

HOUSE BILL 167

C3
HB 1360/20 – HGO

(PRE-FILED)

1r1052
CF SB 290

By: **Delegate P. Young**

Requested: October 21, 2020

Introduced and read first time: January 13, 2021

Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements –**
3 **Calculation**

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

10 BY repealing and reenacting, with amendments,
11 Article – Insurance
12 Section 15–118
13 Annotated Code of Maryland
14 (2017 Replacement Volume and 2020 Supplement)

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

17 **Article – Insurance**

18 15–118.

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

20 (2) “Health care service” means a health or medical care procedure or
21 service rendered by a provider that:

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

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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

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

5 (b) This section applies to:

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

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

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

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

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

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

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

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

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