Consumer Protections Discussion Draft
Last Updated: September 23, 2019.

A BILL ENTITLED

AN ACT concerning

Health Insurance – Consumer Protections

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

Article – Insurance

15–137.1.

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

SUBTITLE 1A. CONSUMER PROTECTIONS.

15–1A–01.

Commented [SL1]: Definitions

(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) "ESSENTIAL HEALTH BENEFITS" MEANS:

(1) FOR INDIVIDUAL AND SMALL GROUP PLANS THAT ARE NOT GRANDFATHERED PLANS, BENEFITS IN THE STATE BENCHMARK PLAN SELECTED IN ACCORDANCE WITH § 31–116 OF THIS ARTICLE; OR

(2) FOR LARGE GROUP PLANS, GRANDFATHERED SMALL GROUP PLANS, AND GRANDFATHERED INDIVIDUAL PLANS BENEFITS SELECTED IN ACCORDANCE WITH:

(I) 45 CFR 147.126; OR

(II) IF 45 CFR 147.126 IS REPEALED OR ALTERED AFTER JANUARY 1, 2019, REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF REGULATIONS IS PREEMPTED BY FEDERAL LAW.

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

(E) "GRANDFATHERED PLAN":

(1) MEANS GRANDFATHERED HEALTH PLAN COVERAGE AS DEFINED BY 45 CFR 147.140; OR

(2) IF THE DEFINITION OF GRANDFATHERED HEALTH PLAN UNDER 45 CFR 147.140 IS REPEALED OR ALTERED AFTER JANUARY 1, 2019, HAS THE MEANING ESTABLISHED BY REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF THE REGULATIONS

IS PREEMPTED BY FEDERAL LAW.

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

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

(H) "INSURED INDIVIDUAL" MEANS:

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

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

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

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

15–1A–02.

Commented [SL2]: Applicability of Subtitle

(A) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE AND SUBJECT TO SUBSECTION (B) OF THIS SECTION, THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN THAT IS NOT A GRANDFATHERED PLAN THAT IS OFFERED BY A CARRIER IN THE STATE WITHIN THE SCOPE OF:

(1) SUBTITLE 12 OF THIS TITLE;

(2) SUBTITLE 13 OF THIS TITLE; OR

(3) SUBTITLE 14 OF THIS TITLE.

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

(2) (I) THE PROVISIONS OF § 15–1A–03 OF THIS SUBTITLE RELATED TO PREEXISTING CONDITION EXCLUSIONS APPLY TO ALL GRANDFATHERED PLANS EXCEPT GRANDFATHERED PLANS THAT ARE

INDIVIDUAL PLANS.

(II) THE PROVISIONS OF §§ 15–1A–06 OF THIS SUBTITLE RELATED TO DEPENDENT CHILDREN APPLY TO ALL GRANDFATHERED PLANS.

(III) THE PROVISIONS OF § 15–1A–09(A) OF THIS SUBTITLE RELATED TO LIFETIME LIMITS APPLY TO ALL GRANDFATHERED PLANS.

(IV) THE PROVISIONS OF § 15–1A–09(B) OF THIS SUBTITLE RELATED TO ANNUAL DOLLAR LIMITS APPLY TO GRANDFATHERED PLANS THAT ARE INDIVIDUAL PLANS.

(V) THE PROVISIONS OF § 15–1A–10 OF THIS SUBTITLE RELATED TO WAITING PERIODS APPLY TO ALL GRANDFATHERED PLANS.

(VI) THE PROVISIONS OF § 15–1A–14 OF THIS SUBTITLE RELATED TO MEDICAL LOSS RATIO, APPLY TO ALL GRANDFATHERED PLANS.

15–1A–03.

Commented [SL3]: Preexisting Condition Exclusions

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

(B) A CARRIER MAY NOT:

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

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

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

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

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

(I) A PRE–ENROLLMENT QUESTIONNAIRE OR PHYSICAL

EXAMINATION GIVEN TO AN INDIVIDUAL; OR

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

15–1A–04.

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

(1) HEALTH CONDITION;

(2) CLAIMS EXPERIENCE;

(3) RECEIPT OF HEALTH CARE;

(4) MEDICAL HISTORY;

(5) GENETIC INFORMATION;

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

(7) DISABILITY.

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

15–1A–05.

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

Commented [SL4]: Prohibiting Discrimination Based on Health Status

Commented [SL5]: Note Sec. 1557 of the ACA in Workgroup report; suggest separate bill to address the discrimination based on sex and gender identity

Commented [SL6]: Added for protection of premiums because of health status. Was part of 300gg–4(b)

Commented [SL7]: Health Insurance Premium Rates

Commented [SL8]: Added to cross reference 15–1205. Final bill language will also need to amend out references to ACA in 15–1205.

(B) SUBJECT TO TITLE 11, SUBTITLE 6 OF THIS ARTICLE, A CARRIER MAY DETERMINE A PREMIUM RATE BASED ON:

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

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

(I) THE BALTIMORE METROPOLITAN AREA;

(II) THE DISTRICT OF COLUMBIA METROPOLITAN AREA;

(III) WESTERN MARYLAND; AND

(IV) EASTERN AND SOUTHERN MARYLAND;

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

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

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

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

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

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

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

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

(I) BE ACTUARIALLY JUSTIFIED AND CONSISTENT WITH

THE UNIFORM AGE RATING CURVE ESTABLISHED IN ACCORDANCE WITH PARAGRAPH (4) OF THIS SUBSECTION;

(II) FOR PLAN OR POLICY YEARS BEGINNING BEFORE JANUARY 1, 2019, PROVIDE FOR A SINGLE AGE BAND FOR INDIVIDUALS UNDER THE AGE OF 21 YEARS; AND

(III) FOR PLAN OR POLICY YEARS BEGINNING ON OR AFTER JANUARY 1, 2019:

1. PROVIDE FOR A SINGLE AGE BAND FOR INDIVIDUALS UNDER THE AGE OF 15 YEARS; AND

2. PROVIDED FOR 1-YEAR AGE BANDS FOR INDIVIDUALS AT LEAST 15 YEARS OLD AND UNDER THE AGE OF 20 YEARS.

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

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

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

(II) FOR A HEALTH BENEFIT PLAN THAT PROVIDES FAMILY COVERAGE FOR INDIVIDUALS UNDER 21 YEARS OF AGE, THE SUM SHALL INCLUDE NO MORE THAN THE 3 OLDEST INDIVIDUALS UNDER 21 YEARS OF AGE.

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

15–1A–06.

Commented [TA9]: Coverage of children up to the age of 26 years.

(A) IN THIS SECTION, "CHILD" MEANS:

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

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

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

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

15–1A–07.

(A) SUBJECT TO §§ 15-1206(C), 15-1208.1, 15-1208.2, 15-1209, 15-1210, 15-1316, 15–1406, AND 15–1410 OF THIS ARTICLE, AND EXCEPT AS PROVIDED IN SUBSECTIONS (B) THROUGH (D) OF THIS SECTION, A CARRIER SHALL ACCEPT EVERY EMPLOYER AND INDIVIDUAL IN THE STATE THAT APPLIES FOR A HEALTH BENEFIT PLAN.

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

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

(C) IF A CARRIER USES A NETWORK FOR A HEALTH BENEFIT PLAN, THE CARRIER:

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

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

Commented [TA10]: Changed this definition from "dependent child" to "child" based on feedback from the bill drafting office. Took "grandchild" out of the definition, per workgroup comments.

Commented [TA11]: From Carefirst: "This language is not in the ACA. The ACA grants the Secretary the authority to promulgate regulations to define dependents to which coverage should be made available. Could grant same authority to Commissioner." Do others have thoughts on this?

Commented [TA12]: Guaranteed availability of coverage

Commented [TA13]: Took out language on guaranteed renewability and references to guaranteed renewability.

Commented [TA14]: Eliminated (c)(1)(ii): "may limit the individuals who may apply for coverage in the individual market to those who live or reside in the service area for the network; or"

CARRIER:

(I) DEMONSTRATES TO THE COMMISSIONER THAT:

1. THE CARRIER DOES NOT HAVE THE CAPACITY TO DELIVER ADEQUATE SERVICES TO ADDITIONAL ENROLLEES OF GROUPS OR ADDITIONAL INDIVIDUALS BECAUSE OF ITS OBLIGATIONS TO EXISTING GROUP CONTRACT HOLDERS AND ENROLLEES; AND

2. THE CARRIER APPLIES THIS PARAGRAPH UNIFORMLY TO ALL EMPLOYERS AND INDIVIDUALS WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTOR; AND

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

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

(1) DEMONSTRATES TO THE COMMISSIONER THAT:

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

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

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

15-1A-08.

Commented [TA15]: Preventive and wellness services and chronic disease management

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

(1) EVIDENCE-BASED ITEMS OR SERVICES THAT HAVE IN EFFECT A RATING OF A OR B IN THE CURRENT RECOMMENDATIONS OF THE

UNITED STATES PREVENTIVE SERVICES TASK FORCE WITH RESPECT TO THE INDIVIDUAL INVOLVED;

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

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

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

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

(4) WITH RESPECT TO WOMEN, AND SUBJECT TO § 15–826 OF THIS ARTICLE, PREVENTIVE CARE AND SCREENINGS AS PROVIDED FOR IN COMPREHENSIVE GUIDELINES SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION FOR PURPOSES OF § 2713(A)(4) OF THE PUBLIC HEALTH SERVICE ACT.

Commented [TA16]: I put this here as a placeholder for a religious exemption – we will talk to the Chairs about their preferences.

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

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

15–1A–09.

Commented [TA17]: Annual and lifetime limits

(A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C) OF THIS

SECTION, A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN, INCLUDING A GRANDFATHERED PLAN, MAY NOT ESTABLISH LIFETIME LIMITS OR ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR ANY INSURED INDIVIDUAL.

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

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

Commented [TA18]: There will be a definition of "essential health benefits" in 15–1A–01.

15–1A–10.

Commented [TA19]: Waiting periods

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

15–1A–11.

Commented [SL20]: Designation of primary care providers; Access to obstetrical and gynecological services

(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 OF TREATMENT DECISIONS.

(2) A CARRIER SHALL TREAT THE PROVISION OF OBSTETRICAL AND GYNECOLOGICAL CARE AND THE ORDERING OF RELATED OBSTETRICAL AND GYNECOLOGICAL ITEMS AND SERVICES BY A PARTICIPATING HEALTH CARE PROVIDER WHO SPECIALIZES IN OBSTETRICS OR GYNECOLOGY AS THE AUTHORIZATION OF THE PRIMARY CARE PROVIDER.

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

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

15–1A–12.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE

Commented [TA21]: CareFirst recommends removing this subsection. Do others have thoughts? Their comment: This is already in MD law at 15-816. Redundant. Could change to (c)(1)(I) Carriers that provide coverage for obstetric or gynecological care and require the designation by an insured individual of a participating primary care provider must comply with section 15-816 of this title."

Commented [SL22]: Emergency Services

MEANINGS INDICATED.

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

(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 FACILITY, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE AN EMERGENCY MEDICAL CONDITION; OR

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

(B) IF A CARRIER 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.

Commented [TA23]: These definitions are revised.

(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) SUBJECT TO § 19–710.1 OF THE HEALTH – GENERAL ARTICLE, 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, AND PAY THE REIMBURSEMENT RATE SPECIFIED IN SUBSECTION (D) OF THIS SECTION.

(D) A CARRIER SHALL REIMBURSE A HEALTH CARE PROVIDER OF EMERGENCY SERVICES WHO DOES NOT HAVE A CONTRACTUAL RELATIONSHIP WITH THE CARRIER THE GREATER OF:

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

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

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

15–1A–13.

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

(2) "INSURANCE–RELATED TERMS" MEANS:

Commented [TA24]: This subsection is intended to incorporate the reimbursement methodology found in 45 CFR 147.138(b)(3).

Commented [SL25]: Summary of Benefits and Coverage Explanation

Commented [TA26]: From CareFirst: "CareFirst questions whether this provision should be included in this law-it is not one of the fundamental consumer protections of ACA that the workgroup is charged with codifying." Do others have thoughts?

(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 MARYLAND HEALTH BENEFIT EXCHANGE 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 MARYLAND HEALTH BENEFIT EXCHANGE 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) THE MARYLAND HEALTH BENEFIT EXCHANGE 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.

(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;

Commented [TA27]: Took out required consultation with NAIC.

Commented [TA28]: From HEAU: "(B)(2) To the extent that regulations have been adopted pursuant to 42 USC 300gg-15, the Commissioner may, except as preempted by federal law, adopt standards that provide more information to consumers than that required to be provided by federal regulations.

(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 MARYLAND HEALTH BENEFIT EXCHANGE;

(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 MARYLAND HEALTH BENEFIT EXCHANGE

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 MARYLAND HEALTH BENEFIT EXCHANGE TO:

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

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

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

(G) EXCEPT AS OTHERWISE PROVIDED IN THIS ARTICLE, IF A CARRIER MAKES ANY MATERIAL MODIFICATION IN ANY OF THE TERMS OF THE PLAN OR COVERAGE INVOLVED THAT IS NOT REFLECTED IN THE MOST RECENTLY PROVIDED SUMMARY OF BENEFITS AND COVERAGE EXPLANATION, THE CARRIER SHALL PROVIDE NOTICE OF THE MODIFICATION TO INSURED INDIVIDUALS NO LATER THAN 60 DAYS BEFORE THE EFFECTIVE DATE OF THE MODIFICATION.

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

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

15–1A–14.

Commented [SL29]: Minimum Loss Ratio Requirements and Premium Rebates

EACH CARRIER SHALL COMPLY WITH THE MINIMUM LOSS RATIO REQUIREMENTS AND CORRESPONDING REPORTING AND REBATE REQUIREMENTS ESTABLISHED UNDER:

(1) 45 CFR PART 158; OR

(2) IF THE MINIMUM LOSS RATIO REQUIREMENTS UNDER 45 CFR PART 158 AND CORRESPONDING REPORTING AND REBATE REQUIREMENTS ARE REPEALED OR ALTERED AFTER JANUARY 1, 2019, REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF REGULATIONS IS PREEMPTED BY FEDERAL LAW.

15–1A–15.

Commented [SL30]: Disclosure of Information

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

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

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

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

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

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

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

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

15–1A–16.

Commented [SL31]: Child–only Plans

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, EACH CARRIER THAT OFFERS A HEALTH BENEFIT PLAN AT ANY LEVEL OF COVERAGE SHALL OFFER AT THE SAME LEVEL OF COVERAGE A HEALTH BENEFIT PLAN IN WHICH THE ONLY INSURED INDIVIDUALS ARE UNDER THE AGE OF 21 YEARS, AS OF THE BEGINNING OF THE HEALTH BENEFIT PLAN YEAR.

(B) THE REQUIREMENT IN SUBSECTION (A) OF THIS SECTION DOES NOT APPLY TO CHILDREN WHO ARE ELIGIBLE FOR THE MARYLAND CHILDREN'S HEALTH PROGRAM.

15–1A–17.

Commented [SL32]: Catastrophic Plans

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

(B) (1) A CATASTROPHIC PLAN SHALL BE OFFERED ONLY 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 IN ACCORDANCE WITH PARAGRAPH (2) OF THIS SUBSECTION.

(2) AN INDIVIDUAL SHALL HOLD A HARDSHIP EXEMPTION OR AFFORDABILITY EXEMPTION UNDER:

(I) 42 USC 5000A; OR

(II) IF 42 USC 5000A IS REPEALED OR ALTERED AFTER JANUARY 1, 2019, REGULATIONS ADOPTED BY THE MARYLAND HEALTH BENEFIT EXCHANGE THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF REGULATIONS IS PREEMPTED BY FEDERAL LAW.

(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SECTION, A CATASTROPHIC PLAN SHALL PROVIDE COVERAGE FOR:

(I) ESSENTIAL HEALTH BENEFITS; AND

(II) AT LEAST 3 PRIMARY CARE VISITS EACH PLAN YEAR.

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

(I) IS EQUAL TO THE ANNUAL LIMIT ON COST SHARING DESCRIBED IN § 31–116 OF THIS ARTICLE;

(II) APPLIES TO ESSENTIAL HEALTH BENEFITS; AND

(III) DOES NOT APPLY TO 3 PRIMARY CARE VISITS EACH PLAN YEAR OR TO ANY COVERED BENEFITS FOR WHICH A DEDUCTIBLE IS PROHIBITED UNDER THIS TITLE.

15–1A–18.

Commented [SL33]: Annual Cost–sharing Limits

ANNUAL LIMITATIONS ON COST–SHARING FOR ESSENTIAL HEALTH BENEFITS COVERED UNDER HEALTH BENEFIT PLANS SHALL BE DETERMINED IN ACCORDANCE WITH:

(1) 45 CFR 155.20, 156.20, AND 156.130; OR

(2) IF 45 CFR 155.20, 156.20, AND 156.130 ARE REPEALED OR ALTERED AFTER JANUARY 1, 2019, REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF REGULATIONS IS PREEMPTED BY FEDERAL LAW.

15–1A–19.

Commented [SL34]: Prescription Drug Benefits

PRESCRIPTION DRUG BENEFITS COVERED UNDER HEALTH BENEFIT PLANS SHALL BE DETERMINED IN ACCORDANCE WITH:

(1) 45 CFR 156.122; OR

(2) IF 45 CFR 156.122 IS REPEALED OR ALTERED AFTER

JANUARY 1, 2019, REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF REGULATIONS IS PREEMPTED BY FEDERAL LAW.

15–1A–20.

Commented [SL35]: Policy Rescission

SUBJECT TO § 15–1106 OF THIS ARTICLE, A CARRIER MAY NOT RESCIND A HEALTH BENEFIT PLAN UNLESS THE REQUIREMENTS ARE MET FOR:

(1) 45 CFR 147.128; OR

(2) IF 45 CFR 147.128 IS REPEALED OR ALTERED AFTER JANUARY 1, 2019, REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019, UNLESS THE ADOPTION OF REGULATIONS IS PREEMPTED BY FEDERAL LAW.