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BULLETIN 22-06 (Revised)

To: All Interested Parties Including Insurers, Non-Profit Health Service Plans, Health Maintenance Organizations, Dental Plan Organizations, Pharmacy Benefit Managers, and Producers

Re: Summary of Insurance Laws Enacted in 2022 (Corrected)

Date: June 7, 2022

The purpose of this Bulletin is to summarize laws enacted during the 2022 Session of the Maryland General Assembly that are enforced by the Maryland Insurance Administration ("MIA"). ***The attached summary is intended only as notice of passage of the legislation and is not a representation of the MIA's interpretation of the new laws, nor is it a representation of how the MIA may enforce these new provisions.*** All regulated entities should refer to the Chapter Laws of Maryland for the 2022 Session for the complete text of these recently enacted laws. Regulated entities are advised that other bills passed by the General Assembly and not listed on the summary may also affect their business operations in Maryland.

You may obtain a copy of a specific law passed by the General Assembly during the 2022 Session by accessing the Maryland General Assembly's web site at http://mgaleg.maryland.gov or by contacting the Department of Legislative Services at (410) 946-5400. You should refer to the House or Senate Bill number when searching for a law on the web site. You may also obtain a copy of "The 90 Day Report – A Review of the 2022 Legislative Session" on the Internet or from Library and Information Services, Office of Policy Analysis, Department of Legislative Services.

A previous version of this bulletin issued on June 2, 2022 stated that SB834 / HB1148 (Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization) prohibits carriers from reducing the fee schedule of a health care provider "solely" because the provider does not participate in the carrier's bonus or other incentive–based compensation or two–sided incentive arrangement program. However, the word "solely" does not appear in this section of the bill as passed. This version of the bulletin has been updated to reflect that.

For additional information concerning the MIA's summary of 2022 insurance legislation, please contact Kory Boone at kory.boone@maryland.gov.

PROPERTY & CASUALTY

SENATE BILL 278 (Chapter 453) – Maryland Automobile Insurance Fund – Installment Payment Plans

- Alters the requirements for the Maryland Automobile Insurance Fund (MAIF) to accept premiums on an installment basis for motor vehicle liability insurance policies by amending § 20–507 of the Insurance Article and repealing existing limitations;
- Requires the Commissioner to continue to approve MAIF's plan to accept premiums by installment and requires the Commissioner to consider the following factors when approving MAIF's plan for accepting premiums on an installment payment basis:
    - Percentage of the initial premium payment in comparison to the total premium under the policy;
    - The number of installment premium payments accepted on a policy under the installment payment plan;
    - The overall affordability of the installment payment plan in comparison to other payment options available to the policyholder;
- Authorizes MAIF to charge and collect reasonable installment and late payment fees, subject to review and approval by the Commissioner, by amending § 27–216 of the Insurance Article to apply the same requirements to MAIF's installment payment plans.

Effective Date: October 1, 2022

SENATE BILL 425 (Chapter 650) / HOUSE BILL 568 (Chapter 649) – Real Estate Associate Brokers and Salespersons – Compensation – Payment From Title Insurance Producer

- Amends § 17-604 of the Business Occupations and Professions Article to allow a title insurance producer to pay compensation, on behalf of a real estate broker and in accordance with a written disbursement authorization provided by the real estate broker, to an associate real estate broker, a real estate salesperson or a business entity formed under § 17-512 of the Business Occupations and Professions Article.

Effective Date: October 1, 2022

SENATE BILL 572 (Chapter 724) / HOUSE BILL 563 (Chapter 723) – Insurance – Surplus Lines Brokers – Policy Fees

- Amends § 27-216 of the Insurance Article and increases the policy fee a surplus lines broker may charge on a policy issued by a surplus lines insurer by raising the fee cap to $200 on each personal lines policy and $500 or 7% of the policy's premium, whichever is greater, on each commercial lines policy.
- Allows a surplus lines broker to charge a reasonable policy fee on a policy issued by a surplus lines insurer to an exempt commercial policyholder.

Effective Date: October 1, 2022

SENATE BILL 697 (Chapter 587) / HOUSE BILL 926 (Chapter 586) – Vehicle Laws – Mechanical Repair Contracts – Policies of Insurance

- Requires an obligor under a mechanical repair contract to maintain insurance coverage to provide performance or payment on behalf of the obligor in the event of contract nonperformance by amending § 15-311.2 of the Transportation Article;
- Authorizes a policy issued by a risk retention group that is in good standing to satisfy the obligor's coverage requirement.

Effective Date: October 1, 2022

LIFE & HEALTH

SENATE BILL 164 (Chapter 693) / HOUSE BILL 119 (Chapter 692) – Insurance – Annuities – Nonforfeiture – Interest Rate

- Alters the minimum interest rate from 1% to 0.15%, used to determine minimum nonforfeiture amounts for annuity contracts by amending § 16-504 of the Insurance Article.

Effective Date: October 1, 2022

HOUSE BILL 247 (Chapter 680) – Insurance – Medicare Supplement Policies – Open Enrollment Period Following Birthday

- Establishes a guaranteed issue period each year for Medicare supplement policyholders, permitting an insured to change to a Medicare supplement policy of equal or lesser benefits, during the 30 days following the insured's birthday, by amending § 15-909 of the Insurance Article;
- Provides that policies are considered to have equal or lesser benefits unless:
    - the policy contains one or more significant benefits not included in the Medicare supplement policy being replaced; or
    - the policy contains the same significant benefits included in the Medicare supplement policy being replaced but it reduces the cost–sharing responsibilities of the enrollee for the benefits;
- Prohibits the replacing carrier from denying or conditioning the issuance of a Medicare supplement policy, or discriminating in the pricing, or denying, reducing or conditioning coverage because of the health status, claims experience, or medical condition of the individual;
- Requires an annual notice of an insured's right to switch policies be given to a policyholder at least 30 days, but no more than 60 days, before the insured's birthday,

Effective Date: January 1, 2023

HOUSE BILL 413 (Chapter 59) – Health Insurance – Individual Market Stabilization – Extension of Provider Fee

- Continues the stabilization of the individual health insurance market by extending the health insurance provider fee assessment through 2028, by amending § 6-102.1 of the Insurance Article;
- Exempts a stand-alone dental plan or stand-alone vision plan carrier subject to the health insurance provider fee assessment from the health care regulatory assessment under § 2-112.2 of the Insurance Article and the annual assessment fee under § 2-502 of the Insurance Article for each calendar year in which the health insurance provider fee is paid, by adding § 6-105.3 to the Insurance Article;
- Requires the Maryland Insurance Administration, in consultation with Maryland Health Benefits Exchange and Maryland Healthcare Commission, to report to the Governor and the General Assembly on the impact of State Reinsurance Program on or before December 1, 2023.

Effective Date: October 1, 2022

HOUSE BILL 536 (Chapter 495) – Maryland Insurance Commissioner – Authority – Federal Health Emergency

- Amends § 2-115 of the Insurance Article to authorize the Maryland Insurance Commissioner to apply the emergency regulations when a national or public health emergency the Commissioner determines affects the State is declared by the President of the United States under provisions of the federal National Emergencies Act or the U.S. Secretary of Health and Human Services under the federal Public Health Services Act and is based on a serious threat to health resulting from the existence of a deadly agent;
- Provides that any regulation issued under these circumstances may not apply beyond the duration of the President's or Secretary of Health and Human Service's declaration;
- Requires carriers offering Medicare supplement plans in Maryland to provide a guaranteed issue period during the 63 days after a public health emergency ends, when certain eligible individuals terminated from Medicaid more than six months following the effective date of enrollment in Medicare Part B may enroll in any Medicare supplement policy without underwriting or imposition of a pre-existing condition exclusion.

Effective Date: April 7, 2022 (Upon Enactment - Emergency Bill)

HOUSE BILL 820 (Chapter 321) – Health Insurance – Pediatric Autoimmune Neuropsychiatric Disorders – Modification of Coverage Requirements

- Repeals the exemption from coverage for rituximab unless the federal Food and Drug Administration approves the use of rituximab for the treatment of certain pediatric autoimmune neuropsychiatric disorders, by amending § 15-865 of the Insurance Article.

Effective Date: January 1, 2023

SENATE BILL 707 (Chapter 727) / HOUSE BILL 912 (Chapter 271) – Health Insurance – Provider Panels – Coverage for Nonparticipation

- Amends § 15-830 of the Insurance Article to include providers that are licensed as a behavioral health program under § 7.5–401 of the Health – General Article, in the definition of a non-physician specialist;
- Requires carriers to cover services for mental health or substance use disorders at no greater cost to the member than if the covered services were provided by a provider on the provider panel when the services are provided under a referral to a specialist or nonphysician specialist in accordance with § 15-830(d) of the Insurance Article;
- Requires carriers to inform members of the procedure to request a referral to a specialist, or non-physician specialist, who is not part of the carrier's provider panel;
- Requires the Consumer Education and Advocacy Program, in collaboration with the Health Education and Advocacy Unit of the Office of the Attorney General, to provide public education to inform consumers of the procedures to request a referral to a specialist or nonphysician specialist in certain circumstances.

Effective Date: July 1, 2022

HOUSE BILL 970 (Chapter 684) – Managed Care Organizations and Health Insurance Carriers – Prior Authorization for HIV Postexposure Prophylaxis – Prohibition

- Amends § 15-103 of the Health General Article to restrict Managed Care Organizations from applying a prior authorization requirement for a prescription drug used as post exposure prophylaxis for the prevention of HIV.
- Creates a new § 15-857 of the Insurance Article to restrict health insurance carriers from applying a prior authorization requirement for a prescription drug used as prost exposure prophylaxis for the prevention of HIV.

Effective Date: January 1, 2023

SENATE BILL 823 (Chapter 308) / HOUSE BILL 973 (Chapter 307) – Pharmacy Services Administrative Organizations and Pharmacy Benefits Managers – Contracts

- Amends § 15-1628 of the Insurance Article to require a contract form or an amendment to a contract form between a pharmacy benefits manager (PBM) and a pharmacy services administrative organizations (PSAO) acting on behalf of a pharmacy, to be filed with the MIA at least 30 days before the contract form or amendment is to become effective;
- Amends § 15-2004 of the Insurance Article, to repeal the requirement that a PSAO register with the MIA in order to contract with a PBM. The prohibition against a PSAO that has not registered with the MIA from entering into a contract with an independent pharmacy remains;
- Amends § 15-2010 of the Insurance Article to repeal the requirement that a PSAO file with the MIA contracts and amendments to contracts between the PSAO and a PBM;
- Amends § 15-2011 of the Insurance Article to require a PSAO contract to include a provision that requires the PSAO to provide to the independent pharmacy an electronic or

paper copy of any contracts, amendments, payment schedules, or reimbursement rates within five working days after the execution of a contract, or an amendment to a contract, signed on behalf of the independent pharmacy by the PSAO.

Effective Date: October 1, 2022

SENATE BILL 824 (Chapter 312) / HOUSE BILL 1073 (Chapter 311) –Health – Accessibility of Electronic Advance Care Planning Documents

- Among other things, amends § 15-122.1 of the Insurance Article to require health insurance carriers to maintain a link on their website to a forthcoming state–designated health information exchange website that contains resources on advanced care planning;
- Requires health insurance carriers to provide new and renewing members with an advance directive information sheet;
- Adds § 19-145 to the Health-General Article that, among other things, requires the MHCC to coordinate the accessibility of electronic advance care planning documents in the State and provides an option for a carrier or Managed Care Organization to contract with an MHCC approved electronic advance directives service.

Effective Date: June 1, 2022

SENATE BILL 834 (Chapter 298) / HOUSE BILL 1148 (Chapter 297) – Health Insurance – Two-Sided Incentive Arrangements and Capitated Payments – Authorization

- Amends § 15-113 of the Insurance Article to authorize carriers to enter into two-sided incentive arrangements and includes provisions that act as guardrails to protect the integrity of the voluntary agreement including certain disclosure requirements;
- Prohibits carriers from reducing the fee schedule of a health care provider because the provider does not participate in the carrier's bonus or other incentive–based compensation or two–sided incentive arrangement program;
- Specifies that participation in a two–sided incentive arrangement may not be the sole opportunity for a health care provider to be eligible to receive increases in reimbursement;
- Prohibits carriers from requiring, as a condition of participation in the carrier's provider network, a provider to participate in the carrier's incentive–based compensation or two–sided incentive arrangement programs;
- Requires the acceptance of a capitated payment to be voluntary;
- Permits a carrier to recoup funds paid to an eligible provider based on the terms of a written contract between the carrier and the eligible provider, under a two–sided incentive arrangement, provide that the contract meets specific standards.
- Amends § 4-205 of the Insurance Article to provide that a health care provider or practitioner that accepts capitated payments in accordance with new §15-2102 of the Insurance Article is not engaging in insurance business;
- Amends § 15-1008 of the Insurance Article to clarify that the limitations on a carrier's right to retroactively deny reimbursement to a provider are not applicable to

reimbursement adjustments made under a two-sided incentive arrangement described in § 15-113

- Adds new Subtitle 21 to Title 15 of the Insurance Article, creating §§ 15-2101 through 15-2102, which authorizes health care providers to receive capitated payments under insured or self-funded plans without being considered as engaging in insurance business.

Effective Date: October 1, 2022

SENATE BILL 661 (Chapter 372) / HOUSE BILL 1219 (Chapter 371) – Pharmacists – Status as Health Care Providers and Study on Reimbursement

- Requires the MIA to establish a working group to identify options and requirements necessary for the reimbursement of pharmacists who provide medical services within their scope of practice and work setting, and report its findings and recommendations to the Senate Finance Committee and the House Health & Government Operations Committee on or before December 31, 2022.
- Provides that, for purposes of record retention requirements imposed on health care providers by § 4-403 of the Health – General Article, the term "health care provider" includes a pharmacist.

Effective Date: July 1, 2022

HOUSEE BILL 1274 (Chapter 365) – Prescription Drugs – Pharmacy Benefits Managers – Federal 340B Program

- Adds § 15-1611.2 to the Insurance Article to prohibit Pharmacy Benefits Managers (PBMs) from taking certain actions towards pharmacies or pharmacists that participate in the drug pricing program established under §602 of the federal Veterans Health Care Act, known as the "340B program." These actions include:
    - refusing to cover prescription drugs purchased under the 340B program;
    - transferring 340B program savings from a pharmacy or pharmacist that participates in the 340B program to a PBM;
    - offering lower reimbursement for a prescription drug purchased under the 340B program than the reimbursement it offers for the same prescription drug if it is not purchased under the 340B program;
    - refusing to allow pharmacies or pharmacists that participate in the 340B program from participating in the PBM's network on the sole basis that the pharmacy or pharmacist participates in the 340B program;
    - imposing different reimbursement or network participation contract terms on pharmacies or pharmacists that participate in a PBM's network based on whether a pharmacy or pharmacist participates in the 340B program;
    - imposing different fees, chargebacks, or other adjustments on pharmacies or pharmacists based on whether a pharmacy or pharmacist participates in the 340B program;
    - modifying a beneficiary's copayment on the basis of whether a pharmacy or pharmacist participates in the 340B program;

    - establishing or setting network adequacy requirements based on whether a pharmacy or pharmacist participates in the 340B program;
    - prohibiting a covered entity authorized to participate in the 340B program, or a pharmacy or pharmacist under contract with a covered entity authorized to participate in the 340B program, from participating in the PBM's network on the basis of the entity's participation in the 340B program.
- Requires a PBM to make formulary and coverage decisions for a pharmacy or pharmacist that participates in the 340B program based on the normal course of business of the PBM;
- Requires a PBM to allow a beneficiary to use any in-network pharmacy or pharmacist that the beneficiary chooses without regard to whether the pharmacy or pharmacist participates in 340B program;
- Prohibits a PBM from basing a formulary or prescription drug coverage decisions on the price of the prescription drug under the 340B program or whether the dispensing pharmacy or pharmacist participates in the 340B program.

Effective Date: October 1, 2022

SENATE BILL 353 / HOUSE BILL 1397 (Chapter 405) – <u>Health Insurance – Prescription Insulin Drugs – Limits on Copayment and Coinsurance (Insulin Cost Reduction Act)</u>

- Creates new § 15-822.1 of the Insurance Article, which require insurers, nonprofit health service plans, and HMOs that provide coverage for prescription drugs under individual and group contracts to limit the amount a covered person is required to pay in copayments and coinsurance for a covered prescription insulin drug, to no more than $30 for a 30-day supply, regardless of the amount or type of insulin needed to fill the covered individual's prescription;
- Prohibits a participating provider pharmacy contract from authorizing a pharmacy to charge more, collect from a covered individual more, or require a covered individual to pay more than $30 for a 30-day supply for a covered prescription insulin drug.
- Amends § 15-847.1 of the Insurance Article to clarify that the copayment or coinsurance limit in existing law for a prescription drug prescribed for diabetes is subject to the new § 15-822.1.

Effective Date: January 1, 2023

SENATE BILL 19 (Chapter 720) – Pharmacists – Administration of Injectable Medications for Treatment of Sexually Transmitted Infections

- In addition to other changes not in the Insurance Article, this bill amends § 15-716 of the Insurance Article to require insurers, nonprofit health service plans, and HMOs that provide coverage under individual group or blanket health insurance policies for patient assessment regarding, and administration of self-administered medications, maintenance injectable medications, and injectable medications for treatment of sexually transmitted infections, to provide that coverage if the services are rendered by a licensed pharmacist, to the same extent as the services rendered by any other licensed health care practitioner.

Effective Date: October 1, 2022

SENATE BILL 180 (Chapter 229) –Insurance – Conformity with Federal Law – The No Surprises Act and Other Provisions of the Consolidated Appropriations Act, 2021

- Creates new § 15-146 of the Insurance Article to specify that the provisions of the Federal No Surprises Act and Division BB, Title II, § 201 of the federal Consolidated Appropriations Act, 2021 apply to all insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery in the State policies or contracts for a health benefit plan or blanket health insurance;
- Specifies that the provisions of Division BB, Title II, §§ 202 and 203 of the federal Consolidated Appropriations Act, 2021, apply to all insurers, nonprofit health service plans, and health maintenance organizations that deliver or issue for delivery in the State policies or contracts for a health benefit plan, blanket health insurance, or short–term limited duration insurance;
- Authorizes the Commissioner to enforce the new § 15-146 under any applicable provisions of the Insurance Article.

Effective Date: April 21, 2022

SENATE BILL 173 (Chapter 305) / HOUSE BILL 106 (Chapter 304) – Health Insurance – Nonprofit Health Service Plan – Board of Directors

- Amends § 14-115 of the Insurance Article to require the board of directors of a nonprofit health service plan to be composed of at least 11 members and no more than 21 voting members, and to seek to include individuals with a diverse range of experience relevant to the mission of the nonprofit health service plan;
- Alters the required composition of the board of directors to include three consumer members and no more than five members who are licensed health care professionals, hospital administrators, or employees of health care professionals or hospitals;
- Requires the three consumer members of the board to be either subscribers or certificate holders of the nonprofit health service plan or its affiliates, at the time of their initial election to the board.

Effective Date: July 1, 2022

OTHER

SENATE BILL 167 (Chapter 120) – Maryland Insurance Administration – Enforcement Authority – Payment of Claims

- Amends § 4-113 of the Insurance Article to clarify the Commissioner's authority to instead of, or in addition to suspending or revoking a certificate of authority, require an insurer to make restitution to any person who has suffered financial injury including requiring the holder to fulfill any obligation under the policies or contracts of the holder that the holder failed to fulfill in violation of the Insurance Article, or pay a claim or an amount due under any insurance policy or contract not paid in violation of the Insurance Article;
- Amends § 27-305 of the Insurance Article to authorizes the Commissioner, upon finding a violation of an unfair claim settlement practice, to require an insurer, nonprofit health service plan, or health maintenance organization to provide a payment to a claimant that has been determined to be denied in violation of the Insurance Article.

Effective Date: October 1, 2022

SENATE BILL 207 (Chapter 231) – Insurance Carriers and Managed Care Organizations - Cybersecurity Standard

- Adds Title 33 to the Insurance Article to establish cybersecurity standards for insurers and certain other licensees of the Commissioner and establishes data security and incident response requirements for segments of the insurance industry, including insurance companies;
- Establishes standards for the investigation of and notification to the Commissioner of a cybersecurity event applicable to carriers;
- Specifies that compliance with Title 33 does not relieve a carrier from a duty to comply with any other requirements of federal law relating to the protection and privacy of personal information;
- Requires carriers to develop, implement, and maintain a comprehensive written information security program based on the carrier's risk assessment, in accordance with specific guidelines;
- Requires carriers to stay informed regarding emerging cybersecurity threats or vulnerabilities and use reasonable security measures when sharing information;
- Requires carriers to maintain an incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity, or availability of nonpublic information in its possession, and meet other guidelines in Title 33;
- Requires carriers, on or before April 15 each year, to submit to the Commissioner a written statement certifying that the carrier has adopted an information security program and is in compliance with the additional requirements set forth in Title 33;
- Exempts certain carriers not domiciled in the State that meet certain criteria;

- Establishes certain courses of action carriers are required to take when a cybersecurity event occurs;
- Provides for certain penalties for each violation of Title 33;
- Specifies that carriers have until October 1, 2023 to implement § 33–103 and until October 1, 2024, to implement § 33–103(h), of the Insurance Article.
- Provides that carriers that meet certain criteria may defer implementation of Title 33 for up to one year.

Effective Date: October 1, 2022