

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.

(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) “GRANDFATHERED PLAN”:

(1) MEANS A HEALTH BENEFIT PLAN THAT HAS CONTINUOUSLY COVERED AT LEAST ONE INDIVIDUAL SINCE MARCH 23, 2019“GRANDFATHERED HEALTH PLAN COVERAGE” AS DEFINED BY 45 CFR 147.140; OR

(2) UNLESS PREEMPTED BY FEDERAL LAW, HAS THE MEANING ESTABLISHED BY REGULATIONS ADOPTED BY THE COMMISSIONER THAT ARE CONSISTENT WITH FEDERAL RULES AND GUIDANCE IN EFFECT ON JANUARY 1, 2019.

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

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

(G) (1) “INSURED INDIVIDUAL” MEANS AN INSURED, AN ENROLLEE, A SUBSCRIBER, A POLICY HOLDER, A PARTICIPANT, A MEMBER, OR A BENEFICIARY OF A HEALTH BENEFIT PLAN.

(2) “INSURED INDIVIDUAL” INCLUDES A POLICY HOLDER OF AN INDIVIDUAL PLAN.

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

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

15-1A-02.

(A) EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS SUBTITLE, THIS SUBTITLE APPLIES TO ALL CARRIERS IN CONNECTION WITH 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.**

(B) EXCEPT AS OTHERWISE SPECIFICALLY PROVIDED IN THIS SUBTITLE, THE PROVISIONS OF THE SUBTITLE DO NOT APPLY TO A GRANDFATHERED PLAN.

15-1A-03.

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

(B) 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.

(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 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;

(8) SEX; OR

(9) GENDER IDENTITY.

(B) EXCEPT AS PROVIDED IN § 12-205(G) OF THIS ARTICLE, 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 WHICH IS GREATER THAN THE PREMIUM OR CONTRIBUTION FOR A SIMILARLY SITUATED INDIVIDUAL ENROLLED IN THE PLAN ON THE BASIS OF ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE INDIVIDUAL OR TO AN INDIVIDUAL ENROLLED UNDER THE PLAN AS A DEPENDENT OF THE INDIVIDUAL.

(C) (1) FOR PURPOSES OF THIS SECTION, THE CARRIER OF A GROUP PLAN MAY NOT:

(I) IN ACCORDANCE WITH § 27-909 OF THIS ARTICLE:

1. ADJUST PREMIUM OR CONTRIBUTION AMOUNTS FOR THE GROUP COVERED UNDER THE PLAN ON THE BASIS OF GENETIC INFORMATION;

2. REQUEST OR REQUIRE A GENETIC INFORMATION BEFORE AN INDIVIDUAL IS ENROLLED IN A GROUP PLAN OR FOR PURPOSES OF UNDERWRITING; OR

(II) PURCHASE GENETIC INFORMATION BEFORE AN INDIVIDUAL IS ENROLLED IN A GROUP PLAN OR FOR PURPOSES OF UNDERWRITING.

(2) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, NOTHING IN THIS SUBSECTION MAY BE CONSTRUED TO PROHIBIT A CARRIER OF AN INDIVIDUAL OR GROUP PLAN FROM INCREASING THE PREMIUM FOR AN EMPLOYER BASED ON THE MANIFESTATION OF A DISEASE OR DISORDER OF AN INDIVIDUAL WHO IS ENROLLED IN THE PLAN.

(II) THE MANIFESTATION OF A DISEASE OR DISORDER IN ONE INDIVIDUAL CANNOT ALSO BE USED AN GENETIC INFORMATION ABOUT OTHER GROUP MEMBERS AND TO FURTHER INCREASE THE PREMIUM FOR THE

EMPLOYER.

15-1A-05.

(A) SUBJECT TO TITLE 11, SUBTITLE 6 OF THIS ARTICLE, A CARRIER OFFERING AN INDIVIDUAL PLAN OR SMALL GROUP PLAN MAY DETERMINE A PREMIUM RATE BASED ON:

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

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

(B) (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 ~~MORE THAN~~ 3 TO 1 FOR ADULTS;

(II) SHALL PROVIDE FOR ONE-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, 2018, 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, 2018:

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

2. PROVIDED FOR ONE-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.

(C) (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) EXCEPT AS PROVIDED IN 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.

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