

A BILL ENTITLED

AN ACT concerning

**Health Insurance – Consumer Protections**

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

**Article – Insurance**

[15–137.1.

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

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

- (1) coverage of children up to the age of 26 years;
- (2) preexisting condition exclusions;
- (3) policy rescissions;
- (4) bona fide wellness programs;
- (5) lifetime limits;
- (6) annual limits for essential benefits;
- (7) waiting periods;
- (8) designation of primary care providers;

- (9) access to obstetrical and gynecological services;
- (10) emergency services;
- (11) summary of benefits and coverage explanation;
- (12) minimum loss ratio requirements and premium rebates;
- (13) disclosure of information;
- (14) annual limitations on cost sharing;
- (15) child-only plan offerings in the individual market;
- (16) minimum benefit requirements for catastrophic plans;
- (17) health insurance premium rates;
- (18) coverage for individuals participating in approved clinical trials;
- (19) contract requirements for stand-alone dental plans sold on the Maryland Health Benefit Exchange;
- (20) guaranteed availability of coverage;
- (21) prescription drug benefit requirements; and
- (22) preventive and wellness services and chronic disease management.

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

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

**SUBTITLE 1A. CONSUMER PROTECTIONS.**

**15-1A-01.**

**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) “CHILD” MEANS:**

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

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

**(D) “ESSENTIAL HEALTH BENEFIT” MEANS A HEALTH BENEFIT THAT MEETS THE CRITERIA ESTABLISHED BY REGULATIONS ADOPTED IN ACCORDANCE WITH § 15-1A-04 OF THIS SUBTITLE.**

**(E) “GROUP PLAN” MEANS A SMALL GROUP PLAN OR A LARGE GROUP PLAN.**

**(F) “GRANDFATHERED PLAN” MEANS A HEALTH BENEFIT PLAN THAT MEETS THE CRITERIA ESTABLISHED BY REGULATIONS ADOPTED IN ACCORDANCE WITH § 15-1A-03 OF THIS SUBTITLE.**

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

**(H) “INDIVIDUAL PLAN” MEANS AN INDIVIDUAL HEALTH BENEFIT PLAN AS DEFINED IN § 15-1301(O) OF THIS TITLE.**

**(I) “INSURED INDIVIDUAL” MEANS:**

**(1) AN INSURED, AN ENROLLEE, A SUBSCRIBER, A PARTICIPANT,**

A MEMBER, OR A BENEFICIARY, OF A HEALTH BENEFIT PLAN; OR

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

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

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

15-1A-02.

Commented [SL2]: Intent

(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 PATIENT PROTECTION AND AFFORDABLE CARE ACT CONTINUE TO PROTECT MARYLAND RESIDENTS IN LIGHT OF ITS UNCERTAIN FUTURE ENFORCEMENT.

Commented [SL3]: Enforceability? Effectiveness?

(B) THE COMMISSIONER MAY ENFORCE THIS SUBTITLE UNDER ANY APPLICABLE PROVISIONS OF THIS ARTICLE.

15-1A-03.

Commented [SL4]: Scope/Grandfathered Provisions

(A) FOR PURPOSES OF THIS SUBTITLE, UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

Commented [TA5]: If we don't go with the contingency, consider "shall adopt, to the extent necessary"

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

(2) ARE CONSISTENT WITH 45 C.F.R. § 147.140 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE FEDERAL AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.

Commented [TA6]: Consider putting in a specific date (here and throughout)

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

(1) SUBTITLE 12 OF THIS TITLE;

(2) SUBTITLE 13 OF THIS TITLE; OR

(3) SUBTITLE 14 OF THIS TITLE.

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

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

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

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

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

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

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

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

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

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

2. THE PROVISIONS OF § 15-1A-11 OF THIS

**SUBTITLE RELATED TO THE PROHIBITION ON ESTABLISHING ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS.**

**15-1A-04.**

**Commented [SL7]:** Essential Health Benefits

**FOR PURPOSES OF THIS SUBTITLE, UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:**

**(1) ESTABLISH CRITERIA THAT A HEALTH BENEFIT MUST MEET TO BE CONSIDERED AN ESSENTIAL HEALTH BENEFIT; AND**

**Commented [TA8]:** "covered required" (?)

**(2) ARE CONSISTENT WITH 45 C.F.R. PART 156 SUBPART B AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE FEDERAL AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.**

**15-1A-05.**

**Commented [SL9]:** Preexisting Condition Exclusions

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

**(B) A CARRIER MAY NOT:**

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

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

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

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

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

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

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

15-1A-06.

**Commented [SL10]:** Prohibition on Discrimination Based on Health Status

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

- (1) HEALTH CONDITION;
- (2) CLAIMS EXPERIENCE;
- (3) RECEIPT OF HEALTH CARE;
- (4) MEDICAL HISTORY;
- (5) GENETIC INFORMATION;

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

- (7) DISABILITY.

**Commented [SL11]:** Note Sec. 1557 of the ACA in Workgroup report; suggest separate bill to address the discrimination based on sex and gender identity

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

15-1A-07.

**Commented [SL12]:** Health Insurance Premium Rates

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

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

**OFFERING A SMALL GROUP PLAN.**

**Commented [SL13]:** Added to cross reference 15-1205. Final bill language will also need to amend out references to ACA in 15-1205.

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

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

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

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

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

**(III) WESTERN MARYLAND; AND**

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

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

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

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

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

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

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

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

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



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

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

(III) PROVIDE FOR 1-YEAR AGE BANDS FOR INDIVIDUALS AT LEAST 15 YEARS OLD AND UNDER THE AGE OF 20 YEARS.

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

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

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

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

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

15-1A-08.

Commented [TA14]: Coverage of children up to the age of 26 years.

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

(B) A CARRIER MAY NOT ESTABLISH RULES FOR ELIGIBILITY,

INCLUDING CONTINUED ELIGIBILITY, FOR COVERAGE OF A CHILD UNDER THE AGE OF 26 YEARS BASED ON ANY FACTOR OTHER THAN THE RELATIONSHIP BETWEEN THE CHILD AND THE INSURED.

15-1A-09.

Commented [TA15]: Guaranteed availability of coverage

(A) EXCEPT AS PROVIDED IN SUBSECTIONS (B) THROUGH (D) OF THIS SECTION, A CARRIER SHALL ACCEPT EVERY EMPLOYER AND INDIVIDUAL IN THE STATE THAT APPLIES FOR A HEALTH BENEFIT PLAN, SUBJECT TO THE FOLLOWING PROVISIONS OF THIS ARTICLE:

(1) SUBTITLE 4 OF THIS TITLE;

Commented [TA16]: Look at this again. Kim recommended removing.

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

(3) §§ 15-1308(G), 15-1316, AND 15-1318 OF THIS TITLE; AND

Commented [TA17]: David and Kim recommend removing.

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

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

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

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

Commented [TA18]: David recommends the definition below. I added it to the lead in of this subsection. Lisa, let me know what you think.

*Network plan* means [health insurance coverage](#) of a [health insurance issuer](#) under which the financing and delivery of [medical care](#) (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the [issuer](#). From 45 CFR 144.103.

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

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

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

**(I) DEMONSTRATES TO THE COMMISSIONER THAT:**

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

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

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

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

**(1) DEMONSTRATES TO THE COMMISSIONER THAT:**

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

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

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

**15-1A-10.**

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

**Commented [TA19]:** Preventive and wellness services and chronic disease management

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

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

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

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

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

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

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

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

**15-1A-11.**

**Commented [TA20]:** 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 CARRIER MAY ESTABLISH ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR AN INSURED INDIVIDUAL FOR A GRANDFATHERED PLAN THAT IS AN INDIVIDUAL PLAN.**

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

**15-1A-12.**

**Commented [TA21]:** 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-13.**

**Commented [SL22]:** 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 SHALL COMPLY WITH A CARRIER'S POLICIES AND PROCEDURES.

15-1A-14.

Commented [SL23]: Emergency Services

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

(2) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED BY A PRUDENT LAYPERSON, WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, TO RESULT IN A CONDITION DESCRIBED IN § 1867(E)(1) OF THE SOCIAL SECURITY ACT.

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

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

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

(B) IF A CARRIER PROVIDES OR COVERS ANY BENEFITS FOR EMERGENCY SERVICES IN AN EMERGENCY DEPARTMENT OF A FACILITY, THE CARRIER:

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

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

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

(1) MAY NOT IMPOSE ANY ADMINISTRATIVE

REQUIREMENT OR LIMITATION ON COVERAGE THAT WOULD BE MORE RESTRICTIVE THAN ADMINISTRATIVE REQUIREMENTS OR LIMITATIONS IMPOSED ON COVERAGE FOR EMERGENCY SERVICES FURNISHED BY A HEALTH CARE PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER; AND

(2) SUBJECT TO § 14-205.2 OF THIS ARTICLE AND § 19-710.1 OF THE HEALTH – GENERAL ARTICLE, MAY NOT IMPOSE ANY COST-SHARING AMOUNT GREATER THAN THE AMOUNT IMPOSED FOR EMERGENCY SERVICES FURNISHED BY A HEALTH CARE PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER; AND

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

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

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

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

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

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

15-1A-15.

**Commented [SL25]:** Summary of Benefits and Coverage Explanation

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

(B) A CARRIER SHALL 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) UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER, IN CONSULTATION WITH THE MARYLAND HEALTH BENEFIT EXCHANGE, SHALL ADOPT REGULATIONS THAT:

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

(2) ARE CONSISTENT WITH 45 C.F.R. § 147.200 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.

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

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

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

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

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

(I) PREMIUM;

(II) DEDUCTIBLE;

(III) CO-INSURANCE;

- (IV) CO-PAYMENT;
- (V) OUT-OF-POCKET LIMIT;
- (VI) PREFERRED PROVIDER;
- (VII) NONPREFERRED PROVIDER;
- (VIII) OUT-OF-NETWORK CO-PAYMENTS;
- (IX) USUAL, CUSTOMARY, AND REASONABLE FEES;
- (X) EXCLUDED SERVICES;
- (XI) GRIEVANCE AND APPEALS;
- (XII) HOSPITALIZATION;
- (XII) HOSPITAL OUTPATIENT CARE;
- (XIV) EMERGENCY ROOM CARE;
- (XV) PHYSICIAN SERVICES;
- (XVI) PRESCRIPTION DRUG COVERAGE;
- (XVII) DURABLE MEDICAL EQUIPMENT;
- (XVIII) HOME HEALTH CARE;
- (XIX) SKILLED NURSING CARE;
- (XX) REHABILITATION SERVICES;
- (XXI) HOSPICE SERVICES;
- (XXII) EMERGENCY MEDICAL TRANSPORTATION; AND

(XXIII) ANY OTHER TERMS THE COMMISSIONER DETERMINES ARE IMPORTANT TO DEFINE SO THAT A CONSUMER MAY COMPARE THE MEDICAL BENEFITS OFFERED BY HEALTH BENEFIT PLANS AND

UNDERSTAND THE EXTENT OF AND EXCEPTIONS TO THOSE MEDICAL BENEFITS;

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

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

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

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

(4) THE RENEWABILITY AND CONTINUATION OF COVERAGE PROVISIONS;

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

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

(7) A STATEMENT THAT:

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

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

(8) A CONTACT NUMBER FOR THE CONSUMER TO CALL WITH ADDITIONAL QUESTIONS AND A WEBSITE WHERE A COPY OF THE ACTUAL

HEALTH BENEFIT PLAN CAN BE REVIEWED AND OBTAINED.

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

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

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

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

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

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

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

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

15-1A-16.

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

Commented [SL26]: Minimum Loss Ratio Requirements and Premium Rebates

**(B) EACH CARRIER SHALL COMPLY WITH THE MINIMUM LOSS RATIO REQUIREMENTS AND CORRESPONDING REPORTING AND REBATE REQUIREMENTS ESTABLISHED IN ACCORDANCE WITH REGULATIONS ADOPTED UNDER SUBSECTION (C) OF THIS SECTION.**

**(C) UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:**

**(1) ESTABLISH MINIMUM LOSS RATIO REQUIREMENTS AND CORRESPONDING REPORTING AND REBATE REQUIREMENTS; AND**

**(2) ARE CONSISTENT WITH 45 C.F.R. PART 158 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE FEDERAL AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.**

**15-1A-17.**

**Commented [SL27]:** 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 ONLY TO CARRIERS OFFERING AN INDIVIDUAL PLAN OR SMALL GROUP PLAN.**

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

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

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

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

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

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

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

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

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

15-1A-18.

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

(B) (1) A CATASTROPHIC PLAN MAY ONLY BE 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 ISSUED BY THE MARYLAND HEALTH BENEFIT EXCHANGE.

(2) UNLESS THE REGULATIONS THAT WOULD BE ADOPTED ARE PREEMPTED BY FEDERAL LAW, THE MARYLAND HEALTH BENEFIT EXCHANGE SHALL ADOPT REGULATIONS THAT:

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

(II) ARE CONSISTENT WITH 42 USC § 5000A AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE FEDERAL AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.

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

Commented [SL28]: Catastrophic Plans

Commented [TA29]: If we don't go with the contingency language, we need to include the Federal Health Insurance Marketplace, per Kim.

Commented [TA30]: From David: MIA reiterates that MHBE would be better suited to handle the exemption issues. MHBE previously stated they agreed with this.

Unlike the SBC issue, where CareFirst correctly pointed out that it was important for the Commissioner to adopt the regulations since only the Commissioner has authority over carriers offering non-Exchange plans, this issue is specific to individual market plans, and it applies to the consumers, not to the carriers.

CATASTROPHIC PLAN SHALL PROVIDE COVERAGE FOR ESSENTIAL HEALTH BENEFITS.

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

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

(II) APPLIES TO ESSENTIAL HEALTH BENEFITS;

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

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

15-1A-19.

Commented [SL31]: Annual Limits On Cost Sharing

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

(2) “COST SHARING” INCLUDES:

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

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

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

(B) EACH CARRIER SHALL COMPLY WITH ANNUAL LIMITATIONS ON COST-SHARING FOR ESSENTIAL HEALTH BENEFITS COVERED UNDER HEALTH BENEFIT PLANS AS ESTABLISHED BY THE COMMISSIONER UNDER SUBSECTION (C) OF THIS SECTION.

**(C) UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:**

**(1) ESTABLISH ANNUAL LIMITATIONS ON COST-SHARING; AND**

**(2) ARE CONSISTENT WITH 45 C.F.R. § 156.130 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.**

**15-1A-20.**

**Commented [SL32]:** Prescription Drug Benefits

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

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

**(B) (1) AN INDIVIDUAL PLAN OR SMALL GROUP PLAN SHALL BE CONSIDERED TO PROVIDE PRESCRIPTION DRUG ESSENTIAL HEALTH BENEFITS ONLY IF THE INDIVIDUAL PLAN OR SMALL GROUP PLAN COMPLIES WITH THE REGULATIONS ADOPTED UNDER SUBSECTION (C) OF THIS SECTION.**

**(C) UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:**

**(1) ESTABLISH CRITERIA TO DETERMINE WHETHER AN INDIVIDUAL PLAN OR A SMALL GROUP PLAN PROVIDES PRESCRIPTION DRUG ESSENTIAL HEALTH BENEFIT COVERAGE; AND**

**(2) ARE CONSISTENT WITH 45 C.F.R. 156.122 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE AFFORDABLE CARE ACT WAS IN REPEALED OR WAS NO LONGER ENFORCEABLE.**

**15-1A-21.**

**Commented [SL33]:** Rescission

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



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

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

**(2) THE CARRIER COMPLIES WITH THE REGULATIONS FOR THE RESCISSION OF COVERAGE ADOPTED UNDER SUBSECTION (C) OF THIS SECTION.**

**(C) UNLESS PREEMPTED BY FEDERAL LAW, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:**

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

**(2) ARE CONSISTENT WITH 45 C.F.R. 147.128 AND ANY FEDERAL RULES AND GUIDANCE IN EFFECT ON THE DAY BEFORE THE AFFORDABLE CARE ACT WAS REPEALED OR WAS NO LONGER ENFORCEABLE.**

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

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

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

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

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

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) Section 1 of this Act is contingent on:

(1) the repeal of the federal Affordable Care Act; or

(2) a final judgment by the Fifth Circuit Court of Appeals or the U.S. Supreme Court in *Texas, et. al. v. United States, et. al.*, No. 4:18-cv-167-O, that the federal Affordable Care Act is unconstitutional.

(b) The Attorney General shall notify the Department of Legislative Services within 5 days after the repeal or final judgment.

(c) If notice of a repeal or final judgement is not received by the Department of Legislative Services on or before July 1, 2025, Section 1 of this Act, with no further action required by the General Assembly, shall be null and void.

SECTION 4. AND BE IT FURTHER ENACTED, That, subject to Section 3 of this Act, 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.