

Article - Insurance

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§14-505.

(a) (1) The Board shall establish a standard benefit package to be offered by the Plan.

(2) The Board may exclude from the benefit package:

(i) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(ii) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(b) (1) The Board shall develop a master plan document that sets forth in detail all of the terms and conditions of the standard benefit package required by subsection (a)(1) of this section, including:

(i) the benefits provided in the package;

(ii) any exclusions from coverage;

(iii) any conditions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service;

(iv) any conditions or limitations on the selection of a primary care provider or provider of specialty medical care;

(v) any cost-sharing requirements, including any premiums, deductibles, coinsurance, and copayment amounts for which a member may be responsible; and

(vi) the procedures to be followed in presenting a claim.

(2) The Board shall:

(i) file the master plan document with the Commissioner; and

(ii) provide a copy of the most recent version of the master plan document to a member, at no charge, on request of the member.

(c) (1) The Board shall develop a certificate of coverage that describes the essential features of the Plan and the standard benefit package.

- (2) The certificate of coverage shall:
 - (i) be written in clear and easy to understand language; and
 - (ii) be sufficiently accurate and comprehensive to reasonably inform members of their rights and obligations under the standard benefit package.
- (3) The Board shall update the certificate of coverage as necessary to reflect changes to the standard benefit package.
- (4) The Board shall:
 - (i) within 30 days after a member's enrollment in the Plan, provide the most recent version of the certificate of coverage to:
 1. the member; or
 2. if dependents are included in the coverage, to the family unit;
 - (ii) make the most recent version of the certificate of coverage available on the Plan Web site; and
 - (iii) provide notice of any change to the standard benefit package to:
 1. each member of the Plan to whom a certificate of coverage previously has been provided; or
 2. if dependents are included in the coverage, to each family unit to which a certificate of coverage previously has been provided.
- (d) The Board may make a change to the standard benefit package only if:
 - (1) the proposed change is submitted in writing to the Board at least 15 days before the meeting at which a vote on the proposed change will be taken;
 - (2) consideration of the proposed change is listed as an action item on the agenda for the meeting;
 - (3) the proposed change is set forth in a written motion that:
 - (i) identifies the specific changes to be made; and
 - (ii) is included in the minutes of the meeting of the Board at which the motion is made;
 - (4) the deliberations and vote on the proposed change occur during a public session of a meeting with the Board; and

(5) the vote approving the proposed change is reflected in the minutes of the meeting of the Board at which the vote is taken.

(e) A change to the standard benefit package is not effective until the later of:

(1) 30 days after the date the Board adopts the change;

(2) the date an updated master plan document reflecting the change is filed with the Commissioner; or

(3) 15 days after notice of the change and the effective date of change is:

(i) sent to:

1. each member of the Plan; or

2. if dependents are included in the coverage, to the family unit; and

(ii) posted on the Plan Web site.

(f) On or before September 1 of each year, in accordance with § 2-1246 of the State Government Article, the Board shall report to the House Health and Government Operations Committee and the Senate Finance Committee on:

(1) the current standard benefit package offered by the Plan; and

(2) any changes to the standard benefit package implemented during the immediately preceding fiscal year.

(g) (1) If there is a conflict between a provision of the master plan document and a provision of the certificate of coverage, the provision that is most beneficial to the member shall control.

(2) Notwithstanding the terms and conditions of the standard benefit package, the master plan document, or the certificate of coverage, the Plan shall comply with the terms of any written representation or authorization of coverage made by or on behalf of the Plan to the extent that a member has incurred costs for health care services in reasonable reliance on the written representation or authorization.

(h) (1) The Board shall establish a premium rate for Plan coverage subject to review and approval by the Commissioner.

(2) The premium rate may vary on the basis of family composition.

(3) If the Board determines that a standard risk rate would create market dislocation, the Board may adjust the premium rate based on member age.

(4) The Board may charge different premiums based on the benefit

package delivery system or cost-sharing arrangement when more than one benefit package delivery system or cost-sharing arrangement is offered.

(i) (1) The Board shall determine a standard risk rate by considering the premium rates charged by carriers in the State for coverage comparable to that of the Plan.

(2) The premium rate for Plan coverage:

(i) may not be less than 110% of the standard risk rate established under paragraph (1) of this subsection; and

(ii) may not exceed 200% of the standard risk rate.

(3) Premium rates shall be reasonably calculated to encourage enrollment in the Plan.

(4) The Board may subsidize premiums, deductibles, and other policy expenses, based on a member's income.

(j) (1) Notwithstanding the provisions of subsection (h) of this section, if the Board has implemented a preexisting condition limitation, the Board may offer members an optional endorsement to remove the preexisting condition limitation.

(2) The Board may charge an actuarially justified additional premium amount in addition to the premium rate for the standard benefit package for the optional endorsement under paragraph (1) of this subsection.

(3) An amount charged in addition to the premium rate for the standard benefit package for the optional endorsement under paragraph (1) of this subsection shall be subject to review and approval by the Commissioner.

(k) Losses incurred by the Plan shall be subsidized by the Fund.

(l) (1) (i) In this subsection, "governmental unit" means a county, municipal corporation, unit of State or local government, or other public body created under State or local law.

(ii) "Governmental unit" does not include the Plan.

(2) This subsection does not apply to a member of the Plan who receives a tax credit for health insurance costs under § 35 of the Internal Revenue Code.

(3) The Board may establish a Plan option for a member of the Plan whose premiums are paid by a governmental unit.

(4) (i) Subject to subparagraph (ii) of this paragraph, in setting premium rates and cost-sharing arrangements for the Plan option established under

paragraph (3) of this subsection, the Board may include amounts to limit the shifting of costs from a governmental unit to the Plan.

(ii) The Board may not set premium rates and cost-sharing arrangements at a level that would make a governmental unit unable to pay the premiums and cost-sharing for the entire membership of a program of the governmental unit due to restrictions in federal law or policy on the use of federal funds by the governmental unit.

(5) If the premiums of a member of the Plan are paid by a governmental unit, the Board may:

(i) limit the eligibility of the member to the Plan option established under paragraph (3) of this subsection; and

(ii) limit or eliminate the availability to the member of any premium subsidy based on income.

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