HOUSE BILL 959

C3 EMERGENCY BILL 0lr2965
CF SB 872

By: **Delegates Pendergrass and Pena–Melnyk**
Introduced and read first time: February 5, 2020
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Consumer Protections

FOR the purpose of authorizing the Maryland Insurance Commissioner to enforce certain provisions of law under certain applicable powers; requiring the Commissioner to adopt certain regulations under certain circumstances that are consistent with certain federal regulations, rules, and guidance and that establish certain criteria, certain standards, a certain definition, a certain calculation, certain reporting, certain rebate requirements, certain limitations, and certain requirements; prohibiting certain carriers from excluding or limiting certain benefits or denying certain coverage because a certain health condition was present before or on a certain date; prohibiting certain carriers from establishing certain rules for eligibility based on certain health status–related factors; prohibiting certain carriers from requiring certain individuals to pay a certain premium or contribution on the basis of certain health status–related factors; authorizing certain carriers to determine certain premium rates based on certain factors under certain circumstances; requiring certain carriers that provide certain coverage of a child to continue to make certain coverage available until the child is a certain age; prohibiting certain carriers from establishing certain rules for eligibility for coverage of a certain child; requiring certain carriers to accept certain employers and individuals that apply for certain health benefit plans subject to certain provisions of law and except under certain circumstances; providing that certain carriers must provide certain coverage without imposing certain cost–sharing requirements for certain items, services, immunizations, preventive care, and screenings except under certain circumstances; prohibiting certain carriers from establishing certain lifetime limits or annual limits on the dollar value of certain benefits except under certain circumstances; prohibiting certain carriers from applying certain waiting periods before certain coverage becomes effective for certain individuals; requiring certain carriers to allow certain insured individuals to designate certain primary care providers under certain circumstances; requiring certain carriers to treat certain actions by certain providers as care authorized by certain providers; prohibiting certain carriers from requiring authorization or referral by certain persons for an insured individual who seeks

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

certain coverage; requiring certain providers to comply with certain policies and procedures; prohibiting certain carriers from requiring certain individuals from obtaining certain authorization for certain emergency services; requiring certain carriers to provide certain coverage and certain reimbursement for emergency services under certain circumstances; requiring certain carriers to compile and provide consumers a summary of benefits and coverage explanation that includes certain information; requiring the Commissioner to adopt certain regulations in consultation with the Maryland Health Benefits Exchange; requiring the Commissioner to review and update certain standards in a certain manner under certain circumstances; requiring certain carriers to provide a certain notice to certain insured individuals not later than a certain number of days before a certain date; requiring the Maryland Insurance Administration to levy a certain fine for a certain violation; requiring the Commissioner to adopt certain regulations; establishing certain medical loss ratios for certain markets; requiring certain carriers to comply with certain requirements for calculating certain medical loss ratios and related reporting and rebate requirements; requiring certain carriers to disclose certain information to certain individuals or employers under certain circumstances; authorizing certain carriers to offer certain catastrophic plans to certain individuals under certain circumstances; requiring the Exchange to adopt certain regulations under certain circumstances that are consistent with certain federal laws, regulations, rules, and guidance and that establish a process for issuing certain hardship exemptions and affordability exemptions; establishing certain requirements for certain catastrophic plans; requiring certain carriers to comply with certain annual limitations on cost–sharing for certain essential health benefits covered under certain health benefit plans except under certain circumstances; providing that certain plans must be considered to provide certain prescription drug benefits if the plan complies with certain provisions of federal law or certain regulations; prohibiting certain carriers from rescinding certain health benefit plan coverage unless certain requirements are met; prohibiting certain carriers from refusing, withholding from, or denying certain coverage to certain persons based on certain factors under certain circumstances; requiring the Commission on Civil Rights to enforce certain provisions of this Act; requiring the Administration, the Health Education and Advocacy Unit of the Office of the Attorney General, and the Exchange to monitor certain federal statutes and regulations for a certain purpose and submit a certain annual report to certain committees of the General Assembly on or before a certain date of certain years; providing certain legislative history and intent of the General Assembly; defining certain terms; providing for the application of this Act; making this Act an emergency measure; and generally relating to health insurance and consumer protections.

BY repealing
Article – Insurance
Section 15–137.1
Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

BY adding to

Article – Insurance
Section 15–1A–01 through 15–1A–22 to be under the new subtitle "Subtitle 1A. Consumer Protections"
Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

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.

(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, A STEPCHILD, A FOSTER CHILD, OR AN 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:

(1) MEETS THE CRITERIA ESTABLISHED UNDER § 1302(B) OF THE AFFORDABLE CARE ACT; OR

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN § 15–1A–04 OF THIS SUBTITLE, MEETS THE CRITERIA ESTABLISHED BY THE ADOPTED REGULATIONS.

(E) "GRANDFATHERED PLAN" MEANS A HEALTH BENEFIT PLAN THAT:

(1) MEETS THE CRITERIA ESTABLISHED UNDER 45 C.F.R. § 147.140 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019; OR

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN § 15–1A–03 OF THE SUBTITLE, MEETS THE CRITERIA ESTABLISHED BY THE ADOPTED REGULATIONS.

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

(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 § 15–1201 OF THIS TITLE.

15–1A–02.

(A) THE COMMISSIONER MAY ENFORCE:

(1) THE PROVISIONS OF THIS SUBTITLE; AND

(2) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW, THE FOLLOWING PROVISIONS OF TITLE 1, SUBTITLES A, C, AND D OF THE AFFORDABLE CARE ACT AS THEY 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:

(I) COVERAGE OF CHILDREN UP TO THE AGE OF 26 YEARS;

(II) PREEXISTING CONDITION EXCLUSIONS;

(III) POLICY RESCISSIONS;

(IV) BONA FIDE WELLNESS PROGRAMS;

(V) LIFETIME LIMITS;

(VI) ANNUAL LIMITS FOR ESSENTIAL BENEFITS;

(VII) WAITING PERIODS;

(VIII) DESIGNATION OF PRIMARY CARE PROVIDERS;

(IX) ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES;

(X) EMERGENCY SERVICES;

(XI) SUMMARY OF BENEFITS AND COVERAGE EXPLANATION;

(XII) MINIMUM LOSS RATIO REQUIREMENTS AND PREMIUM REBATES;

(XIII) DISCLOSURE OF INFORMATION;

(XIV) ANNUAL LIMITATIONS ON COST–SHARING;

(XV) CHILD–ONLY PLAN OFFERINGS IN THE INDIVIDUAL MARKET;

(XVI) MINIMUM BENEFIT REQUIREMENTS FOR CATASTROPHIC PLANS;

(XVII) HEALTH INSURANCE PREMIUM RATES;

(XVIII) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS;

(XIX) CONTRACT REQUIREMENTS FOR STAND–ALONE DENTAL PLANS SOLD ON THE MARYLAND HEALTH BENEFIT EXCHANGE;

(XX) GUARANTEED AVAILABILITY OF COVERAGE;

(XXI) PRESCRIPTION DRUG BENEFIT REQUIREMENTS; AND

(XXII) PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT.

(B) THE COMMISSIONER MAY ENFORCE THE PROVISIONS IDENTIFIED UNDER SUBSECTION (A) OF THIS SECTION UNDER ANY APPLICABLE POWERS GRANTED TO THE COMMISSIONER UNDER THIS ARTICLE.

15–1A–03.

(A) FOR PURPOSES OF THIS SUBTITLE, TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(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 AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

(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.

FOR PURPOSES OF THIS SUBTITLE, TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

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

(2) ARE CONSISTENT WITH 45 C.F.R. PART 156 SUBPART B AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

15–1A–05.

(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.

(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.

(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.

(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.

(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 MARYLAND AND SOUTHERN MARYLAND;

(3) SUBJECT TO SUBSECTION (D) OF THIS SECTION, WHETHER THE PLAN COVERS AN INDIVIDUAL OR A 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 THE AGE OF 64 YEARS; 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 YEARS, 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 THE AGE OF 21 YEARS, THE SUM SHALL INCLUDE NOT MORE THAN THE PREMIUMS FOR THE THREE OLDEST INDIVIDUALS UNDER THE AGE OF 21 YEARS.

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

15–1A–08.

(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 OLD.

(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.

(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;

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

(3) §§ 15–1316 AND 15–1318 OF THIS TITLE; AND

(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:

(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–RELATED 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:

(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:

(I) EXCEPT AS PROVIDED IN ITEM (II) OF THIS ITEM, 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; AND

(II) SUBJECT TO §§ 15–826 AND 15–826.1 OF THIS TITLE, CONTRACEPTIVE COVERAGE 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.

(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.

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.

(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 THE INDIVIDUAL'S 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 OBSTETRICAL OR GYNECOLOGICAL 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 THAT SPECIALIZES IN OBSTETRICS OR GYNECOLOGY AS CARE AUTHORIZED BY THE PRIMARY CARE PROVIDER FOR THE INSURED INDIVIDUAL.

(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 THAT PROVIDES OBSTETRICAL OR GYNECOLOGICAL CARE SHALL COMPLY WITH A CARRIER'S POLICIES AND PROCEDURES.

15–1A–14.

(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 SUCH 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 PROVIDING 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 PROVIDE 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;

(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 THAT 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 COINSURANCE;

(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 COINSURANCE, WITHOUT REDUCTION FOR OUT–OF–NETWORK COST–SHARING THAT GENERALLY APPLIES UNDER THE HEALTH BENEFIT 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 COINSURANCE.

15–1A–15.

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

(B) (1) A CARRIER SHALL COMPILE AND PROVIDE TO CONSUMERS A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION THAT:

(I) ACCURATELY DESCRIBES THE BENEFITS AND COVERAGE UNDER THE APPLICABLE HEALTH BENEFIT PLAN; AND

(II) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, COMPLIES WITH THE STANDARDS UNDER 45 C.F.R. § 147.200.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION, A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION SHALL COMPLY WITH THE STANDARDS IN THE ADOPTED REGULATIONS.

(C) TO THE EXTENT NECESSARY, 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 DECEMBER 1, 2019.

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

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

(2) 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 CONSUMERS MAY COMPARE HEALTH BENEFIT PLANS AND UNDERSTAND THE TERMS OF AND EXCEPTIONS TO COVERAGE, INCLUDING:

(I) PREMIUM;

(II) DEDUCTIBLE;

(III) COINSURANCE;

(IV) COPAYMENT;

(V) OUT–OF–POCKET LIMIT;

(VI) PREFERRED PROVIDER;

(VII) NONPREFERRED PROVIDER;

(VIII) OUT–OF–NETWORK COPAYMENTS;

(IX) USUAL, CUSTOMARY, AND REASONABLE FEES;

(X) EXCLUDED SERVICES;

(XI) GRIEVANCE AND APPEALS;

(XII) HOSPITALIZATION;

(XIII) 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 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 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 NOT 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) (1) FOR PURPOSES OF THIS SECTION, "MEDICAL LOSS RATIO":

(I) HAS THE MEANING ESTABLISHED IN 45 C.F.R. § 158.221; OR

(II) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION, HAS THE MEANING ESTABLISHED BY THE ADOPTED REGULATIONS.

(2) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(I) ESTABLISH A DEFINITION FOR "MEDICAL LOSS RATIO"; AND

(II) ARE CONSISTENT WITH 45 C.F.R. § 158.221 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

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

(C) THE MINIMUM ACCEPTABLE MEDICAL LOSS RATIO IS:

(1) FOR THE LARGE GROUP MARKET, 85% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS; AND

(2) FOR THE SMALL GROUP MARKET AND INDIVIDUAL MARKET, 80% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS.

(D) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, EACH CARRIER SHALL COMPLY WITH THE REQUIREMENTS FOR CALCULATING MEDICAL LOSS RATIOS AND RELATED REPORTING AND REBATE REQUIREMENTS ESTABLISHED IN 45 C.F.R. PART 158 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (E) OF THIS SECTION, EACH CARRIER SHALL COMPLY WITH THE REQUIREMENTS IN THE ADOPTED REGULATIONS.

(E) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(1) ESTABLISH REQUIREMENTS FOR CALCULATING MEDICAL LOSS RATIOS AND RELATED REPORTING AND REBATE REQUIREMENTS; AND

(2) ARE CONSISTENT WITH 45 C.F.R. PART 158 AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

15–1A–17.

(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 A 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 THE EMPLOYER'S OR INDIVIDUAL'S 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) A CATASTROPHIC PLAN MAY BE OFFERED ONLY TO INDIVIDUALS WHO:

(1) ARE UNDER THE AGE OF 30 YEARS BEFORE THE BEGINNING OF THE PLAN YEAR; OR

(2) HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AN AFFORDABILITY EXEMPTION AS REQUIRED IN SUBSECTION (C) OF THIS SECTION.

(C) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, TO BE OFFERED A CATASTROPHIC PLAN, AN INDIVIDUAL SHALL HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AN AFFORDABILITY EXEMPTION UNDER 42 U.S.C. § 5000A.

(2) IF THE MARYLAND HEALTH BENEFIT EXCHANGE ADOPTS REGULATIONS AS DESCRIBED UNDER SUBSECTION (D) OF THIS SECTION, AN INDIVIDUAL SHALL HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AN AFFORDABILITY EXEMPTION UNDER THE REGULATIONS ADOPTED BY THE EXCHANGE.

(D) TO THE EXTENT NECESSARY, THE MARYLAND HEALTH BENEFIT EXCHANGE SHALL ADOPT REGULATIONS THAT:

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

(2) ARE CONSISTENT WITH 42 U.S.C. § 5000A AND ANY CORRESPONDING FEDERAL RULES AND GUIDANCE AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

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

(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 THAT IS A QUALIFIED MEDICAL EXPENSE, AS DEFINED IN 26 U.S.C. § 223(D)(2), WITH RESPECT TO ESSENTIAL HEALTH BENEFITS COVERED UNDER THE PLAN.

(3) "COST–SHARING" DOES NOT INCLUDE PREMIUMS, BALANCE BILLING AMOUNTS FOR NONNETWORK PROVIDERS, OR SPENDING FOR NONCOVERED SERVICES.

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, EACH CARRIER SHALL COMPLY WITH ANNUAL LIMITATIONS ON COST–SHARING FOR ESSENTIAL HEALTH BENEFITS COVERED UNDER HEALTH BENEFIT PLANS AS ESTABLISHED BY 45 C.F.R. § 156.130.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION, EACH CARRIER SHALL COMPLY WITH THE ADOPTED REGULATIONS.

(C) TO THE EXTENT NECESSARY, 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 AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

15–1A–20.

(A) (1) THIS SECTION APPLIES ONLY 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) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, AN INDIVIDUAL PLAN OR A SMALL GROUP PLAN SHALL BE CONSIDERED TO PROVIDE PRESCRIPTION DRUG ESSENTIAL HEALTH BENEFITS ONLY IF THE INDIVIDUAL PLAN OR SMALL GROUP PLAN COMPLIES WITH 45 C.F.R. § 156.122.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION, AN INDIVIDUAL PLAN OR A 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 BY THE COMMISSIONER.

(C) TO THE EXTENT NECESSARY, 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 AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

15–1A–21.

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

(B) (1) SUBJECT TO § 15–1106 OF THIS TITLE, A CARRIER MAY NOT RESCIND THE COVERAGE UNDER A HEALTH BENEFIT PLAN UNLESS:

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

(II) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE CARRIER COMPLIES WITH 45 C.F.R. § 147.128.

(2) IF THE COMMISSIONER ADOPTS REGULATIONS AS DESCRIBED IN SUBSECTION (C) OF THIS SECTION, A CARRIER THAT RESCINDS THE COVERAGE UNDER A HEALTH BENEFIT PLAN IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION SHALL COMPLY WITH THE ADOPTED REGULATIONS.

(C) TO THE EXTENT NECESSARY, THE COMMISSIONER SHALL ADOPT REGULATIONS THAT:

(1) ESTABLISH REQUIREMENTS THAT A CARRIER SHALL 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 AS THOSE PROVISIONS WERE IN EFFECT DECEMBER 1, 2019.

15–1A–22.

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

(2) "GENDER IDENTITY" HAS THE MEANING STATED IN § 20–101 OF THE STATE GOVERNMENT ARTICLE.

(3) "SEXUAL ORIENTATION" HAS THE MEANING STATED IN § 20–101 OF THE STATE GOVERNMENT ARTICLE.

(B) THIS SECTION DOES NOT PROHIBIT A CARRIER FROM REFUSING, WITHHOLDING, OR DENYING COVERAGE UNDER A HEALTH BENEFIT PLAN TO ANY INDIVIDUAL FOR FAILURE TO CONFORM TO THE USUAL AND REGULAR REQUIREMENTS, STANDARDS, AND REGULATIONS OF THE CARRIER, UNLESS THE DENIAL IS BASED ON DISCRIMINATION ON THE GROUNDS OF RACE, SEX, COLOR,

CREED, NATIONAL ORIGIN, MARITAL STATUS, SEXUAL ORIENTATION, AGE, GENDER IDENTITY, OR DISABILITY.

(C) A CARRIER MAY NOT REFUSE, WITHHOLD, OR DENY ANY INDIVIDUAL COVERAGE UNDER A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER OR OTHERWISE DISCRIMINATE AGAINST ANY INDIVIDUAL BECAUSE OF THE INDIVIDUAL'S RACE, SEX, CREED, COLOR, NATIONAL ORIGIN, MARITAL STATUS, SEXUAL ORIENTATION, AGE, GENDER IDENTITY, OR DISABILITY.

(D) THE COMMISSION ON CIVIL RIGHTS SHALL ENFORCE THE PROVISIONS OF THIS SECTION AS PROVIDED FOR IN § 2–202 OF THIS ARTICLE.

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 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) The General Assembly, in Chapters 3 and 4 of the Acts of the General Assembly of 2011, enacted the list of protections in § 15–137.1 of the Insurance Article to protect Maryland residents approximately 1 year after the Patient Protection and Affordable Care Act (ACA) was passed and approximately 1 year before the United States Supreme Court upheld the majority of the ACA in National Federation of Independent Business v. Sebelius.

(b) The General Assembly, regardless of whether the ACA was found to be constitutional, intended for the protections listed in § 15–137.1 of the Insurance Article, as enacted by Chapters 3 and 4 of the Acts of the General Assembly of 2011 and as amended thereafter, to apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets issued or delivered in the State by an authorized insurer, nonprofit health service plan, or health maintenance organization.

(c) The General Assembly, in Chapters 3 and 4 of the Acts of the General Assembly of 2011 and in yearly conformity bills thereafter consistent with the General Assembly's intent, repealed some provisions of Maryland law that provided the same or similar protections as the ACA and used cross–references to the ACA as a stylistic drafting choice for the purpose of maintaining consistency between State and federal law.

(d) In recent years, the federal government has reduced the shared responsibility payment for individuals failing to demonstrate health insurance coverage to $0, has taken regulatory action to minimize the protections provided to Americans by the ACA, and, after refusing to defend the ACA, has asserted, in the context of Texas v. United States, that 26 U.S.C. § 5000(A), the minimum essential coverage requirement, is unconstitutional and that the remainder of the ACA is inseverable.

(e) Moving the provisions in § 15–137.1 of the Insurance Article to § 15–1A–02 of the Insurance Article and supplementing the cross–references to the ACA with the codification of specific statutory language in Title 15, Subtitle 1A of the Insurance Article, as enacted by Section 1 of this Act, further implements the continuing intent of the General Assembly to ensure that Maryland residents benefit from the consumer protections.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.