SENATE BILL 868

C3 9lr1146
CF 9lr1116

By: **Senators Feldman, Augustine, Beidle, Benson, Carter, Elfreth, Ellis, Ferguson, Griffith, Guzzone, Hayes, Hester, Kagan, Kelley, King, Klausmeier, Kramer, Lam, Lee, McCray, Miller, Nathan–Pulliam, Patterson, Peters, Pinsky, Rosapepe, Smith, Waldstreicher, Washington, West, Young, Zirkin, and Zucker**

Introduced and read first time: February 6, 2019
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Health Insurance – Consumer Protections

FOR the purpose of 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

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

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; 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.

BY repealing
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
Section 1(b)

BY repealing and reenacting, with amendments,
Chapter 17 of the Acts of the General Assembly of 2017
Section 2

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.

(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.

(H) (1) A CARRIER THAT WILLFULLY FAILS TO PROVIDE THE

INFORMATION REQUIRED UNDER THIS SECTION SHALL BE SUBJECT TO A FINE OF NOT MORE THAN $1,000 FOR EACH FAILURE.

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

15–1A–13.

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

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

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

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

2. ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY; AND

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

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

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

(2) THE REPORT SHALL:

(I) SPECIFY THE AMOUNT SPENT ON:

1. TOTAL REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES;

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

3. ALL OTHER NONCLAIMS COSTS; AND

(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

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

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

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