IN ESTABLISHING COST-SHARING AS PART OF THE STANDARD PLAN, THE COMMISSION SHALL:

(1) INCLUDE COST-SHARING AND OTHER INCENTIVES TO HELP PREVENT CONSUMERS FROM SEEKING UNNECESSARY SERVICES;

(2) BALANCE THE EFFECT OF COST-SHARING IN REDUCING PREMIUMS AND IN AFFECTING UTILIZATION OF APPROPRIATE SERVICES; AND

(3) LIMIT THE TOTAL COST-SHARING THAT MAY BE INCURRED BY AN INDIVIDUAL IN A YEAR.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, §§ 700 and 698(j).

In subsection (e) of this section, the former definition of "mandated benefit" is incorporated into the substantive provision because the defined term was used only once in the former law.

Subsection (e)(1) of this section is revised to clarify that the mandated benefit is the "health care service, benefit, coverage, or reimbursement for covered health care services" and not the statute that mandates that the benefit be provided or offered. Similarly, subsection (e)(2) of this section is revised to clarify that the mandated benefit is the "reimbursement required by statute, by a health benefit plan for a service" and not the "statute" that requires the reimbursement.

Defined terms: "Carrier" § 15–1201
"Commission" § 15–1201
"Health benefit plan" § 15–1201
"Insurer" § 1–101
"Premium" § 1–101
"Standard Plan" § 15–1201

15–1208. COVERAGE OF PREEXISTING CONDITIONS.

(A) LIMITATION PROHIBITED.

(1) A CARRIER MAY NOT LIMIT COVERAGE UNDER A HEALTH BENEFIT PLAN FOR A PREEXISTING CONDITION.

(2) AN EXCLUSION OF COVERAGE FOR PREEXISTING CONDITIONS MAY NOT BE APPLIED TO HEALTH CARE SERVICES FURNISHED FOR PREGNANCY OR NEWBORNS.

(B) EXCEPTION FOR LATE ENROLLEE.

(1) THIS SUBSECTION DOES NOT APPLY TO A LATE ENROLLEE IF:

(I) THE INDIVIDUAL REQUESTS ENROLLMENT WITHIN 30 DAYS AFTER BECOMING AN ELIGIBLE EMPLOYEE;