(4) THE BOARD MAY CHARGE DIFFERENT PREMIUMS BASED ON THE BENEFIT PACKAGE DELIVERY SYSTEM WHEN MORE THAN ONE BENEFIT PACKAGE DELIVERY SYSTEM IS OFFERED.

(c) (1) The Board shall determine a standard risk rate by considering the premium rates charged by carriers in the State for coverage comparable to that of the Plan.

(2) The premium rate for Plan coverage:

(i) may not be less than 110% of the standard risk rate established under paragraph (1) of this subsection; and

(ii) may not exceed 200% of the standard risk rate.

(3) Premium rates shall be reasonably calculated to encourage enrollment in the Plan.

(4) The Board may subsidize premiums, deductibles, and other policy expenses, based on a member's income.

(d) Losses incurred by the Plan shall be subsidized by the Fund.

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(a) In addition to any other requirements under this article, a carrier that offers individual health benefit plans in this State shall:

(1) have demonstrated the capacity to administer the individual health benefit plans, including adequate numbers and types of administrative staff;

(2) have a satisfactory grievance procedure and ability to respond to calls, questions, and complaints from enrollees or insureds; and

(3) design policies to help ensure that enrollees or insureds have adequate access to providers of health care.

(b) (1) For each calendar quarter, a carrier that offers individual health benefit plans in the State shall submit to the Commissioner a report that includes:

(i) the number of applications submitted to the carrier for individual coverage; and

(ii) the number of declinations issued by the carrier for individual coverage.

(2) The report required under paragraph (1) of this subsection shall be filed with the Commissioner no later than 30 days after the last day of the quarter for which the information is provided.

(c) (1) If a carrier denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market, the carrier shall provide: