Report of the Maryland Health Insurance Coverage Protection Commission

Annapolis, Maryland
December 2021

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THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401-1991

December 31, 2021

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

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

Dear President Ferguson and Speaker Jones:

The Maryland Health Insurance Coverage Protection Commission respectfully submits its fifth annual report containing a summary of the commission's activities during the 2021 interim.

During the 2021 interim, the commission held two meetings, which included presentations on major health insurance developments at the federal level, Maryland's State Reinsurance Program, implementation of the new Young Adult Subsidy Program and Maryland Easy Enrollment programs, analysis of potential Medicaid buy-in options, and *Joint Chairmen's Report* responses regarding options for increasing coverage of ineligible individuals and the impacts of high deductible health plans.

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

Sincerely,

Brian J. Feldman

Senator Brian J. Feldman
Senate Chair

Joseline A. Peña-Melnyk

Delegate Joseline A. Peña-Melnyk
House Chair

BJF:JAP/LJS:JBC/kkh

Enclosure

Maryland Health Insurance Coverage Protection Commission
2021 Membership

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

Senators

Delores G. Kelley
Chris West

Delegates

Bonnie Cullison
Kirill Reznik

Nonlegislative Members

Bob Atlas
David Cooney
Vincent DeMarco
Lori Doyle
Jamal Lee
Carolyn A. Quattrocki
Deborah R. Rivkin
Dr. Stephen Rockower
Dennis R. Schrader
Allison W. Taylor
Sanford Walters

Staff

Jennifer B. Chasse
Lisa J. Simpson

Agency Staff

Laura Goodman
Michael Paddy
Webster Ye

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

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

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

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

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

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

State Actions to Stabilize the Individual Health Insurance Market

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

State Reinsurance Program

Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to apply for a State Innovation Waiver under Section 1332 of the ACA to establish an SRP 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 January 1, 2019, provides reimbursement to carriers in the individual market that incur certain total annual claims cost on a per individual basis. Carriers are reimbursed for 80% of claims between $20,000 and $250,000. Payments to carriers are made after the plan year ends, and all costs have been recorded and reconciled.

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

SRP is projected to pay out approximately $400 million for calendar 2020 (33% of the total $1.2 billion in paid claims in the individual market), $433 million in 2021, and $492 million in 2022. Through calendar 2021, federal pass-through funding alone has been sufficient to cover costs. After a transfer of $100 million under the Budget Reconciliation and Financing Act of 2021, SRP is expected have a fund balance of $478 million ($369 million in federal pass-through funds and $109 million in State special funds). Beginning in calendar 2022, federal funding for the program is expected to decrease with annual program costs exceeding combined annual federal and State funding. However, when accounting for the current balance of surplus funds available for future year program costs, the program is adequately funded through 2023.

For calendar 2019, individual market premium rates approved by the Maryland Insurance Administration, reflecting the anticipated impact of SRP, declined by 13.2% overall. For calendar 2020 and 2021, approved rates fell an additional 10.3% and 11.9%, respectively. As a result of the success of SRP, a third carrier, UnitedHealthcare, joined CareFirst BlueCross BlueShield and Kaiser Permanente in the individual market in calendar 2021. However, for calendar 2022, individual market premium rates will increase by an average of 2.1%. The overall 2.1% increase is less than half the increase in the average medical claims trend of 4.4%, reflecting the ongoing stabilizing impact of SRP. Affordability is particularly an issue for individuals who do not receive federal advanced premium tax credits.

Maryland Health Benefit Exchange Affordability Workgroup

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

State-Based Young Adult Health Insurance Subsidies Pilot Program

Chapters 777 and 778 of 2021 required MHBE to establish and implement the State-Based Young Adult Health Insurance Subsidies Pilot Program for calendar 2022 and 2023 to help make health insurance more affordable for uninsured young adults. Under the program, young adults ages 18 to 34 with incomes between 138% and 400% of the federal poverty level will be eligible

for State premium assistance subsidies. At a projected annual cost of $17 million, subsidies will be allocated to reduce the maximum expected premium contribution of individuals age 18 to 30 by 2.5%. For individuals age 31 to 34, the subsidy is progressively lower for each age, reducing the maximum expected contribution by 0.5% each year. Of the 40,646 young adults eligible to be automatically renewed for coverage in 2022, 34,619 will be eligible for a State subsidy under the program.

Maryland Easy Enrollment Health Insurance Program

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

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

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

Response Relating to the Impact of COVID-19

On March 5, 2020, the Governor declared a state of emergency and the existence of a catastrophic health emergency to deploy resources and implement the emergency powers of the Governor to control and prevent the spread of COVID-19. Although a federal public health emergency will continue through at least April 2022, on June 15, 2021, Governor Lawrence J. Hogan, Jr. announced the end of Maryland's COVID-19 state of emergency. All statewide emergency mandates and restrictions terminated July 1, 2021. A 45-day administrative grace

period ran through August 15, 2021, during which some regulations were relaxed, including winding down emergency health operations.

As part of the State's response to COVID-19, MHBE offered a Coronavirus Emergency SEP that began in March 2020, was extended several times, and concluded in August 2021. MHBE reports that more than 201,000 Marylanders enrolled in coverage through the SEP, including more than 74,800 individuals in QHPs and the remainder in Medicaid. Enrollment included individuals from demographic groups significantly impacted by the pandemic, such as 69,749 young adults, 60,555 enrollees self-reporting as Black, and 25,892 enrollees self-reporting as Hispanic.

Update on Legal Challenges to the Affordable Care Act

In *Texas v. United States*, 20 states filed suit in the U.S. District Court, Northern District of Texas arguing that the ACA, as amended by the Tax Cuts and Jobs Act of 2017 (which eliminated the tax penalty of the individual mandate), is no longer constitutional without a tax penalty. In December 2018, Judge Reed C. O'Connor ruled in favor of the plaintiffs, concluding that the mandate is no longer permissible under Congress' taxing power and is thus unconstitutional. The judge found the individual mandate to be "essential" to and inseverable from the ACA and declared the entire law invalid. On appeal, the Fifth Circuit Court of Appeals affirmed the District Court opinion that Congress does not have constitutional authority to enforce the mandate. However, the circuit court did not affirm the District Court's determination that the individual mandate is not severable. Instead, the circuit court remanded the severability issue to the District Court.

The Supreme Court heard oral arguments in the case, now known as *California v. Texas*, on November 10, 2020. Issues before the Supreme Court included (1) whether Texas and the individual plaintiffs had standing; (2) if so, whether the individual mandate is unconstitutional; (3) if unconstitutional, whether the rest of the ACA can survive; and (4) if the entire ACA is held invalid, whether the entire law should be unenforceable nationwide or whether it should be unenforceable only to the extent that provisions injure individual plaintiffs. In a 7-2 decision issued in June 2021, the Supreme Court reversed the Fifth Circuit and upheld the ACA in its entirety. The court held that both the individual plaintiffs and the state plaintiffs lacked standing to challenge the individual mandate. As a result, the court did not need to reach the merits of the constitutional challenge to the individual mandate or determine whether the individual mandate was severable from the rest of the ACA.

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

Chapter 2. Work of the Commission

Agenda and Presentations

During the 2021 interim, the Maryland Health Insurance Coverage Protection Commission held two virtual meetings that were live streamed to the public. Below is a summary of information as it was presented to the commission at the commission meetings. Accordingly, there may be some variation in figures referenced by presenters due to their drawing upon differing sources of information for their presentations. The views expressed by the presenters do not necessarily reflect the views of the commission or its members.

September Meeting

The commission held its first meeting on September 8, 2021. To open the meeting, House Chair, Delegate Joseline A. Peña-Melnyk, summarized the commission's 2020 annual report, in which the commission did not act to pursue establishing a standardized benefit design or a basic health plan. The commission indicated a desire to seek additional information on pursing a Medicaid buy-in program via a high-level actuarial analysis. The commission expressed support for the Maryland Health Benefit Exchange (MHBE) to pursue a Young Adult Subsidy Pilot Program and report back on long-term costs. The commission deferred on making a recommendation on whether to adopt a State-based individual health insurance mandate until the Maryland Easy Enrollment Health Insurance Program Advisory Workgroup submits a report, due December 1, 2022. The commission also expressed continued support for the State Reinsurance Program (SRP) and recommended that the program be extended past 2023. Most of the commission members also supported extending the assessment that funds SRP at an amount sufficient to continue the current program. The commission further recommended that MHBE and the Maryland Department of Labor continue to work together to establish a means to connect unemployment insurance (UI) claimants with health insurance options.

Delegate Peña-Melnyk then summarized related legislation flowing from the commission's recommendations that was enacted during the 2021 legislative session, specifically Chapters 49 and 65 of 2021, which intended to link UI claimants with health insurance, and Chapters 777 and 778 of 2021, which require MHBE to establish and implement a State-Based Young Adult Health Insurance Subsidies Pilot Program.

During the meeting, the commission heard three presentations regarding policy developments nationally, the status of SRP, and implementation of the Young Adult Subsidy Pilot Program.

Federal and State Health Insurance Policy Updates

Ms. JoAnn Volk, research professor and founder/co-director of the Center on Health Insurance Reforms at the Georgetown University McCourt School of Public Policy provided a presentation on federal and State health insurance policy updates.

Federal American Rescue Plan Act

Ms. Volk described the federal American Rescue Plan Act (ARPA), which made historic improvements in affordability for marketplace plans for all consumers. The ARPA made advanced premium tax credits (APTC) available to all regardless of income, eliminating the previous cliff at 400% of the federal poverty level (FPL). The ARPA provides more generous subsidies across all incomes. Those with incomes up to 150% FPL receive subsidies that cover their entire premium for a silver plan. Individuals with incomes up to 300% FPL now contribute no more than 6% of their income toward their premium (previously 9.83%). These changes are retroactive and apply to calendar 2021 and 2022. ARPA also includes extra help for individuals receiving UI for at least one week in 2021. These individuals are eligible for an APTC based on an income of 100% FPL (and therefore receive $0 premiums and access enhanced cost-sharing reduction plans). Regarding reinsurance, ARPA's enhanced subsidies have meant larger federal pass-through funding for states, with Maryland expected to receive an addition $140 million.

Federal No Surprises Act

Ms. Volk then provided a summary of the federal No Surprises Act, which takes effect January 1, 2022. The law bans balance billing for emergency services (including air ambulances but not ground ambulances) and nonemergency services provided by out-of-network (OON) providers at in-network facilities. The Act extends protections to the 135 million individuals nationally in self-insured plans and to those insured in states without their own protections. Patients will be responsible only for in-network cost sharing, which must count toward their in-network deductible and out-of-pocket limit. Protections do not apply where a patient agrees to receive care from certain OON providers if they receive a good-faith cost estimate and are made aware of available in-network options. Protections cannot be waived when there is no in-network provider available, for urgent or unforeseen care, or for services delivered by providers in designated specialties.

Health plans or insurers can negotiate payment with OON providers. Failing that, either party can request arbitration through an independent dispute resolution entity. State departments of insurance are the primary enforcers of provisions that apply to insurers and fully insured group health plans. State law applies where it is more consumer protective than the federal Act. For self-funded plans, the federal arbitration regime applies to payment of OON providers and facilities, as do other provisions of the federal law, including provisions regarding notice and consent and disclosure of balance billing protections.

Recent State Actions

Ms. Volk provided a brief update on recent state actions. Regarding public option-style laws, state action has taken the form of privately funded plans (not public plans) that must meet heightened requirements for cost and value. Washington made public option plans available in calendar 2021 in about half of the state's counties, with enrollment of only about 2,000 individuals. Colorado and Nevada have also enacted legislation and are following Washington's lead. The states have taken varying approaches regarding the markets in which public option plans are available, how they intend to achieve cost-containment (capping provider reimbursement rates or premium reduction targets), and provider participation requirements. Colorado plans to offer public option plans in 2023 and Nevada in 2026.

States are following Maryland's lead regarding easy enrollment. Colorado and Pennsylvania will implement programs in 2022. Virginia will implement easy enrollment for Medicaid coverage in 2022, and marketplace coverage in 2025. Other states are considering other variations of the program. Mr. Vincent DeMarco noted that Pennsylvania has enacted the easy enrollment program administratively without legislation and that U.S. Senator Chris Van Hollen plans to introduce legislation for a national easy enrollment program that includes auto-enrollment.

Ms. Volk closed her presentation by raising key issues looking forward, such as whether there will be federal legislation to make enhanced ARPA subsidies permanent, address the family glitch (which renders an employee and their family members ineligible for subsidized marketplace coverage if self-only employer coverage for the employee is affordable as defined by the Affordable Care Act (ACA), even if family coverage is not), or establish a public option.

State Reinsurance Program

Ms. Johanna Fabian-Marks, Director of Policy and Plan Management for MHBE, provided a program performance update on SRP. As a result of the program, average premium rates are down more than 30% compared to 2018 (the year before the program started). In 2021, Maryland's average lowest cost plans at each metal level are about 20% to 30% below national averages, depending on metal level. Without reinsurance, MHBE would have expected 2021 rates to increase by at least 23%, depending on the carrier; with reinsurance, each carrier has at least an 11% reduction in premiums.

For 2020, the program cost a total of $400 million, slightly more than the $378 million projected in summer 2020. Maryland received $447 million in federal funding for the program in 2020 (6% more than projected). In the individual market in total, both on and off exchange, total claims paid in 2020 were about $1.2 billion for about 212,000 enrollees. Reinsurance payments were paid for about 6% of total enrollees. Of total claims paid, SRP paid 33% of total claim dollars.

If enhanced ARPA subsidies end after 2022, SRP is projected to cost $491.6 million in 2022 and $506 million in 2023, with anticipated federal funding of $289.2 million and

$243.8 million, respectively. SRP is anticipated to spend its full federal balance in 2021, with a balance of available State funds of $204 million at the end of 2023. Should ARPA subsidies continue, federal funding would increase, resulting in a larger balance of State funds of $260.8 million at the end of 2023.

Ms. Fabian-Marks reviewed the renewal timeline for SRP's federal Section 1332 waiver. To amend and extend the existing waiver, the State must submit a letter of intent at least 15 months prior to the waiver amendment's proposed implementation date and the waiver amendment application by the end of the first quarter of the year prior to the year the amendment would take effect. If MHBE were to amend and extend the waiver application, the federal government would need to be notified by October 1, 2022, and the application would need to be submitted by March 31, 2023. Issues for consideration for the waiver renewal for the General Assembly include whether to extend current State funding for the waiver and whether to extend and incorporate into the waiver renewal the Young Adult Subsidy Pilot Program to get additional federal funds.

Ms. Fabian-Marks then shared information about carrier accountability reports. State regulations require all carriers participating in SRP to submit an annual report describing carrier activities to manage the costs and utilization of enrollees whose claims are reimbursed under SRP and efforts to control costs. Carrier reports collect targeted information on diabetes, behavioral health, asthma, and pregnancy/childbirth, as well as information on common diagnoses among enrollees whose claims were reimbursed under the program. Calendar 2019 reports will serve as a baseline. Calendar 2020 reports will enable initial evaluation of the effectiveness of and savings from carrier activities. MHBE plans to use 2019 and 2020 reports as a basis for conversation with carriers about their care management programs and initiatives to improve outcomes, as well as to explore how carriers can be encouraged to align care management activities for individual market enrollees with State population health initiatives and focus on conditions that are driving reinsurance payments and involve potentially preventable costs.

State-Based Young Adult Health Insurance Subsidies Pilot Program

Ms. Fabian-Marks provided an implementation status update on the State-Based Young Adult Health Insurance Subsidies Pilot Program. Final eligibility and payment parameters for 2022 were adopted by the MHBE Board in May 2021, and implementing regulations were published in the *Maryland Register* on December 17, 2021. Young adult premium assistance will be displayed on Maryland Health Connection during open enrollment and applied automatically for eligible renewing enrollees.

Ms. Michele S. Eberle, Executive Director of MHBE, thanked the commission for supporting MHBE, emphasizing the significant enrollment growth among individuals on exchange who do not receive financial assistance because of the success of SRP. Ms. Eberle noted the continued challenge in enrolling young adults, which has increased about 18% but is anticipated to increase more under the young adult subsidy. Ms. Eberle also noted that Maryland was first state in the nation to implement all facets of the additional APRA subsidies.

Commissioner Questions and Comments

Delegate Bonnie Cullison inquired about the commission's work on looking at potentially different options on how to fund SRP. Ms. Eberle noted that an updated study on *how* to fund SRP has not been conducted by MHBE; however, studies on *how much* funding will be needed have been done. [**Staff note:** The commission received a presentation on Funding States' Share of Reinsurance Programs at the September 2020 meeting.]

Dr. Stephen Rockower noted that end-stage renal disease was among the disease states that receive the most reinsurance, noting that federal funding typically covered that disease. Ms. Fabian-Marks noted she would confer with carriers to find out additional information. Mr. Sanford Walters commented that this may be due to playing early claims before federal coverage begins.

Mr. Bob Atlas questioned how MHBE planned to get carriers more involved in population health initiatives (particularly the timing of that involvement) given that requirements are already committed as part of the Total Cost of Care Model for which the federal government will be measuring Maryland's progress in the next few years. Ms. Fabian-Marks noted that MHBE's engagement is specific to the individual market, which accounts for a small segment overall, but they seek to align with larger efforts underway in the State. Ms. Eberle noted that MHBE participates in the Population Health Management Workgroup and is working with other agencies to ensure that its efforts are collaborative with other health initiatives. Mr. Atlas noted that the Total Cost of Care Model is an agreement between the federal government and the State, and that other parties (not just hospitals) should be accountable for improvements. Mr. Atlas asked if there was any reason to think that there will not be movement to keep SRP going and if there might be any pitfalls looming within the State. Ms. Eberle responded that the only risk is if there is no State funding available (as it is required to have State funds). Should enhanced ARPA be made permanent, and premiums are subsequently lowered due to additional APTCs, reevaluation of the purpose of the program may be necessary. Ms. Fabian-Marks added that MHBE has broadly heard support from all stakeholders for continuing the program. Senator Brian J. Feldman remarked that the General Assembly will have to address how to fund the program on an ongoing basis.

Senator Delores G. Kelley suggested that the commission and the Maryland Department of Health in late spring 2022 consider putting together an education program for gubernatorial candidates who may be unfamiliar with major health insurance programs and what needs to happen next (such as SRP waiver renewal). Senator Feldman noted that the standing committees may wish to invite gubernatorial candidates to attend upcoming health care briefings.

Mr. Walters remarked that when originally considering the young adult subsidy, part of the rationale was that there was excess federal funding available for SRP and questioned that if that extra funding will be spent down in future years, will additional State money be required. Senator Feldman clarified that the young adult subsidy is a two-year pilot program and is subject to

budgetary appropriation. Ms. Fabian-Marks noted that the State will need to reconsider whether to continue and how to fund the young adult subsidy at the end of the pilot program.

Senator Chris West indicated that the average member of the General Assembly likely does not know about how SRP works, what has been done to date, and what needs to be done to ensure that it continues to work. Ms. Eberle replied that the MHBE website has significant information about SRP and noted that they could produce something more straightforward such as a pamphlet that can be easily downloaded.

In closing, Senator Feldman reminded members that the commission will again produce and annual report in December and that each of the four prior years' reports have resulted in legislation passing the General Assembly.

December Meeting

On December 16, 2021, during its second virtual meeting, the commission received a presentation from Wakely Consulting Group LLC on options for implementing Medicaid buy-in programs in Maryland and several updates from MHBE regarding the Maryland Easy Enrollment Program, increasing affordable health insurance coverage for individuals ineligible for existing programs, and high deductible health plan (HDHP) enrollees.

Wakely Actuarial Report on Options for Medicaid Buy-in Programs

Ms. Julie Peper, Principal, Wakely Consulting Group LLC, presented Wakely's *State of Maryland Analysis of Potential Medicaid Buy-in Options* analysis. The Department of Legislative Services (DLS) requested an analysis on behalf of the commission that would analyze the potential effects of three separate options: (1) a Targeted Medicaid Buy-in; (2) a Qualified Health Plan (QHP) Public Option; and (3) a Medicaid Buy-in for All. The goal of all options is to reduce the number of uninsured and improve affordability, but each option targets a different segment of the population and has differing impacts on consumers and on the number of uninsured. A key assumption for all options in the analysis was that the current provider network will be the Medicaid provider network with Medicaid payment rates, which are below commercial rates by about 12%.

The Targeted Medicaid Buy-in would offer Medicaid-like coverage off exchange to those who are ineligible for Medicaid, Medicare, or subsidized coverage. Maryland would provide subsidies like those provided on-exchange (prior to ARPA). This option would target individuals impacted by the family glitch, undocumented individuals, and those typically ineligible for APTCs (individuals with incomes greater than 400% FPL). Wakely modeled two cost-sharing scenarios for this option: one at 60% actuarial value (similar to a bronze level plan) and one at an average market rate actuarial value of 73% (slightly richer than silver plan). Estimates for 2023 assume enrollment of between 36,023 and 66,0024. Enrollment is predominately from those impacted by

the family glitch moving from employer-sponsored coverage to this option (27,752 to 36,291) and uninsured undocumented individuals (2,953 to 12,040). Up to 9,983 uninsured individuals with incomes greater than 400% FPL may enroll. State costs for a Targeted Medicaid Buy-in range from $46.6 million to $110.8 million for State subsidies but may be as much as $228.0 million if those who enroll under this option are included in SRP with additional State funds provided to offset costs.

Under the QHP Public Option, the State would offer a lower-cost QHP on the exchange, likely in partnership with an existing insurer. Targeted populations including the uninsured and those with incomes greater than 400% FPL who do not receive subsidies on the exchange. Wakely's analysis estimates that the premiums for this QHP would be 6% lower than the lowest cost silver and gold plans currently available. Enrollment is estimated for 2023 at between 12,300 to 20,700 new enrollees, mostly individuals migrating from other available plans. As there are no subsidies, there is no explicit cost to the State.

Under the Medicaid Buy-in for All option, the State would offer a product for all non-Medicare enrollees. Ms. Peper noted that there is considerable uncertainty for this option and additional modeling would be needed should this model be pursued further. Wakely modeled two options – one in which enrollees would pay premiums comparable to current levels and one with no premiums. The analysis assumes all employers would migrate to the new plan. Estimated enrollment is between 3.4 million (a decrease of approximately 19.000 uninsured) under the current premium scenario up to 3.7 million (a decrease of approximately 210,000 uninsured) under the no premium scenario. The cost to the State would range from $16.0 billion to $16.7 billion in premium equivalents but could be offset by employee contributions and potentially foregone federal APTCs (with a waiver). Additionally, supply constraints may reduce costs but would also reduce access. Consequently, State costs that would require funding are estimated between $9.0 billion and $15.8 billion.

Ms. Peper emphasized several additional considerations when reviewing all options, including that federal policy is in flux and may see action on the family glitch, different policies benefit different groups, the availability and sustainability of State funds, provider considerations, the potential need for federal waivers (which could yield additional options or funding), and differing impacts on SRP.

Delegate Kirill Reznik asked about Ms. Peper's initial perspective on the cost to the State of a mandatory requirement for all Marylanders to use Medicaid and employers to contribute to cost through payroll taxes of about 10%. Ms. Peper noted that the cost would likely be very similar to the Wakely estimate.

Ms. Lori Doyle remarked that behavioral health providers are very interested in Medicaid buy-in options because in Maryland, Medicaid has a much more robust benefit package for behavioral health than Medicare or commercial plans. Ms. Doyle asked if there has been any movement in other states toward these kinds of plans for people who have behavioral health concerns and which option is better in terms of the ability to make the benefits package what you

want (or if it is simply a matter of cost). Ms. Peper responded that Wakely modeled the options using the current essential health benefits (EHB) for the commercial market, but that a state could pursue some non-EHBs in the QHP option, as there is flexibility outside of the ACA market.

Mr. DeMarco asked how the targeted buy-in option compares with Massachusetts' direct subsidy program and what the difference would be to the State of choosing one over the other. Ms. Peper replied that Wakely has not done that specific analysis. Mr. Michael Cohen, Senior Consultant, Wakely Consulting Group LLC, noted that Massachusetts' program is not targeted to those who are ineligible for federal subsidies, but is more general. Ms. Peper added that Wakely has seen a lot of other states, in light of the potential for additional subsidies continuing into the future, shift their focus to providing more subsidies rather than providing subsidies to additional populations. [**Staff note:** The Massachusetts' ConnectorCare Program selects plans from commercial carriers using the lowest-cost silver plan as the base then layers on additional state premium and cost-sharing subsidies for eligible individuals with incomes up to 300% FPL. Premium subsidy amounts are based on an affordability standard (0% to 5% of income) set by the Massachusetts Health Connector.]

Dr. Rockower expressed concerns about network adequacy should the State pursue options that yield large increases in enrollment, noting that current capacity is barely adequate and that while commercial payment rates in Maryland are higher than in some states, they remain below Medicare.

Deputy Secretary for Health Care Financing, Steven R. Schuh inquired about the cost per enrollee under the Medicaid Buy-in for All option. Mr. Cohen clarified that the State costs reflect coverage for all individuals (including those who have coverage now) not just those currently uninsured. Ms. Peper noted that the option was modeled to replace the employer and individual market for all individuals younger than 65 (with potentially different treatment for Medicaid enrollees). Deputy Secretary Schuh asked if there would still be a traditional Medicaid system for which the State could access federal matching funds. Ms. Pepper replied that Medicaid was excluded from the analysis under the assumption that it would continue or somehow be rolled into a new program using a federal waiver, but that the analysis assumes that current Medicaid funding streams continue.

Mr. Walters asked if, under a Medicaid Buy-in for All option, if all provider rates would be reduced to Medicaid or Medicare rates, and, if so, what would be the impact on providers remaining in the State (when they could easily move across state lines to pursue higher reimbursement rates). Ms. Peper concurred that the potential impact on providers would need further analysis if the State wished to pursue this option. Ms. Peper also noted that, based on work they did for Vermont, while revenues would be reduced under a Medicaid Buy-in for All option, providers would also realize reductions in uncompensated care and administrative efficiencies. Mr. Walters also asked if Maryland could solve the family glitch problem in a simpler way if the federal government does not act. Mr. Cohen responded that while Maryland can provide subsidies to those impacted by the family glitch using State dollars, it cannot make changes to the federal definition of affordability that drives the underlying family glitch issue.

Ms. Cathy Grason asked if any other states have already pursued any of the three options presented. Ms. Peper noted that the options modeled are like what New Mexico investigated and that Wakely has done other analyses for multiple other states; however, to date, the only public option plan that has been implemented is in Washington and thus no real data is yet available on the impact of public options.

Delegate Cullison asked if there has been any consideration of the impact of raising Maryland Medicaid eligibility to higher income levels such as 600% FPL. Delegate Peña-Melnyk noted she had not seen that before, but that the commission will ask Medicaid to provide additional information.

Maryland Easy Enrollment Programs

Ms. Michele Eberle, Executive Director of MHBE, provided an update on the easy enrollment programs. Based on the second year of tax filing for easy enrollment, in 2021, 33,151 individuals checked the box to release their information to MHBE and 27,223 individuals were deemed eligible. Of those 27,223, 2,962 (10.9%) enrolled during the tax time special enrollment period. Ms. Eberle noted that while fewer individuals checked the box on their tax forms, a greater percentage of those who did were eligible. New for 2021, MHBE navigators conducted direct outreach via telephone and e-mail. Highest enrollment success occurred in Montgomery County and Central Maryland. Ultimately, 772 individuals enrolled in MHBE (665 with assistance and 107 without) and 2,190 individuals enrolled in Medicaid or the Maryland Children's Health Program. MHBE plans to drill down in the data to better understand potential enrollees and where there may be barriers in the process.

MHBE continues to work with the Comptroller's Office toward implementing phase II, with the intent to prepopulate applications with data from State income tax returns as much as possible to simplify the enrollment process. MHBE also continues to work with the Maryland Department of Labor (MDL) to create an easy enrollment process for UI claimants, with a target to be operational by the second quarter of 2022.

Delegate Cullison inquired if there are parts of the State with a greater number of uninsured in which we are not seeing as much success as in Montgomery County and Central Maryland and how we could improve in those areas. Ms. Eberle stated that this is part of what MHBE will look at to see why certain regions are more successful than others.

Ms. Allison W. Taylor asked if there is any timeline for phase II and being able to prepopulate the forms and if there was any plan to update the next incoming Comptroller. Ms. Eberle noted that there is no timeline yet for getting all data to prepopulate.

Access to Affordable Coverage for Ineligible Individuals

Ms. Eberle presented the findings from a *Joint Chairman's Report* (JCR) on coverage options for individuals who are ineligible for existing programs. Current populations who are ineligible include undocumented immigrants (244,700 in Maryland, 115,900 of whom are uninsured) and Deferred Action for Childhood Arrivals recipients (7,560 in Maryland) who are ineligible for Medicaid or to purchase QHPs, and individuals impacted by the family glitch (83,000 in Maryland, 7,470 of whom are uninsured) who cannot access APTCs or cost-sharing reduction plans. Qualified immigrants lawfully present for less than five years, those exempt from the five-year bar (children, pregnant women, asylees, refugees), and lawfully residing nonqualified immigrants and individuals with valid nonimmigrant status are eligible for individual marketplace coverage. Financial assistance is available to lawfully present immigrants with incomes between 138% and 400% FPL and qualified immigrants here for less than five years with incomes up to 400% FPL.

Certain Medicaid services are currently available for otherwise qualified noncitizens (emergency care, prenatal, expanded COVID-19 testing/treatment). Current resources in Maryland for individuals who are not eligible include emergency Medicaid coverage, emergency department treatment without regard to ability to pay under the federal Emergency Medical Treatment and Active Labor Act, hospital financial assistance policies, and federally qualified health centers.

Ms. Eberle summarized three options for Maryland outlined in the response. A Section 1332 waiver with State subsidy would waive the provision barring undocumented individuals from purchasing QHPs and recoup and reinvest federal savings. This option would require legislative approval and implementation would take 18 months after legislation authorizing a waiver. Considerations regarding this option include whether the State would provide a tax credit or simple subsidy, whether to administer cost-sharing subsidies, and the cost impact of expanded coverage on existing emergency Medicaid services and federal funding. Actuarial firm Lewis & Ellis prepared estimated enrollment ranging from 29,413 in year one to 52,541 in year five. Federal pass-through funds of between $14.8 million and $32.7 million were projected. The net cost to the State would range from $90.2 million in year one to $189.5 million in year five. Overall premiums in the individual market are estimated to be reduced by 2.3% in year one, increasing to 3.9% by year five. Ms. Eberle noted that eligibility could be limited to young adults or individuals with income less than 200% FPL, State-only Medicaid, with varying impacts on enrollment, cost, federal pass-through funding, and premium impacts. Coverage of the targeted populations could also be provided as a State-only Medicaid program; however, expansion to the currently ineligible populations would require State-only funding as these populations are ineligible for federal Medicaid matching funds.

Mr. Walters asked if the number of individuals impacted by the family glitch are the same under the Wakely and Lewis & Ellis studies. [**Staff note:** Both analyses estimated that there are 83,000 Marylanders impacted by the family glitch.]

Ms. Taylor inquired why California withdrew its 2017 waiver application that would have permitted undocumented immigrants to purchase coverage on California's exchange without tax credits. Ms. Eberle replied that due to the change in federal administration at that time, California assumed the waiver would not be approved and thus withdrew it.

High Deductible Health Plan Enrollees

In response to the 2021 JCR, MHBE submitted a report on the prevalence of HDHPs in the individual market and the impact of such plans on enrollees and on service utilization. Ms. Eberle presented the findings of the report to the commission. Literature indicates an association between costs and utilization of health care services. Higher cost sharing is associated with lower care utilization and leads to avoidance of necessary and preventive care. Consumers perceive deductibles to be too high and a barrier to care. In calendar 2019, 97,949 individuals were enrolled in an HDHP, with 58,410 of those enrolled for 320 or more days. A total of 76,915 individuals were enrolled in a non-HDHP (49,324 for 320 or more days). The number of individuals enrolled in HDHPs increased in calendar 2019 due to an increase in deductibles in other marketplace plans.

Utilization of services was consistently higher among non-HDHP enrollees for several services in calendar 2016 through 2019. Regarding complaints, the Health Education and Advocacy Unit (HEAU) in the Office of the Attorney General and the Maryland Insurance Administration do not separately categorize complaints specifically related to HDHPs. However, based on calls to the HEAU hotline, consumers choose HDHPs mostly based on premiums, avoid routine care because of out-of-pocket costs, use their HDHPs only for major emergencies, are afraid of unexpected out-of-pocket costs, and worry about how to pay medical bills without savings.

Mr. Atlas noted that these findings confirm what the Maryland Hospital Association has worried about – individuals being uninsured but without much first dollar coverage, which has a chilling effect on seeking necessary care, puts a burden on consumers, and drives medical debt.

Mr. DeMarco announced that legislation is forthcoming in the 2022 legislative session that is intended to help small businesses afford health care by establishing a small business health insurance subsidies program using federal funding, with $45 million for subsidies and $3 million for outreach. This is similar to legislation introduced in 2020.

Summary of the Commission's Work

Delegate Peña-Melnyk provided a summary of what the commission has done and what is pending. To date, the commission has:

- recommended tabling discussion on establishing a standardized benefit design or a basic health program for Maryland or merging the individual and small group markets;

- expressed support for MHBE to purse a young adult subsidy pilot program, with MHBE reporting back on the impact and long-term cost;

- deferred making a recommendation on whether to adopt a State-based individual health insurance mandate until the Maryland Easy Enrollment Health Insurance Program Advisory Workgroup submits a forthcoming report (due December 1, 2022);

- recommended that MHBE and MDL to work together to find a way to establish a means to connect UI claimants with health insurance coverage options; and

- expressed continued support for SRP and recommended that the program be extended past 2023.

Delegate Peña-Melnyk commended the commission on reducing the number of uninsured in Maryland, being creative, thinking outside the box, and working with partners, and noted that there are some outstanding issues. In 2020, the commission heard a presentation on how other states fund their reinsurance programs. The commission's 2020 report noted that most commissioners supported extending the current assessment that supports SRP at an amount sufficient to continue the current program; however, the commission stopped short of making a formal recommendation. Also in 2020, the commission requested additional information on pursuing a Medicaid buy-in program. DLS contracted Wakely Consulting to do a high-level analysis, which the commission has now heard. Delegate Peña-Melnyk then opened the meeting to discussion on outstanding these issues.

Discussion

Senator Feldman remarked that not only has the commission made multiple recommendations, but most of those recommendations resulted in legislation getting passed and enacted into State law. Senator Feldman noted that it is one thing for commissions to put together reports, but it is another thing for those reports to make their way through the General Assembly to the Governor's desk. Delegate Peña-Melnyk concurred, adding that before the creation of MHBE, Maryland had 756,000 uninsured. After the creation of MHBE and the expansion of Medicaid, the number of uninsured were reduced by more than 50%, and for the first time many people throughout the State gained access to insurance. The State then assisted those in the individual market to access their coverage more affordably through the creation of SRP, which has been a very successful program. The commission's work with partners has made a real difference.

Mr. Jamal Lee urged support for the proposed small business health insurance subsidies program, emphasizing that small businesses need good health care for their employees to continue to grow and to attract high caliber individuals.

Delegate Cullison expressed support for looking at the small business health insurance subsidies bill during session. Delegate Cullison added that commission also needs to process the

tremendous information that it received today and use it to address the issues presented, particularly HDHPs, and requested that the commission continue to dig into options that would make health care more accessible. Delegate Peña-Melnyk advised legislative members of the commission to work with Ms. Eberle to find out what possible bills could be proposed to address HDHPs.

Ms. Doyle implored the commission to keep behavioral health treatment in mind with every option considered, stating that there continues to be a big problem in Maryland that the State must deal with and asking that the commission address behavioral health in whatever option it decides to pursue to reduce to total cost of overall health care.

Ms. Cathy Grayson expressed CareFirst's ongoing support for SRP and the essential need to continue to the program.

Ms. Taylor stated that there is still some uncertainty at the federal level about how much funding will be available to support something like reinsurance and that however the commission proceeds should be a careful analysis of what is out there and what the program should look like going forward.

Delegate Peña-Melnyk noted that the commission's annual report needs to reflect that the commission supports the continuation of SRP beyond 2023, although how to fund it on an ongoing basis remains to be agreed upon and can be addressed by the standing committees. The report should also reflect the need to address issues with HDHPs and options for covering individuals who are ineligible for coverage such as the undocumented community.

Chapter 3. Next Steps

The commission is dedicated to making health insurance affordable and accessible to all Marylanders. In 2022, the commission will focus its attention on extending the State Reinsurance Program (SRP), further exploration of reducing the uninsured rate, and lessening the negative impact of high deductible health plans (HDHP).

State Reinsurance Program

SRP is the largest reinsurance program in the nation and has been a successful tool for stabilizing Maryland's individual health insurance market. As a result of SRP, monthly premiums have decreased more than 30% compared to 2018 rates. Lower premiums have contributed to increased enrollment in the individual market, allowed enrollees to upgrade to higher value plans with lower cost sharing, and led UnitedHealthcare to rejoin the individual market in 2021.

The federal terms and conditions of the Section 1332 waiver authoring SRP require the Maryland Health Benefit Plan (MHBE) "to ensure sufficient funds, on an annual or other appropriate basis, for the reinsurance program to operate as described in MHBE's waiver application." The State share is currently funded by a State assessment, initially modeled on Section 9010 of the Affordable Care Act, which imposed a federal assessment on each covered entity engaged in the business of providing health insurance roughly proportional to the entity's market share. The fee was suspended by the federal government in calendar 2017 and 2019 and later repealed for calendar 2021 and thereafter. Chapters 37 and 38 of 2018 established a one-time State assessment of 2.75% to be collected in 2019 to help fund SRP. Chapters 597 and 598 of 2019 extended the assessment through 2023 and reduced the amount of assessment to 1%.

The commission continues to support SRP because of its proven success and has recommended that the program be extended beyond 2023. As SRP requires a source of State funding, the commissioners will assist the Senate Finance and House Health and Government Operations committees determine appropriate funding sources and levels, as requested.

Reducing the Uninsured Rate

The commission received a vast amount of information on Medicaid buy-in options at its December meeting. Commissioners seemed intrigued but cautious about moving forward with any of the options. A Targeted Buy-in option may result in enrollment of between 36,023 and 66,024 individuals (5,892 to 15,883 of whom are currently uninsured) and cost the State between $46.6 million to $228.0 million. A Qualified Health Plan (QHP) option would result in minimal costs to the State but could increase premiums for individuals who currently receive subsidies. The

analysis of a Medicaid Buy-in For All option assumes all employers would migrate to the new plan and that the uninsured population would be reduced by between 18,600 and 210,000 individuals. The net cost to the State for a Medicaid Buy-in for All option (assuming total costs are offset by employee contributions) is estimated at between $9.0 billion and $15.8 billion. The impact of any of the Medicaid Buy-in options presented is dependent on potential federal policy changes, and further modeling is necessary to pursue specific options, particularly for a Medicaid Buy-in For All option.

The commission also received a significant amount of information on coverage options for individuals who are ineligible for existing programs. The State could apply for a Section 1332 waiver to waive the rule prohibiting undocumented individuals from QHP enrollment and implement a State subsidy program. Under this option, the uninsured rate could be reduced by 0.6% at an approximate cost to the State of $90 million in 2024 increasing to $190 million in 2028 (with enrollment phased in over three years). Costs to the State could be reduced by limiting the subsidies to young adults or individuals with income less than 200% of the federal poverty level. Another option is to establish a Medicaid expansion using 100% State funds, which covers individuals who are ineligible for existing programs.

In 2022, the commission will monitor federal policy changes and discuss any additional information the State needs to determine whether to pursue one of the potential Medicaid Buy-in options, apply for a Section 1332 waiver and implement State-based subsidies, or pursue a Medicaid expansion with State-only funds.

High Deductible Health Plans

Commissioners learned from MHBE that higher cost sharing is associated with lower care utilization and leads to avoidance of necessary and preventive care. However, many Marylanders choose HDHP coverage because of lower premiums. Commissioners have expressed concern that the trend of consumers choosing HDHPs for the lower premiums but avoiding use of coverage for major medical events has caused HDHPs to increase overall health care costs. In 2022, the commission will work with MHBE to explore ways to minimize the impact of HDHPs on utilization and overall health care costs.

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.

Appendix 3

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.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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.