HOUSE BILL 30

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(PRE–FILED) CF SB 217

By: **Chair, Health and Government Operations Committee (By Request – Departmental – Maryland Insurance Administration)**

Requested: September 15, 2023
Introduced and read first time: January 10, 2024
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Conformity With Federal Law

FOR the purpose of conforming provisions of State health insurance law with existing federal requirements, including by updating effective dates for federal regulations, clarifying federal consumer protection regulations resulting from changes to the federal No Surprises Act, altering the material errors that trigger special enrollment periods, and authorizing the Maryland Health Benefits Exchange to adopt an expanded open enrollment period under certain circumstances; and generally relating to health insurance and federal law.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–701(a)
Annotated Code of Maryland
(2023 Replacement Volume)

BY repealing
Article – Health – General
Section 19–701(e)
Annotated Code of Maryland
(2023 Replacement Volume)

BY adding to
Article – Health – General
Section 19–701(e) and (e–1)
Annotated Code of Maryland
(2023 Replacement Volume)

BY repealing and reenacting, with amendments,

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

Article – Insurance
Section 15–1A–03, 15–1A–04, 15–1A–14, 15–1A–16(a) and (e), 15–1208.2(d)(4)(vi), and 15–1316(b)(3) and (6)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1A–13, 15–1208.2(d)(1), (2), and (3), and 15–1316(b)(1) and (2)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY adding to
Article – Insurance
Section 15–1208.2(d)(11)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

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

Article – Health – General

19–701.

(a) In this subtitle the following words have the meanings indicated.

[(e) "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of 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:

(1) Placing the patient's health in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.**]**

(E) "EMERGENCY MEDICAL CONDITION" MEANS A MEDICAL CONDITION, INCLUDING A MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER, THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUCH SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED BY A PRUDENT LAYPERSON, WHO POSSESSES AN AVERAGE KNOWLEDGE OF HEALTH AND MEDICINE, TO RESULT IN A CONDITION DESCRIBED IN § 1867(E)(1) OF THE SOCIAL SECURITY ACT.

(E–1) (1) "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 OR FREESTANDING MEDICAL FACILITY, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE AN EMERGENCY MEDICAL CONDITION;

(II) ANY OTHER EXAMINATION OR TREATMENT WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL OR FREESTANDING MEDICAL FACILITY THAT IS NECESSARY TO STABILIZE THE PATIENT, REGARDLESS OF THE DEPARTMENT OF THE HOSPITAL IN WHICH THE EXAMINATION OR TREATMENT IS FURNISHED; OR

(III) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, ADDITIONAL COVERED ITEMS AND SERVICES FURNISHED BY A HEALTH CARE PROVIDER OF EMERGENCY SERVICES THAT DOES NOT HAVE A CONTRACTUAL RELATIONSHIP WITH THE CARRIER AFTER THE PATIENT IS STABILIZED AND AS PART OF OUTPATIENT OBSERVATION OR AN INPATIENT OR OUTPATIENT STAY WITH RESPECT TO THE VISIT IN WHICH THE SERVICES DESCRIBED IN ITEMS (I) AND (II) OF THIS PARAGRAPH ARE FURNISHED.

(2) "EMERGENCY SERVICES" INCLUDES SERVICES DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION THAT ARE PROVIDED IN SPECIALIZED FACILITIES THAT ARE STAFFED BY BEHAVIORAL HEALTH PROVIDERS TRAINED TO PROVIDE CRISIS SERVICES.

(3) SUBJECT TO § 19–710(P) OF THIS ARTICLE AND § 14–205.2 OF THE INSURANCE ARTICLE, "EMERGENCY SERVICES" DOES NOT INCLUDE ITEMS AND SERVICES DESCRIBED IN PARAGRAPH (1)(III) OF THIS SUBSECTION IF ALL OF THE CONDITIONS IN 45 C.F.R. § 149.410(B) ARE MET.

Article – Insurance

15–1A–03.

(a) For purposes of this subtitle, to the extent necessary, the Commissioner shall adopt regulations that:

(1) establish criteria that a health benefit plan must meet to be considered a grandfathered plan; and

(2) are consistent with 45 C.F.R. § 147.140 and any corresponding federal

rules and guidance as those provisions were in effect December 1, **[**2019**]** **2023**.

(b) Except as otherwise provided in this subtitle and subject to subsection (c) of this section, this subtitle applies to any health benefit plan that is offered by a carrier in the State within the scope of:

(1) Subtitle 12 of this title;

(2) Subtitle 13 of this title; or

(3) Subtitle 14 of this title.

(c) (1) Except as provided in paragraph (2) of this subsection, the provisions of this subtitle do not apply to a grandfathered plan.

(2) (i) The following provisions apply to all grandfathered plans:

1. the provisions of § 15–1A–08 of this subtitle related to health benefit plans that provide dependent coverage of a child;

2. the provisions of § 15–1A–11 of this subtitle related to the prohibition on establishing lifetime limits on the dollar value of benefits;

3. the provisions of § 15–1A–12 of this subtitle related to waiting periods;

4. THE PROVISIONS OF § 15–1A–13 OF THIS SUBTITLE RELATED TO CHOICE OF PROVIDER;

5. THE PROVISIONS OF § 15–1A–14 OF THIS SUBTITLE RELATED TO COVERAGE OF EMERGENCY SERVICES;

[4.**]** **6.** the provisions of § 15–1A–15 of this subtitle related to summary of benefits and coverage requirements;

[5.**]** **7.** the provisions of § 15–1A–16 of this subtitle related to medical loss ratio and corresponding reporting and rebate requirements; and

[6.**]** **8.** the provisions of § 15–1A–21 of this subtitle related to rescission of a health benefit plan.

(ii) The following provisions apply to all grandfathered plans except grandfathered plans that are individual plans:

1. the provisions of § 15–1A–05 of this subtitle related to preexisting condition exclusions; and

2. the provisions of § 15–1A–11 of this subtitle related to the prohibition on establishing annual limits on the dollar value of benefits.

15–1A–04.

For purposes of this subtitle, to the extent necessary, the Commissioner shall adopt regulations that:

(1) establish criteria that a health benefit plan must meet to be considered a health benefit plan that covers essential health benefits; and

(2) are consistent with 45 C.F.R. Part 156 Subpart B and any corresponding federal rules and guidance as those provisions were in effect December 1, **[**2019**]** **2023**.

15–1A–13.

(a) If a carrier requires or provides for the designation of a participating primary care provider for an insured individual, the carrier shall allow each insured individual to designate any participating primary care provider if the provider is available to accept the insured individual.

(b) (1) (i) This subsection applies only to an individual who has a child who is an insured individual under the individual's health benefit plan.

(ii) This subsection may not be construed to waive any exclusions of coverage under the terms and conditions of a health benefit plan with respect to coverage of pediatric care.

(2) If a carrier requires or provides for the designation of a participating primary care provider for a child, the carrier shall allow the individual to designate any participating physician who specializes in pediatrics as the child's primary care provider if the provider is available to accept the child.

(c) (1) (i) This subsection applies only to a carrier that:

1. provides coverage for obstetrical or gynecological care; and

2. requires the designation by an insured individual of a participating primary care provider.

(ii) This subsection may not be construed to:

1. waive any exclusions of coverage under the terms and conditions of a health benefit plan with respect to coverage of obstetrical or gynecological care; or

2. prohibit a carrier from requiring that the obstetrical or gynecological provider notify the primary care provider or carrier for an insured individual of treatment decisions.

(2) A carrier shall treat the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services by a participating health care provider that specializes in obstetrics or gynecology as care authorized by the primary care provider for the insured individual.

(3) A carrier may not require authorization or referral by any person, including the primary care provider for the insured individual, for an insured individual who seeks coverage for obstetrical or gynecological care provided by a participating health care provider who specializes in obstetrics or gynecology.

(4) A health care provider that provides obstetrical or gynecological care shall comply with a carrier's policies and procedures.

15–1A–14.

(a) (1) In this section the following words have the meanings indicated.

(2) "Emergency medical condition" means a medical condition**, INCLUDING A MENTAL HEALTH CONDITION OR SUBSTANCE USE DISORDER,** that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in a condition described in § 1867(e)(1) of the Social Security Act.

(3) **(I)** "Emergency services" means, with respect to an emergency medical condition:

[(i)**]** **1.** a medical screening examination that is within the capability of the emergency department of a hospital or freestanding medical facility, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; **[**or**]**

[(ii)**]** **2.** any other examination or treatment within the capabilities of the staff and facilities available at the hospital or freestanding medical facility that is necessary to stabilize the patient**, REGARDLESS OF THE DEPARTMENT OF THE HOSPITAL IN WHICH THE EXAMINATION OR TREATMENT IS FURNISHED; OR**

3. EXCEPT AS PROVIDED IN SUBPARAGRAPH (III) OF THIS PARAGRAPH, ADDITIONAL COVERED ITEMS AND SERVICES FURNISHED BY A HEALTH CARE PROVIDER OF EMERGENCY SERVICES THAT DOES NOT HAVE A CONTRACTUAL RELATIONSHIP WITH THE CARRIER AFTER THE PATIENT IS

STABILIZED AND AS PART OF OUTPATIENT OBSERVATION OR AN INPATIENT OR OUTPATIENT STAY WITH RESPECT TO THE VISIT IN WHICH THE SERVICES DESCRIBED IN ITEMS 1 AND 2 OF THIS SUBPARAGRAPH ARE FURNISHED.

(II) "EMERGENCY SERVICES" INCLUDES SERVICES DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH THAT ARE PROVIDED IN SPECIALIZED FACILITIES THAT ARE STAFFED BY BEHAVIORAL HEALTH PROVIDERS TRAINED TO PROVIDE CRISIS SERVICES.

(III) SUBJECT TO § 14–205.2 OF THIS ARTICLE AND § 19–710(P) OF THE HEALTH – GENERAL ARTICLE, "EMERGENCY SERVICES" DOES NOT INCLUDE ITEMS AND SERVICES DESCRIBED IN SUBPARAGRAPH (I)3 OF THIS PARAGRAPH IF ALL OF THE CONDITIONS IN 45 C.F.R. § 149.410(B) ARE MET.

(b) If a carrier provides or covers any benefits for emergency services in an emergency department of a hospital or freestanding medical facility, the carrier:

(1) may not require **[**an insured individual to obtain**]** prior authorization for the emergency services; **[**and**]**

(2) shall provide coverage for the emergency services regardless of whether the health care provider providing the emergency services has a contractual relationship with the carrier to furnish emergency services**;**

(3) MAY NOT LIMIT WHAT CONSTITUTES AN EMERGENCY MEDICAL CONDITION SOLELY ON THE BASIS OF DIAGNOSIS CODES; AND

(4) MAY NOT IMPOSE ANY OTHER TERM OR CONDITION ON THE COVERAGE FOR EMERGENCY SERVICES, EXCEPT FOR:

(I) THE EXCLUSION OR COORDINATION OF BENEFITS;

(II) A WAITING PERIOD; AND

(III) APPLICABLE COST–SHARING.

(c) If a health care provider of emergency services does not have a contractual relationship with the carrier to provide emergency services, the carrier:

(1) may not impose any administrative requirement or limitation on coverage that would be more restrictive than administrative requirements or limitations imposed on coverage for emergency services furnished by a health care provider with a contractual relationship with the carrier;

(2) subject to § 14–205.2 of this article and § 19–710.1 of the Health –

General Article, may not impose any cost–sharing amount greater than the amount imposed for emergency services furnished by a health care provider with a contractual relationship with the carrier; **[**and**]**

(3) SHALL CALCULATE AND APPLY THE COST–SHARING AMOUNTS IN ACCORDANCE WITH THE REQUIREMENTS OF 45 C.F.R. § 149.110(B)(3)(III) AND (V); AND

[(3)**] (4) EXCEPT AS PROVIDED IN § 14–205.2 OF THIS ARTICLE AND § 19–710.1 OF THE HEALTH – GENERAL ARTICLE,** shall reimburse the health care provider **[**at the reimbursement rate specified in subsection (d) of this section**]** **IN ACCORDANCE WITH THE REQUIREMENTS OF 45 C.F.R. § 149.110(B)(3)(IV)**.

[(d) Except as provided in § 14–205.2 of this article and § 19–710.1 of the Health – General Article, a carrier shall reimburse a health care provider of emergency services that does not have a contractual relationship with the carrier the greater of:

(1) the median amount negotiated with in–network providers for the emergency service, excluding any in–network copayment or coinsurance;

(2) the amount for the emergency service calculated using the same method the health benefit plan generally uses to determine payments for out–of–network services, excluding any in–network copayment or coinsurance, without reduction for out–of–network cost–sharing that generally applies under the health benefit plan; or

(3) the amount that would be paid under Medicare Part A or Part B for the emergency service, excluding any in–network copayment or coinsurance.**]**

15–1A–16.

(a) (1) For purposes of this section, "medical loss ratio":

(i) has the meaning established in 45 C.F.R. § 158.221; or

(ii) if the Commissioner adopts regulations as described in paragraph (2) of this subsection, has the meaning established by the adopted regulations.

(2) To the extent necessary, the Commissioner shall adopt regulations that:

(i) establish a definition for "medical loss ratio"; and

(ii) are consistent with 45 C.F.R. § 158.221 and any corresponding federal rules and guidance as those provisions were in effect December 1, **[**2019**] 2023**.

(e) To the extent necessary, the Commissioner shall adopt regulations that:

(1) establish requirements for calculating medical loss ratios and related reporting and rebate requirements; and

(2) are consistent with 45 C.F.R. Part 158 and any corresponding federal rules and guidance as those provisions were in effect December 1, **[**2019**]** **2023**.

15–1208.2.

(d) (1) A carrier shall provide an open enrollment period for each individual who experiences a triggering event described in paragraph (4) of this subsection.

(2) The open enrollment period shall be for at least 30 days, beginning on the date of the triggering event.

(3) During the open enrollment period for an individual who experiences a triggering event, a carrier shall permit the individual to enroll in or change from one health benefit plan offered by the small employer to another health benefit plan offered by the small employer.

(4) A triggering event occurs when:

(vi) for SHOP Exchange health benefit plans:

1. an eligible employee's or a dependent's enrollment or nonenrollment in a qualified health plan is, as evaluated and determined by the Exchange:

A. unintentional, inadvertent, or erroneous; and

B. the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or the federal Department of Health and Human Services, or its instrumentalities, or a non–Exchange entity providing enrollment assistance or conducting enrollment activities;

2. an eligible employee is an Indian as defined in § 4 of the federal Indian Health Care Improvement Act;

3. **[**an eligible employee or dependent adequately demonstrates to the Exchange that**]** **SUBJECT TO PARAGRAPH (11) OF THIS SUBSECTION,** a material error related to plan benefits, service area, **COST–SHARING,** or premium influenced the eligible employee's or dependent's decision to purchase a qualified health plan through the Exchange; or

4. an eligible employee or dependent demonstrates to the SHOP Exchange, in accordance with guidelines issued by the federal Department of Health and Human Services, that the eligible employee or a dependent meets other exceptional circumstances as the SHOP Exchange may provide;

(11) A MATERIAL ERROR UNDER PARAGRAPH (4)(VI)3 OF THIS SUBSECTION IS AN ERROR THAT IS LIKELY TO HAVE INFLUENCED THE ENROLLMENT OF AN ELIGIBLE EMPLOYEE OR THE DEPENDENT OF THE ELIGIBLE EMPLOYEE IN A QUALIFIED HEALTH PLAN.

15–1316.

(b) (1) Beginning November 15, 2014, unless an alternative date is adopted by the federal Department of Health and Human Services, a carrier that sells health benefit plans to individuals in the State shall establish an annual open enrollment period.

(2) The annual open enrollment period for 2014 shall begin on November 15, 2014, and extend through January 15, 2015, unless alternative dates are adopted by the federal Department of Health and Human Services.

(3) The annual open enrollment period for years beginning on and after January 1, 2015, shall be**:**

(I) the dates adopted by the federal Department of Health and Human Services**; OR**

(II) IF AUTHORIZED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE DATES ADOPTED BY THE EXCHANGE.

(6) If an individual enrolls in a health benefit plan offered by the carrier during the annual open enrollment period for years beginning on and after January 1, 2015, the effective date of coverage shall be**:**

(I) the date adopted by the federal Department of Health and Human Services**; OR**

(II) IF AUTHORIZED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE DATE ADOPTED BY THE EXCHANGE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2024.