Unofficial Copy **1998 Regular Session**
SB0085/629486/1

BY: Environmental Matters Committee and Economic Matters Committee

AMENDMENTS TO SENATE BILL NO. 85
(Third Reading File Bill)

AMENDMENT NO. 1

On page 1, at the top of the page, insert "EMERGENCY BILL".

AMENDMENT NO. 2

On page 1, strike line 2 in its entirety and substitute:

"Children and Families First Health Care Act of 1998";

and strike lines 3 through 12, inclusive, and substitute:

"FOR the purpose of establishing the Children and Families Health Care Program under which certain individuals who meet certain family income standards would be eligible for certain health benefits either through an employer sponsored health benefit plan or through the Maryland Medical Assistance Program; altering the eligibility requirements for certain individuals under the Children and Families Health Care Program; requiring the Department of Health and Mental Hygiene to provide expedited eligibility to certain individuals under certain circumstances; permitting certain enrollees of certain programs to have guaranteed eligibility for a certain time; requiring the Department to establish a certain school-based enrollment program; requiring the Department to develop certain outreach and enrollment options; providing that abortion services under the Children and Families Health Care Program shall be made available only in accordance with certain federal law; establishing certain guidelines for terminating employer sponsored health insurance; requiring that after the Governor appoints the initial members of the Board of Trustees for the Health Care Foundation, subsequent trustees shall be elected by the board members; providing for the appointment, compensation, and duties of an Executive Director for the Foundation; requiring certain entities to conduct a certain study and to provide recommendations in a report to the General Assembly on certain dates; authorizing the Department to establish

(Over)

certain regulations for the imposition of premiums; requiring managed care organizations participating in the managed care program to provide information to the Department and the Foundation on the cost of premiums for a certain health benefit package that would cover a family with dependents; requiring insurers and nonprofit health service plans that issue or deliver group or blanket health insurance policies to provide enrollment information for the Children and Families Health Care Program; prohibiting an agent, broker, or insurer from referring an employee or a dependent of an employee to the Children and Families Health Care Program or arranging for an employee or a dependent of an employee to apply to the Children and Families Health Care Program under certain circumstances; providing for the construction of certain provisions of this Act; providing for the termination of certain provisions of this Act; requiring the Department to seek approval from the federal Health Care Financing Administration for a tax credit program; providing for certain funds to be included in the budget for the Foundation; making this Act an emergency measure; providing for the effective date of certain provisions of this Act; altering a certain definition; defining certain terms; and generally relating to establishing the Children and Families Health Care Program.".

AMENDMENT NO. 3

On pages 1 and 2, strike in their entirety the lines beginning with line 13 on page 1 through line 7 on page 2, inclusive, and substitute:

"BY renumbering

Article - Health - General
Section 15-301 and the subtitle "Subtitle 3. Evaluation and Planning Services"
to be Section 15-501 and the subtitle "Subtitle 5. Evaluation and Planning Services"
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,

Article - Health - General
Section 15-101 and 15-103
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY adding to
Article - Health - General
Section 15-301 through 15-305, inclusive, to be under the new subtitle "Subtitle 3. Children and Families Health Care Program"
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 20-504, 20-505, and 20-506
Annotated Code of Maryland
(1996 Replacement Volume and 1997 Supplement)

BY adding to
Article - Insurance
Section 15-124 and 27-220
Annotated Code of Maryland
(1997 Volume)

BY repealing and reenacting, with amendments,
Article - State Government
Section 15-601
Annotated Code of Maryland
(1995 Replacement Volume and 1997 Supplement)

By repealing and reenacting, with amendments,
Article - Health - General
Section 15-301
Annotated Code of Maryland
(1994 Replacement Volume and 1997 Supplement)
(As enacted by Section 3 of this Act)".

(Over)

AMENDMENT NO. 4

On pages 2 through 4, strike in their entirety the lines beginning with line 8 on page 2 through line 2 on page 4, inclusive, and substitute:

"SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That Section(s) 15-301 and the subtitle "Subtitle 3. Evaluation and Planning Services" of Article - Health - General of the Annotated Code of Maryland be renumbered to be Section(s) 15-501 and the subtitle "Subtitle 5. Evaluation and Planning Services".

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

15-101.

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

(b) "Enrollee" means a program recipient who is enrolled in a managed care organization.

(c) "Facility" means a hospital or nursing facility including an intermediate care facility, skilled nursing facility, comprehensive care facility, or extended care facility.

(D) "FOUNDATION" MEANS THE MARYLAND HEALTH CARE FOUNDATION ESTABLISHED UNDER TITLE 20, SUBTITLE 5 OF THIS ARTICLE.

(E) "HEALTH MAINTENANCE ORGANIZATION" HAS THE MEANING STATED IN § 19-701 OF THIS ARTICLE.

[(d)] (F) (1) "Historic provider" means a health care provider, as defined in § 19-1501 of this article who, on or before June 30, 1995, had a demonstrated history of providing services to program recipients, as defined by the Department in regulations.

(2) "Historic provider", to the extent the provider meets the requirements in paragraph (1) of this subsection, shall include:

(i) A federal or State qualified community health center;

(ii) A provider with a program for the training of health care professionals, including an academic medical center;

(iii) A hospital outpatient program, physician, or advanced practice nurse that is a Maryland Access to Care (MAC) provider;

(iv) A local health department;

(v) A hospice, as defined in Title 19, Subtitle 9 of this article;

(vi) A pharmacy; and

(vii) Any other historic provider designated in accordance with regulations adopted by the Department.

[(e)] (G) "Managed care organization" means:

(1) A certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments; or

(2) A corporation that:

(i) Is a managed care system that is authorized to receive medical assistance prepaid capitation payments;

(ii) Enrolls only program recipients OR INDIVIDUALS OR FAMILIES SERVED UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM; and

(iii) Is subject to the requirements of § 15-102.4 of this title.

[(f)] (H) "Ombudsman program" means a program that assists enrollees in resolving disputes with managed care organizations in a timely manner and that is responsible, at a minimum, for the following functions:

(1) Investigating disputes between enrollees and managed care organizations referred by the enrollee hotline;

(2) Reporting to the Department:

(i) The resolution of all disputes;

(ii) A managed care organization's failure to meet the Department's requirements; and

(iii) Any other information specified by the Department;

(3) Educating enrollees about:

(i) The services provided by the enrollee's managed care organization; and

(ii) The enrollee's rights and responsibilities in receiving services from the managed care organization; and

(4) Advocating on behalf of the enrollee before the managed care organization, including assisting the enrollee in using the managed care organization's grievance process.

[(g)] (I) "Primary mental health services" means the clinical evaluation and assessment of services needed by an individual and the provision of services or referral for additional services as deemed medically appropriate by a primary care provider.

[(h)] (J) "Program" means the Maryland Medical Assistance Program.

[(i)] (K) "Program recipient" means an individual who receives benefits under the Program.

[(j)] (L) "Specialty mental health services" means any mental health services other than primary mental health services.

15-103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(i) Subject to the limitations of the State budget, shall provide comprehensive medical and other health care services for indigent individuals or medically indigent individuals or both;

(ii) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all eligible pregnant women [and, at a minimum, all children currently under the age of 1 whose family income falls below 185] WHOSE FAMILY INCOME IS AT OR BELOW 200 percent of the poverty level, as permitted by the federal law;

(III) SHALL PROVIDE, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET, COMPREHENSIVE MEDICAL AND OTHER HEALTH CARE SERVICES FOR ALL ELIGIBLE CHILDREN CURRENTLY UNDER THE AGE OF 1 WHOSE FAMILY INCOME FALLS BELOW 185 PERCENT OF THE POVERTY LEVEL, AS PERMITTED BY FEDERAL LAW;

[(iii)](IV) Shall provide, subject to the limitations of the State budget, family planning services to women currently eligible for comprehensive medical care and other health care under item (ii) of this paragraph for 5 years after the second month following the month in which the woman delivers her child;

[(iv)](V) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all children from the age of 1 year up

through and including the age of 5 years whose family income falls below 133 percent of the poverty level, as permitted by the federal law;

[(v)](VI) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all children born after September 30, 1983 who are at least 6 years of age but are under 19 years of age whose family income falls below 100 percent of the poverty level, as permitted by federal law;

[(vi)](VII) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all legal immigrants who meet Program eligibility standards and who arrived in the United States before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act, as permitted by federal law;

[(vii)](VIII) Shall provide, subject to the limitations of the State budget and any other requirements imposed by the State, comprehensive medical care and other health care services for all legal immigrant children under the age of 18 years and pregnant women who meet Program eligibility standards and who arrived in the United States on or after August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

[(viii)](IX) May include bedside nursing care for eligible Program recipients; and

[(ix)](X) Shall provide services in accordance with funding restrictions included in the annual State budget bill.

(3) Subject to restrictions in federal law or waivers, the Department may impose cost-sharing on Program recipients.

(4) (I) TO THE EXTENT ALLOWED UNDER FEDERAL LAW AND REGULATIONS, THE SECRETARY SHALL IMPLEMENT EXPEDITED ELIGIBILITY FOR ANY CHILD WHO APPLIES FOR THE PROGRAM UNDER THIS SECTION OR FOR THE PROGRAM UNDER § 15-301 OF THIS TITLE.

(II) THE SECRETARY SHALL ADOPT REGULATIONS TO ESTABLISH STANDARDS AND PROCEDURES FOR THE DESIGNATION OF ORGANIZATIONS, SUCH AS FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS AND DISPROPORTIONATE SHARE HOSPITALS, AS QUALIFIED ENTITIES TO GRANT EXPEDITED ELIGIBILITY.

(III) IN DEVELOPING THE REGULATIONS REQUIRED UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE SECRETARY SHALL ENSURE THE REPRESENTATION OF STATEWIDE AND LOCAL ORGANIZATIONS THAT PROVIDE SERVICES TO CHILDREN OF ALL AGES IN EACH REGION OF THE STATE.

(IV) THE SECRETARY SHALL PROVIDE QUALIFIED ENTITIES:

1. WITH FORMS THAT ARE NECESSARY FOR PARENTS, GUARDIANS, AND OTHER INDIVIDUALS TO SUBMIT APPLICATIONS TO THE PROGRAMS ON BEHALF OF A CHILD; AND

2. INFORMATION ON HOW TO ASSIST PARENTS, GUARDIANS, AND OTHER INDIVIDUALS IN COMPLETING AND FILING SUCH APPLICATIONS.

(b) (1) As permitted by federal law or waiver, the Secretary may establish a program under which Program recipients are required to enroll in managed care organizations.

(2) (i) The benefits required by the program developed under paragraph (1) of this subsection shall be adopted by regulation and shall be equivalent to the benefit level required by the Maryland Medical Assistance Program on January 1, 1996.

(ii) Subject to the limitations of the State budget and as permitted by federal law or waiver, the Department shall provide reimbursement for medically necessary and appropriate inpatient, intermediate care, and halfway house substance abuse treatment services for substance abusing enrollees 21 years of age or older who are recipients of temporary cash assistance under the Family Investment Program.

(Over)

(iii) Each managed care organization participating in the program developed under paragraph (1) of this subsection shall provide or arrange for the provision of the benefits described in subparagraph (ii) of this paragraph.

(iv) Nothing in this paragraph may be construed to prohibit a managed care organization from offering additional benefits, if the managed care organization is not receiving capitation payments based on the provision of the additional benefits.

(3) Subject to the limitations of the State budget and as permitted by federal law or waiver, the program developed under paragraph (1) of this subsection AND THE PROGRAM DEVELOPED UNDER § 15-301 OF THIS TITLE may provide guaranteed eligibility for each enrollee for up to 6 months, unless an enrollee obtains health insurance through another source.

(4) (i) The Secretary may exclude specific populations or services from the program developed under paragraph (1) of this subsection.

(ii) For any populations or services excluded under this paragraph, the Secretary may authorize a managed care organization, to provide the services or provide for the population, including authorization of a separate dental managed care organization or a managed care organization to provide services to Program recipients with special needs.

(5) (i) Except for a service excluded by the Secretary under paragraph (4) of this subsection, each managed care organization shall provide all the benefits required by regulations adopted under paragraph (2) of this subsection.

(ii) For a population or service excluded by the Secretary under paragraph (4) of this subsection, the Secretary may authorize a managed care organization to provide only for that population or provide only that service.

(iii) A managed care organization may subcontract specified required services to a health care provider that is licensed or authorized to provide those services.

(6) Except for the Program of All-inclusive Care for the Elderly ("PACE") Program,

the Secretary may not include the long-term care population or long-term care services in the program developed under paragraph (1) of this subsection.

(7) The program developed under paragraph (1) of this subsection shall ensure that enrollees have access to a pharmacy that:

(i) Is licensed in the State; and

(ii) Is within a reasonable distance from the enrollee's residence.

(8) For cause, the Department may disenroll enrollees from a managed care organization and enroll them in another managed care organization.

(9) Each managed care organization shall:

(i) Have a quality assurance program in effect which is subject to the approval of the Department and which, at a minimum:

1. Complies with any health care quality improvement system developed by the Health Care Financing Administration;

2. Complies with the quality requirements of applicable State licensure laws and regulations;

3. Complies with practice guidelines and protocols specified by the Department;

4. Provides for an enrollee grievance system, including an enrollee hotline;

5. Provides a provider grievance system;

6. Provides for enrollee and provider satisfaction surveys, to be taken

at least annually;

7. Provides for a consumer advisory board to receive regular input from enrollees;

8. Provides for an annual consumer advisory board report to be submitted to the Secretary; and

9. Complies with specific quality, access, data, and performance measurements adopted by the Department for treating enrollees with special needs;

(ii) Submit to the Department:

1. Service-specific data by service type in a format to be established by the Department; and

2. Utilization and outcome reports, such as the Health Plan Employer Data and Information Set (HEDIS), as directed by the Department;

(iii) Promote timely access to and continuity of health care services for enrollees;

(iv) Demonstrate organizational capacity to provide special programs, including outreach, case management, and home visiting, tailored to meet the individual needs of all enrollees;

(v) Provide assistance to enrollees in securing necessary health care services;

(vi) Provide or assure alcohol and drug abuse treatment for substance abusing pregnant women and all other enrollees of managed care organizations who require these services;

(vii) Educate enrollees on health care prevention and good health habits;

(viii) Assure necessary provider capacity in all geographic areas under contract;

(ix) Be accountable and hold its subcontractors accountable for standards established by the Department and, upon failure to meet those standards, be subject to one or more of the following penalties:

1. Fines;

2. Suspension of further enrollments;

3. Withholding of all or part of the capitation payment;

4. Termination of the contract;

5. Disqualification from future participation in the Program; and

6. Any other penalties that may be imposed by the Department;

(x) Subject to applicable federal and State law, include incentives for enrollees to comply with provisions of the managed care organization;

(xi) Provide or arrange to provide primary mental health services;

(xii) Provide or arrange to provide all Medicaid-covered services required to comply with State statutes and regulations mandating health and mental health services for children in State supervised care:

1. According to standards set by the Department; and

2. Locally, to the extent the services are available locally;

(xiii) Submit to the Department aggregate information from the quality assurance program, including complaints and resolutions from the enrollee and provider grievance systems, the enrollee hotline, and enrollee satisfaction surveys;

(xiv) Maintain as part of the enrollee's medical record the following information:

1. The basic health risk assessment conducted on enrollment;

2. Any information the managed care organization receives that results from an assessment of the enrollee conducted for the purpose of any early intervention, evaluation, planning, or case management program;

3. Information from the local department of social services regarding any other service or benefit the enrollee receives, including assistance or benefits under Article 88A of the Code; and

4. Any information the managed care organization receives from a school-based clinic, a core services agency, a local health department, or any other person that has provided health services to the enrollee; and

(xv) Upon provision of information specified by the Department under paragraph (19) of this subsection, pay school-based clinics for services provided to the managed care organization's enrollees.

(10) The Department shall adopt regulations that assure that managed care organizations employ appropriate personnel to:

(i) Assure that individuals with special needs obtain needed services; and

(ii) Coordinate those services.

(11) (i) A managed care organization shall reimburse a hospital emergency facility and provider for:

1. Health care services that meet the definition of emergency services in § 19-701 of this article;

2. Medical screening services rendered to meet the requirements of the federal Emergency Medical Treatment and Active Labor Act;

3. Medically necessary services if the managed care organization authorized, referred, or otherwise allowed the enrollee to use the emergency facility and the medically necessary services are related to the condition for which the enrollee was allowed to use the emergency facility; and

4. Medically necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to the enrollee if the managed care organization fails to provide 24-hour access to a physician as required by the Department.

(ii) A provider may not be required to obtain prior authorization or approval for payment from a managed care organization in order to obtain reimbursement under this paragraph.

(12) (i) Each managed care organization shall notify each enrollee when the enrollee should obtain an immunization, examination, or other wellness service.

(ii) Managed care organizations shall:

1. Maintain evidence of compliance with paragraph (9)(i) of this subsection; and

2. Upon request by the Department, provide to the Department evidence of compliance with paragraph (9)(i) of this subsection.

(iii) A managed care organization that does not comply with subparagraph (i) of this paragraph for at least 90% of its new enrollees:

1. Within 90 days of their enrollment may not receive more than 80% of its capitation payments;

2. Within 180 days of their enrollment may not receive more than 70% of its capitation payments; and

3. Within 270 days of their enrollment may not receive more than 50% of its capitation payments.

(13) The Department shall:

(i) Establish and maintain an ombudsman program and a locally accessible enrollee hotline;

(ii) Perform focused medical reviews of managed care organizations that include reviews of how the managed care organizations are providing health care services to special populations;

(iii) Provide timely feedback to each managed care organization on its compliance with the Department's quality and access system;

(iv) Establish and maintain within the Department a process for handling provider complaints about managed care organizations; and

(v) Adopt regulations relating to appeals by managed care organizations of penalties imposed by the Department, including regulations providing for an appeal to the Office of Administrative Hearings.

(14) (i) Except as provided in subparagraph (iii) of this paragraph, the Department shall delegate responsibility for maintaining the ombudsman program for a county to that county's local health department on the request of the local health department.

(ii) A local health department may not subcontract the ombudsman program.

(iii) Before the Department delegates responsibility to a local health department to maintain the ombudsman program for a county, a local health department that is also a

Medicaid provider must receive the approval of the Secretary and the local governing body.

(15) A managed care organization may not:

(i) Without authorization by the Department, enroll an individual who at the time is a Program recipient; or

(ii) Have face-to-face or telephone contact, or otherwise solicit with an individual who at the time is a Program recipient before the Program recipient enrolls in the managed care organization unless:

1. Authorized by the Department; or

2. The Program recipient initiates contact.

(16) (i) The Department shall be responsible for enrolling Program recipients into managed care organizations.

(ii) The Department may contract with an entity to perform the enrollment function.

(iii) The Department or its enrollment contractor shall administer a health risk assessment developed by the Department to ensure that individuals who need special or immediate health care services will receive the services on a timely basis.

(iv) The Department or its enrollment contractor:

1. May administer the health risk assessment only after the Program recipient has chosen a managed care organization; and

2. Shall forward the results of the health risk assessment to the managed care organization chosen by the Program recipient within 5 business days.

(17) For a managed care organization with which the Secretary contracts to provide

services to Program recipients under this subsection, the Secretary shall establish a mechanism to initially assure that each historic provider that meets the Department's quality standards has the opportunity to continue to serve Program recipients as a subcontractor of at least one managed care organization.

(18) (i) The Department shall make capitation payments to each managed care organization as provided in this paragraph.

(ii) In consultation with the Insurance Commissioner, the Secretary shall:

1. Set capitation payments at a level that is actuarially adjusted to the benefits provided; and

2. Actuarially adjust the capitation payments to reflect the relative risk assumed by the managed care organization.

(19) (i) School-based clinics and managed care organizations shall collaborate to provide continuity of care to enrollees.

(ii) School-based clinics shall be defined by the Department in consultation with the State Department of Education.

(iii) Each managed care organization shall require a school-based clinic to provide to the managed care organization certain information, as specified by the Department, about an encounter with an enrollee of the managed care organization prior to paying the school-based clinic.

(iv) Upon receipt of information specified by the Department, the managed care organization shall pay, at Medicaid-established rates, school-based clinics for covered services provided to enrollees of the managed care organization.

(v) The Department shall work with managed care organizations and school-based clinics to develop collaboration standards, guidelines, and a process to assure that the services provided are covered and medically appropriate and that the process provides for timely notification

among the parties.

(vi) Each managed care organization shall maintain records of all health care services:

1. Provided to its enrollees by school-based clinics; and
2. For which the managed care organization has been billed.

(20) The Department shall establish standards for the timely delivery of services to enrollees.

(21) (i) The Department shall establish a delivery system for specialty mental health services for enrollees of managed care organizations.

(ii) The Mental Hygiene Administration shall:

1. Design and monitor the delivery system;

2. Establish performance standards for providers in the delivery system; and

3. Establish procedures to ensure appropriate and timely referrals from managed care organizations to the delivery system that include:

A. Specification of the diagnoses and conditions eligible for referral to the delivery system;

B. Training and clinical guidance in appropriate use of the delivery system for managed care organization primary care providers;

C. Preauthorization by the utilization review agent of the delivery system; and

D. Penalties for a pattern of improper referrals.

(iii) The Department shall collaborate with managed care organizations to develop standards and guidelines for the provision of specialty mental health services.

(iv) The delivery system shall:

1. Provide all specialty mental health services needed by enrollees;

2. For enrollees who are dually-diagnosed, coordinate the provision of substance abuse services provided by the managed care organizations of the enrollees;

3. Consist of a network of qualified mental health professionals from all core disciplines;

4. Include linkages with other public service systems; and

5. Comply with quality assurance, enrollee input, data collection, and other requirements specified by the Department in regulation.

(v) The Department may contract with a managed care organization for delivery of specialty mental health services if the managed care organization meets the performance standards adopted by the Department in regulations.

(22) The Department shall include a definition of medical necessity in its quality and access standards.

(23) (i) The Department shall adopt regulations relating to enrollment, disenrollment, and enrollee appeals.

(ii) An enrollee may disenroll from a managed care organization:

1. Without cause in the month following the anniversary date of the enrollee's enrollment; and

2. For cause, at any time as determined by the Secretary.

(24) The Department or its subcontractor, to the extent feasible in its marketing or enrollment programs, shall hire individuals receiving assistance under the program of Aid to Families with Dependent Children established under Title IV, Part A, of the Social Security Act, or the successor to the program.

(25) The Department shall disenroll an enrollee who is a child in State-supervised care if the child is transferred to an area outside of the territory of the managed care organization.

(26) The Secretary shall adopt regulations to implement the provisions of this section.

(27) (i) The Department shall establish the Maryland Medicaid Advisory Committee, composed of no more than 25 members, the majority of whom are enrollees or enrollee advocates.

(ii) The Committee members shall include:

1. Current or former enrollees or the parents or guardians of current or former enrollees;

2. Providers who are familiar with the medical needs of low-income population groups, including board-certified physicians;

3. Hospital representatives;

4. Advocates for the Medicaid population, including representatives of special needs populations;

5. Two members of the Finance Committee of the Senate of Maryland, appointed by the President of the Senate; and

6. Three members of the Maryland House of Delegates, appointed by the Speaker of the House.

(iii) A designee of each of the following shall serve as an ex-officio member of the Committee:

1. The Secretary of Human Resources;

2. The Executive Director of the Maryland Health Care Access and Cost Commission; and

3. The Maryland Association of County Health Officers.

(iv) In addition to any duties imposed by federal law and regulation, the Committee shall:

1. Advise the Secretary on the implementation, operation, and evaluation of managed care programs under this section;

2. Review and make recommendations on the regulations developed to implement managed care programs under this section;

3. Review and make recommendations on the standards used in contracts between the Department and managed care organizations;

4. Review and make recommendations on the Department's oversight of quality assurance standards;

5. Review data collected by the Department from managed care organizations participating in the Program and data collected by the Maryland Health Care Access and Cost Commission;

6. Promote the dissemination of managed care organization performance information, including loss ratios, to enrollees in a manner that facilitates quality comparisons and uses layman's language;

7. Assist the Department in evaluating the enrollment process;

8. Review reports of the ombudsmen; and

9. Publish and submit an annual report to the Governor and, subject to § 2-1246 of the State Government Article, the General Assembly.

(v) Except as specified in subparagraphs (ii) and (iii) of this paragraph, the members of the Maryland Medicaid Advisory Committee shall be appointed by the Secretary and serve for a 4-year term.

(vi) In making appointments to the Committee, the Secretary shall provide for continuity and rotation.

(vii) The Secretary shall appoint the chairman of the Committee.

(viii) The Secretary shall appoint nonvoting members from managed care organizations who may participate in Committee meetings, unless the Committee meets in closed session as provided in § 10-508 of the State Government Article.

(ix) The Committee shall determine the times and places of its meetings.

(x) A member of the Committee:

1. May not receive compensation; but

2. Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(c) (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Certified nurse practitioner" means a registered nurse who is licensed in this State, has completed a nurse practitioner program approved by the State Board of Nursing, and has passed an examination approved by that Board.

(iii) "Nurse anesthetist" means a registered nurse who is:

1. Certified under the Health Occupations Article to practice nurse anesthesia; and

2. Certified by the Council on Certification or the Council on Recertification of Nurse Anesthetists.

(iv) "Nurse midwife" means a registered nurse who is licensed in this State and has been certified by the American College of Nurse-Midwives as a nurse midwife.

(v) "Optometrist" has the meaning stated in § 11-101 of the Health Occupations Article.

(2) The Secretary may contract for the provision of care under the Program to eligible Program recipients.

(3) The Secretary may contract with insurance companies or nonprofit health service plans or with individuals, associations, partnerships, incorporated or unincorporated groups of physicians, chiropractors, dentists, podiatrists, optometrists, pharmacists, hospitals, nursing homes, nurses, including nurse anesthetists, nurse midwives and certified nurse practitioners, opticians, and other health practitioners who are licensed or certified in this State and perform services on the prescription or referral of a physician.

(4) For the purposes of this section, the nurse midwife need not be under the supervision of a physician.

(5) Except as otherwise provided by law, a contract that the Secretary makes under this subsection shall continue unless terminated under the terms of the contract by the Program or by the provider.

(d) The Secretary shall apply for a waiver from the Health Care Financing Administration of the U.S. Department of Health and Human Services or take any other steps necessary to obtain

federal reimbursement for providing program services to any minor who had qualified, and subsequently lost eligibility, as disabled under the federal Supplemental Security Income (SSI) Program before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act.

(E) EACH MANAGED CARE ORGANIZATION UNDER CONTRACT WITH THE DEPARTMENT TO PROVIDE SERVICES TO ENROLLEES UNDER SUBSECTION (B) OF THIS SECTION SHALL SUBMIT TO THE DEPARTMENT AND TO THE FOUNDATION INFORMATION ON THE COST OF PREMIUMS TO COVER A FAMILY WITH DEPENDENTS UNDER A HEALTH BENEFIT PACKAGE THAT:

(1) SATISFIES THE REQUIREMENTS UNDER FEDERAL LAW OR REGULATION FOR PURPOSES OF RECEIVING FEDERAL REIMBURSEMENT; AND

(2) IS SUBSTANTIALLY EQUIVALENT TO THE BENEFITS OFFERED IN THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ADOPTED BY THE HEALTH CARE ACCESS AND COST COMMISSION UNDER TITLE 19, SUBTITLE 15 OF THIS ARTICLE AND § 15-1207 OF THE INSURANCE ARTICLE.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

SUBTITLE 3. CHILDREN AND FAMILIES HEALTH CARE PROGRAM.

15-301.

(A) IN THIS SECTION, "CARRIER" MEANS:

(1) AN INSURER;

(2) A NONPROFIT SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION; OR

(4) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO REGULATION BY THE STATE.

(B) THERE IS A CHILDREN AND FAMILIES HEALTH CARE PROGRAM.

(C) THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM SHALL PROVIDE, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND ANY OTHER REQUIREMENTS IMPOSED BY THE STATE AND AS PERMITTED BY FEDERAL LAW OR WAIVER, COMPREHENSIVE MEDICAL CARE AND OTHER HEALTH CARE SERVICES TO AN INDIVIDUAL WHO HAS A FAMILY INCOME AT OR BELOW 200 PERCENT OF THE FEDERAL POVERTY LEVEL AND WHO IS UNDER THE AGE OF 19 YEARS.

(D) EXCEPT AS PROVIDED IN SUBSECTION (E) OF THIS SECTION, THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM SHALL BE ADMINISTERED THROUGH THE PROGRAM DEVELOPED UNDER SUBTITLE 1 OF THIS TITLE REQUIRING INDIVIDUALS TO ENROLL IN MANAGED CARE ORGANIZATIONS.

(E) (1) IF AN INDIVIDUAL'S PARENT OR GUARDIAN IS COVERED UNDER AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN WITH DEPENDENT COVERAGE, CERTIFIED UNDER PARAGRAPH (4) OF THIS SUBSECTION, THE INDIVIDUAL IS NOT ELIGIBLE FOR THE PROGRAM DEVELOPED UNDER SUBTITLE 1 OF THIS TITLE AND IS ONLY ELIGIBLE TO RECEIVE A VOUCHER TO COVER THE COSTS OF DEPENDENT COVERAGE.

(2) UNTIL DEPENDENT COVERAGE UNDER AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN HAS BEEN CERTIFIED BY THE SECRETARY UNDER PARAGRAPH (4) OF THIS SUBSECTION, THE INDIVIDUAL IS ELIGIBLE THROUGH THE PROGRAM DEVELOPED UNDER SUBTITLE 1 OF THIS TITLE.

(3) AN ELIGIBLE INDIVIDUAL MAY BE ENROLLED IN AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN UNDER:

(I) AN INDEPENDENT INSURANCE POLICY; OR

(II) AN ADD-ON TO AN EXISTING POLICY.

(4) (I) A CARRIER THAT OFFERS AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN OR A CARRIER THAT INTENDS TO OFFER AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL SUBMIT THE PLAN TO THE SECRETARY.

(II) THE SECRETARY, IN CONSULTATION WITH THE COMMISSIONER, SHALL CERTIFY, WITHIN A REASONABLE TIME, THE EMPLOYER SPONSORED HEALTH BENEFIT PLAN, IF THE PLAN MEETS THE COVERAGE REQUIREMENTS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT AND ANY OTHER FEDERAL REQUIREMENTS, AND INCLUDES A BENEFIT THAT IS SUBSTANTIALLY EQUIVALENT TO THE EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM.

(III) IF THE SECRETARY DETERMINES THAT THE EMPLOYER SPONSORED HEALTH BENEFIT PLAN DOES NOT MEET THE REQUIREMENTS OF SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE SECRETARY SHALL NOTIFY THE CARRIER OF THAT DETERMINATION WITHIN A REASONABLE TIME.

(5) A CARRIER THAT OFFERS AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN SHALL SUBMIT A CERTIFICATION OF ELIGIBILITY FOR THE ELIGIBLE INDIVIDUAL ON THE FORM REQUIRED BY THE SECRETARY.

(6) IN CONSULTATION WITH THE COMMISSIONER, THE SECRETARY SHALL:

(I) SET PREMIUM PAYMENTS AT A LEVEL THAT IS ADJUSTED TO THE BENEFITS PROVIDED; AND

(II) UPON NOTICE OF ENROLLMENT OF AN ELIGIBLE INDIVIDUAL INTO A QUALIFIED EMPLOYER SPONSORED HEALTH BENEFIT PLAN, MAKE PREMIUM PAYMENTS FOR THE ELIGIBLE INDIVIDUAL'S PORTION OF THE BENEFIT COST DIRECTLY TO THE CARRIER.

(F) (1) IN THIS SUBSECTION, "FAMILY CONTRIBUTION" MEANS THE COST TO AN ELIGIBLE INDIVIDUAL UNDER THE AGE OF 19 YEARS TO ENROLL AND PARTICIPATE IN THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM.

(2) IN ADDITION TO ANY OTHER REQUIREMENTS OF THIS SUBTITLE, AS A REQUIREMENT TO ENROLL AND MAINTAIN PARTICIPATION IN THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM, AN APPLICANT SHALL AGREE TO PAY AN ANNUAL FAMILY CONTRIBUTION AMOUNT DETERMINED BY THE DEPARTMENT IN ACCORDANCE WITH PARAGRAPH (3) OF THIS SUBSECTION.

(3) (I) FOR ELIGIBLE INDIVIDUALS WHOSE FAMILY INCOME IS AT OR ABOVE 185 PERCENT OF THE FEDERAL POVERTY LEVEL, THE DEPARTMENT, IN CONSULTATION WITH THE MANAGED CARE ORGANIZATIONS UNDER CONTRACT WITH THE DEPARTMENT UNDER SUBTITLE 1 OF THIS TITLE, SHALL DEVELOP A PREMIUM PAYMENT SYSTEM THAT IS BASED ON A SLIDING SCALE SUCH THAT THE COST OF THE PREMIUM IS AT LEAST 1 PERCENT OF THE ANNUAL FAMILY INCOME BUT DOES NOT EXCEED 3 PERCENT OF THE ANNUAL FAMILY INCOME.

(II) IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE DEPARTMENT SHALL DETERMINE BY REGULATION THE FAMILY CONTRIBUTION AMOUNT SCHEDULES AND THE METHOD OF COLLECTION.

SECTION 4. AND BE IT FURTHER ENACTED, That the Laws of Maryland shall read as follows:

Article - Health - General

15-302.

(A) (1) THE DEPARTMENT SHALL MONITOR APPLICATIONS TO DETERMINE WHETHER EMPLOYERS AND EMPLOYEES HAVE VOLUNTARILY TERMINATED COVERAGE UNDER AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN THAT INCLUDED DEPENDENT COVERAGE IN ORDER TO PARTICIPATE IN THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(2) THE DEPARTMENT, IN PARTICULAR, SHALL REVIEW APPLICATIONS OF INDIVIDUALS WHO QUALIFIED FOR PROGRAM BENEFITS UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(B) (1) AN APPLICATION MAY BE DISAPPROVED IF IT IS DETERMINED THAT AN INDIVIDUAL UNDER THE AGE OF 19 YEARS TO BE COVERED UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER §15-301 OF THIS SUBTITLE FOR WHOM THE APPLICATION WAS SUBMITTED WAS COVERED BY AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN WITH DEPENDENT COVERAGE WHICH WAS VOLUNTARILY TERMINATED WITHIN 6 MONTHS PRECEDING THE DATE OF THE APPLICATION.

(2) IN DETERMINING WHETHER AN APPLICANT HAS VOLUNTARILY TERMINATED COVERAGE UNDER AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN FOR PURPOSES OF PARAGRAPH (1) OF THIS SUBSECTION, A VOLUNTARY TERMINATION MAY NOT BE CONSTRUED TO INCLUDE:

(I) LOSS OF EMPLOYMENT DUE TO FACTORS OTHER THAN VOLUNTARY TERMINATION;

(II) CHANGE TO A NEW EMPLOYER THAT DOES NOT PROVIDE AN OPTION FOR DEPENDENT COVERAGE;

(III) CHANGE OF ADDRESS SO THAT NO EMPLOYER SPONSORED HEALTH BENEFIT PLAN IS AVAILABLE;

(IV) DISCONTINUATION OF HEALTH BENEFITS TO ALL DEPENDENTS OF EMPLOYEES OF THE APPLICANT'S EMPLOYER; OR

(V) EXPIRATION OF THE APPLICANT'S CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA).

15-303.

(A) (1) THE DEPARTMENT SHALL BE RESPONSIBLE FOR ENROLLING PROGRAM RECIPIENTS INTO MANAGED CARE ORGANIZATIONS UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(2) THE DEPARTMENT MAY CONTRACT WITH AN ENTITY TO PERFORM ANY PART OR ALL OF ITS ENROLLMENT RESPONSIBILITIES UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(3) THE DEPARTMENT OR ITS ENROLLMENT CONTRACTOR, TO THE EXTENT FEASIBLE IN ITS MARKETING, OUTREACH, AND ENROLLMENT PROGRAMS, SHALL HIRE INDIVIDUALS RECEIVING ASSISTANCE UNDER THE FAMILY INVESTMENT PROGRAM ESTABLISHED UNDER ARTICLE 88A OF THE CODE.

(B) (1) FOR PURPOSES OF ENROLLING ELIGIBLE CHILDREN INTO THE PROGRAM ESTABLISHED UNDER § 15-103 OF THIS TITLE AND THE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE AND IN MANAGED CARE ORGANIZATIONS IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION, THE DEPARTMENT SHALL DEVELOP AND IMPLEMENT A SCHOOL-BASED ENROLLMENT PROGRAM.

(2) AS APPROPRIATE TO CARRY OUT ITS RESPONSIBILITIES UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE DEPARTMENT MAY ENTER INTO CONTRACTS WITH COUNTY BOARDS OF EDUCATION TO PROVIDE ON SITE AT PUBLIC SCHOOLS INFORMATION ABOUT THE PROGRAM AND ENROLL ELIGIBLE

PROGRAM RECIPIENTS IN MANAGED CARE ORGANIZATIONS UNDER THE PROGRAM ESTABLISHED UNDER § 15-103 OF THIS TITLE AND THE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

15-304.

(A) (1) IN ADDITION TO THE SCHOOL-BASED ENROLLMENT PROGRAM ESTABLISHED UNDER § 15-303 OF THIS SUBTITLE, THE DEPARTMENT, IN CONSULTATION WITH THE MARYLAND MEDICAID ADVISORY COMMITTEE ESTABLISHED UNDER § 15-103(B) OF THIS TITLE, SHALL DEVELOP MECHANISMS FOR OUTREACH FOR THE PROGRAM WITH A SPECIAL EMPHASIS ON IDENTIFYING CHILDREN WHO MAY BE ELIGIBLE FOR PROGRAM BENEFITS UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(2) FROM THE MECHANISMS TO BE DEVELOPED FOR OUTREACH UNDER PARAGRAPH (1) OF THIS SUBSECTION, ONE MECHANISM SHALL INCLUDE THE DEVELOPMENT AND DISSEMINATION OF MAIL-IN APPLICATIONS AND APPROPRIATE OUTREACH MATERIALS THROUGH COMMUNITY-BASED ORGANIZATIONS, COMMUNITY-BASED PROVIDERS, THE OFFICE OF THE STATE COMPTROLLER, THE DEPARTMENTS OF HUMAN RESOURCES AND HEALTH AND MENTAL HYGIENE, COUNTY BOARDS OF EDUCATION, AND ANY OTHER APPROPRIATE STATE AGENCY OR UNIT THE DEPARTMENT CONSIDERS APPROPRIATE.

(B) FOR PURPOSES OF THIS SECTION, "COMMUNITY-BASED ORGANIZATION" INCLUDES DAY CARE CENTERS, SCHOOLS, SCHOOL-BASED HEALTH CLINICS, COMMUNITY-BASED DIAGNOSTIC AND TREATMENT CENTERS, FEDERAL OR STATE QUALIFIED COMMUNITY HEALTH CENTERS, AND HOSPITALS.

15.304.1.

ABORTION SERVICES UNDER THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE SHALL BE MADE

AVAILABLE ONLY IN ACCORDANCE WITH FEDERAL LAW GOVERNING THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

20-504.

(a) The powers and duties of the Maryland Health Care Foundation shall rest in and be exercised by a board of 19 trustees.

(b) The INITIAL Board of Trustees shall consist of:

(1) The President of the Senate of Maryland or the President's designee;

(2) The Speaker of the House of Delegates of Maryland or the Speaker's designee;

(3) The Secretaries of Health and Mental Hygiene and Human Resources and the Maryland Insurance Commissioner, ex officio, or their designees; and

(4) Fourteen individuals initially appointed by the Governor, with the advice and consent of the Senate, as follows:

(i) Three shall represent the interests of the payor community;

(ii) Three shall represent the interests of the health care provider community;

(iii) Two shall represent the business community;

(iv) Two shall represent the labor community; and

(v) Four shall represent the interests of the general public and may not have any connection with the management or policy of a health care provider or payor.

(c) The Governor shall consider geographical balance in making appointments to the Board of Trustees.

(d) Except for the ex officio members or their designees:

(1) The term of a member is 4 years;

(2) The terms of members are staggered as required by the terms provided for members of the Board on October 1, 1997;

(3) At the end of a term, a member continues to serve until a successor is [appointed and qualifies] ELECTED UNDER SUBSECTION (E) OF THIS SECTION;

(4) A member who is appointed after a term is begun serves for the rest of the term and until a successor is [appointed and qualifies] ELECTED UNDER SUBSECTION (E) OF THIS SECTION; and

(5) A member may serve no more than two terms.

(E) (1) AFTER THE EXPIRATION OF THE TERM OF A MEMBER APPOINTED UNDER SUBSECTION (B)(4) OF THIS SECTION OR UPON EARLIER VACANCY BY THE MEMBER, THE BOARD SHALL ELECT A SUBSEQUENT MEMBER AT THE FIRST ANNUAL MEETING OF THE BOARD AND, AS NECESSARY, AT EACH ANNUAL MEETING THEREAFTER.

(2) IN CARRYING OUT THE DUTIES UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE BOARD SHALL CONSIDER THE GEOGRAPHICAL, RACIAL, ETHNIC, AND GENDER MAKEUP OF THE POPULATION OF THE STATE AND SHALL ENSURE THAT THE ORIGINAL REPRESENTATION OF THE BOARD UNDER SUBSECTION (B)(4) OF THIS SECTION IS MAINTAINED.

20-505.

(a) The Board of Trustees shall elect one of their members to serve as chairman.

(b) The Board shall meet at places and dates to be determined by the Board, but not less

than two times a year.

(c) Nine trustees shall constitute a quorum, but action may not be taken by less than a vote of nine members.

(d) A trustee:

(1) May not receive compensation; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations as provided in the State budget.

(e) Except as provided in subsection (d) of this section, a trustee may not financially benefit either directly or indirectly from the activities of the Foundation.

(f) The State agencies represented on the Foundation shall provide staff, supplies, and office space and shall be reimbursed for these expenses from moneys of the Foundation.

(G) (1) THE BOARD OF TRUSTEES SHALL APPOINT AN EXECUTIVE DIRECTOR WHO SHALL BE THE CHIEF ADMINISTRATIVE OFFICER OF THE FOUNDATION AND WHO SHALL SERVE AT THE PLEASURE OF THE BOARD OF TRUSTEES.

(2) THE BOARD OF TRUSTEES SHALL DETERMINE THE COMPENSATION FOR THE EXECUTIVE DIRECTOR, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET.

(3) UNDER THE DIRECTION OF THE BOARD OF TRUSTEES, THE EXECUTIVE DIRECTOR SHALL PERFORM ANY DUTY OR FUNCTION THAT THE BOARD OF TRUSTEES REQUIRES.

(4) THE EXECUTIVE DIRECTOR, WITH THE APPROVAL OF THE BOARD OF TRUSTEES, MAY EMPLOY ANY ADDITIONAL STAFF, SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET.

(H) THE FOUNDATION IS SUBJECT TO THE PROVISIONS OF § 15-601(C) OF THE STATE GOVERNMENT ARTICLE.

20-506.

(a) The Foundation shall:

(1) Solicit and accept any gift, grant, legacy, or endowment of money, including in-kind services, from the federal government, State government, local government, or any private source in furtherance of the Foundation;

(2) Provide grants to programs that:

(i) Promote public awareness of the need to provide more timely and cost-effective care for uninsured Marylanders;

(ii) Expand access to health care services for uninsured individuals; or

(iii) Provide or subsidize health insurance coverage for uninsured individuals;

(3) STUDY THE FEASIBILITY AND COST-EFFECTIVENESS OF PROVIDING HEALTH INSURANCE COVERAGE THROUGH THE PRIVATE MARKET TO UNINSURED CHILDREN AND THEIR FAMILIES AS PART OF THE PROGRAM ESTABLISHED IN § 15-301 OF THIS ARTICLE;

[(3)] (4) Develop programs for sponsorship by corporate and business organizations or private individuals;

[(4)] (5) Develop criteria for awarding grants to health care delivery programs, insurance coverage programs, or corporate sponsorship programs;

[(5)] (6) Develop criteria for prioritizing programs to be supported;

[(6)] (7) Develop criteria for evaluating the effectiveness of programs receiving grants;

[(7)] (8) Make, execute, and enter into any contract or other legal instrument;

[(8)] (9) Receive appropriations as provided in the State budget;

[(9)] (10) Lease and maintain an office at a place within the State that the Foundation designates;

[(10)] (11) Adopt bylaws for the regulation of its affairs and the conduct of its business;

[(11)] (12) Take any other action necessary to carry out the purposes of the Foundation; and

[(12)] (13) Report annually to the Governor and, subject to § 2-1246 of the State Government Article, to the General Assembly, on its activities during the preceding year, including an evaluation of the effectiveness of funded programs, together with any recommendations or requests deemed appropriate to further the purposes of the Foundation.

(b) The Foundation may sue and be sued, but only to enforce contractual or similar agreements with the Foundation.

Article - Insurance

15-124.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "BLANKET HEALTH INSURANCE" HAS THE MEANING STATED IN § 15-301 OF THIS TITLE.

(3) "GROUP HEALTH INSURANCE" HAS THE MEANING STATED IN § 15-301 OF THIS TITLE.

(B) THIS SECTION APPLIES TO INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT ISSUE OR DELIVER GROUP HEALTH INSURANCE POLICIES OR BLANKET HEALTH INSURANCE POLICIES IN THE STATE.

(C) AN ENTITY SUBJECT TO THIS SECTION WHEN ISSUING OR RENEWING A GROUP OR BLANKET HEALTH INSURANCE POLICY WITH AN EMPLOYER THAT DOES NOT INCLUDE DEPENDENT COVERAGE SHALL PROVIDE ENROLLMENT INFORMATION TO INSURED EMPLOYEES REGARDING THE METHODS OF ENROLLING ANY DEPENDENT OF AN INSURED EMPLOYEE IN THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER § 15-301 OF THE HEALTH - GENERAL ARTICLE.

27-220.

AN AGENT, BROKER, OR INSURER MAY NOT REFER AN INDIVIDUAL EMPLOYEE OR DEPENDENT OF AN EMPLOYEE TO THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER TITLE 15, SUBTITLE 3 OF THE HEALTH - GENERAL ARTICLE OR ARRANGE FOR AN INDIVIDUAL EMPLOYEE OR DEPENDENT OF AN EMPLOYEE TO APPLY FOR THE CHILDREN AND FAMILIES HEALTH CARE PROGRAM ESTABLISHED UNDER TITLE 15, SUBTITLE 3 OF THE HEALTH - GENERAL ARTICLE IF THE AGENT, BROKER, OR INSURER HAS AN ECONOMIC INTEREST IN THE REFERRAL OR THE ARRANGEMENT AND THE AGENT'S, BROKER'S, OR INSURER'S SOLE PURPOSE IS TO SEPARATE THAT EMPLOYEE OR THAT EMPLOYEE'S DEPENDENT FROM GROUP OR BLANKET HEALTH INSURANCE COVERAGE PROVIDED IN CONNECTION WITH THE EMPLOYEE'S EMPLOYMENT.

Article - State Government

15-601.

(a) Except as provided in subsection (b) of this section, and subject to subsections (c) and (d) of this section, each official and candidate for office as a State official shall file a statement as specified in §§ 15-602 through 15-608 of this subtitle.

(b) Financial disclosure by a judge of a court under Article IV, § 1 of the Constitution, a candidate for elective office as a judge, or a judicial appointee as defined in Maryland Rule 1232 is governed by § 15-610 of this subtitle.

(c) An individual who is a public official only as a member of a board OR WHO IS A MEMBER OF THE BOARD OF TRUSTEES OF THE MARYLAND HEALTH CARE FOUNDATION ESTABLISHED UNDER § 2-501 OF THE HEALTH - GENERAL ARTICLE and who receives annual compensation that is less than 25% of the lowest annual compensation at State grade level 16 shall file the statement required by subsection (a) of this section in accordance with § 15-609 of this subtitle.

(d) A commissioner or an applicant for appointment as commissioner of a bicounty commission shall file the statement required by subsection (a) of this section in accordance with Subtitle 8, Part III of this title.

SECTION 5. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article - Health - General

15-305.

(A) THE PURPOSE OF THE HEALTH CARE FOUNDATION UNDER THIS SECTION IS TO:

(1) DEVELOP PROGRAMS TO EXPAND THE AVAILABILITY OF HEALTH INSURANCE COVERAGE TO LOW-INCOME, UNINSURED CHILDREN IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION;

(2) INVOLVE THE PRIVATE HEALTH INSURANCE MARKET IN THE

DELIVERY OF HEALTH INSURANCE COVERAGE IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION;

(3) IDENTIFY AND AGGRESSIVELY PURSUE A MIX OF STATE, FEDERAL, AND PRIVATE FUNDS, INCLUDING GRANTS, TO ENABLE THE FOUNDATION TO PROVIDE AND FUND HEALTH CARE INSURANCE COVERAGE IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION;

(4) DEVELOP METHODS TO MINIMIZE THE EFFECT OF EMPLOYERS OR EMPLOYEES TERMINATING EMPLOYER SPONSORED HEALTH INSURANCE OR PRIVATELY PURCHASED HEALTH CARE INSURANCE; AND

(5) COORDINATE ITS ACTIVITIES WITH THE OTHER NECESSARY ENTITIES IN ORDER TO ADDRESS THE HEALTH CARE NEEDS OF THE LOW-INCOME, UNINSURED CHILDREN OF THE STATE AND THEIR FAMILIES.

(B) THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, IN CONSULTATION WITH THE MARYLAND INSURANCE ADMINISTRATION, THE HEALTH CARE ACCESS AND COST COMMISSION, THE FOUNDATION, THE BUSINESS COMMUNITY, AND THE HEALTH CARE INSURANCE INDUSTRY SHALL:

(1) CONDUCT A STUDY TO DETERMINE THE FEASIBILITY AND COST EFFECTIVENESS OF PROVIDING HEALTH INSURANCE COVERAGE THROUGH THE PRIVATE MARKET TO UNINSURED CHILDREN AND THEIR FAMILIES AS PART OF THE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE; AND

(2) RECOMMEND PROGRAMS TO PROVIDE HEALTH INSURANCE COVERAGE THROUGH THE PRIVATE MARKET TO UNINSURED CHILDREN AND THEIR FAMILIES THAT WOULD QUALIFY FOR THE ENHANCED FEDERAL MATCH PROVIDED FOR UNDER TITLE XXI OF THE SOCIAL SECURITY ACT AS PART OF THE PROGRAM ESTABLISHED UNDER § 15-301 OF THIS SUBTITLE.

(C) THE DEPARTMENT SHALL REPORT ON THE RESULT OF ITS STUDY AND ITS

RECOMMENDATIONS TO THE SENATE FINANCE COMMITTEE, THE HOUSE ENVIRONMENTAL MATTERS COMMITTEE, THE HOUSE ECONOMIC MATTERS COMMITTEE, THE HOUSE APPROPRIATIONS COMMITTEE, THE HOUSE WAYS AND MEANS COMMITTEE, AND, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY, ON OR BEFORE DECEMBER 1, 1998 AND EACH DECEMBER 1 THEREAFTER.

SECTION 6. AND BE IT FURTHER ENACTED, That the Laws of Maryland shall read as follows:

Article - Health - General

Subtitle 3. Children and Families Health Care Program.

15-301.

(a) In this section, "carrier" means:

(1) An insurer;

(2) A nonprofit service plan;

(3) A health maintenance organization; or

(4) Any other person that provides health benefit plans subject to regulation by the State.

(b) There is a Children and Families Health Care Program.

(c) The Children and Families Health Care Program shall provide, subject to the limitations of the State budget and any other requirements imposed by the State and as permitted by federal law or waiver, comprehensive medical care and other health care services to an individual who has a family income at or below 200 percent of the federal poverty level and who is under the age of 19 years UNDER EITHER SUBSECTION (D) OR (E) OF THIS SECTION.

(d) (1) Except as provided in subsection (e) of this section, the Children and Families Health Care Program shall be administered:

(I) FOR AN INDIVIDUAL WHOSE FAMILY INCOME IS UNDER 185 PERCENT OF THE FEDERAL POVERTY LEVEL, through the program developed under Subtitle 1 of this title requiring [individuals] AN INDIVIDUAL to enroll in managed care organizations; AND

(II) FOR AN INDIVIDUAL WHOSE FAMILY INCOME IS AT LEAST 185 PERCENT OF THE FEDERAL POVERTY LEVEL BUT DOES NOT EXCEED 200 PERCENT OF THE FEDERAL POVERTY LEVEL, THROUGH A PROGRAM DEVELOPED UNDER § 15-305 OF THIS SUBTITLE.

(2) IF AN INDIVIDUAL IS NOT ELIGIBLE FOR A PROGRAM UNDER § 15-305 OF THIS SUBTITLE, THE INDIVIDUAL IS ELIGIBLE THROUGH THE PROGRAM DEVELOPED UNDER SUBTITLE 1 OF THIS TITLE.

(e) (1) If an individual's parent or guardian is covered under an employer sponsored health benefit plan with dependent coverage, certified under paragraph (4) of this subsection, the individual is not eligible for the program developed under Subtitle 1 of this title and is only eligible to receive a voucher to cover the costs of dependent coverage.

(2) Until dependent coverage under an employer sponsored health benefit plan has been certified by the Secretary under paragraph (4) of this subsection, the individual is eligible through the program developed under Subtitle 1 of this title.

(3) An eligible individual may be enrolled in an employer sponsored health benefit plan under:

(i) An independent insurance policy; or

(ii) An add-on to an existing policy.

(4) (i) A carrier that offers an employer sponsored health benefit plan or a carrier that intends to offer an employer sponsored health benefit plan under paragraph (1) of this subsection shall submit the plan to the Secretary.

(ii) The Secretary, in consultation with the Commissioner, shall certify, within a reasonable time, the employer sponsored health benefit plan, if the plan meets the coverage requirements under Title XXI of the Social Security Act and any other federal requirements, and includes a benefit that is substantially equivalent to the early periodic screening diagnosis and treatment program.

(iii) If the Secretary determines that the employer sponsored health benefit plan does not meet the requirements of subparagraph (ii) of this paragraph, the Secretary shall notify the carrier of that determination within a reasonable time.

(5) A carrier that offers an employer sponsored health benefit plan shall submit a certification of eligibility for the eligible individual on the form required by the Secretary.

(6) In consultation with the Commissioner, the Secretary shall:

(i) Set premium payments at a level that is adjusted to the benefits provided; and

(ii) Upon notice of enrollment of an eligible individual into a qualified employer sponsored health benefit plan, make premium payments for the eligible individual's portion of the benefit cost directly to the carrier.

(f) (1) In this subsection, "family contribution" means the cost to an eligible individual under the age of 19 years to enroll and participate in the Children and Families Health Care Program.

(2) In addition to any other requirements of this subtitle, as a requirement to enroll and maintain participation in the Children and Families Health Care Program, an applicant shall agree to pay an annual family contribution amount determined by the Department in accordance with paragraph (3) of this subsection.

(3) (i) For eligible individuals whose family income is at or above 185 percent of the federal poverty level, the Department, in consultation with the managed care organizations under contract with the Department under Subtitle 1 of this title, shall develop a premium payment system that is based on a sliding scale such that the cost of the premium is at least 1 percent of the annual family income but does not exceed 3 percent of the annual family income.

(ii) In accordance with subparagraph (i) of this paragraph, the Department shall determine by regulation the family contribution amount schedules and the method of collection.

SECTION 7. AND BE IT FURTHER ENACTED, That, in the budget submitted to the General Assembly, the Governor shall include a General Fund appropriation to a dedicated purpose account for the Maryland Health Care Foundation to fund proposals developed under § 15-305 of the Health - General Article equivalent to the amount by which the legislative appropriations from the General Fund for the Children and Families Health Care Program exceed actual expenditures for the second year prior to the fiscal year for which the budget is introduced.

SECTION 8. AND BE IT FURTHER ENACTED, That the Governor shall include at least $500,000 for the Maryland Health Care Foundation, to cover the expenses associated with the operation of the Foundation, in the budget submitted at the 1999 Session of the General Assembly and each year thereafter, for the duration of this Act. Authorization is granted to the Governor to transfer by contract, grant, or otherwise, $500,000 to the Foundation in the 1999 fiscal year, to cover the expenses associated with the operation of the Foundation.

SECTION 9. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene shall take whatever steps are necessary to receive approval from the federal Health Care Financing Administration for a tax credit program for the Maryland Children and Families Health Care Program. On or before December 1, 1998, the Department shall report to the General Assembly, in accordance with § 2-1246 of the State Government Article, on the status of the Department's efforts to receive approval for a tax credit program for the General Assembly to consider modifications to the Maryland Children and Families Health Care Program.

SECTION 10. AND BE IT FURTHER ENACTED, That Section 6 of this Act does not apply to any individual who:

(1) enrolled in the Children and Families Health Care Program established under § 15-301 of the Health - General Article before July 1, 2000;

(2) maintains a family income over 185 percent of the federal poverty level; and

(3) otherwise remains eligible for the Children and Families Health Care Program established under § 15-301 of the Health - General Article.

SECTION 11. AND BE IT FURTHER ENACTED, That at the end of June 30, 2000, with no further action required by the General Assembly, Section 3 of this Act shall be abrogated and of no further force and effect.

SECTION 12. AND BE IT FURTHER ENACTED, That at the end of June 30, 2004, with no further action required by the General Assembly, Section 5 of this Act shall be abrogated and of no further force and effect.

SECTION 13. AND BE IT FURTHER ENACTED, That Section 6 of this Act shall take effect July 1, 2000.

SECTION 14. AND BE IT FURTHER ENACTED, That, except as provided in Section 13 of this Act, this Act is an emergency measure, is necessary for the immediate preservation of the public health and safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.".