting.

Preexisting Condition Protections in Other States

Ms. Dania Palanker, Assistant Research Professor at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute, provided an update on the *Texas v. United States* ACA litigation. In December 2018, a District Court Judge from the Northern District of Texas ruled that the entire ACA was unconstitutional since Congress had acted to set the penalty

for failing to purchase health insurance to $0. Without a penalty, the judge ruled, the individual mandate was no longer a valid exercise of Congress' power to tax.

The case was appealed to the Fifth Circuit Court of Appeals, which heard oral arguments in July. The oral arguments were organized around three topics: (1) whether the parties have standing; (2) whether the ACA was unconstitutional without the mandate; and (3) whether any part of ACA is severable. Ms. Palanker observed that the case will likely turn on the third item – whether or not any part of the ACA is severable. The court is likely to find that the parties have standing to sue. Furthermore, she noted that two of the judges seemed to think that the individual mandate was unconstitutional without the tax penalty. Therefore, the question about severability will be of high importance. If the entire ACA is unconstitutional, then the premium tax credits and the Medicaid expansion would also go away. The court is expected to reach a decision before the end of the year, and the case will likely be appealed to the Supreme Court.

Ms. Emily Curran, Research Fellow at the Center on Health Insurance Reforms at Georgetown University's Health Policy Institute, provided an overview of what other states have done to protect consumers in light of the uncertainty around the ACA. A number of states have "baked in" some of the ACA's consumer protections by codifying those provisions into their states' laws. Some states (Connecticut, Hawaii, Maryland, Massachusetts, Minnesota, Oregon, and Vermont) implemented early market reforms in 2014 by establishing a state-based marketplace and expanding their Medicaid programs. By 2018, 14 states adopted community rating provisions, 9 states adopted guaranteed issue, and 10 states adopted prohibitions on preexisting condition exclusions.

Other states have taken different approaches. In two states – New Jersey and Rhode Island – the states' respective governors have issued executive orders directing agencies to uphold the ACA's principles. Maine has issued bulletins clarifying state law on dependent coverage, the medical loss ratio, annual and lifetime limits, and essential health benefits, along with other provisions. North Dakota has created a workgroup to study consumer protections and make recommendations to the General Assembly.

Options to Stabilize the Individual Market as Presented to the Commission in 2017 and 2018

During the 2017 and 2018 interims, the commission received presentations on options to stabilize the individual market. These include (1) merging the individual and small group markets; (2) pursuing a standardized benefit design; and (3) developing a Basic Health Program. Delegate Peña-Melnyk provided a recap of each of these three options and opened the floor for discussion. The purpose of the conversation was to determine whether the commission wanted to continue pursuing any of those options, or alternatively, to table discussions for now.

Merging the Individual and Small Group Markets

The ACA provides states with the option of merging their individual and small group health insurance markets. This would result in a single risk pool and a single index rate for the total combined claims costs for providing essential health benefits within that risk pool.

Under the direction of the General Assembly in 2011, MHBE convened advisory committees and worked with several consultants to conduct studies to help MHBE develop a number of initial policies required for MHBE's establishment and operations. One of these considerations was whether the individual and small group markets should be merged. Based on the work of the advisory committees, the MHBE Board of Trustees recommended against merging markets for several reasons:

- Maryland's small group market was twice as large as the individual market;
- concern that combining the risk pools would drive up costs in the small group market;
- concern that rising costs would drive more small groups to self-insure; and
- not all carriers participated in both markets.

MHBE revisited this recommendation in 2016 and 2018, and in both instances, continued to recommend against it.

During the 2018 interim, Wakely Consulting Group provided the commission with an analysis of merging markets in Maryland. Wakely laid out four policy options that Maryland should consider if the State wants to move forward with a merger. Wakely also noted that merging the markets would lessen the effect of the State Reinsurance Program. Wakely recommended that if Maryland decided to pursue a merger, it should wait until after the reinsurance program ends.

Delegate Peña-Melnyk opened the floor for discussions. The commission did not take a formal vote, but members indicated that their preference was to table this discussion for the foreseeable future.

Standardized Benefit Design

Standardized benefit designs are health benefit plans with benefits and cost-sharing set by a noncarrier entity with the intent of assisting consumers in comparing plans "apples-to-apples" across the carriers that offer them. A standardized benefit design workgroup was convened in 2017, and MHBE reported to the commission on the findings of that workgroup during the 2018 interim. The workgroup did not reach consensus on whether plans should be standardized in the individual market.

In 2018, commissioners raised questions about the extent to which a standardized benefit design would benefit Maryland consumers, particularly given that there are only two carriers that participate in the individual market that have significantly different models of coverage. It is unclear how a standardized benefit design would assist consumers in choosing between such fundamentally different plans. It is also unclear how standardized benefit design would affect deductibles and premiums.

Delegate Peña-Melnyk opened the floor for further comment. The commission did not take a formal vote, but members indicated that their preference was to table this discussion for the foreseeable future.

Basic Health Program

Section 1331 of the ACA gives states the option of creating a Basic Health Program, a health benefits coverage program for low-income residents who would otherwise be eligible to purchase coverage through MHBE. The Basic Health Program gives states the ability to provide more affordable coverage for these low-income residents and improve continuity of care for people whose income fluctuates above and below Medicaid and the federal Children's Health Insurance Program (CHIP) levels. States can provide coverage to individuals who are citizens or lawfully present noncitizens, who do not qualify for Medicaid, CHIP, or other minimum essential coverage and have income between 133% and 200% of federal poverty guidelines (FPG). People who are lawfully present noncitizens who have income that does not exceed 133% FPG but who are unable to qualify for Medicaid due to citizenship status are also eligible to enroll.

Two states (Minnesota and New York) currently offer basic health plans; however both states are confronting funding shortages for their programs with the federal government's decision to stop paying cost-sharing reductions.

The commission did not take a formal vote, but members indicated their preference was to table this discussion for the foreseeable future.

October Meeting

On October 15, 2019, the commission received briefings on Maryland Insurance Administration's (MIA) *Report on Cost-Sharing Trends in Health Insurance*, MHBE's Affordability Work Group report, Medicaid buy-in programs, and health insurance coverage reforms in Massachusetts.

Trends in Health Insurance

The 2019 *Joint Chairmen's Report* requested that MIA produce an informational report on the trends and changes of health insurance benefit design and actuarial value between 2013 and 2018 and the impact of these changes on utilization trends. MIA found that the average actuarial

value (the percent of allowed essential health benefits that are paid by the carriers) of plans in the individual and small group markets increased between 2016 and 2018. The average medical deductible decrease slightly between 2013 and 2015 and increased steadily between 2016 and 2018 to $4,168 in 2018. The impact of these cost-sharing changes on claims utilization has been a slight upward pressure for all years except for 2016, which saw a moderate downward trend. The average drug deductible has gradually declined since 2016 to $2,113 in 2018. The average out-of-pocket (OOP) maximum increased for all years through 2018 to $6,938 and is approaching the maximum allowable for OOP expenses under federal regulations.

Affordability Workgroup

MHBE discussed the affordability landscape for plans that will be offered on the exchange in calendar 2020. In general, premium decreases are the greatest for bronze and gold plans, in part due to reinsurance program funding. While calendar 2020 premiums decreased by 10.3%, affordability issues remain, particularly for those who do not receive financial assistance and for households with older individuals. Notably, of the remaining uninsured who are eligible to purchase a qualified health plan (QHP) in the exchange, 29% are ineligible for financial assistance (*e.g.,* the household has income greater than 400% of FPG).

MHBE established an Affordability Work Group under 2020 plan certifications standards to develop recommendations to reduce OOP costs and maximize affordability for both subsidized and unsubsidized consumers. The workgroup found that Maryland's reinsurance program has helped to stabilize the individual market and provide insurance to individuals with chronic illnesses that would not otherwise be able to obtain insurance. The workgroup also considered who are the remaining uninsured in Maryland and found that the largest group is young adults ages 19 to 34 (94,000), of which nearly 70% are eligible for financial assistance. The workgroup recommended continuing the reinsurance program and considering a young adult subsidy, which would improve the individual market risk pool by adding individuals who are healthier than average and lowering costs for all. If a subsidy is implemented under a State Innovation (Section 1332) Waiver, Maryland may be able to receive federal pass-through funding. The workgroup noted that a study should be performed to determine whether it would be more advantageous to pair a young adult subsidy with or without a waiver.

MHBE has also required carriers to offer value plans in the individual exchange for calendar 2020. Value plans will cap deductibles at $2,500 for silver plans and $1,000 for gold plans and are designed to give consumers greater access to primary care, mental health care, and generic drugs before their deductibles apply.

Medicaid Buy-in Programs

Ms. Chiquita Brooks-LaSure, Managing Director of Manatt Health, discussed evolving public option/Medicaid buy-in models and associated considerations. Nationally, as of 2017, 30 million people remained uninsured, 34% of whom are eligible for Medicaid and 25% of whom are eligible for federal financial assistance in exchanges. Each state has specific market dynamics

and health policy goals to consider when choosing affordability and cost-containment policies (*i.e.,* reducing premiums, reducing cost-sharing, increasing access for the uninsured). Medicaid buy-in is generally defined as a state leveraging the government bargaining power in some way to offer a more affordable coverage option.

State options include off-market buy-ins (Medicaid-like coverage for consumers who are not eligible for Medicaid offered as an off-market, state administered plan), on-market public options (a state-sponsored QHP on the exchange and often a "mirror plan" outside the exchange), and Basic Health Program buy-ins. Savings sources may include provider payment rates, administrative efficiencies, leveraging of purchasing power, and long-term savings through investments in population health and delivery systems. Financing can be self-sustaining (enrollee premiums), subsidized with state dollars, funded through federal pass-through funding under Section 1332 waivers, or a combination of the above.

Washington state enacted the nation's first public option legislation in 2019. The goal of the program is to increase affordability and choice for unsubsidized customers priced out of the state exchange. The Washington Health Care Authority (the state's Medicaid agency) will contract with one or more insurers to offer one or more state-sponsored plans on the state's exchange for calendar 2021. Plans will be subject to an aggregate cap of 160% of Medicare rates with specified exceptions. Plans are projected to reduce premiums by 5% to 10%. Of note, Washington has one of the lowest percentages of subsidized consumers in the nation (only 65% of enrollees receive subsidies).

In 2018, New Mexico considered four options for public options: (1) a targeted Medicaid buy-in; (2) a QHP public option; (3) the Basic Health Program; and (4) a Medicaid buy-in for all. New Mexico has a small marketplace population (82% of whom receive subsidies) and lower than average benchmark premiums. More than one-third (34%) of New Mexicans were enrolled in Medicaid in 2017 (the highest proportion in the country). After targeted Medicaid buy-in legislation did not pass, the state continues to weigh its options.

In 2019, Colorado enacted legislation to study a state option for health care coverage. According to the initial report, all state residents would be eligible, and plans would be available both on and off-exchange through existing insurers. Savings are anticipated to be generated through an required 85% medical loss ratio (up from the current 80%), prescription drug rebates, and caps on facility reimbursement at 175% to 225% of Medicare rates. Any provider that offers insurance in either the individual or group market will be expected to offer the state option if they meet certain thresholds. Premiums are anticipated to decrease by between 9% and 18%. The state option would be self-funded, but the report recommends applying for a Section 1332 waiver to obtain federal pass-through funding.

Emerging themes among states to date is that specific state dynamics heavily influence design choices, provider responses depend on reimbursement rates and the option's targeted population, stakeholders will need to balance priorities, designs often impact subsidized and unsubsidized populations differently, and concerns about state risk and the effects on other

populations. State options cannot solve all issues and may not be the simplest away to address high OOP costs or high premiums, nor may they change behavior among people who are currently eligible for other programs but do not enroll.

Key questions for Maryland to consider if they want to consider a public option are (1) what problem(s) is Maryland trying to solve and is a buy-in an effective strategy; (2) who remains uninsured and how will that influence policy design; (3) what are the potential sources of cost savings; (4) what existing infrastructure is the best fit for a public option; (5) what are the potential impacts on other insurance markets; (6) does the State require, or would it be beneficial to pursue, a Section 1332 waiver; and (7) is Maryland positioned to implement a state option?

Health Insurance Coverage in Massachusetts

Antecedents to 2016 Reforms

Mr. Michael Miller, Director of Strategic Policy for Community Catalyst, discussed the unique dynamics that have made Massachusetts' robust health insurance coverage system possible. Several policy antecedents paved the way for larger reforms in 2006: (1) creation of an uncompensated care pool in the 1980s (which made these costs transparent and later served as a financing tool for insurance premium subsidies); (2) small group insurance reform (open to groups as small as one, which began to blur the differences between the small and individual markets); (3) nongroup insurance reform (adopted medical underwriting protections, preserved carrier participation by requiring sale of products in both the group and nongroup markets); and (4) Medicaid expansion in the 1990s. Several "environmental" factors also made reform possible: Massachusetts has had an iterative policymaking process, employers embrace "high road" economic development strategies, consumers embrace a pragmatic approach to policymaking, policymakers have looked for the "big tent," and the state has many consensus building institutions. This has resulted in a "better boat" and a "calmer sea" – more affordable coverage; lower premiums and cost-sharing; a bigger, more stable risk pool; high coverage rates; and alignment of financial and operational responsibilities. Three key takeaways from Massachusetts' experience have been (1) affordability makes the world go around; (2) shared responsibility and trust building are key; (2) you do not – and maybe cannot– do everything at once, thus an iterative approach is a good approach to building success.

Role of the Massachusetts Health Connector

Ms. Audrey Morse Gasteier, Chief of Policy and Strategy for the Massachusetts Health Connector, provided a presentation on health coverage expansion in Massachusetts. Massachusetts currently has the highest insurance rate of any state, the lowest average exchange premiums in the country, and the second lowest benchmark plan in the country. Three key features of the connector help make this possible: (1) the state's unique "wrap program," ConnectorCare, which uses state-financed subsidies on top of ACA subsidies; (2) program dynamics in the unsubsidized market; and (3) the state's individual mandate.

ConnectorCare State Premium Wrap

Unique to Massachusetts, the Health Connector layers additional state subsidies on top of federal advanced premium tax credits (APTC) for eligible individuals with incomes up to 300% FPG via the ConnectorCare program. Minnesota, New Hampshire, New York, and Vermont also have subsidy "wrap" programs, but ConnectorCare is particularly robust.

ConnectorCare selects plans from commercial carriers (including carriers that participate in Medicaid), and enrollees are part of the commercial "merged market" risk pool. ConnectorCare uses each selected carrier's lowest-cost silver plan as the base and enriches it with state premium and cost-sharing subsidies, in addition to federal APTCs, to create a selection of plans with low premiums and co-payments for eligible individuals. Enrollees are divided into five "plan types" based on income. Enrollees make per member premium contributions based on their plan types, in base amounts ranging from $0 to $130/month (calendar 2020). Plans have modest copayments, but no deductibles or coinsurance.

Funding comes from the Commonwealth Care Trust Fund (created to support affordability and coverage expansion), which obtains revenue from tobacco taxes, penalties paid by uninsured individuals who do not meet the individual mandate, an assessments from the employer community. The state also receives federal matching funds for some of the population in the program through a Section 1115 waiver. The net cost to the State for the program is approximately $165 million annually – about half to buy down premium costs and half to buy down cost-sharing. The program currently covers about 200,000 enrollees and has five carriers participating statewide.

Dynamics of Massachusetts' Unsubsidized Market and the State Individual Mandate

Converse to most states' experiences, Massachusetts has continued to see growth in its unsubsidized market. This is helped by competition in the ConnectorCare Program, which creates competitive dynamics between carriers. Massachusetts has also had an individual mandate since 2007, which has helped to keep the risk pool stable, stem against adverse selection, and keep coverage rates high. There are also cost-sharing ceilings and significant consumer protections inherent in the state's individual mandate.

Next Steps for Massachusetts

Ms. Amy F. Rosenthal, Executive Director of Massachusetts' Health Care For All, described the role of the organization in supporting insurance and enrollment issues and discussed next steps for Massachusetts. Future efforts will expand coverage to all residents; address prescription drug prices; address out-of-network and balance billing issues; think about social determinants of health; and work on integration of oral health, mental health parity, and pediatric mental health services.

December Meeting

During its third meeting on December 17, 2019, the commission received briefings on the Task Force to Study Cooperative Purchasing of Health Insurance and health insurance options for small businesses. DLS provided a presentation on state health insurance subsidies at the commission's request. The commission also received a report from the Health Insurance Consumer Protections Workgroup and discussed the commission's next steps and recommendations for 2020.

Update on Task Force to Study Cooperative Purchasing of Health Insurance

Ms. Gabriel Gnall, Procurement Advisor to the Board of Public Works, provided an update on the Task Force to Study Cooperative Purchasing of Health Insurance. The task force was created by Chapter 307 of 2018 and is comprised of 15 members, including representatives of the Department of Budget and Management (DBM), the Maryland Association of Counties, the Maryland Association of Boards of Education, and the Maryland State and DC AFL-CIO.

In order to pool public employee health care purchasing by the State, counties, municipal corporations, and county boards to maximize value while maintaining a broad package of benefits and reasonable premiums, the task force was required to study models of cooperative purchasing and make specified recommendations about health benefit options, ways to minimize administrative costs, and means to control health costs and offer a variety of health benefit plans.

The task force convened on four dates: August 29, September 30, October 21, and November 7, 2019. DBM's health care consultants, the Segal Group, provided presentations on various topics at each of the meetings and provided further information upon request from task force members.

The task force's recommendations include the following:

- increase outreach to local governmental entities that are allowed to join the State's plan and provide information regarding the benefits and costs;

- analyze the potential costs to the State and cost savings to local government entities by the State assuming or sharing the administrative burden for any local governmental entities that join the State's plan;

- if participation by local governmental entities in the State's plan is not increased after outreach efforts are performed, consider establishment of a governing body or joint health care committee that would allow local governmental entities to have representation and substantive input into the plan design and procurement evaluation processes for the State's health plan (DBM did not concur with this recommendation); and

- Encourage enabling legislation to support nonprofits in combining resources to form a pool of nonprofits to cooperatively purchase health benefits.

The task force's report to the Governor and General Assembly is due January 1, 2020.

Health Insurance Options for Small Businesses

Ms. Michele Eberle, Executive Director of MHBE, provided an overview of the Small Business Option Program (SHOP). The program was created under ACA to help small businesses (*i.e.,* 50 or fewer employees) provide health insurance to their employees. Key tenants of SHOP include eligibility requirements, availability of tax credits, and more coverage choices for employees.

MHBE has identified needs in the small group market that can be addressed. To that end, MHBE has been working on the following initiatives:

- ***1332 Waiver:*** MHBE is pursuing a Section 1332 waiver to allow the State to administer the federal small business health care tax credit subsidy on a monthly basis, rather than annually. This change would help small businesses by providing the tax credit more regularly, which would help businesses that depend on a consistent cash flow. MHBE plans to file the application by fall 2020, and it would apply for plan years starting in 2021.

- ***Small Business Health Advisory Committee:*** MHBE has convened a committee of 17 members, with representatives from small businesses, chambers of commerce, carriers, and other stakeholders. The committee has two workgroups, (1) a platform workgroup that focuses on overall integration of a small business platform into Maryland Health Connection (MHC); and (2) a policy workgroup that will focus primarily on examining and informing MHBE activity pertaining to the Section 1332 waiver application.

- ***Small Business Insights Survey:*** MHBE hired a firm to administer a 10-minute online survey of Maryland-based businesses with 25 or fewer employees, including a minimum of 33% businesses with between 2 and 10 employees. The objective was to investigate knowledge, attitudes, receptivity, and motivations around health insurance for employees overall and specifically about the SHOP.

- ***MHC for SmallBiz:*** MHBE is working on the development of a small business platform, similar to the platform used for the individual exchange.

Ms. Eberle provided an overview of some of the findings from the small business insights survey. The majority (62%) of Maryland-based small businesses (with 2 to 25 employees) offer some form of financial support for health insurance to their employees, while 39% do not. Primary reasons to sponsor a group health insurance plan center on employee needs; satisfying demand

from employees, attracting talented staff, and investing in employees as an investment in their business overall; 63% each say that these are major reasons to sponsor a group health plan.

The factors driving decision making on whether to sponsor a group health plan are cost, complexity of plans, regulations, and employee considerations (*i.e.,* the ability to recruit talent without providing insurance and considering whether to subsidize employee coverage in the individual market in lieu of providing a group health plan). Knowledge of the tax savings a business could receive has a positive impact on interest and motivation to sponsor a SHOP plan. After reviewing scenarios tailored to their situation, 64% of businesses are more likely to consider the SHOP.

Ms. Stephanie Klapper, Deputy Director of the Maryland Citizens' Health Initiative gave a presentation on expanding health coverage for small businesses in Maryland. She highlighted some potential benefits of increased SHOP participation that include more flexibility for small businesses that currently purchase off-exchange coverage, new opportunities for people enrolled in the individual market to potentially shift to lower-cost SHOP coverage, and improved health equity.

Ms. Klapper also noted some current barriers to SHOP participation, such as lack of awareness among employers and business tax credit concerns. She noted that there is a burdensome application process for the credit, it is only available for two years, and it is provided to small businesses only at the end of the year. She provided some proposed solutions to these problems: (1) simplify the small business tax credit formula; (2) increase funding for the small business tax credit (at a cost of at least $15 million per year); and (3) increase funding by $5 million for MHBE administration and marketing. She suggested that the proposed solutions could be included in a Section 1332 waiver application.

Fiscal Comparison of Massachusetts and Maryland

Ms. Jennifer B. Chasse, Principal Policy Analyst at DLS and staff to the commission, provided a presentation at the request of the commission, which reviewed details on Massachusetts' ConnectorCare Program and presented a preliminary estimate on how much it would cost to implement similar subsidies in Maryland. Information was also provided about recent actions related to state premium subsidies in other states.

Massachusetts' ConnectorCare Subsidies

ConnectorCare layers additional state subsidies on top of ACA subsidies and cost-sharing reduction plans for eligible individuals with incomes up to 300% of FPG. ConnectorCare selects plans from commercial carriers using the lowest-cost silver plan as the base, then layers on both a premium subsidy and a cost-sharing subsidy. Premium subsidy amounts are based on an affordability standard (0% to 5% of income) set by the Massachusetts Health Connector.

ConnectorCare costs total $299 million annually ($151.1 million for premium subsidies and $147.7 million for cost-sharing subsidies). The program is funded by the Commonwealth Care Trust Fund and federal matching funds. The Commonwealth Care Trust Fund comprises a surcharge on the state cigarette tax, individual mandate penalties, and assessments on employers and provides about $165 million in annual funding for ConnectorCare. Massachusetts also receives $134 million in federal matching funds for the program through a Section 1115 waiver. ConnectorCare currently covers about 200,000 enrollees with five carriers participating statewide.

Preliminary Estimated Cost to Implement Similar Subsidies in Maryland

DLS prepared preliminary low, mid-range, and high estimates for the cost to implement premium subsidies similar to those in Massachusetts based on set assumptions. Specifically, estimated were based on MHBE enrollment data as of October 31, 2019, and estimated monthly premium costs after the federal APTC for the CareFirst Silver Value Plan for 2020 for an individual aged 40. Actual costs will depend on the specific distribution of enrollees across income brackets, which drives the amount of APTC received by enrollees. The estimates do not reflect the age of enrollees, though age is a less sensitive factor regarding premium rates for individuals that receive an APTC compared with those that do not. Based on these assumptions, the cost of premium subsidies is likely between $59.1 million (low estimate) and $110.0 million (high estimate), with a mid-range estimate of $79.1 million. These estimates reflect the cost to further subsidize existing enrollees with incomes up to 300% FPG and do not reflect any impact from increased enrollment or underlying premium costs.

DLS was not able to prepare an estimate to replicate cost-sharing reductions similar to those in Massachusetts due to the inability to access carrier utilization data. In ConnectorCare, the Massachusetts Health Connector actuarial team determines the value of the cost-sharing reduction, which is paid to carriers as a monthly advanced state cost-sharing subsidy based on enrollment. In June of the following plan year, the connector receives carrier claims files, which are compared to the advanced payments. Several months later, the connector reconciles costs with carriers as needed. DLS noted that additional data and analysis is needed to determine the how much it would cost to implement cost-sharing subsidies in Maryland as they a factor of enrollment and utilization. However, based on Massachusetts experience, the cost of cost-sharing subsidies is likely equal to that of premium subsidies.

State Premium Subsidy Actions in Other States

Two other states are either planning to offer or are studying offering state premium subsidies. California will provide state-funded subsidies to residents with incomes up to 600% FPG in plan years 2020 through 2022. Subsidies will be set to limit premiums to a percentage of household income (ranging from 6% for households at 200% FPG to 18% for households at 600% FPG). Most funding (about 80%) will go toward households with incomes between 401% FPG and 600% FPG. California will use money generated from imposing individual mandate penalties

(estimated at $317 million in 2020) to partially finance these costs, along with general fund contributions. The total cost of the subsidies is estimated at $429 million for plan year 2020.

Legislation enacted in Washington (Chapter 364 of 2019) requires the state to develop a plan to implement and fund premium subsidies for individuals with incomes up to 500% FPG. Subsidies are intended to ensure that individuals spend no more than 10% of household income on premiums. The plan must include an assessment of providing cost-sharing reductions and assess the impact of the subsidies on the uninsured rate. The plan is due to the legislature by November 15, 2020.

Report from the Health Insurance Consumer Protections Workgroup

Ms. Lisa J. Simpson and Ms. Allison Taylor, both senior policy analysts for DLS and staff to the commission and the Health Insurance Consumers Protections Workgroup, briefed the commission on the workgroup's report and proposed legislation. Senator Brian J. Feldman and Delegate Shane E. Pendergrass introduced Senate Bill 868 and House Bill 697 in 2019. As introduced, the legislation established specific ACA protections in Maryland law. Determining language that was agreeable to all of the interested parties proved to be more complicated than anticipated and could not be completed during the 2019 legislative session. Instead, Senate Bill 868 and House Bill 697 were amended to establish the Health Insurance Consumer Protections Workgroup. The charge of the workgroup was to monitor the appeal of *Texas v. United States*, monitor federal enforcement of the ACA, and make recommendations on the most effective manner of ensuring Maryland consumers continue to have access to quality health insurance.

The workgroup included representatives from MIA, the Health Education and Advocacy Unit of the Office of the Attorney General, carriers, the Maryland Hospital Association, and consumer advocates. The workgroup met four times during the 2019 interim. It reviewed House Bill 697 and Senate Bill 868, as introduced, and after considering several drafts and comments made recommendations for legislation for the 2020 session.

The starting point for the legislation proposed by the workgroup was § 15-137.1 of the Insurance Article, which lists protections of the ACA that are incorporated by cross-reference into Maryland law. Section 15-137.1 was enacted during the 2011 session and amended several times through conformity legislation sponsored by MIA. Workgroup members were not confident that the cross-references in the statute would adequately protect Maryland consumers if the ACA is repealed or found to be unconstitutional. The workgroup used the list in § 15-137.1 to draft a new subtitle that would more specifically establish the protections in Maryland law.

The goals in drafting the legislation were to (1) mirror the ACA without providing additional requirements and (2) come to consensus, as much as possible, on the language. The workgroup agreed on most issues but authorized MIA to adopt regulations for some of the more complex protections, like annual cost-sharing limits and prescription drug essential health benefit

coverage. The workgroup also left the issues for which the workgroup did not reach consensus for consideration by the full commission and the General Assembly.

The issues that lacked consensus included funding, antidiscrimination provisions, and a religious exemption for preventive wellness services. The members of the workgroup agreed that the ACA provides substantial federal funding to maintain market stability and make coverage affordable for consumers. The funding streams include premium subsidies for individuals and families between 133% and 400% FPG and advanced premium tax credits of $676 million for 2019. If the ACA is found to be unconstitutional, this funding is jeopardized. The workgroup agreed that premiums would rise in the absence of ACA funding sources or an adequate substitute.

The list of ACA protections in § 15-137.1 of the Insurance Article includes health status-related factors but does not include the ACA's nondiscrimination provisions. In the ACA, health status-related factors are established separately from § 1557 that prohibits discrimination on the basis of race, color, national origin, sex (defined under contested Obama-era regulations to include gender identity, sex stereotyping, and pregnancy status), disability, and age in a broad range of health programs and activities. The majority of the workgroup determined that, since the antidiscrimination protections are not included in § 15-137.1, including these protections in this proposed legislation was beyond the charge of the workgroup and would be more appropriate as a standalone bill if a legislator chooses to address the issue.

The ACA requires coverage without cost sharing for certain women's preventive care and screenings, including contraceptive coverage, and federal regulations offer certain religious exemptions. While the workgroup specifically incorporated the preventive services mandate in § 15-1A-10(a)(4) of the proposed legislation, the workgroup did not include a religious exemption. The religious exemption in the ACA is different from the exemptions provided in Maryland law and has been subject to judicial challenge. Given the uncertain state of the federal exemption and inconsistency with existing Maryland exemptions, the workgroup determined the scope of the language for the exemption was beyond the charge of the workgroup but noted that most likely, the General Assembly will need to decide what type of religious exemption to include for the women's preventive services benefit (specifically, for contraception, sterilization, and related education and counseling).

Discussion on Next Steps

Delegate Peña-Melnyk led a discussion on next steps. Staff emailed members a draft of the commission's annual report for 2019 that included an introduction and summaries of the September and October meetings. Members of the commission were asked to submit comments to staff as soon as possible which staff will include the annual report along with a summary of today's meeting and a conclusion. The complete draft was sent out on December 18, 2019, and members were asked to respond with any comments on the complete report by December 27, 2019, so the report may be completed by the December 31 due date.

Delegate Peña-Melnyk summarized some of the major issues discussed by the commission during the interim. In October, the commission learned that while the average actuarial value of plans in the individual and small group markets has somewhat increased, deductibles and OOP expenses have steadily increased with the average OOP maximum for plans approaching the maximum allowed under federal regulations. While 2020 premiums decreased by 10.3% due to the State Reinsurance Program, affordability issues remain, particularly for those who *do not* receive financial assistance and for households with older individuals. MHBE's Affordability Work Group found that the largest group of the remaining uninsured in Maryland is young adults ages 19 to 34 (94,000, 70% of whom are eligible for financial assistance). The workgroup recommended considering a young adult subsidy to improve the individual market risk pool by adding individuals who are healthier than average. MHBE has contracted with Lewis & Ellis for further analysis and is anticipating more information by the end of January, which can inform additional commission actions. This analysis will also include information on the potential for expanded subsidies for individuals with incomes between 400% and 600% FPG as well as some small group subsidies.

The commission also heard about the potential for additional state premium and cost-sharing subsidies, such as those in Massachusetts ConnectorCare Program. Additional information is needed to fully estimate the cost of such a proposal and its potential impact. Delegate Peña-Melnyk suggested that the General Assembly and commission work with the Presiding Officers to use funds to further study whether or not Maryland should pursue state subsidies (not limited just to the Massachusetts model). The commission concurred that it is worth continuing to look into this option. After reviewing the Lewis & Ellis analysis, the commission can determine what additional information it will seek and discuss it further in January.

In October, the commission heard about Medicaid buy-in plans. There are several options to structure and finance these programs. Washington state has been the first to move forward with a public option and will offer one or more state-sponsored plans on its exchange in 2021 with the intention of increasing affordability and choice for unsubsidized customers priced out of the state exchange. New Mexico has studied and considered four options, but legislation to implement a targeted Medicaid buy-in program did not pass. Colorado has also studied a state option. The commission agreed that it should continue to keep options open for long-term solutions. Delegate Peña-Melnyk suggested that the state contract with a consultant to look at this option for Maryland. The commission concurred.

The commission then discussed the report of the Health Insurance Consumer Protections Workgroup. The commission agreed that it was comfortable with the report, but that any future actions hinge on the pending decision and appeal in *Texas v. United States*. The commission also agreed that it was comfortable with having a workgroup to study funding associated with continuing consumer protections, and some members suggested that the study include an analysis of the cost of the entire health system in the State.

The ACA provides two sets of nondiscrimination provisions: (1) health status related factors; and (2) civil rights (race, color, national origin, sex, disability, and age). Maryland's

provisions cover health status but are silent on civil rights. The workgroup recommended that if the ACA's civil rights provisions are specifically incorporated in State law, the provisions should be included in separate legislation. The commission concurred that civil rights should be included but did not reach agreement on whether or not it should be included in the consumer protections bill proposed by the workgroup or separate, stand-alone legislation. The commission agreed to consider draft legislation at the January meeting.

The ACA requires coverage without cost-sharing for certain women's preventative care and screenings. Federal regulations also include a religious exemption. Some State provisions for similar preventative services have religious exemptions that are different from federal law. The workgroup recommended that the General Assembly decide the best language for the religious exemption. The commission concurred but notes that this remains an open issue that the sponsors of the legislation or committees will need to address when considering this legislation.

The commission will meet again in January 2020. Staff will send a date to commission members.

Chapter 3. Recommendations

During the 2019 interim, the Maryland Health Insurance Coverage Protection Commission declined to further pursue three options for stabilizing the individual market (merging the individual and small group markets, establishing a standard plan, and establishing a Basic Health Program) at this time. However, the commission requested additional information for two other options for stabilizing the individual market: (1) Medicaid buy-in plans; and (2) additional State subsidies. The commission also postponed until January 2020 making recommendations on legislation from a workgroup established to study actions that the State could take to specifically incorporate the federal Patient Protection and Affordable Care Act's (ACA) consumer protections including protecting individuals with preexisting conditions should the ACA be ruled unconstitutional.

Tabled Options for Stabilizing the Individual Market

The commission recommended tabling discussions on merging the individual and small group markets, establishing a standard plan design, and establishing a Basic Health Program. The commission considered the recommendations of the Maryland Health Benefit Exchange (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 at this time.

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 State Subsidies and Medicaid Buy-In

The commission requested additional information before making a recommendation on whether to establish state subsidies or a Medicaid buy-in option. The commission learned that MHBE has contracted with Lewis & Ellis to study the impact of subsidies in Maryland for (1) young adults; (2) individuals with incomes between 400% and 600% of federal poverty

guidelines; and (3) the small group market. The results of the study are expected in late January, and the commission agreed to review the Lewis & Ellis analysis and determine if additional information is needed. The commission also heard that there are several options to structure and finance Medicaid buy-in plans and suggested a consultant could help determine what option would be most beneficial to Maryland consumers.

Postponed Recommendation on Workgroup Legislation

During its December 17, 2019 meeting, the commission learned that a decision from the Fifth Circuit Court of Appeals on the appeal of *Texas v. United States* is imminent. Based on this information, the commission decided that it would be beneficial to know the circuit court's decision before making recommendations on whether or not to support the legislation proposed by the Health Insurance Consumer Protections Workgroup and agreed to meet in January. The commission did however discuss the workgroup report and reached consensus that:

- funding is a significant part of the ACA and, at the least, a workgroup should be formed to identify substitute funding sources and possibly study the financial structure of the entire State health care system;

- the ACA's antidiscrimination protections for race, color, national origin, sex, disability, and age should be included in legislation whether it is the workgroup's proposed legislation or a stand-alone bill; and

- legislation that requires coverage without cost sharing for certain women's preventive care and screening will need to include a religious exemption.

On December 18, 2019, the Fifth Circuit Court of Appeals affirmed the U.S. District Court for the Northern District of Texas determination that the ACA's individual mandate is no longer considered a tax because the penalty for the mandate was reduced to $0 in the Tax Cuts and Jobs Act of 2017 and, therefore, 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 several from the other provisions in the ACA and that therefore the entire ACA is unconstitutional. Instead, the Circuit Court remanded the severability issue to the District Court and advised the District Court to "employ a finer toothed comb" in determining which portions of the ACA are inseverable.

This decision came after the commission's last meeting and was not discussed by commission members. California Attorney General Xavier Becerra, who has led the defense of the ACA after the Department of Justice declined to do so, has indicated his intent to appeal the circuit court's decision to the U.S. Supreme Court. Whether or not the Supreme Court will accept or decline the case and both the timing and outcome of the appeal are unknown. The commission will discuss the circuit court decision when it meets in January 2020.

Additional Comments

Commission staff received many comments from commissioners. In response to the comments, commission staff made several stylistic and clarifying changes to the report. Additionally, commission staff received the following substantive comments:

- Ms. Lori Doyle, Public Policy Director for the Community Behavioral Health Association of Maryland, recommended that if the legislation proposed by the Health Insurance Consumer Protections Workgroup is introduced in the General Assembly, it should include a requirement for a uniform definition of "behavioral health coverage;"

- Mr. Bob Atlas, President for the Maryland Hospital Association, requested that the report acknowledge that the ACA enables the Total Cost of Care Model in Maryland to assure access to care for people across the State regardless of ability to pay;

- Mr. David Cooney, Associate Commissioner of Life and Health for the Maryland Insurance Administration (MIA), requested that the report reflect, in regard to incorporating the civil rights protections in § 1557 of the ACA in the legislation proposed by the Health Insurance Consumer Protections Workgroup, that (1) the workgroup concluded that the proposed legislation was intended only to codify the specific ACA requirements that the Maryland legislature had previously elected to include in State law through cross-references in § 15-137.1 of the Insurance Article to specific provisions of the ACA; (2) the workgroup concluded that including the § 1557 protections, which were not previously codified in State law, was a policy decision for the Maryland legislature to codify at this or another time; and (3) MIA has concerns that any language regarding the § 1557 protections will need to be carefully drafted to avoid unintended consequences, including the unresolved issue of the Trump Administration versus the Obama Administration interpretation of the term "sex"; and

- Ms. Deborah Rivkin, Vice President of Government Affairs for Maryland CareFirst BlueCross BlueShield, (1) recommended that the commission and the General Assembly strategically determine the best option for Maryland to further stabilize the individual market by maximizing the number of people enrolled and reducing premiums and out-of-pocket costs and (2) suggested that to determine the best option the commission and the General Assembly should compare the Lewis & Ellis analysis on establishing new subsidies for young adults and the small group market and expanding subsidies for individuals with incomes between 400% and 600% FPG with further analysis on additional options such as increased funding for the State reinsurance program.

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.

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.~~

~~[31–117.~~

~~(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.

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.

~~(c)~~ **(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~~

~~(II) 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.~~

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

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

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

~~1. PROVIDES COVERAGE FOR OBSTETRIC OR GYNECOLOGIC CARE; AND~~

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

~~(II) 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.~~

~~(II) (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~~

~~(II) INCLUDE AN EXPLANATION OF THE NATURE OF THE COSTS SPECIFIED UNDER ITEM (I)3 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.~~

~~15–1A–14.~~

~~(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; AND~~

~~(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.~~

[~~(c)~~**] (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.

(I) (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 ~~3.~~ 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~July~~ June 1, 2019.

Approved by the Governor, May 13, 2019.

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.

Appendix 5

MEMORANDUM

To: **Maryland Health Insurance Coverage Protection Commission**

From: **Health Insurance Consumer Protections Workgroup**

Date: **December 17, 2019**

Re: **Consumer Protections Legislation**

The Health Insurance Consumer Protections Workgroup was created by Chapters 417 and 418 (House Bill 697 and Senate Bill 868) of the Acts of 2019. The purpose of the workgroup was 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 Patient Protection and Affordable Care Act (ACA) continue to protect Maryland residents in light of continued threats to the ACA."

Specifically, the workgroup was required to:

(1) 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;

(2) monitor the enforcement of the ACA by the U.S. Department of Health and Human Services (HHS); and

(3) 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.

This memo outlines the workgroup's actions regarding item (3), above. The workgroup met four times during the interim to review HB 697 and SB 868 of 2019, as introduced, and to make recommendations for legislation for the 2020 session. The meetings were open to the public, and video recordings of the meetings as well as meeting materials can be found at http://dls.maryland.gov/policy-areas/md-health-insurance-coverage-protection-commission.

The starting point for this legislation was § 15-137.1 of the Insurance Article (see **Appendix 1**). This section lists provisions of the ACA that are incorporated by reference into Maryland law. Since the statute cross-references the ACA, workgroup members were not confident that the statute would adequately protect Maryland consumers if the ACA was repealed or found to be unconstitutional. The workgroup used the § 15-137.1 list to draft a new subtitle that would more specifically codify these protections in Maryland law. **Appendix 2** identifies the sections in the new legislation that correspond to items in § 15-137.1.

The attached legislation represents the workgroup's best effort to draft language that mirrors the ACA and come to consensus on the bill's technical requirements. The items listed below merit special consideration by the Maryland Health Insurance Coverage Protection Commission and the General Assembly.

Funding

All members of the workgroup agreed that the ACA provides substantial federal funding[1] to maintain market stability and make coverage affordable for consumers. These funding streams include, among other things, (1) Medicaid expansion up to 138% of the Federal Poverty Level (FPL), (2) premium subsidies for individuals and families between 133% and 400% FPL; (3) reinsurance pass-through dollars; and (4) Small Business Health Options Program tax credits. If the ACA is repealed or found to be unconstitutional, this funding would be jeopardized. In addition to these specific funds, State regulatory agencies such as the Maryland Insurance Administration (MIA) and the Maryland Health Benefit Exchange (MHBE) may require additional funds and resources to effectively administer new regulatory and operational tasks imposed by State implementation of other ACA provisions currently administered by the federal HHS such as risk adjustment.

Additionally, members of the workgroup acknowledged that perpetuating the ACA's consumer protections in the absence of ACA funding sources or an adequate substitute will likely cause premiums to become unaffordable. The significance of the impact to premiums will depend on whether consumers currently receiving federal subsidies elect to drop coverage once these subsidies end or federal funding for Maryland's reinsurance program is not replaced by State funding. The conversation around funding dominated workgroup discussions, and the opinions of workgroup members were not reconciled by the conclusion of the workgroup.

Some workgroup members firmly believe that the draft legislation should be enacted in 2020 to demonstrate a commitment to ensuring Maryland citizens remain covered by ACA consumer protections regardless of federal or court action or inaction, interpretation, or whether funding is provided for in the draft legislation. One member expressed concern that by not enacting these protections because there is no funding source, "a message will be sent to women that maternity benefits will not be available unless the federal government subsidizes individual coverage," for example, and that carriers would be able to reduce the medical loss ratio required for individual coverage. Other members noted that a number of other states have passed legislation enacting the ACA's consumer protections without a funding component and suggested that a loss of federal funding would have to be addressed in any instance and should not prevent the legislation from moving forward.

[1] A recent Urban Institute study concluded that the loss of 2019 federal funding for Advanced Premium Tax Credits, Medicaid/Children's Health Insurance Program, and reinsurance only would be $2.94 billion in Maryland (a loss of 42.4% of current federal health funding under the ACA).

Workgroup members representing carriers noted that consumer protections in this bill, such as the ability to obtain coverage without consideration of pre-existing conditions as well as with guaranteed basic and essential health benefits, provide no protection for Marylanders who cannot afford coverage without subsidies. Additionally, workgroup members representing carriers recommended a number of strategies to prioritize funding. CareFirst BlueCross BlueShield recommended that in order to fully evaluate, quantify, and prioritize funding needs for the State, the commission should include language in the attached legislation to convene a workgroup in 2020 to (1) evaluate and quantify all federal funds currently being used to implement the ACA in Maryland; (2) determine which funds are necessary to maintain market stability; and (3) determine the administrative processes and funding necessary for the State to administer provisions of the ACA absent administration by the federal government. No member of the workgroup had concerns with such a study, and many agreed that is was important. Kaiser Permanente suggested language that would make the bill contingent on a state appropriation for Advanced Premium Tax Credits for individuals whose modified adjusted gross income is between 100% and 400% FPL who are purchasing individual market coverage on the exchange. Language from CareFirst and Kaiser is included as **Appendix 3**.

Members of the workgroup felt strongly on both sides of the issue. Generally, it was decided that the legislative intent for the workgroup was to craft statutory language to specifically incorporate the ACA protections that exist in § 15-137.1 and that ultimately the issue of funding was beyond the jurisdiction of the workgroup. The workgroup acknowledged that funding will be an ongoing policy discussion that will need to be addressed by the General Assembly with additional input from the full Maryland Health Insurance Coverage Protection Commission and that a workgroup to study the issue will help to frame the discussion and find a solution.

ACA § 1557 Antidiscrimination Provision

The list of ACA protections in § 15-137.1 does not include the ACA's nondiscrimination provisions, a fact that was highlighted by the workgroup discussion surrounding § 15-1A-06 of the draft legislation. Section 15-1A-06 prohibits a carrier from establishing rules for eligibility based on health status-related factors, including health condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex (as defined under contested Obama-era regulations to include gender identity, sex stereotyping, and pregnancy status), disability, and age in a broad range of health programs and activities. The majority of the workgroup determined that, since the antidiscrimination protections are not included in § 15-137.1, including these protections in the draft legislation was beyond the charge of the workgroup and would be more appropriate as a stand-alone bill if a legislator chooses to introduce legislation to address the issue.

One workgroup member noted that the President Donald J. Trump Administration has issued proposed regulations to eliminate antidiscrimination provisions currently applicable to carriers' health benefit plan designs in all markets. This member argued that if these regulations are adopted by carriers, they may implement discriminatory benefit designs such as (1) covering inpatient treatment for eating disorders in men but not women; or (2) placing all medications used to treat HIV on the highest formulary tier. This member argued that including the § 1557 provisions in this legislation would prevent this and other potential harm to consumers. In response to this concern, MIA noted that its Commissioner already has the authority to prohibit these plan designs in many markets. However, MIA agreed that the antidiscrimination provisions in current State law are not as specific and have a more limited scope than the federal provisions in § 1557.

Preventive Wellness Services

The ACA requires coverage without cost sharing for certain women's preventive care and screenings, including contraceptive coverage, and federal regulations offer certain religious exemptions. While the workgroup specifically incorporated the preventive services mandate in § 15-1A-10(a)(4), the workgroup did not draft a religious exemption. In Maryland, the existing mandates for contraceptive drugs and devices (§ 15-826), male sterilization (§ 15-826.2), in-vitro fertilization (§ 15-810), and fertility preservation procedures (§ 15-810.1) include an exemption for religious organizations that could be used as a model for a religious exemption to Maryland's preventive service mandate. Given the uncertain state of the federal exemption, the workgroup noted that most likely the General Assembly will need to decide what type of religious exemption to include for the women's preventive services benefit (specifically, for contraception, sterilization, and related education and counseling).

Summary of Benefits and Coverage Explanation

Section 15-1A-15 requires the Maryland Insurance Commissioner, in consultation with MHBE, to develop standards to be used 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. The workgroup discussed whether the summary of benefits is a core consumer protection that the group is charged with including in the bill. The majority of the workgroup concluded that it is within the scope of the workgroup, and the section is included in the draft legislation attached to this memo for the commission's consideration.

Contingency Based on Status of ACA Consumer Protections

The workgroup had lengthy discussions on whether or not to include a contingency provision in the bill based on a repeal of the ACA or a final determination in *Texas v. United States* that the ACA is unconstitutional. MIA voiced concerns that the bill could potentially require the Commissioner to adopt substantial new regulations but acknowledged that if the ACA remains

intact, additional regulations may not be necessary. As a compromise, the workgroup recommended not including a contingency and instead requiring MIA to only adopt regulations *as necessary* to implement the provisions of this legislation.

Date of Federal Regulations for Required Consistency of State Regulations

The workgroup determined that some protections provided in the ACA and federal regulations are extremely dense and complicated and are better suited for State regulations than statute. The workgroup discussed whether to require State regulations to be consistent with federal regulations on a specific static date, or "on the day before the ACA was repealed or was no longer enforceable." The workgroup recommended that State regulations should be consistent with federal regulations in effect on December 1, 2019. Given the uncertainty about future changes to the regulations, this approach would ensure that Maryland residents continue to have the protections they enjoy today. The draft legislation provides for annual reports to the General Assembly regarding any federal statutory or regulatory changes that benefit or harm Marylanders and recommendations for legislation to address the changes.

Appendix 1

Insurance § 15-137.1.

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

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

(1) coverage of children up to the age of 26 years;

(2) preexisting condition exclusions;

(3) policy rescissions;

(4) bona fide wellness programs;

(5) lifetime limits;

(6) annual limits for essential benefits;

(7) waiting periods;

(8) designation of primary care providers;

(9) access to obstetrical and gynecological services;

(10) emergency services;

(11) summary of benefits and coverage explanation;

(12) minimum loss ratio requirements and premium rebates;

(13) disclosure of information;

(14) annual limitations on cost sharing;

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

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

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

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

(20) guaranteed availability of coverage;

(21) prescription drug benefit requirements; and

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

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

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

Appendix 2
Citations for Consumer Protections in Insurance § 15-137.1

Insurance § 15-137.1		New Legislation
(1)	coverage of children up to the age of 26 years;	15-1A-08
(2)	preexisting condition exclusions;	15-1A-05
(3)	policy rescissions;	15-1A-21
(4)	bona fide wellness programs;	n/a*
(5)	lifetime limits;	15-1A-11
(6)	annual limits for essential benefits;	15-1A-11
(7)	waiting periods;	15-1A-12
(8)	designation of primary care providers;	15-1A-13
(9)	access to obstetrical and gynecological services;	15-1A-13
(10)	emergency services;	15-1A-14
(11)	summary of benefits and coverage explanation;	15-1A-15
(12)	minimum loss ratio requirements and premium rebates;	15-1A-16
(13)	disclosure of information;	15-1A-17
(14)	annual limitations on cost sharing;	15-1A-19
(15)	child-only plan offerings in the individual market;	n/a*
(16)	minimum benefit requirements for catastrophic plans;	15-1A-18
(17)	health insurance premium rates;	15-1A-07
(18)	coverage for individuals participating in approved clinical trials;	n/a*
(19)	contract requirements for stand-alone dental plans sold on the Maryland Health Benefit Exchange;	n/a*
(20)	guaranteed availability of coverage;	15-1A-09
(21)	prescription drug benefit requirements; and	15-1A-20
(22)	preventive and wellness services and chronic disease management.	15-1A-10

* Legislation was not needed for the items marked "n/a" because corresponding requirements are already codified in Maryland law.

Appendix 3

Language from CareFirst BlueCross BlueShield for a Workgroup Related to Funding

SECTION X. AND BE IT FURTHER ENACTED, That,

(a) On June 1, 2020, regardless of whether Section 1 is implemented, the Health Insurance Coverage Protection Commission will convene a workgroup to:

(1) Evaluate and quantify all federal funds currently being used to fund the Affordable Care Act;

(2) Determine which funds are necessary to maintain market stability if the ACA is repealed or deemed unconstitutional and the provisions in Section 1 are codified into state law; and

(3) Determine the administrative processes necessary to support the Affordable Care Act if codified into state law, including but not limited to setting up state-based risk adjustment administration and an advanced premium tax credit mechanism.

(b) The workgroup shall submit a report to the General Assembly by December 31, 2020, with its recommendations for legislation necessary to address the items in (a)(1) through (3) above.

Language from Kaiser Permanente Related to Funding

The provisions contained herein shall take effect at such time as the State appropriates funding for advanceable tax credits for individuals whose modified adjusted gross incomes are between 100 and 400 percent of the Federal Poverty Level and who are purchasing individual market coverage on the Exchange, and the State implements a plan for distributing such funding.

Consumer Protections Discussion Draft
December 17, 2019.

EMERGENCY BILL

A BILL ENTITLED

AN ACT concerning

Health Insurance – Consumer Protections

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

Article – Insurance

[15–137.1.

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

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

(1) coverage of children up to the age of 26 years;

(2) preexisting condition exclusions;

(3) policy rescissions;

(4) bona fide wellness programs;

(5) lifetime limits;

(6) annual limits for essential benefits;

(7) waiting periods;

(8) designation of primary care providers;

(9) access to obstetrical and gynecological services;

(10) emergency services;

(11) summary of benefits and coverage explanation;

(12) minimum loss ratio requirements and premium rebates;

(13) disclosure of information;

(14) annual limitations on cost sharing;

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

(16) minimum benefit requirements for catastrophic plans;

(17) health insurance premium rates;

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

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

(20) guaranteed availability of coverage;

(21) prescription drug benefit requirements; and

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

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

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

SUBTITLE 1A. CONSUMER PROTECTIONS.

15–1A–01.

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

(B) "CARRIER" MEANS:

(1) AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY IN THE STATE AND PROVIDES HEALTH INSURANCE IN THE STATE;

(2) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO OPERATE IN THE STATE;

(3) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO OPERATE IN THE STATE; OR

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

(C) "CHILD" MEANS:

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

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

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

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

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

(E) "GROUP PLAN" MEANS A SMALL GROUP PLAN OR A LARGE GROUP PLAN.

(F) "GRANDFATHERED PLAN" MEANS A HEALTH BENEFIT PLAN THAT:

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

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

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

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

(I) "INSURED INDIVIDUAL" MEANS:

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

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

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

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

15–1A–02.

(A) THE COMMISSIONER MAY ENFORCE:

(1) THE PROVISIONS OF THIS SUBTITLE; AND

(2) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW, THE FOLLOWING PROVISIONS OF TITLE 1, SUBTITLES A, C, AND D OF THE AFFORDABLE CARE ACT AS THEY 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:

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

(II) PREEXISTING CONDITION EXCLUSIONS;

(III) POLICY RESCISSIONS;

(IV) BONA FIDE WELLNESS PROGRAMS;

(V) LIFETIME LIMITS;

(VI) ANNUAL LIMITS FOR ESSENTIAL BENEFITS;

(VII) WAITING PERIODS;

(VIII) DESIGNATION OF PRIMARY CARE PROVIDERS;

(IX) ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES;

(X) EMERGENCY SERVICES;

(XI) SUMMARY OF BENEFITS AND COVERAGE EXPLANATION;

(XII) MINIMUM LOSS RATIO REQUIREMENTS AND PREMIUM REBATES;

(XIII) DISCLOSURE OF INFORMATION;

(XIV) ANNUAL LIMITATIONS ON COST SHARING;

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

(XVI) MINIMUM BENEFIT REQUIREMENTS FOR CATASTROPHIC PLANS;

(XVII) HEALTH INSURANCE PREMIUM RATES;

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

(IXX) CONTRACT REQUIREMENTS FOR STAND–ALONE

DENTAL PLANS SOLD ON THE MARYLAND HEALTH BENEFIT EXCHANGE;

(XX) GUARANTEED AVAILABILITY OF COVERAGE;

(XXI) PRESCRIPTION DRUG BENEFIT REQUIREMENTS; AND

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

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

15–1A–03.

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

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

(2) ARE CONSISTENT WITH 45 C.F.R. § 147.140 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT ON DECEMBER 1, 2019.

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

(1) SUBTITLE 12 OF THIS TITLE;

(2) SUBTITLE 13 OF THIS TITLE; OR

(3) SUBTITLE 14 OF THIS TITLE.

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

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

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

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

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

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

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

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

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

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

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

15–1A–04.

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

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

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

15–1A–05.

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

(B) A CARRIER MAY NOT:

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

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

(C) THE PROHIBITION IN SUBSECTION (B) 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 HEALTH CONDITION WAS IDENTIFIED AS A RESULT OF:

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

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

15–1A–06.

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

INCLUDING:

(1) HEALTH CONDITION;

(2) CLAIMS EXPERIENCE;

(3) RECEIPT OF HEALTH CARE;

(4) MEDICAL HISTORY;

(5) GENETIC INFORMATION;

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

(7) DISABILITY.

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

15–1A–07.

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

(2) THIS SECTION APPLIES ONLY TO A CARRIER OFFERING AN INDIVIDUAL PLAN AND, SUBJECT TO § 15–1205 OF THIS TITLE, A CARRIER OFFERING A SMALL GROUP PLAN.

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

(1) SUBJECT TO SUBSECTION (C) OF THIS SECTION, 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) SUBJECT TO SUBSECTION (D) OF THIS SECTION, WHETHER THE PLAN COVERS AN INDIVIDUAL OR FAMILY; AND

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

(C) (1) IN THIS SUBSECTION, "AGE" MEANS AN INDIVIDUAL'S AGE AS OF THE DATE OF ISSUANCE OR RENEWAL OF A HEALTH BENEFIT PLAN.

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

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

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

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

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

(I) BE ACTUARIALLY JUSTIFIED AND CONSISTENT WITH THE UNIFORM AGE RATING CURVE ESTABLISHED IN ACCORDANCE WITH PARAGRAPH (4) OF THIS SUBSECTION;

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

(III) PROVIDE FOR 1-YEAR AGE BANDS FOR INDIVIDUALS

AT LEAST 15 YEARS OLD AND UNDER THE AGE OF 20 YEARS.

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

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

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

(II) FOR A HEALTH BENEFIT PLAN THAT PROVIDES FAMILY COVERAGE FOR INDIVIDUALS UNDER 21 YEARS OF AGE, THE SUM SHALL INCLUDE NO MORE THAN THE THREE OLDEST INDIVIDUALS UNDER 21 YEARS OF AGE.

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

15–1A–08.

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

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

15–1A–09.

(A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) THROUGH (D) OF THIS SECTION, A CARRIER SHALL ACCEPT EVERY EMPLOYER AND INDIVIDUAL IN

THE STATE THAT APPLIES FOR A HEALTH BENEFIT PLAN, SUBJECT TO THE FOLLOWING PROVISIONS OF THIS ARTICLE:

(1) SUBTITLE 4 OF THIS TITLE;

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

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

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

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

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

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

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

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

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

(I) DEMONSTRATES TO THE COMMISSIONER THAT:

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

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

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

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

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

(1) DEMONSTRATES TO THE COMMISSIONER THAT:

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

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

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

15–1A–10.

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

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

(2) IMMUNIZATIONS FOR ROUTINE USE IN CHILDREN, ADOLESCENTS, AND ADULTS THAT HAVE IN EFFECT A RECOMMENDATION

FROM THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION WITH RESPECT TO THE INDIVIDUAL INVOLVED, IF THE RECOMMENDATION:

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

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

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

(4) WITH RESPECT TO WOMEN, PREVENTIVE CARE AND SCREENINGS AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR PURPOSES OF § 2713(A)(4) OF THE FEDERAL PUBLIC HEALTH SERVICE ACT.

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

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

15–1A–11.

(A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C) OF THIS SECTION, A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN, INCLUDING A GRANDFATHERED PLAN, 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, A CARRIER MAY ESTABLISH ANNUAL LIMITS

ON THE DOLLAR VALUE OF BENEFITS FOR AN INSURED INDIVIDUAL FOR A GRANDFATHERED PLAN THAT IS AN INDIVIDUAL PLAN.

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

15–1A–12.

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

15–1A–13.

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

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

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

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

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

1. PROVIDES COVERAGE FOR OBSTETRIC OR GYNECOLOGIC CARE; AND

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

(II) 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 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 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 SHALL COMPLY WITH A CARRIER'S POLICIES AND PROCEDURES.

15–1A–14.

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

(2) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION THAT MANIFESTS ITSELF BY ACUTE 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 A CONDITION DESCRIBED IN § 1867(E)(1) OF THE SOCIAL SECURITY ACT.

(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 FACILITY, 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 FACILITY THAT IS NECESSARY TO STABILIZE THE PATIENT.

(B) IF A CARRIER PROVIDES OR COVERS ANY BENEFITS FOR EMERGENCY SERVICES IN AN EMERGENCY DEPARTMENT OF A FACILITY, 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 ADMINISTRATIVE REQUIREMENT OR LIMITATION ON COVERAGE THAT WOULD BE MORE RESTRICTIVE THAN ADMINISTRATIVE REQUIREMENTS OR LIMITATIONS IMPOSED ON COVERAGE FOR EMERGENCY SERVICES FURNISHED BY A HEALTH CARE PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER; AND

(2) SUBJECT TO § 14–205.2 OF THIS ARTICLE AND § 19–710.1 OF THE HEALTH – GENERAL ARTICLE, MAY NOT IMPOSE ANY COST–

SHARING AMOUNT GREATER THAN THE AMOUNT IMPOSED FOR EMERGENCY SERVICES FURNISHED BY A HEALTH CARE PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER; AND

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

(D) EXCEPT AS PROVIDED IN § 14–205.2 OF THIS ARTICLE AND § 19–710.1 OF THE HEALTH – GENERAL ARTICLE, A CARRIER SHALL REIMBURSE A HEALTH CARE PROVIDER OF EMERGENCY SERVICES WHO DOES NOT HAVE A CONTRACTUAL RELATIONSHIP WITH THE CARRIER THE GREATER OF:

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

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

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

15–1A–15.

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

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

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

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

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

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

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

(2) ARE CONSISTENT WITH 45 C.F.R. § 147.200 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON DECEMBER 1, 2019.

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

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

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

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

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

(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;

(XII) HOSPITALIZATION;

(XII) HOSPITAL OUTPATIENT CARE;

(XIV) EMERGENCY ROOM CARE;

(XV) PHYSICIAN SERVICES;

(XVI) PRESCRIPTION DRUG COVERAGE;

(XVII) DURABLE MEDICAL EQUIPMENT;

(XVIII) HOME HEALTH CARE;

(XIX) SKILLED NURSING CARE;

(XX) REHABILITATION SERVICES;

(XXI) HOSPICE SERVICES;

(XXII) EMERGENCY MEDICAL TRANSPORTATION; AND

(XXIII) 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;

(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.

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

(G) (1) EACH CARRIER SHALL PROVIDE A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION THAT COMPLIES WITH THE STANDARDS DEVELOPED UNDER SUBSECTION (C) 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.

(H) 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.

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

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

15–1A–16.

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

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

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

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

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

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

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

(C) THE MINIMUM ACCEPTABLE MEDICAL LOSS RATIO IS:

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

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

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

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

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

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

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

15–1A–17.

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

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

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

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

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

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

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

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

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

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

(2) SUFFICIENT TO REASONABLY INFORM THE EMPLOYER OR INDIVIDUAL OF THEIR RIGHTS AND OBLIGATIONS UNDER THE HEALTH BENEFIT PLAN.

15–1A–18.

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

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

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

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

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

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

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

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

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

(E) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A

CATASTROPHIC PLAN SHALL PROVIDE COVERAGE FOR ESSENTIAL HEALTH BENEFITS.

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

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

(II) APPLIES TO ESSENTIAL HEALTH BENEFITS;

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

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

15–1A–19.

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

(2) "COST SHARING" INCLUDES:

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

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

(3) "COST SHARING" DOES NOT INCLUDE PREMIUMS, BALANCE BILLING AMOUNTS FOR NON–NETWORK PROVIDERS, AND SPENDING FOR NON–COVERED SERVICES.

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

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

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

(1) ESTABLISH ANNUAL LIMITATIONS ON COST–SHARING; AND

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

15–1A–20.

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

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

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

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

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

(1) ESTABLISH CRITERIA TO DETERMINE WHETHER AN INDIVIDUAL PLAN OR A SMALL GROUP PLAN PROVIDES PRESCRIPTION DRUG

ESSENTIAL HEALTH BENEFIT COVERAGE; AND

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

15–1A–21.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The General Assembly, through Chapters 3 and 4 of 2011, enacted the list of protections in § 15–137.1 of the Insurance Article to protect Maryland residents approximately one year after the Affordable Care Act (ACA) was passed and approximately one year before the United States Supreme Court upheld the majority of the ACA in National Federation of Independent Business v. Sebelius.

(b) The General Assembly, regardless of whether or not the ACA was found to be constitutional, intended for the protections listed in § 15–137.1 of the Insurance Article, as enacted by Chapters 3 and 4 of 2011 and as amended thereafter, to apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets issued or delivered in the State by an authorized insurer, nonprofit health service plan, or health maintenance organization.

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

(d) In recent years, the federal government has reduced the shared responsibility payment for individuals failing to demonstrate health insurance coverage to $0, has taken regulatory action to minimize the protections provided to Americans by the ACA, and, after refusing to defend the ACA, has asserted in the context of *Texas v. United States,* No. 18-00167 (N.D. Tex.), that 26 U.S.C. § 5000(A),

the minimum essential coverage requirement, is unconstitutional and that the remainder of the ACA is inseverable.

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

SECTION 4. 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.