



Report of the  
Maryland Health Insurance  
Coverage Protection Commission

---

Annapolis, Maryland  
January 2023

---

**Report of the  
Maryland Health Insurance Coverage  
Protection Commission**

---

**Annapolis, Maryland**

**January 2023**

## **Contributing Staff**

### **Writers**

Jennifer B. Chasse

Lisa J. Simpson

### **For further information concerning this document contact:**

Library and Information Services  
Office of Policy Analysis  
Department of Legislative Services  
90 State Circle  
Annapolis, Maryland 21401

Baltimore Area: 410-946-5400 • Washington Area: 301-970-5400

Other Areas: 1-800-492-7122, Extension 5400

TTY: 410-946-5401 • 301-970-5401

TTY users may also use the Maryland Relay Service  
to contact the General Assembly.

Email: [libr@mlis.state.md.us](mailto:libr@mlis.state.md.us)

Home Page: <http://mgaleg.maryland.gov>

The Department of Legislative Services does not discriminate on the basis of age, ancestry, color, creed, marital status, national origin, race, religion, gender, gender identity, sexual orientation, or disability in the admission or access to its programs, services, or activities. The Department's Information Officer has been designated to coordinate compliance with the nondiscrimination requirements contained in Section 35.107 of the Department of Justice regulations. Requests for assistance should be directed to the Information Officer at the telephone numbers shown above.



THE MARYLAND GENERAL ASSEMBLY  
ANNAPOLIS, MARYLAND 21401-1991

January 9, 2023

The Honorable Bill Ferguson  
President of the Senate  
H-107 State House  
Annapolis, Maryland 21401-1991

The Honorable Adrienne A. Jones  
Speaker of the House of Delegates  
101 State House  
Annapolis, Maryland 21401-1991

Dear President Ferguson and Speaker Jones:

The Maryland Health Insurance Coverage Protection Commission respectfully submits its annual report containing a summary of action taken by the General Assembly in response to the commission's activities since it was established in 2017.

The commission did not meet during the 2022 interim. However, over the past six years, legislative action to stabilize the individual market has resulted from the commission's work including the establishment of Maryland's State Reinsurance Program and the implementation of the State-Based Young Adult Health Insurance Subsidies Pilot Program, Maryland Easy Enrollment Health Insurance Program, and an enrollment initiative for unemployment claimants.

We wish to thank the commission members, the commission staff, and the many individuals who briefed the commission over the years for their support of the commission's work.

Sincerely,

*Brian J. Feldman*

Senator Brian J. Feldman  
Senate Chair

*Joseline A. Peña-Melnyk*

Delegate Joseline A. Peña-Melnyk  
House Chair

BJF:JAP/LJS:JBC/bhj



**Maryland Health Insurance Coverage  
Protection Commission  
2022 Membership**

---

**Senator Brian J. Feldman, Senate Chair  
Delegate Joseline A. Peña-Melnyk, House Chair**

**Senators**

Delores G. Kelley  
Chris West

**Delegates**

Bonnie Cullison  
Kirill Reznik

**Nonlegislative Members**

Bob Atlas  
Donna M. Carris  
David Cooney  
Vincent DeMarco  
Lori Doyle  
Jamal Lee  
Carolyn A. Quattrochi  
Deborah R. Rivkin  
Dr. Stephen Rockower  
Dennis R. Schrader  
Allison W. Taylor  
Sanford Walters

**Staff**

Jennifer B. Chasse  
Lisa J. Simpson

**Agency Staff**

Laura Goodman  
Michael Paddy  
Webster Ye



# Contents

---

Transmittal Letter.....	iii
Membership Roster.....	v
Report of the Maryland Health Insurance Coverage Protection Commission.....	1
The Maryland Health Insurance Coverage Protection Commission.....	1
State Actions to Stabilize the Individual Health Insurance Market.....	2
State Reinsurance Program.....	2
Maryland Health Benefit Exchange Affordability Workgroup.....	3
State-based Young Adult Health Insurance Subsidies Pilot Program.....	3
Maryland Easy Enrollment Health Insurance Program.....	3
Enrollment Initiative for Unemployment Claimants.....	4
Appendix 1.....	5
Appendix 2.....	11
Appendix 3.....	29
Appendix 4.....	53





# Report of the Maryland Health Insurance Coverage Protection Commission

---

## The Maryland Health Insurance Coverage Protection Commission

Both in response to and in anticipation of efforts at the federal level to repeal and replace the Patient Protection and Affordable Care Act (ACA), Chapter 17 of 2017 (**Appendix 1**) established the Maryland Health Insurance Coverage Protection Commission. Section 2 of Chapters 37 and 38 of 2018 altered the membership and charge of the commission (**Appendix 2**). Chapters 417 and 418 of 2019 required the commission to establish a workgroup and extended the termination date of the commission (**Appendix 3**), and Chapters 597 and 598 of 2019 further altered the commission's charge (**Appendix 4**).

The commission was established to (1) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program (MCHP), Medicare, and the Maryland All-payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. The commission will terminate on June 30, 2023.

The commission consists of (1) three members of the Senate; (2) three members of the House of Delegates; (3) the Secretary of Health (or designee); (4) the Maryland Insurance Commissioner (or designee); (5) the Attorney General (or designee); (6) one representative of the Maryland Hospital Association; (7) one representative of a managed care organization; (8) one consumer; (9) one representative of a health insurance carrier; (10) one representative who is an employer; (11) one representative of the nursing home industry; (12) one representative of the Maryland State Medical Society, also known as MedChi; (13) one representative of behavioral health care providers; (14) two members of the public; and (15) one representative of a group model health maintenance organization that participates in the individual market.

The duties of the commission encompass a requirement for a study that includes (1) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and the economy of the State resulting from changes to the ACA, Medicaid, MCHP, Medicare, or the Maryland All-payer Model; (2) an estimate of the costs of such adverse effects and the resulting loss of health coverage; (3) an examination of measures that may prevent or mitigate such adverse effects and the resulting loss of health coverage; and (4) recommendations for laws that may be warranted to minimize such adverse effects and assist residents in obtaining and maintaining affordable health coverage. The commission may hold public meetings across the State to carry out its duties and convene workgroups to solicit input from stakeholders.

More specifically, the commission is required to study and make recommendations for individual and group health insurance market stability, including:

- the need for and components of one or more Section 1332 waivers;
- whether to pursue a standard plan design that limits cost sharing;
- whether to merge the individual and small group health insurance markets for rating purposes;
- whether to pursue a basic health program;
- whether to pursue a Medicaid buy-in program for the individual market;
- whether to provide subsidies that supplement premium tax credits or cost-sharing reductions;
- whether to adopt a State-based individual health insurance mandate, and how to use payments collected from individuals who do not maintain minimum essential coverage including use of the payments to assist individuals in purchasing health insurance; and
- whether the State Reinsurance Program (SRP) should be extended after calendar 2023 and, if so, how it will be funded.

By December 31 each year, the commission must submit a report on its findings and recommendations to the General Assembly and the Governor. This report is the fifth annual report of the commission.

## **State Actions to Stabilize the Individual Health Insurance Market**

In response to recommendations by the commission, emergency legislation was enacted to adopt measures to stabilize Maryland's individual market.

### **State Reinsurance Program**

Chapters 6 and 7 of 2018 required the Maryland Health Benefit Exchange (MHBE) to apply for a State Innovation Waiver under Section 1332 of the ACA to establish an SRP and seek federal pass-through funding (federal funding that would have been provided to Maryland residents in the form of federal tax credits in the absence of the program). In August 2018, the federal government approved the waiver, which is valid through calendar 2023. The program, which began January 1, 2019, provides reimbursement to carriers in the individual market that

incur certain total annual claims cost on a per individual basis. In calendar 2023, carriers will be reimbursed for 80% of claims between \$18,500 (down from \$20,000 after the Maryland Insurance Administration expressed concern about the premium rate increases requested by carriers for 2023) and \$250,000. Payments to carriers are made after the plan year ends, and all costs have been recorded and reconciled.

SRP is funded by a combination of assessment revenues and federal pass-through funds. Originally, the revenues came from a 2.75% assessment on specified health insurance carriers to recoup the aggregate amount of the health insurance provider fee that would have been assessed under the ACA for calendar 2019 but was temporarily suspended for that year by action at the federal level. Chapters 597 and 598 extended the assessment through 2023, and Chapter 59 of 2022 extended the assessment through 2028 to provide additional funding for the program; however, for calendar 2020 through 2028, the assessment was reduced to 1.0%.

SRP will pay out approximately \$468 million in 2021, \$520 million in 2022, and \$572 million in 2023. Through calendar 2021, federal pass-through funding alone was sufficient to cover costs. Beginning in calendar 2022, annual program costs will exceed available federal funding, and SRP will begin to spend down the program's State funds. In 2022 and 2023, the balance of State funds is projected to be \$369 million and \$338 million, respectively. Original projections had SRP costs exceeding both federal and State annual funding and surplus State funds by calendar 2026. However, MHBE is revising the estimates to reflect the impact of lowering the attachment point of SRP to \$18,500, the retention of \$50 million in State funds that was transferred to Medicaid in the Budget Reconciliation and Financing Act of 2021, and final 2023 approved insurance rates.

SRP is authorized under a federal State Innovation Waiver valid through calendar 2023. MHBE intends to send a letter of intent to the federal government in November 2022 to extend SRP and submit a new waiver application in February 2023. MHBE will work with federal officials to get the waiver approved between March and June 2023, and the new five-year waiver should begin in calendar 2024. MHBE advises that additional State funding or parameter adjustments to SRP will need to be made for the program to remain solvent throughout the new waiver period.

### **State-Based Young Adult Health Insurance Subsidies Pilot Program**

Chapters 777 and 778 of 2021 required MHBE to establish and implement the State-Based Young Adult Health Insurance Subsidies Pilot Program for calendar 2022 and 2023. Under the program, young adults ages 18 to 34 with incomes between 138% and 400% of the federal poverty level are eligible for State premium assistance subsidies that reduce the maximum expected premium contribution. More than 13,000 new young adults joined the individual market in 2022 under the pilot program at an estimated cost of \$15.7 million as of October 4, 2022.

## **Maryland Easy Enrollment Health Insurance Program**

Established by Chapters 423 and 424 of 2019, the Maryland Easy Enrollment Health Insurance Program allows an uninsured individual to elect on their State income tax return to authorize the Comptroller to share information with MHBE to determine the individual's eligibility for insurance affordability programs. MHBE assists in enrolling individuals in Medicaid or health insurance. In 2022, more than 19,900 eligible individuals expressed interest in coverage on their tax year 2021 State income tax return, and 1,477 (7.4%) individuals enrolled in a special enrollment period during tax time with more expected to enroll during the 2023 open enrollment period.

## **Enrollment Initiative for Unemployment Claimants**

Chapter 49 of 2021 required the Maryland Department of Labor (MDL) to begin implementing a system through which an unemployment insurance claimant may consent to the sharing of relevant information by MDL, with MHBE and the Maryland Department of Health to determine whether the individual qualifies for free or low-cost health insurance and, if so, to help the individual enroll. As of October 3, 2022, approximately 21,886 eligible individuals had indicated an interest in obtaining health insurance, and more than 1,300 individuals had enrolled through a special enrollment period.

# Appendix 1

LAWRENCE J. HOGAN, JR., Governor

Ch. 17

## Chapter 17

### (Senate Bill 571)

AN ACT concerning

#### **Maryland Health Insurance Coverage Protection Act**

FOR the purpose of establishing the Maryland Health Insurance Coverage Protection Commission; providing for the composition, ~~chair~~ cochairs, and staffing of the Commission; prohibiting a member of the Commission from receiving certain compensation, but authorizing the reimbursement of certain expenses; requiring the Commission to ~~study~~ monitor and assess the impact of certain changes to certain laws and programs and make recommendations regarding certain matters; requiring the duties of the Commission to include a certain study; authorizing the Commission to hold public meetings across the State for a certain purpose; authorizing the Commission to convene certain workgroups; requiring the Commission to report its findings and recommendations to the Governor and the General Assembly on or before a certain date each year; providing for the termination of this Act; defining a certain term; and generally relating to the Maryland Health Insurance Coverage Protection Commission.

#### Preamble

WHEREAS, The Congressional Budget Office estimates that a repeal of the Patient Protection and Affordable Care Act (ACA) may result in 22 million individuals becoming uninsured in the United States; and

WHEREAS, With a health insurance market collapse potentially resulting from a repeal of the ACA, an additional 7.3 million individuals could lose insurance coverage, leading to a total of nearly 30 million individuals losing health care coverage nationwide; and

WHEREAS, In Maryland, more than 350,000 people may become uninsured in the aftermath of a repeal of the ACA; and

WHEREAS, A repeal or weakening of the ACA, Medicaid, or Medicare could more than double the number of individuals without health insurance by 2019; and

WHEREAS, One in five of the nonelderly population in the State could become uninsured, which would be more individuals uninsured than before the implementation of the ACA in 2009; and

WHEREAS, About 12.9 million individuals in the United States could lose Medicaid or Children's Health Insurance Program coverage as a result of a repeal or weakening of the ACA or Medicaid, including more than 200,000 individuals in our State; and

WHEREAS, A repeal or weakening of the ACA, Medicaid, or Medicare ~~would~~ could disproportionately affect working and retired individuals and families; and

WHEREAS, Millions of American seniors, including ~~hundreds of~~ thousands of Maryland seniors, could see their prescription drug costs rise substantially as a result of a repeal or weakening of the ACA or Medicare; and

WHEREAS, It is prudent for Maryland to study and develop a plan to mitigate these negative effects of a repeal or weakening of the ACA, Medicaid, or Medicare, address economic impacts, help save lives, and protect public health by recommending and implementing solutions to this broad-scale loss of health coverage; and

WHEREAS, The United States Congress should not diminish any of the benefits of the ACA, Medicaid, or Medicare; now, therefore,

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

(a) In this section, “ACA” means the federal Patient Protection and Affordable Care Act.

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

(c) The Commission consists of the following members:

(1) ~~two~~ three members of the Senate of Maryland, appointed by the President of the Senate;

(2) ~~two~~ three members of the House of Delegates, appointed by the Speaker of the House;

(3) the Secretary of Health and Mental Hygiene, or the Secretary’s designee;

(4) the Maryland Insurance Commissioner, or the Commissioner’s designee; and

(5) the Attorney General, or the Attorney General’s designee; and

~~(5) (6) five the following members of the public, appointed jointly by the President of the Senate and the Speaker of the House;~~

~~(i) one representative of a hospital, appointed jointly by the President of the Senate and the Speaker of the House;~~

(i) one representative of the Maryland Hospital Association;

(ii) one representative of a managed care organization, appointed jointly by the President of the Senate and the Speaker of the House;

(iii) one consumer of health care services, appointed jointly by the President of the Senate and the Speaker of the House;

~~(iv) one representative of a health insurance carrier, appointed by the Governor;~~

~~(iv) one representative of a nonprofit health service plan that has continuously offered plans in all jurisdictions and in all fully insured markets in the State both before and after the enactment of the ACA, appointed by the Governor~~ health insurance carrier, appointed jointly by the President of the Senate and the Speaker of the House;

(v) one representative who is an employer, appointed by the Governor;

(vi) one representative of the nursing home industry, appointed by the Governor; and

(vii) one representative of MedChi;

(viii) one representative of behavioral health providers, appointed jointly by the President of the Senate and the Speaker of the House; and

~~(vii)~~ (ix) two members of the public:

1. one of whom shall be appointed jointly by the President of the Senate and the Speaker of the House; and

2. one of whom shall be appointed by the Governor.

(d) ~~The chair of the Commission shall be designated jointly by the~~ President of the Senate and the Speaker of the House of Delegates shall designate a member who is a Senator and a member who is a Delegate, respectively, to serve as cochairs of the Commission.

(e) The Department of Legislative Services, the Department of Health and Mental Hygiene, and the Maryland Insurance Administration jointly shall provide staff for the Commission.

(f) A member of the Commission:

(1) may not receive compensation as a member of the Commission; but



(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(g) (1) The Commission shall:

(i) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, and Medicare Medicare, and the Maryland All-Payer Model;

~~(i)~~ (ii) conduct a study to assess the impact of potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, and Medicare Medicare, and the Maryland All-Payer Model; and

~~(ii)~~ (iii) provide recommendations for State and local action to protect access of residents of the State to affordable health coverage.

(2) The ~~study conducted~~ duties of the Commission under paragraph (1) of this subsection shall include a study that includes:

(i) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model;

(ii) an estimate of the costs to the State and State residents of adverse effects from ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model and the resulting loss of health coverage;

(iii) an examination of measures that may prevent or mitigate the adverse effects of ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model and the resulting loss of health coverage on the residents, public health, and economy of the State; and

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with ~~a repeal or weakening of~~ changes to the ACA, Medicaid, the Maryland Children's Health Program, or Medicare, or the Maryland All-Payer Model; and

2. will assist residents in obtaining and maintaining affordable health coverage.

(h) The Commission may:

(1) hold public meetings across the State to ~~conduct the study~~ carry out the duties of the Commission; and

(2) convene workgroups to solicit input from stakeholders.

(i) On or before December 31, ~~2017~~ each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017. It shall remain effective for a period of ~~1 year~~ 3 years and 1 month and, at the end of June 30, ~~2018~~ 2020, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

**Enacted under Article II, § 17(b) of the Maryland Constitution, April 6, 2017.**



# Appendix 2

LAWRENCE J. HOGAN, JR., Governor

Ch. 37

Chapter 37

(House Bill 1782)

AN ACT concerning

**Health Insurance – ~~Health Care Access Program – Establishment~~ Individual Market Stabilization  
(Maryland Health Care Access Act of 2018)**

FOR the purpose of ~~requiring the State Health Services Cost Review Commission, for a certain fiscal year, to assess on each hospital a certain fee for a certain purpose; prohibiting the State Health Services Cost Review Commission from raising certain hospital rates as part of a certain update factor to offset the fee; prohibiting the fee from exceeding a certain percentage of certain revenue; requiring each hospital to remit the fee to the Maryland Health Benefit Exchange Fund; requiring a carrier to pay a certain assessment on certain premiums under certain circumstances beginning on a certain date; requiring the assessment to be in addition to certain taxes and certain penalties or actions; requiring certain health insurers, nonprofit health service plans, health maintenance organizations, and managed care organizations to pay, in a certain calendar year, a certain additional assessment for a certain purpose; providing for the distribution of the assessments; altering the purpose, contents, and authorized use of the Maryland Health Benefit Exchange Fund; requiring that certain funds be used in a certain manner; repealing the requirement that the Maryland Health Benefit Exchange implement or oversee the implementation of state-specific requirements for transitional reinsurance and risk adjustment under the Affordable Care Act; repealing the authority of the Exchange to establish a State Reinsurance Program; requiring the Exchange to establish a Health Care Access Program to provide reinsurance to certain carriers; requiring that the Program be designed to mitigate the impact of certain individuals on certain rates; providing that, beginning on a certain date, funding for reinsurance in the individual health insurance market through the Program may be made from certain sources; requiring that, beginning on a certain date and under certain circumstances, certain State funding for the reinsurance of the individual market through the Program be contingent on the Centers for Medicare and Medicaid Services approving a waiver under a certain provision of federal law; requiring the Exchange to adopt certain regulations on or before a certain date; authorizing the Exchange and the Maryland Insurance Commissioner to submit a waiver under a certain provision of federal law in accordance with the recommendations of the Maryland Health Insurance Coverage Protection Commission; authorizing, on or before a certain date, the Commissioner to waive certain statutory requirements under certain circumstances; requiring, beginning on a certain date, an individual to maintain certain coverage for certain individuals; requiring that an individual pay a certain penalty under certain circumstances; requiring that the penalty be in addition to a certain State income tax and included with a certain income tax return; requiring that certain individuals be jointly liable for the penalty under certain circumstances; establishing the amount of the penalty; exempting an individual who qualifies for a~~

~~certain exemption under federal law from being assessed the penalty; requiring an individual to indicate certain information on a certain income tax return; requiring the Comptroller to distribute certain revenues from the penalty to a certain fund for certain purposes; defining certain terms; repealing certain provisions of law rendered obsolete by certain provisions of this Act; requiring the Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group market stability; requiring the Maryland Health Insurance Coverage Protection Commission to engage an independent actuarial firm to assist in its study; requiring the Maryland Health Insurance Coverage Protection Commission, on or before a certain date, to report certain findings and recommendations to the Governor and the General Assembly requiring certain health insurers, nonprofit health service plans, health maintenance organizations, ~~and~~ dental plan organizations, fraternal benefit organizations, managed care organizations, and certain other persons to be subject to a certain assessment in a certain year; establishing the purpose and providing for the distribution of the assessment; establishing that certain provisions of law that apply to certain small employer health benefit plans apply to health benefit plans offered by certain entities; altering the definition of “short-term limited duration insurance” as it relates to certain provisions of law governing individual health benefit plans; altering the membership of the Maryland Health Insurance Coverage Protection Commission; requiring the Commission to study and make recommendations for individual and group health insurance market stability; requiring the Commission to engage an independent actuarial firm to assist in a certain study; requiring the Commission to include its findings and recommendations from a certain study in a certain report; making this Act an emergency measure; and generally relating to health insurance.~~

~~BY repealing and reenacting, with amendments,  
Article – Health – General  
Section 19–214(d)  
Annotated Code of Maryland  
(2015 Replacement Volume and 2017 Supplement)~~

BY adding to  
Article – Insurance  
Section 6–102.1, ~~6–102.2, 31–117, and 31–117.1~~  
Annotated Code of Maryland  
(2017 Replacement Volume)

BY repealing and reenacting, with amendments,  
Article – Insurance  
Section ~~31–107~~ 15–1202 and 15–1301(s)  
Annotated Code of Maryland  
(2017 Replacement Volume)

~~BY repealing~~

~~Article — Insurance  
Section 31-117  
Annotated Code of Maryland  
(2017 Replacement Volume)~~

~~BY adding to  
Article — Tax — General  
Section 10-102.2  
Annotated Code of Maryland  
(2016 Replacement Volume and 2017 Supplement)~~

BY repealing and reenacting, without amendments,  
Chapter 17 of the Acts of the General Assembly of 2017  
Section 1(b) and (g)

BY repealing and reenacting, with amendments,  
Chapter 17 of the Acts of the General Assembly of 2017  
Section 1(c)(6)(viii) and (ix), (h), and (i)

BY adding to  
Chapter 17 of the Acts of the General Assembly of 2017  
Section 1(c)(6)(x) and ~~(xi)~~ and (h)

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

~~Article — Health — General~~

~~19-214.~~

~~(d) (1) Each year, the Commission shall assess a uniform, broad-based, and reasonable amount in hospital rates to reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly.~~

~~(2) (i) 1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue.~~

~~2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15-701 of this article.~~

~~(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.~~

~~(3) (i) Funds generated from the assessment under this subsection may be used only to supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008.~~

~~(ii) Any funds remaining after the expenditure of funds under subparagraph (i) of this paragraph has been made may be used for the general operations of the Medicaid program.~~

~~(4) (i) IN ADDITION TO THE RATES IMPOSED UNDER PARAGRAPH (1) OF THIS SUBSECTION AND SUBJECT TO SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH, FOR FISCAL YEAR 2019, THE COMMISSION SHALL ASSESS A UNIFORM, BROAD BASED AND REASONABLE FEE ON EACH HOSPITAL FOR THE PURPOSE OF SUPPORTING THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~

~~(II) THE COMMISSION MAY NOT RAISE HOSPITAL RATES AS PART OF THE ANNUAL UPDATE FACTOR FOR FISCAL YEAR 2019 TO OFFSET THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH.~~

~~(III) THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH MAY NOT EXCEED 0.5% OF EACH HOSPITAL'S NET PATIENT REVENUE.~~

~~(IV) EACH HOSPITAL SHALL REMIT THE FEE ASSESSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THE INSURANCE ARTICLE.~~

#### Article - Insurance

##### 6-102.1.

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

~~(2) "CARRIER" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(3) "HEALTH BENEFIT PLAN" HAS THE MEANING STATED IN § 15-1201 OF THIS ARTICLE.~~

~~(B) (1) BEGINNING JANUARY 1, 2019, A CARRIER SHALL PAY AN ASSESSMENT OF 3% ON THE CARRIER'S NEW AND RENEWAL GROSS DIRECT PREMIUMS IF THE CARRIER FAILS TO OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE IN ACCORDANCE WITH TITLE 15, SUBTITLE 13 OF THIS ARTICLE.~~

~~(2) THE ASSESSMENT PAYABLE BY A CARRIER UNDER THIS SECTION SHALL BE BASED ON THE CARRIER'S PREMIUMS IN ANY MARKET SEGMENT:~~

~~(I) ALLOCABLE TO THE STATE; AND~~

~~(II) WRITTEN DURING THE IMMEDIATELY PRECEDING CALENDAR YEAR.~~

~~(C) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, BEGINNING JANUARY 1, 2019, THE ASSESSMENT REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE DISTRIBUTED ANNUALLY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE FOR THE SOLE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE HEALTH CARE ACCESS PROGRAM AUTHORIZED UNDER § 31-117 OF THIS ARTICLE.~~

~~(D) THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE IN ADDITION TO:~~

~~(1) TAXES OWED BY THE CARRIER UNDER ANY OTHER PROVISION OF LAW; AND~~

~~(2) ANY PENALTIES IMPOSED OR ACTIONS TAKEN BY THE COMMISSIONER IN RESPONSE TO THE CARRIER'S FAILURE TO COMPLY WITH THIS ARTICLE.~~

~~6-102.2.~~

(A) THIS SECTION APPLIES TO:

(1) A HEALTH AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, A DENTAL PLAN ORGANIZATION, A FRATERNAL BENEFIT ORGANIZATION, AND ANY OTHER PERSON SUBJECT TO REGULATION BY THE STATE THAT PROVIDES A HEALTH BENEFIT PLAN REGULATED PRODUCT THAT:

(I) IS SUBJECT TO THE FEE UNDER § 9010 OF THE AFFORDABLE CARE ACT; AND

(II) MAY BE SUBJECT TO AN ASSESSMENT BY THE STATE; AND

(2) A MANAGED CARE ORGANIZATION AUTHORIZED UNDER TITLE 15, SUBTITLE 1 OF THE HEALTH – GENERAL ARTICLE.



**(B) THE PURPOSE OF THIS SECTION IS TO RECOUP THE AGGREGATE AMOUNT OF THE HEALTH INSURANCE PROVIDER FEE THAT OTHERWISE WOULD HAVE BEEN ASSESSED UNDER § 9010 OF THE AFFORDABLE CARE ACT THAT IS ATTRIBUTABLE TO STATE HEALTH RISK FOR CALENDAR YEAR 2019 AS A BRIDGE TO STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.**

**(C) (1) IN CALENDAR YEAR 2019, IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 2.75% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6-102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR CALENDAR YEAR 2018.**

**(2) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, THE ASSESSMENT REQUIRED UNDER THIS SECTION SHALL BE DISTRIBUTED BY THE COMMISSIONER TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE.**

15-1202.

**(a) This subtitle applies only to a health benefit plan that:**

**(1) covers eligible employees of small employers in the State; and**

**(2) is issued or renewed on or after July 1, 1994, if:**

**(i) any part of the premium or benefits is paid by or on behalf of the small employer;**

**(ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;**

**(iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or**

**(iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.**

**(b) A carrier is subject to the requirements of § 15-1403 of this title in connection with health benefit plans issued under this subtitle.**

**(C) THIS SUBTITLE APPLIES TO ANY HEALTH BENEFIT PLAN OFFERED BY AN ASSOCIATION, A PROFESSIONAL ~~EMPLOYEE~~ EMPLOYER ORGANIZATION, OR ANY**

OTHER ENTITY, INCLUDING A PLAN ISSUED UNDER THE LAWS OF ANOTHER STATE, IF THE HEALTH BENEFIT PLAN COVERS ELIGIBLE EMPLOYEES OF ONE OR MORE SMALL EMPLOYERS AND MEETS THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION.

15-1301.

(s) "Short-term limited duration insurance" [has the meaning stated in 45 C.F.R. § 144.103] MEANS HEALTH INSURANCE COVERAGE PROVIDED UNDER A POLICY OR CONTRACT WITH A CARRIER AND THAT:

(1) HAS A POLICY TERM THAT IS LESS THAN 3 MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE POLICY OR CONTRACT;

(2) MAY NOT BE EXTENDED OR RENEWED;

(3) APPLIES THE SAME UNDERWRITING STANDARDS TO ALL APPLICANTS REGARDLESS OF WHETHER THEY HAVE PREVIOUSLY BEEN COVERED BY SHORT-TERM LIMITED DURATION INSURANCE; AND

(4) CONTAINS THE NOTICE REQUIRED BY FEDERAL LAW PROMINENTLY DISPLAYED IN THE CONTRACT AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION WITH ENROLLMENT.

~~31-107.~~

~~(a) There is a Maryland Health Benefit Exchange Fund.~~

~~(b) (1) The purpose of the Fund is to:~~

~~(i) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title; and~~

~~(ii) provide funding for the establishment and operation of the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(2) The operation and administration of the Exchange and the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM may include functions delegated by the Exchange to a third party under law or by contract.~~

~~(c) The Exchange shall administer the Fund.~~

~~(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7-302 of the State Finance and Procurement Article.~~

~~(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.~~

~~(e) The Fund consists of:~~

~~(1) any user fees or other assessments collected by the Exchange;~~

~~(2) all revenue deposited into the Fund that is received from the distribution of the premium tax under § 6-103.2 of this article;~~

~~(3) all revenue transferred to the Fund before July 1, 2016, from the Maryland Health Insurance Plan Fund;~~

~~(4) ASSESSMENTS COLLECTED BY THE COMMISSIONER UNDER §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(5) ASSESSMENTS REMITTED IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(6) PENALTIES COLLECTED BY THE COMPTROLLER UNDER § 10-102.2 OF THE TAX GENERAL ARTICLE;~~

~~[(4)] (7) income from investments made on behalf of the Fund;~~

~~[(5)] (8) interest on deposits or investments of money in the Fund;~~

~~[(6)] (9) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;~~

~~[(7)] (10) money donated to the Fund;~~

~~[(8)] (11) money awarded to the Fund through grants; and~~

~~[(9)] (12) any other money from any other source accepted for the benefit of the Fund.~~

~~(f) The Fund may be used only:~~

~~(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title; and~~

~~(2) for the establishment and operation of the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM authorized under § 31-117 of this title.~~

~~(g) (1) The Board shall maintain separate accounts within the Fund for Exchange operations and for the [State Reinsurance Program] HEALTH CARE ACCESS PROGRAM.~~

~~(2) Accounts within the Fund shall contain the money that is intended to support the purpose for which each account is designated.~~

~~(3) Funds received from the distribution of the premium tax under § 6-103.2 of this article shall be placed in the account for Exchange operations and may be used only for the purpose of funding the operation and administration of the Exchange.~~

~~[(4) Funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, shall be placed in the account for the State Reinsurance Program and may be used only for the purpose of funding the State Reinsurance Program.]~~

~~(4) THE FOLLOWING FUNDS MAY BE USED ONLY FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM:~~

~~(I) ASSESSMENTS DISTRIBUTED TO THE FUND IN ACCORDANCE WITH §§ 6-102.1 AND 6-102.2 OF THIS ARTICLE;~~

~~(II) ASSESSMENTS REMITTED TO THE FUND IN ACCORDANCE WITH § 19-214 OF THE HEALTH GENERAL ARTICLE;~~

~~(III) PENALTIES DISTRIBUTED TO THE FUND IN ACCORDANCE WITH § 10-102.2 OF THE TAX GENERAL ARTICLE; AND~~

~~(IV) ANY FUNDS THAT THE STATE RECEIVES FROM THE FEDERAL GOVERNMENT UNDER ANY FEDERALLY SPONSORED OR DEVELOPED PROGRAM TO PROMOTE OR ENHANCE STABILITY IN THE INDIVIDUAL HEALTH INSURANCE MARKET.~~

~~(h) (1) Expenditures from the Fund for the purposes authorized by this subtitle may be made only:~~

~~(i) with an appropriation from the Fund approved by the General Assembly in the State budget; or~~

~~(ii) by the budget amendment procedure provided for in Title 7, Subtitle 2 of the State Finance and Procurement Article.~~

~~(2) Notwithstanding § 7-304 of the State Finance and Procurement Article, if the amount of the distribution from the premium tax under § 6-103.2 of this article exceeds in any State fiscal year the actual expenditures incurred for the operation and administration of the Exchange, funds in the Exchange operations account from the~~

~~premium tax that remain unspent at the end of the State fiscal year shall revert to the General Fund of the State.~~

~~(3) If operating expenses of the Exchange may be charged to either State or non-State fund sources, the non-State funds shall be charged before State funds are charged.~~

~~(i) (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.~~

~~(2) Any investment earnings of the Fund shall be credited to the Fund.~~

~~(3) Except as provided in subsection (h)(2) of this section, no part of the Fund may revert or be credited to the General Fund or any special fund of the State.~~

~~(j) A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.~~

~~[31-117.~~

~~(a) The Exchange, with the approval of the Commissioner, shall implement or oversee the implementation of the state-specific requirements of §§ 1341 and 1343 of the Affordable Care Act relating to transitional reinsurance and risk adjustment.~~

~~(b) The Exchange may not assume responsibility for the program corridors for health benefit plans in the Individual Exchange and the SHOP Exchange established under § 1342 of the Affordable Care Act.~~

~~(c) (1) In compliance with § 1341 of the Affordable Care Act, the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, shall operate or oversee the operation of a transitional reinsurance program in accordance with regulations adopted by the Secretary for coverage years 2014 through 2016.~~

~~(2) As required by the Affordable Care Act and regulations adopted by the Secretary, the transitional reinsurance program shall be designed to protect carriers that offer individual health benefit plans inside and outside the Exchange against excessive health care expenses incurred by high-risk individuals.~~

~~(3) (i) The Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, may establish a State Reinsurance Program to take effect on or after January 1, 2014.~~

~~(ii) The purpose of the State Reinsurance Program is to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the Exchange.~~

~~(iii) The Exchange shall use funds transferred from the Maryland Health Insurance Plan Fund before July 1, 2016, to fund the State Reinsurance Program.~~

~~(d) (1) In compliance with § 1343 of the Affordable Care Act, the Exchange, with the approval of the Commissioner, shall operate or oversee the operation of a risk adjustment program designed to:~~

~~(i) reduce the incentive for carriers to manage their risk by seeking to enroll individuals with a lower than average health risk;~~

~~(ii) increase the incentive for carriers to enhance the quality and cost-effectiveness of their enrollees' health care services; and~~

~~(iii) require appropriate adjustments among all health benefit plans in the individual and small group markets inside and outside the Exchange to compensate for the enrollment of high-risk individuals.~~

~~(2) Beginning in 2014, the Exchange, with the approval of the Commissioner, shall strongly consider using the federal model adopted by the Secretary in the operation of the State's risk adjustment program.]~~

~~31-117.~~

~~(A) THE EXCHANGE SHALL ESTABLISH A HEALTH CARE ACCESS PROGRAM TO PROVIDE REINSURANCE TO CARRIERS THAT OFFER INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE.~~

~~(B) THE HEALTH CARE ACCESS PROGRAM SHALL BE DESIGNED TO MITIGATE THE IMPACT OF HIGH-RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.~~

~~(C) BEGINNING JANUARY 1, 2020, FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM MAY BE MADE FROM:~~

~~(1) ANY AVAILABLE STATE FUNDING SOURCE; AND~~

~~(2) ANY AVAILABLE FEDERAL FUNDING SOURCE.~~

~~(D) BEGINNING JANUARY 1, 2020, IF REQUIRED UNDER THE TERMS AND CONDITIONS OF RECEIVING FEDERAL FUNDS, STATE FUNDING FOR REINSURANCE IN THE INDIVIDUAL MARKET THROUGH THE HEALTH CARE ACCESS PROGRAM SHALL BE CONTINGENT ON THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVING A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~(E) THE EXCHANGE SHALL ADOPT REGULATIONS IMPLEMENTING THE PROVISIONS OF THIS SECTION.~~

~~31-117.1.~~

~~(A) THE EXCHANGE AND THE COMMISSIONER MAY SUBMIT A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT IN ACCORDANCE WITH THE RECOMMENDATIONS OF THE MARYLAND HEALTH INSURANCE COVERAGE PROTECTION COMMISSION ESTABLISHED UNDER CHAPTER 17 OF THE ACTS OF THE GENERAL ASSEMBLY OF 2017.~~

~~(B) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSIONER MAY WAIVE ANY NOTIFICATION OR OTHER REQUIREMENTS THAT APPLY TO A CARRIER UNDER THIS ARTICLE IN CALENDAR YEAR 2019 DUE TO THE IMPLEMENTATION OF A WAIVER APPROVED UNDER § 1332 OF THE AFFORDABLE CARE ACT.~~

~~Article Tax General~~

~~10-102.2.~~

~~(A) THIS SECTION DOES NOT APPLY TO A NONRESIDENT, INCLUDING A NONRESIDENT SPOUSE AND A NONRESIDENT DEPENDENT.~~

~~(B) BEGINNING JANUARY 1, 2019, AN INDIVIDUAL SHALL MAINTAIN FOR THE INDIVIDUAL, AND FOR EACH DEPENDENT OF THE INDIVIDUAL, MINIMUM ESSENTIAL COVERAGE, AS DEFINED IN § 15-1301 OF THE INSURANCE ARTICLE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION AND EXCEPT AS PROVIDED UNDER SUBSECTION (E) OF THIS SECTION, AN INDIVIDUAL SHALL PAY A PENALTY IN THE AMOUNT DETERMINED UNDER SUBSECTION (D) OF THIS SECTION IF THE INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR 3 OR MORE MONTHS OF THE TAXABLE YEAR.~~

~~(2) ANY PENALTY IMPOSED UNDER THIS SUBSECTION FOR ANY MONTH IN WHICH AN INDIVIDUAL FAILS TO MAINTAIN THE COVERAGE REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL BE:~~

~~(i) IN ADDITION TO THE STATE INCOME TAX UNDER § 10-105(A) OF THIS SUBTITLE; AND~~

~~(ii) INCLUDED WITH THE STATE INCOME TAX RETURN FOR THE INDIVIDUAL UNDER SUBTITLE 8 OF THIS TITLE FOR THE TAXABLE YEAR THAT~~

~~INCLUDES THE MONTHS IN WHICH COVERAGE WAS NOT MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION.~~

~~(3) IF AN INDIVIDUAL WHO IS SUBJECT TO A PENALTY UNDER THIS SECTION FILES A JOINT STATE INCOME TAX RETURN UNDER § 10-807 OF THIS TITLE, THE INDIVIDUAL AND THE INDIVIDUAL'S SPOUSE SHALL BE JOINTLY LIABLE FOR THE PENALTY.~~

~~(D) THE AMOUNT OF THE PENALTY IMPOSED UNDER SUBSECTION (C) OF THIS SECTION SHALL BE EQUAL TO THE GREATER OF:~~

~~(1) 2.5% OF THE SUM OF THE INDIVIDUAL'S FEDERAL MODIFIED ADJUSTED GROSS INCOME, AS DEFINED IN 42 U.S.C. § 1395R, AND THE FEDERAL MODIFIED ADJUSTED GROSS INCOME OF ALL INDIVIDUALS CLAIMED ON THE INDIVIDUAL'S INCOME TAX RETURN; OR~~

~~(2) THE FOLLOWING FLAT RATES PER INDIVIDUAL, ADJUSTED ANNUALLY FOR INFLATION:~~

~~(I) \$695 PER ADULT; AND~~

~~(II) \$347.50 PER CHILD UNDER 18 YEARS OLD.~~

~~(E) AN INDIVIDUAL MAY NOT BE ASSESSED A PENALTY UNDER SUBSECTION (C) OF THIS SECTION IF THE INDIVIDUAL QUALIFIES FOR AN EXEMPTION UNDER 26 U.S.C. § 5000A(E).~~

~~(F) AN INDIVIDUAL SHALL INDICATE ON THE INCOME TAX RETURN FOR THE INDIVIDUAL, IN THE FORM REQUIRED BY THE COMPTROLLER, WHETHER MINIMUM ESSENTIAL COVERAGE WAS MAINTAINED AS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION FOR:~~

~~(1) THE INDIVIDUAL;~~

~~(2) THE INDIVIDUAL'S SPOUSE IN THE CASE OF A MARRIED COUPLE;~~

~~AND~~

~~(3) EACH DEPENDENT CHILD OF THE INDIVIDUAL, IF ANY.~~

~~(G) NOTWITHSTANDING § 2-609 OF THIS ARTICLE, AFTER DEDUCTING A REASONABLE AMOUNT FOR ADMINISTRATIVE COSTS, THE COMPTROLLER SHALL DISTRIBUTE THE REVENUES FROM THE PENALTY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSES OF THE HEALTH CARE ACCESS PROGRAM ESTABLISHED UNDER § 31-117 OF THE INSURANCE ARTICLE.~~



~~SECTION 2. AND BE IT FURTHER ENACTED, That:~~

~~(a) (1) The Maryland Health Insurance Coverage Protection Commission, established under Chapter 17 of the Acts of the General Assembly of 2017, shall study and make recommendations for individual and group health insurance market stability, including:~~

~~(i) the components of a waiver under § 1332 of the Affordable Care Act to ensure market stability;~~

~~(ii) whether to pursue a standard plan design that limits cost sharing;~~

~~(iii) whether to merge the individual and small group health insurance markets in the State for rating purposes;~~

~~(iv) whether to pursue a Basic Health Program; and~~

~~(v) whether to pursue a Medicaid buy-in program for the individual market.~~

~~(2) The Maryland Health Insurance Coverage Protection Commission shall engage an independent actuarial firm to assist in its study under this subsection.~~

~~(b) On or before October 1, 2018, the Maryland Health Insurance Coverage Protection Commission shall issue a report on its findings and recommendations, including any legislative proposals, under subsection (a) of this section to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.~~

~~SECTION 3. AND BE IT FURTHER ENACTED, That the Maryland Health Benefit Exchange shall adopt the regulations required under § 31-117 of the Insurance Article, as enacted by Section 1 of this Act, on or before January 1, 2019.~~

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Chapter 17 of the Acts of 2017**

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

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

(c) The Commission consists of the following members:

(6) the following members:

(viii) one representative of behavioral health providers, appointed jointly by the President of the Senate and the Speaker of the House; [and]

(ix) two members of the public:

1. one of whom shall be appointed jointly by the President of the Senate and the Speaker of the House; and

2. one of whom shall be appointed by the Governor; AND

(X) ONE REPRESENTATIVE OF A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION THAT PARTICIPATES IN THE INDIVIDUAL MARKET, APPOINTED BY THE GOVERNOR; AND

~~(XI) ONE REPRESENTATIVE OF THE LEAGUE OF LIFE AND HEALTH INSURERS OF MARYLAND, TO BE APPOINTED JOINTLY BY THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE.~~

(g) (1) The Commission shall:

(i) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, and the Maryland All–Payer Model;

(ii) assess the impact of potential and actual federal changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, and the Maryland All–Payer Model; and

(iii) provide recommendations for State and local action to protect access of residents of the State to affordable health coverage.

(2) The duties of the Commission under paragraph (1) of this subsection shall include a study that includes:

(i) an assessment of the current and potential adverse effects of the loss of health coverage on the residents, public health, and economy of the State resulting from changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model;

(ii) an estimate of the costs to the State and State residents of adverse effects from changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model and the resulting loss of health coverage;

(iii) an examination of measures that may prevent or mitigate the adverse effects of changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model and the resulting loss of health coverage on the residents, public health, and economy of the State; and

(iv) recommendations for laws that:

1. may be warranted to minimize the adverse effects associated with changes to the ACA, Medicaid, the Maryland Children’s Health Program, Medicare, or the Maryland All–Payer Model; and

2. will assist residents in obtaining and maintaining affordable health coverage.

**(H) (1) THE COMMISSION SHALL STUDY AND MAKE RECOMMENDATIONS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE MARKET STABILITY, INCLUDING:**

**(I) THE COMPONENTS OF ONE OR MORE WAIVERS UNDER § 1332 OF THE AFFORDABLE CARE ACT TO ENSURE MARKET STABILITY THAT MAY BE SUBMITTED BY THE STATE;**

**(II) WHETHER TO PURSUE A STANDARD PLAN DESIGN THAT LIMITS COST SHARING;**

**(III) WHETHER TO MERGE THE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS IN THE STATE FOR RATING PURPOSES;**

**(IV) WHETHER TO PURSUE A BASIC HEALTH PROGRAM;**

**(V) WHETHER TO PURSUE A MEDICAID BUY–IN PROGRAM FOR THE INDIVIDUAL MARKET;**

**(VI) WHETHER TO PROVIDE SUBSIDIES THAT SUPPLEMENT PREMIUM TAX CREDITS OR COST–SHARING REDUCTIONS DESCRIBED IN § 1402(C) OF THE AFFORDABLE CARE ACT; AND**

**(VII) WHETHER TO ADOPT A STATE–BASED INDIVIDUAL HEALTH INSURANCE MANDATE AND HOW TO USE PAYMENTS COLLECTED FROM INDIVIDUALS WHO DO NOT MAINTAIN MINIMUM ESSENTIAL COVERAGE, INCLUDING USE OF THE PAYMENTS TO ASSIST INDIVIDUALS IN PURCHASING HEALTH INSURANCE.**

**(2) THE COMMISSION SHALL ENGAGE AN INDEPENDENT ACTUARIAL FIRM TO ASSIST IN ITS STUDY UNDER THIS SUBSECTION.**

**(3) THE COMMISSION SHALL INCLUDE ITS FINDINGS AND RECOMMENDATIONS FROM THE STUDY REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (J) OF THIS SECTION.**

**[(h)] (I)** The Commission may:

(1) hold public meetings across the State to carry out the duties of the Commission; and

(2) convene workgroups to solicit input from stakeholders.

**[(i)] (J)** On or before December 31 each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION ~~4~~ 3. 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.

**Approved by the Governor, April 10, 2018.**



# Appendix 3

LAWRENCE J. HOGAN, JR., Governor

Ch. 417

Chapter 417

(Senate Bill 868)

AN ACT concerning

## **Health Insurance – Consumer Protections and Maryland Health Insurance Coverage Protection Commission**

FOR the purpose of ~~making a certain finding and declaration of the General Assembly; repealing certain provisions of law applying certain provisions of the federal Affordable Care Act to certain health insurance coverage issued or delivered in the State by certain insurers, nonprofit health service plans, or health maintenance organizations; prohibiting certain carriers from excluding or limiting certain benefits or denying coverage under certain circumstances; prohibiting certain carriers from establishing certain rules for eligibility based on health status factors; authorizing certain carriers offering an individual plan to determine a premium rate based on certain factors; prohibiting certain premium rates from varying by more than a certain ratio; requiring certain carriers to provide coverage to certain children until the child is a certain age; prohibiting certain carriers from rescinding a certain health benefit plan once the insured individual is covered under the plan; prohibiting certain carriers from establishing lifetime and annual limits on the dollar value of benefits for any insured individual; prohibiting carriers of a group plan from applying a certain waiting period for eligibility for coverage; requiring certain carriers to allow certain individuals to designate a certain provider as a primary care provider under certain circumstances; requiring a carrier to treat the provision and ordering of certain obstetrical and gynecological care by a certain provider as the authorization of a primary care provider; prohibiting certain carriers from requiring certain authorization or referrals of certain care or services; requiring certain health care providers to comply with certain policies and procedures of a carrier; requiring certain carriers to provide certain coverage for emergency services in a certain manner under certain circumstances; requiring the Maryland Insurance Commissioner to adopt regulations to develop certain standards for use by certain carriers to compile and provide to consumers a certain summary of benefits and coverage explanations; requiring certain carriers to provide a certain summary of benefits and coverage explanation to certain applicants and insured individuals at certain times; authorizing certain carriers to provide a certain summary of benefits and coverage explanation in certain forms; requiring certain carriers to provide certain notification of certain modifications under certain circumstances; establishing a certain penalty; requiring certain carriers to submit a certain report to the Commissioner in certain years; requiring certain carriers to provide a certain rebate to each insured individual based on certain ratios in certain years; requiring the Commissioner to take certain action regarding premiums; requiring a carrier to disclose certain information to insured individuals in a certain manner; requiring certain carriers that offer certain plans to offer certain plans to individuals under a certain age; authorizing certain carriers to offer a certain catastrophic plan under certain circumstances; requiring the Commissioner to adopt regulations to establish~~

~~certain limitations on cost sharing for certain health benefit plans and for prescription drug benefit requirements for certain health benefit plans; making conforming changes; requiring the Maryland Health Insurance Coverage Protection Commission to establish a certain workgroup; requiring that the workgroup include certain members; specifying the duties of the workgroup; requiring the Commission to report to the General Assembly on or before a certain date; altering the date on which the Commission is required to submit a certain report; extending the termination date for the Maryland Health Insurance Coverage Protection Commission; providing for the application and construction of certain provisions of this Act; stating the intent of the General Assembly; defining certain terms; and generally relating to consumer protections for health insurance and the Maryland Health Insurance Coverage Protection Commission.~~

BY repealing and reenacting, with amendments,  
 Article – Insurance  
 Section 15–137.1  
 Annotated Code of Maryland  
 (2017 Replacement Volume and 2018 Supplement)

~~BY adding to  
 Article – Insurance  
 Section 15–1A–01 through 15–1A–17 to be under the new subtitle “Subtitle 1A–  
 Consumer Protections”  
 Annotated Code of Maryland  
 (2017 Replacement Volume and 2018 Supplement)~~

~~BY repealing and reenacting, with amendments,  
 Article – Insurance  
 Section 15–1205(a) and (g) and 15–1406  
 Annotated Code of Maryland  
 (2017 Replacement Volume and 2018 Supplement)~~

BY repealing and reenacting, without amendments,  
 Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37  
 and 38 of the Acts of the General Assembly of 2018  
 Section 1(b)

BY repealing and reenacting, with amendments,  
 Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37  
 and 38 of the Acts of the General Assembly of 2018  
 Section 1(h)(3), (i), and (j) and 2

BY adding to  
 Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37  
 and 38 of the Acts of the General Assembly of 2018  
 Section 1(i)

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.**

~~(A)~~ **(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.

~~(b)~~ **(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.

~~(c)~~ **(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) "GROUP PLAN" MEANS A SMALL GROUP PLAN OR A LARGE GROUP PLAN.~~

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

~~(E) "INDIVIDUAL PLAN" MEANS A HEALTH BENEFIT PLAN AS DEFINED IN § 15-1301 OF THIS TITLE.~~

~~(F) "INSURED INDIVIDUAL" MEANS AN INSURED, AN ENROLLEE, A SUBSCRIBER, A POLICY HOLDER, A PARTICIPANT, OR A BENEFICIARY.~~

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

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

~~15-1A-02.~~

~~EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, THIS SUBTITLE APPLIES ONLY TO CARRIERS THAT OFFER HEALTH BENEFIT PLANS IN THE STATE WITHIN THE SCOPE OF:~~

~~(1) SUBTITLE 12 OF THIS TITLE;~~

~~(2) SUBTITLE 13 OF THIS TITLE; OR~~

~~(3) SUBTITLE 14 OF THIS TITLE.~~

~~15-1A-03.~~

~~(A) A CARRIER MAY NOT:~~

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

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

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

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

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

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

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

~~15-1A-04.~~

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

~~(1) HEALTH CONDITION;~~

~~(2) CLAIMS EXPERIENCE;~~

~~(3) RECEIPT OF HEALTH CARE;~~

~~(4) MEDICAL HISTORY;~~

~~(5) GENETIC INFORMATION;~~

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

~~(7) DISABILITY.~~

~~15-1A-05.~~

~~(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, A CARRIER OFFERING AN INDIVIDUAL PLAN MAY DETERMINE A PREMIUM RATE BASED ON:~~

~~(1) AGE;~~

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

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

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

~~(III) WESTERN MARYLAND; AND~~

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

~~(3) WHETHER THE PLAN COVERS AN INDIVIDUAL OR FAMILY; AND~~

~~(4) TOBACCO USE.~~

~~(B) (1) A PREMIUM RATE BASED ON AGE MAY NOT VARY BY A RATIO OF MORE THAN 3 TO 1 FOR ADULTS.~~

~~(2) A PREMIUM RATE BASED ON TOBACCO USE MAY NOT VARY BY A RATIO OF MORE THAN 1.5 TO 1.~~

~~15-1A-06.~~

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

~~(B) THIS SECTION MAY NOT BE CONSTRUED TO REQUIRE A CARRIER TO ISSUE A HEALTH BENEFIT PLAN TO A CHILD OF A CHILD RECEIVING DEPENDENT COVERAGE.~~

~~15-1A-07.~~

~~(A) (1) IN THIS SECTION, "RESCIND" MEANS TO CANCEL OR DISCONTINUE COVERAGE UNDER A HEALTH BENEFIT PLAN WITH RETROACTIVE EFFECT.~~

~~(2) "RESCIND" DOES NOT INCLUDE:~~

~~(i) THE CANCELLATION OR DISCONTINUATION OF A HEALTH BENEFIT PLAN IF THE CANCELLATION OR DISCONTINUATION OF THE HEALTH BENEFIT PLAN:~~

~~1. HAS ONLY A PROSPECTIVE EFFECT; OR~~

~~2. IS EFFECTIVE RETROACTIVELY TO THE EXTENT THE RETROACTIVE EFFECT IS ATTRIBUTABLE TO A FAILURE OF TIMELY PAYMENT OF REQUIRED PREMIUMS OR CONTRIBUTIONS TOWARDS THE COST OF COVERAGE; OR~~

~~(H) THE CANCELLATION OR DISCONTINUATION OF A HEALTH BENEFIT PLAN THAT COVERS ACTIVE EMPLOYEES AND, IF APPLICABLE, DEPENDENTS AND THOSE COVERED UNDER CONTINUATION COVERAGE PROVISIONS, IF:~~

~~1. THE EMPLOYEE DOES NOT PAY A PREMIUM FOR COVERAGE AFTER TERMINATION OF EMPLOYMENT; AND~~

~~2. THE CANCELLATION OR DISCONTINUATION OF THE HEALTH BENEFIT PLAN IS EFFECTIVE RETROACTIVELY BACK TO THE DATE OF TERMINATION OF EMPLOYMENT DUE TO A DELAY IN ADMINISTRATIVE RECORD KEEPING.~~

~~(B) THIS SECTION DOES NOT APPLY TO AN INSURED INDIVIDUAL WHO:~~

~~(1) HAS PERFORMED AN ACT THAT CONSTITUTES FRAUD OR MAKES AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT AS PROHIBITED BY THE TERMS OF THE HEALTH BENEFIT PLAN; OR~~

~~(2) HAS RECEIVED PRIOR NOTICE OF A DECISION TO RESCIND A HEALTH BENEFIT.~~

~~(C) A CARRIER MAY NOT RESCIND A HEALTH BENEFIT PLAN WITH RESPECT TO AN INSURED INDIVIDUAL ONCE THE INSURED INDIVIDUAL IS COVERED UNDER THE PLAN.~~

~~15-1A-08.~~

~~(A) A CARRIER MAY NOT ESTABLISH LIFETIME LIMITS OR ANNUAL LIMITS ON THE DOLLAR VALUE OF BENEFITS FOR ANY INSURED INDIVIDUAL.~~

~~(B) TO THE EXTENT THAT LIMITS ARE OTHERWISE AUTHORIZED UNDER FEDERAL OR STATE LAW, THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT A CARRIER FROM PLACING ANNUAL OR LIFETIME PER-BENEFICIARY LIMITS ON SPECIFIC COVERED BENEFITS THAT ARE NOT ESSENTIAL HEALTH BENEFITS IN THE STATE BENCHMARK PLAN SELECTED IN ACCORDANCE WITH § 31-116 OF THIS ARTICLE.~~

~~15-1A-09.~~

~~A CARRIER OFFERING A GROUP PLAN MAY NOT APPLY A WAITING PERIOD OF MORE THAN 90 DAYS THAT MUST PASS BEFORE AN INDIVIDUAL IS ELIGIBLE TO BE COVERED FOR BENEFITS UNDER THE TERMS OF THE GROUP PLAN.~~

~~15-1A-10.~~

~~(A) IF A CARRIER REQUIRES OR PROVIDES FOR THE DESIGNATION OF A PARTICIPATING PRIMARY CARE PROVIDER FOR AN INSURED INDIVIDUAL, THE CARRIER SHALL ALLOW EACH INSURED INDIVIDUAL TO DESIGNATE ANY PARTICIPATING PRIMARY CARE PROVIDER IF THE PROVIDER IS AVAILABLE TO ACCEPT THE INSURED INDIVIDUAL.~~

~~(B) (1) (i) THIS SUBSECTION APPLIES ONLY TO AN INDIVIDUAL WHO HAS A CHILD WHO IS AN INSURED INDIVIDUAL UNDER A HEALTH BENEFIT PLAN.~~

~~(H) 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.~~

~~(H) THIS SUBSECTION MAY NOT BE CONSTRUED TO:~~

- ~~1. WAIVE ANY EXCLUSIONS OF COVERAGE UNDER THE TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN WITH RESPECT TO COVERAGE OF OBSTETRICAL OR GYNECOLOGICAL CARE; OR~~
- ~~2. PROHIBIT A CARRIER FROM REQUIRING THAT THE OBSTETRICAL OR GYNECOLOGICAL PROVIDER NOTIFY THE PRIMARY CARE PROVIDER OR CARRIER FOR AN INSURED INDIVIDUAL WHO IS FEMALE OF TREATMENT DECISIONS.~~

~~(2) A CARRIER SHALL TREAT THE PROVISION OF OBSTETRICAL AND GYNECOLOGICAL CARE AND THE ORDERING OF RELATED OBSTETRICAL AND GYNECOLOGICAL ITEMS AND SERVICES BY A PARTICIPATING HEALTH CARE~~

~~PROVIDER WHO SPECIALIZES IN OBSTETRICS OR GYNECOLOGY AS THE AUTHORIZATION OF THE PRIMARY CARE PROVIDER.~~

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

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

~~15-1A-11.~~

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

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

- ~~(I) PLACING THE PATIENT'S HEALTH IN SERIOUS JEOPARDY;~~
- ~~(II) SERIOUS IMPAIRMENT TO BODILY FUNCTIONS; OR~~
- ~~(III) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART.~~

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

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

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

~~(B) IF A CARRIER COVERS ANY BENEFITS FOR EMERGENCY SERVICES TO TREAT EMERGENCY MEDICAL CONDITIONS IN AN EMERGENCY DEPARTMENT OF A HOSPITAL, THE CARRIER:~~

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

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

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

~~(1) MAY NOT IMPOSE ANY LIMITATION ON COVERAGE THAT WOULD BE MORE RESTRICTIVE THAN LIMITATIONS IMPOSED ON COVERAGE FOR EMERGENCY SERVICES FURNISHED BY A PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER; AND~~

~~(2) SHALL REQUIRE THE SAME COST SHARING AMOUNTS OR RATES AS WOULD APPLY IF THE EMERGENCY SERVICES WERE FURNISHED BY A PROVIDER WITH A CONTRACTUAL RELATIONSHIP WITH THE CARRIER.~~

~~15-1A-12.~~

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

~~(2) "INSURANCE RELATED TERMS" MEANS:~~

~~(I) PREMIUM;~~

~~(II) DEDUCTIBLE;~~

~~(III) CO-INSURANCE;~~

~~(IV) CO-PAYMENT;~~

~~(V) OUT-OF-POCKET LIMIT;~~

~~(VI) PREFERRED PROVIDER;~~



~~(VII) NONPREFERRED PROVIDER;~~

~~(VIII) OUT-OF-NETWORK CO-PAYMENTS;~~

~~(IX) USUAL, CUSTOMARY, AND REASONABLE FEES;~~

~~(X) EXCLUDED SERVICES;~~

~~(XI) GRIEVANCE AND APPEALS; AND~~

~~(XII) ANY OTHER TERM THE COMMISSIONER DETERMINES IS IMPORTANT TO DEFINE SO THAT A CONSUMER MAY COMPARE HEALTH BENEFIT PLANS AND UNDERSTAND THE TERMS OF THE CONSUMER'S COVERAGE.~~

~~(3) "MEDICAL TERMS" MEANS:~~

~~(I) HOSPITALIZATION;~~

~~(II) HOSPITAL OUTPATIENT CARE;~~

~~(III) EMERGENCY ROOM CARE;~~

~~(IV) PHYSICIAN SERVICES;~~

~~(V) PRESCRIPTION DRUG COVERAGE;~~

~~(VI) DURABLE MEDICAL EQUIPMENT;~~

~~(VII) HOME HEALTH CARE;~~

~~(VIII) SKILLED NURSING CARE;~~

~~(IX) REHABILITATION SERVICES;~~

~~(X) HOSPICE SERVICES;~~

~~(XI) EMERGENCY MEDICAL TRANSPORTATION; AND~~

~~(XII) ANY OTHER TERMS THE COMMISSIONER DETERMINES ARE IMPORTANT TO DEFINE SO THAT A CONSUMER MAY COMPARE THE MEDICAL BENEFITS OFFERED BY HEALTH BENEFIT PLANS AND UNDERSTAND THE EXTENT OF AND EXCEPTIONS TO THOSE MEDICAL BENEFITS.~~

~~(B) (1) THE COMMISSIONER SHALL ADOPT REGULATIONS TO DEVELOP STANDARDS FOR USE BY A CARRIER TO COMPILE AND PROVIDE TO CONSUMERS A SUMMARY OF BENEFITS AND COVERAGE EXPLANATION THAT ACCURATELY DESCRIBES THE BENEFITS AND COVERAGE UNDER THE APPLICABLE HEALTH BENEFIT PLAN.~~

~~(2) IN DEVELOPING THE STANDARDS UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COMMISSIONER SHALL CONSULT WITH THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.~~

~~(C) THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION SHALL ENSURE THAT THE SUMMARY OF BENEFITS AND COVERAGE:~~

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

~~(2) IS PRESENTED IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE MANNER AND USES TERMINOLOGY UNDERSTANDABLE BY THE AVERAGE INSURED INDIVIDUAL.~~

~~(D) THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION SHALL INCLUDE:~~

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

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

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

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

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

~~(4) THE RENEWABILITY AND CONTINUATION OF COVERAGE PROVISIONS;~~

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

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

~~(7) A STATEMENT THAT:~~

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

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

~~(8) A CONTACT NUMBER FOR THE CONSUMER TO CALL WITH ADDITIONAL QUESTIONS AND A WEBSITE WHERE A COPY OF THE ACTUAL HEALTH BENEFIT PLAN CAN BE REVIEWED AND OBTAINED.~~

~~(E) AS APPROPRIATE, THE COMMISSIONER SHALL PERIODICALLY REVIEW AND UPDATE THE STANDARDS DEVELOPED UNDER SUBSECTION (B)(1) OF THIS SECTION.~~

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

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

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

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

~~(G) EXCEPT AS OTHERWISE PROVIDED IN THIS ARTICLE, IF A CARRIER MAKES ANY MATERIAL MODIFICATION IN ANY OF THE TERMS OF THE PLAN OR COVERAGE INVOLVED THAT IS NOT REFLECTED IN THE MOST RECENTLY PROVIDED SUMMARY OF BENEFITS AND COVERAGE EXPLANATION, THE CARRIER SHALL~~

~~PROVIDE NOTICE OF THE MODIFICATION TO INSURED INDIVIDUALS NO LATER THAN 60 DAYS BEFORE THE EFFECTIVE DATE OF THE MODIFICATION.~~

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

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

~~15-1A-13.~~

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

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

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

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

~~2. ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY;~~  
~~AND~~

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

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

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

~~(2) THE REPORT SHALL:~~

~~(I) SPECIFY THE AMOUNT SPENT ON:~~

~~1. TOTAL REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES;~~

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

~~3. ALL OTHER NONCLAIMS COSTS; AND~~

~~(H) INCLUDE AN EXPLANATION OF THE NATURE OF THE COSTS SPECIFIED UNDER ITEM (I) OF THIS PARAGRAPH.~~

~~(3) THE COMMISSIONER SHALL MAKE REPORTS RECEIVED UNDER THIS SUBSECTION AVAILABLE TO THE PUBLIC ON THE ADMINISTRATION'S WEBSITE.~~

~~(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, FOR EACH HEALTH BENEFIT PLAN YEAR, A CARRIER SHALL PROVIDE AN ANNUAL REBATE TO EACH INSURED INDIVIDUAL UNDER THE HEALTH BENEFIT PLAN ON A PRO RATA BASIS, IF THE AVERAGE OF THE RATIOS REPORTED IN EACH OF THE IMMEDIATELY PRECEDING 3 YEARS IS LESS THAN:~~

~~(I) WITH RESPECT TO A LARGE GROUP PLAN, 85% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS; OR~~

~~(II) WITH RESPECT TO A SMALL GROUP PLAN OR AN INDIVIDUAL HEALTH BENEFIT PLAN, 80% OR A HIGHER PERCENTAGE AS DETERMINED BY THE COMMISSIONER IN REGULATIONS.~~

~~(2) IF THE COMMISSIONER DETERMINES THAT THE APPLICATION OF THE RATIOS ESTABLISHED IN PARAGRAPH (1) OF THIS SUBSECTION MAY DESTABILIZE A MARKET FOR HEALTH BENEFIT PLANS, THE COMMISSIONER MAY DETERMINE A LOWER PERCENTAGE.~~

~~(3) THE TOTAL AMOUNT OF AN ANNUAL REBATE REQUIRED UNDER THIS SUBSECTION SHALL BE IN AN AMOUNT EQUAL TO THE AMOUNT OF THE RATIO DETERMINED UNDER SUBSECTION (A) OF THIS SECTION IF THE RATIO EXCEEDS THE PERCENTAGES ESTABLISHED IN ACCORDANCE WITH PARAGRAPHS (1) AND (2) OF THIS SUBSECTION.~~

~~(4) IN DETERMINING THE PERCENTAGES UNDER PARAGRAPHS (1) AND (2) OF THIS SUBSECTION, THE COMMISSIONER SHALL SEEK TO ENSURE ADEQUATE PARTICIPATION BY CARRIERS, COMPETITION IN THE HEALTH INSURANCE MARKETS IN THE STATE, AND VALUE FOR CONSUMERS SO THAT PREMIUMS ARE USED FOR CLINICAL SERVICES AND QUALITY IMPROVEMENTS.~~

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

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

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

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

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

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

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

~~15-1A-15.~~

~~EACH CARRIER THAT OFFERS A HEALTH BENEFIT PLAN SHALL OFFER AN IDENTICAL HEALTH BENEFIT PLAN IN WHICH THE ONLY INSURED INDIVIDUALS ARE INDIVIDUALS UNDER THE AGE OF 21 YEARS, AS OF THE BEGINNING OF A HEALTH BENEFIT PLAN YEAR.~~

~~15-1A-16.~~

~~A CARRIER MAY OFFER A CATASTROPHIC PLAN IN THE INDIVIDUAL MARKET IF:~~

~~(1) THE PLAN IS ONLY OFFERED TO INDIVIDUALS WHO:~~

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

~~(II) HOLD CERTIFICATION FOR A HARDSHIP EXEMPTION OR AFFORDABILITY EXEMPTION AS DETERMINED IN REGULATION BY THE COMMISSIONER; AND~~

~~(2) THE PLAN COVERS:~~

- ~~(I) AMBULATORY PATIENT SERVICES;~~
- ~~(II) EMERGENCY SERVICES;~~
- ~~(III) HOSPITALIZATION;~~
- ~~(IV) MATERNITY AND NEWBORN CARE;~~
- ~~(V) BEHAVIORAL HEALTH SERVICES;~~
- ~~(VI) PRESCRIPTION DRUGS;~~
- ~~(VII) REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES;~~
- ~~(VIII) LABORATORY SERVICES;~~
- ~~(IX) PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT;~~
- ~~(X) PEDIATRIC SERVICES, INCLUDING ORAL AND VISON CARE;~~
- ~~(XI) AT LEAST THREE PRIMARY CARE VISITS PER PLAN YEAR.~~

AND

~~15-1A-17.~~

~~THE COMMISSIONER SHALL ADOPT REGULATIONS:~~

- ~~(1) TO ESTABLISH ANNUAL LIMITATIONS ON COST SHARING FOR HEALTH BENEFIT PLANS; AND~~
- ~~(2) FOR PRESCRIPTION DRUG BENEFIT REQUIREMENTS FOR HEALTH BENEFIT PLANS.~~

~~15-1205.~~

- ~~(a) (1) This subsection applies to a carrier with respect to any health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act.~~
- ~~(2) In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that~~

~~health benefit plan without regard to any factor not specifically authorized under this subsection or subsection (g) of this section.~~

~~(3) A carrier may adjust the community rate only for:~~

~~(i) age; AND~~

~~(ii) geography based on the following contiguous areas of the State:~~

~~1. the Baltimore metropolitan area;~~

~~2. the District of Columbia metropolitan area;~~

~~3. Western Maryland; and~~

~~4. Eastern and Southern Maryland; and~~

~~(iii) health status, as provided in subsection (g) of this section].~~

~~(4) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.~~

~~(5) (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph (3) of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.~~

~~(ii) A discount offered under subparagraph (i) of this paragraph shall be:~~

~~1. applied to reduce the rate otherwise payable by the small employer;~~

~~2. actuarially justified;~~

~~3. offered uniformly to all small employers; and~~

~~4. approved by the Commissioner.~~

~~(g) (1) [A carrier may adjust the community rate for a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, for health status only if a small employer has not offered a health benefit plan issued under this subtitle to its employees in the 12 months prior to the initial enrollment of the small employer in the health benefit plan.~~



~~(2) (i) Based on the adjustment allowed under paragraph (1) of this subsection, in addition to the adjustments allowed under subsection (d)(1) of this section, a carrier may charge:~~

~~1. in the first year of enrollment, a rate that is 10% above or below the community rate;~~

~~2. in the second year of enrollment, a rate that is 5% above or below the community rate; and~~

~~3. in the third year of enrollment, a rate that is 2% above or below the community rate.~~

~~(ii) A carrier may not make any adjustment for health status in the community rate of a health benefit plan issued under this subtitle after the third year of enrollment of a small employer in the health benefit plan.~~

~~(3) For a health benefit plan that is a grandfathered health plan, as defined in § 1251 of the Affordable Care Act, a carrier may use health statements, in a form approved by the Commissioner, and health screenings to establish an adjustment to the community rate for health status as provided in this subsection.~~

~~(4) A] FOR A HEALTH BENEFIT PLAN THAT IS A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT, A carrier may not limit coverage offered by the carrier, or refuse to issue a health benefit plan to any small employer that meets the requirements of this subtitle, based on a health status related factor.~~

~~[(5)] (2) It is an unfair trade practice for a carrier knowingly to provide coverage to a small employer that discriminates against an employee or applicant for employment, based on the health status of the employee or applicant or a dependent of the employee or applicant, with respect to participation in a health benefit plan sponsored by the small employer.~~

~~15-1406.~~

~~[(a) A carrier may not establish rules for eligibility of an individual to enroll under a group health benefit plan based on any health status related factor.~~

~~(b) Subsection (a) of this section does not:~~

~~(1) require a carrier to provide particular benefits other than those provided under the terms of the particular health benefit plan; or~~

~~(2) prevent a carrier from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the health benefit plan.~~

~~(e) Rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for enrollment.]~~

~~[(d)] (A) A carrier shall allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of a group health benefit plan to enroll for coverage under the terms of the plan if:~~

~~(1) the employee or dependent was covered under an employer sponsored plan or group health benefit plan at the time coverage was previously offered to the employee or dependent;~~

~~(2) the employee states in writing, at the time coverage was previously offered, that coverage under an employer sponsored plan or group health benefit plan was the reason for declining enrollment, but only if the plan sponsor or issuer requires the statement and provides the employee with notice of the requirement;~~

~~(3) the employee's or dependent's coverage described in item (1) of this subsection:~~

~~(i) was under a COBRA continuation provision, and the coverage under that provision was exhausted; or~~

~~(ii) was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and~~

~~(4) under the terms of the plan, the employee requests enrollment not later than 30 days after:~~

~~(i) the date of exhaustion of coverage described in item (3)(i) of this subsection; or~~

~~(ii) termination of coverage or termination of employer contributions described in item (3)(ii) of this subsection.~~

~~[(e)] (B) A carrier shall allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of a group health benefit plan to enroll for coverage under the terms of the plan if the employee or dependent requests enrollment within 30 days after the employee or dependent is determined to be eligible for coverage under the MCHP private option plan in accordance with § 15-301.1 of the Health General Article.~~

**Chapter 17 of the Acts of 2017, as amended by Chapters 37 and 38 of the Acts of  
2018**

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

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

(h) (3) The Commission shall include its findings and recommendations from the study required under paragraph (1) of this subsection in the annual report submitted by the Commission on or before December 31, [2019] 2020, under subsection [(j)](K) of this section.

**(1) (1) THE COMMISSION SHALL ESTABLISH A WORKGROUP TO CARRY OUT THE FINDING AND DECLARATION OF THE GENERAL ASSEMBLY 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.**

**(2) THE WORKGROUP SHALL INCLUDE MEMBERS WHO REPRESENT NONPROFIT AND FOR-PROFIT CARRIERS, CONSUMERS, AND PROVIDERS.**

**(3) THE WORKGROUP SHALL:**

**(I) MONITOR THE APPEAL OF THE DECISION OF THE U.S. DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS IN TEXAS V. UNITED STATES REGARDING THE ACA AND THE IMPLICATIONS OF THE DECISION FOR THE STATE;**

**(II) MONITOR THE ENFORCEMENT OF THE AFFORDABLE CARE ACT BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND**

**(III) DETERMINE THE MOST EFFECTIVE MANNER OF ENSURING THAT MARYLAND CONSUMERS CAN OBTAIN AND RETAIN QUALITY HEALTH INSURANCE INDEPENDENT OF ANY ACTION OR INACTION ON THE PART OF THE FEDERAL GOVERNMENT OR ANY CHANGES TO FEDERAL LAW OR ITS INTERPRETATION.**

**(4) ON OR BEFORE DECEMBER 31, 2019, THE COMMISSION SHALL INCLUDE THE FINDINGS OF THE WORKGROUP IN THE ANNUAL REPORT SUBMITTED BY THE COMMISSION ON OR BEFORE DECEMBER 31, 2019, UNDER SUBSECTION (K) OF THIS SECTION.**

[(i)] (J)      The Commission may:

(1)      hold public meetings across the State to carry out the duties of the Commission; and

(2)      convene workgroups to solicit input from stakeholders.

[(j)] (K)      On or before December 31 each year, the Commission shall submit a report on its findings and recommendations, including any legislative proposals, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2017. It shall remain effective for a period of [3] 6 years and 1 month and, at the end of June 30, [2020] 2023, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

~~SECTION 2. AND BE IT FURTHER ENACTED, That it is the intent of the General Assembly to ensure that the health care protections established by the federal Affordable Care Act continue to protect Maryland residents in light of continued threats to the federal Act.~~

SECTION ~~2.~~ 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~July~~ June 1, 2019.

**Approved by the Governor, May 13, 2019.**



# Appendix 4

LAWRENCE J. HOGAN, JR., Governor

Ch. 597

Chapter 597

## (House Bill 258)

AN ACT concerning

### **Health Insurance – Individual Market Stabilization – Provider Fee**

FOR the purpose of clarifying that certain provisions of law apply to managed care organizations; requiring a managed care organization to pay a certain fee on a certain basis in certain calendar years; altering the purpose of certain provisions of law requiring that certain entities be subject to a certain assessment on all amounts used to calculate a certain premium tax liability or the amount of the entity's premium tax exemption value; requiring that certain entities be subject to certain assessments for in certain calendar years in which the federal government makes an assessment and for certain calendar years in which the federal government does not make an assessment under a certain provision of federal law; ; clarifying that certain assessments are for insurance products that are subject to a certain provision of federal law and may be subject to an assessment by the State; requiring that the calculation of the assessment be made without regard to certain threshold limits or a certain partial exclusion of net premiums; making a conforming change; providing for the application of certain provisions of law; requiring the Maryland Health Insurance Coverage Protection Commission to study a certain matter; providing that certain provisions of this Act apply to stand-alone dental plan carriers and stand-alone vision plan carriers; providing for the termination of a certain provision of this Act, subject to a certain contingency; requiring the Maryland Insurance Commissioner to forward a copy of a certain notice to the Department of Legislative Services within a certain period of time and notify certain carriers; making a certain provision of this Act subject to a certain contingency; and generally relating to the stabilization of the individual market and the health insurance provider fee.

BY adding to

Article – Health – General  
Section 15–102.3(g)  
Annotated Code of Maryland  
(2015 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance  
Section 6–102.1  
Annotated Code of Maryland  
(2017 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, without amendments,

Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37  
and 38 of the Acts of the General Assembly of 2018  
Section 1(b)

BY repealing and reenacting, with amendments,

Chapter 17 of the Acts of the General Assembly of 2017, as amended by Chapters 37 and 38 of the Acts of the General Assembly of 2018

Section 1(h)(1)

BY repealing and reenacting, with amendments,

Article – Insurance

Section 6–102.1(a)

Annotated Code of Maryland

(2017 Replacement Volume and 2018 Supplement)

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

**Article – Health – General**

15–102.3.

**(G) (1) THE PROVISIONS OF § 6–102.1 OF THE INSURANCE ARTICLE APPLY TO MANAGED CARE ORGANIZATIONS.**

**(2) FOR EACH CALENDAR YEAR THAT THE INSURANCE COMMISSIONER ASSESSES A HEALTH INSURANCE PROVIDER FEE UNDER § 6–102.1 OF THE INSURANCE ARTICLE, A MANAGED CARE ORGANIZATION SHALL PAY THE FEE ON A QUARTERLY BASIS IN ACCORDANCE WITH A SCHEDULE ADOPTED BY THE INSURANCE COMMISSIONER.**

**Article – Insurance**

6–102.1.

(a) This section applies to:

(1) an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the State that provides a product that:

- (i) is subject to ~~the fee under~~ § 9010 of the Affordable Care Act; and
- (ii) may be subject to an assessment by the State; and

(2) a managed care organization authorized under Title 15, Subtitle 1 of the Health – General Article.

(b) The purpose of this section is to [recoup the aggregate amount of the] **ASSIST IN THE STABILIZATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET BY ASSESSING A** health insurance provider fee [that otherwise would have been assessed under § 9010 of the Affordable Care Act] that is attributable to State health risk for calendar year 2019 [as a bridge to stability in the individual health insurance market] ~~AND EACH CALENDAR YEAR THEREAFTER~~ **YEARS 2019 THROUGH 2023, BOTH INCLUSIVE, AS PROVIDED FOR UNDER SUBSECTION (C) OF THIS SECTION.**

(c) (1) ~~[In] FOR A~~ calendar year ~~{2019} IN WHICH THE FEDERAL GOVERNMENT DOES NOT MAKE AN ASSESSMENT UNDER § 9010 OF THE AFFORDABLE CARE ACT,~~ in addition to the amounts otherwise due under this subtitle, an entity subject to this section shall be subject to an assessment of 2.75% on all amounts used to calculate the entity's premium tax liability under § 6-102 of this subtitle or the amount of the entity's premium tax exemption value for ~~THE IMMEDIATELY PRECEDING~~ calendar year ~~{2018}~~.

(2) ~~FOR A CALENDAR YEAR IN WHICH THE FEDERAL GOVERNMENT MAKES AN ASSESSMENT UNDER § 9010 OF THE AFFORDABLE CARE ACT IN CALENDAR YEARS 2020 THROUGH 2023, BOTH INCLUSIVE,~~ IN ADDITION TO THE AMOUNTS OTHERWISE DUE UNDER THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION SHALL BE SUBJECT TO AN ASSESSMENT OF 1% ON ALL AMOUNTS USED TO CALCULATE THE ENTITY'S PREMIUM TAX LIABILITY UNDER § 6-102 OF THIS SUBTITLE OR THE AMOUNT OF THE ENTITY'S PREMIUM TAX EXEMPTION VALUE FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR.

(3) THE ASSESSMENTS REQUIRED IN PARAGRAPHS (1) AND (2) OF THIS SUBSECTION ARE FOR PRODUCTS THAT:

(I) ARE SUBJECT TO § 9010 OF THE AFFORDABLE CARE ACT;

AND

(II) MAY BE SUBJECT TO AN ASSESSMENT BY THE STATE.

(4) THE CALCULATION OF THE ASSESSMENTS REQUIRED UNDER PARAGRAPHS (1) AND (2) OF THIS SUBSECTION SHALL BE MADE WITHOUT REGARD TO:

(I) THE THRESHOLD LIMITS ESTABLISHED IN § 9010(B)(2)(A) OF THE AFFORDABLE CARE ACT; OR

(II) THE PARTIAL EXCLUSION OF NET PREMIUMS PROVIDED FOR IN § 9010(B)(2)(B) OF THE AFFORDABLE CARE ACT.



[(2)] (D) Notwithstanding § 2–114 of this article, the assessment required under this section shall be distributed by the Commissioner to the Maryland Health Benefit Exchange Fund established under § 31–107 of this article.

**Chapter 17 of the Acts of 2017, as amended by Chapters 37 and 38 of the Acts of 2018**

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

That:

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

(h) (1) The Commission shall study and make recommendations for individual and group health insurance market stability, including:

(i) the components of one or more waivers under § 1332 of the Affordable Care Act to ensure market stability that may be submitted by the State;

(ii) whether to pursue a standard plan design that limits cost sharing;

(iii) whether to merge the individual and small group health insurance markets in the State for rating purposes;

(iv) whether to pursue a Basic Health Program;

(v) whether to pursue a Medicaid buy-in program for the individual market;

(vi) whether to provide subsidies that supplement premium tax credits or cost-sharing reductions described in § 1402(c) of the Affordable Care Act; [and]

(vii) whether to adopt a State-based individual health insurance mandate and how to use payments collected from individuals who do not maintain minimum essential coverage, including use of the payments to assist individuals in purchasing health insurance; AND

**(VIII) WHETHER THE STATE REINSURANCE PROGRAM SHOULD BE EXTENDED AFTER CALENDAR YEAR 2023 AND, IF SO, HOW IT WILL BE FUNDED.**

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Article – Insurance**

6–102.1.

(a) **(1)** This section applies to:

**[(1)] (I)** EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, an insurer, a nonprofit health service plan, a health maintenance organization, a dental plan organization, a fraternal benefit organization, and any other person subject to regulation by the State that provides a product that:

**[(i)] 1.** is subject to the fee under § 9010 of the Affordable Care Act; and

**[(ii)] 2.** may be subject to an assessment by the State; and

**[(2)] (II)** a managed care organization authorized under Title 15, Subtitle 1 of the Health – General Article.

**(2)** THIS SECTION DOES NOT APPLY TO A STAND-ALONE DENTAL PLAN CARRIER OR A STAND-ALONE VISION PLAN CARRIER.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The assessment established under § 6-102.1 of the Insurance Article, as enacted by Section 2 1 of this Act, shall apply to stand-alone dental plan carriers and stand-alone vision plan carriers.

(b) If the federal government confirms that under the rules that implement § 1903 of the Social Security Act, which requires health care related taxes to be broad-based and uniform in order to apply to Medicaid providers, such as managed care organizations, that the State can impose a 1% assessment on Medicaid managed care organizations if it is imposing that fee on all commercial health insurance plans except dental and vision, subsection (a) of this section, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

(c) If the Maryland Insurance Commissioner receives notice of the confirmation described in subsection (b) of this section, within 5 days after receiving notice of the confirmation, the Commissioner shall:

**(1)** forward a copy of the notice to the Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401; and

**(2)** notify each stand-alone dental plan carrier and stand-alone vision plan carrier.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect contingent on the termination of Section 3(a) of this Act.

SECTION ~~2~~ 5. AND BE IT FURTHER ENACTED, That, subject to Section 4 of this Act, this Act shall take effect October 1, 2019.

**Enacted under Article II, § 17(c) of the Maryland Constitution, May 25, 2019.**