SENATE BILL 290

C3 1lr1053
SB 623/20 – FIN (PRE–FILED) CF HB 167

By: **Senator Benson**
Requested: October 21, 2020
Introduced and read first time: January 13, 2021
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Out–of–Pocket Maximums and Cost–Sharing Requirements – Calculation

FOR the purpose of requiring, to the extent authorized under federal law, certain entities to include payments made by certain persons when calculating certain contributions to an out–of–pocket maximum or a cost–sharing requirement for certain persons; providing for the application of this Act; providing for a delayed effective date; and generally relating to the calculation of cost–sharing requirements for health care services.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–118
Annotated Code of Maryland
(2017 Replacement Volume and 2020 Supplement)

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

Article – Insurance

15–118.

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

(2) "Health care service" means a health or medical care procedure or service rendered by a provider that:

(i) provides testing, diagnosis, or treatment of human disease or dysfunction; or

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

(ii) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

(3) "Provider" means a physician, hospital, or other person that is licensed or otherwise authorized to provide health care services.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide coverage for health care services to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide coverage for health care services to individuals or groups under contracts that are issued or delivered in the State.

(c) If an entity subject to this section negotiates and enters into a contract with providers to render health care services to insureds, subscribers, or members at alternative rates of payment, and coinsurance payments are to be based on a percentage of the fee for health care services rendered by a provider, the entity shall calculate the amount of the coinsurance payment to be paid by the insured, subscriber, or member exclusively from the negotiated alternative rate for the health care service rendered.

(D) TO THE EXTENT AUTHORIZED BY FEDERAL LAW, WHEN CALCULATING THE OVERALL CONTRIBUTION TO AN OUT–OF–POCKET MAXIMUM OR A COST–SHARING REQUIREMENT FOR AN INSURED, A SUBSCRIBER, OR A MEMBER, AN ENTITY SUBJECT TO THIS SECTION SHALL INCLUDE ANY PAYMENTS MADE BY:

(1) THE INSURED, THE SUBSCRIBER, OR THE MEMBER; OR

(2) A PERSON ON BEHALF OF THE INSURED, THE SUBSCRIBER, OR THE MEMBER.

[(d)**] (E)** An entity subject to this section may not charge or collect from an insured, a subscriber, or a member a coinsurance payment amount that is greater than the amount calculated under subsection (c) of this section.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2022.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2022.