# HOUSE BILL 3

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(PRE-FILED)

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By: **Delegates Busch, Taylor, Dewberry, Hurson, Guns, Harrison, Hixson, Howard, Kopp, Menes, Montague, Owings, Rawlings, Rosenberg, ~~and Vallario~~ Vallario, W. Baker, Barkley, Bobo, Bozman, Bronrott, Brown, Cane, Carlson, Clagett, Cole, Conroy, Conway, D'Amato, DeCarlo, Doory, Dypski, Finifter, Franchot, Frush, Giannetti, Goldwater, Griffith, Hammen, Healey, Hecht, Heller, Hubers, James, V. Jones, Krysiak, Love, Mandel, Marriott, McHale, Minnick, Moe, Morhaim, Nathan-Pulliam, Patterson, Pendergrass, Petzold, Pitkin, Proctor, Rosso, Sophocleus, Stern, Turner, Valderrama, Weir, and Zirkin**

Requested: November 15, 1999
Introduced and read first time: January 12, 2000
Assigned to: Economic Matters

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Committee Report: Favorable with amendments
House action: Adopted
Read second time: March 25, 2000

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CHAPTER_____

AN ACT concerning

**Health Insurance for All Marylanders Act**

FOR the purpose of establishing a health insurance subsidy program for certain low-income individuals; establishing a program through which certain high-risk individuals can obtain health insurance; establishing a board to administer certain programs; specifying the terms of the initial members of the board; providing for the powers and duties of the board; defining certain terms; providing the eligibility criteria for certain programs; providing for the enrollment process for certain programs; providing that certain programs are limited by certain funding; providing for a certain assessment to fund certain programs; establishing a certain fund; requiring the board to draft certain regulations; requiring the board to establish certain benefit levels; eliminating certain requirements placed on the Maryland Health Care Commission; exempting a certain insurance plan from certain taxation requirements; requiring the Health Services Cost Review Commission to account for a certain assessment when determining hospital rates; providing that enrollment for certain programs may not begin until a certain time; requiring that a certain program be maintained until a certain time; providing for a delayed effective date for a portion of this Act; and generally relating to health insurance coverage

for low-income and medically uninsurable individuals.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 6-101
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY repealing
Article - Insurance
Section 15-606
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY adding to
Article - Insurance
Section 15-1601 through 15-1630, inclusive, to be under the new subtitle "Subtitle 16. Maryland Health Insurance Governing Board"
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-219
Annotated Code of Maryland
(1996 Replacement Volume and 1999 Supplement)

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

**Article - Insurance**

6-101.

(a) The following persons are subject to taxation under this subtitle:

(1) a person engaged as principal in the business of writing insurance contracts, surety contracts, guaranty contracts, or annuity contracts;

(2) an attorney in fact for a reciprocal insurer;

(3) the Maryland Automobile Insurance Fund; and

(4) a credit indemnity company.

(b) The following persons are not subject to taxation under this subtitle:

(1) a nonprofit health service plan corporation;

(2) a fraternal benefit society;

(3) a health maintenance organization authorized by Title 19, Subtitle 7 of the Health - General Article;

(4) a surplus lines broker, who is subject to taxation in accordance with Title 3, Subtitle 3 of this article; [or]

(5) an unauthorized insurer, who is subject to taxation in accordance with Title 4, Subtitle 2 of this article; OR

(6) THE MARYLAND HEALTH INSURANCE PLAN ESTABLISHED UNDER TITLE 15, SUBTITLE 16 OF THIS ARTICLE.

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

[15-606.

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

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

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

(b) (1) The Maryland Health Care Commission shall adopt regulations that specify a plan for substantial, available, and affordable coverage that shall be offered in the nongroup market by a carrier that qualifies for an approved purchaser differential under regulations adopted by the Health Services Cost Review Commission.

(2) In establishing a plan under this subsection, the Maryland Health Care Commission shall judge preventive services, medical treatments, procedures, and related health services based on:

(i) their effectiveness in improving the health of individuals;

(ii) their impact on maintaining and improving health and encouraging consumers to use only the health care services they need; and

(iii) their impact on the affordability of health care coverage.

(3) The Maryland Health Care Commission may exclude from the plan:

(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.

(4) The plan shall include uniform deductibles and cost-sharing associated with its benefits, as determined by the Maryland Health Care Commission.

(5) In establishing cost-sharing as part of the plan, the Maryland Health Care Commission shall:

(i) include cost-sharing and other incentives to help consumers use only the health care services they need;

(ii) balance the effect of cost-sharing in reducing premiums and in affecting utilization of appropriate services; and

(iii) limit the total cost-sharing that may be incurred by an individual in a year.]

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

SUBTITLE 16. MARYLAND HEALTH INSURANCE GOVERNING BOARD.

PART I. ESTABLISHMENT OF THE BOARD.

15-1601.

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

(B) "BOARD" MEANS THE MARYLAND HEALTH INSURANCE GOVERNING BOARD.

(C) "CARRIER" MEANS:

(1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN THE STATE;

(2) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO OPERATE IN THE STATE;

(3) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO OPERATE IN THE STATE;

(4) THE MARYLAND HEALTH INSURANCE PLAN; OR

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

(D) "FUND" MEANS THE MARYLAND INSURANCE GOVERNING BOARD FUND.

15-1602.

(A) THERE IS A MARYLAND HEALTH INSURANCE GOVERNING BOARD.

(B) THE BOARD IS AN INDEPENDENT BOARD THAT FUNCTIONS IN THE ADMINISTRATION.

(C) THE PURPOSE OF THE BOARD IS TO OVERSEE THE PROVISION OF HEALTH INSURANCE TO LOW-INCOME AND MEDICALLY UNINSURABLE INDIVIDUALS THROUGH PROGRAMS ESTABLISHED UNDER THIS SUBTITLE.

15-1603.

(A) THE BOARD CONSISTS OF ~~9~~ 10 MEMBERS, OF WHOM:

(1) ONE SHALL BE THE INSURANCE COMMISSIONER;

(2) ONE SHALL BE THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH CARE COMMISSION;

(3) ONE SHALL BE THE EXECUTIVE DIRECTOR OF THE HEALTH SERVICES COST REVIEW COMMISSION;

~~(3)~~ (4) ONE SHALL BE THE SECRETARY OF HEALTH AND MENTAL HYGIENE OR THE SECRETARY'S DESIGNEE;

~~(4)~~ (5) THREE SHALL BE KNOWLEDGEABLE ABOUT THE INSURANCE BUSINESS, BUT NOT OFFICERS OR EMPLOYEES OF A CARRIER OR CONSULTANTS TO A CARRIER;

~~(5)~~ (6) ONE SHALL BE AN EMPLOYER IN THE STATE WITH FEWER THAN 100 EMPLOYEES;

~~(6)~~ (7) ONE SHALL REPRESENT ORGANIZED LABOR; AND

~~(7)~~ (8) ONE SHALL BE A CONSUMER MEMBER WHO DOES NOT HAVE A SUBSTANTIAL FINANCIAL INTEREST IN A PERSON REGULATED UNDER THIS ARTICLE.

(B) THE MEMBERS OF THE BOARD, EXCEPT THE EX OFFICIO MEMBERS, SHALL BE APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE.

(C) (1) THE TERM OF A MEMBER IS 4 YEARS.

(2) THE TERMS OF THE MEMBERS ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS ON OCTOBER 1, 2000.

(3) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(4) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(D) THE GOVERNOR MAY REMOVE A MEMBER FOR NEGLECT OF DUTY, INCOMPETENCE, OR MISCONDUCT.

15-1604.

(A) THE GOVERNOR SHALL APPOINT THE CHAIRMAN OF THE BOARD.

(B) THE CHAIRMAN MAY APPOINT A VICE CHAIRMAN OF THE BOARD.

15-1605.

(A) WITH THE APPROVAL OF THE GOVERNOR, THE BOARD SHALL APPOINT AN EXECUTIVE DIRECTOR WHO SHALL BE THE CHIEF ADMINISTRATIVE OFFICER OF THE BOARD.

(B) THE EXECUTIVE DIRECTOR AND THE DEPUTY DIRECTORS SERVE AT THE PLEASURE OF THE BOARD.

(C) (1) THE EXECUTIVE DIRECTOR AND THE DEPUTY DIRECTORS SHALL BE EXECUTIVE SERVICE OR MANAGEMENT SERVICE EMPLOYEES.

(2) THE BOARD, IN CONSULTATION WITH THE COMMISSIONER, SHALL DETERMINE THE APPROPRIATE JOB CLASSIFICATION AND, SUBJECT TO THE STATE BUDGET, THE COMPENSATION FOR THE EXECUTIVE DIRECTOR AND THE DEPUTY DIRECTORS.

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

15-1606.

(A) A MAJORITY OF THE MEMBERS OF THE BOARD CONSTITUTES A QUORUM.

(B) THE BOARD SHALL MEET AT LEAST SIX TIMES EACH YEAR, AT THE TIMES AND PLACES THAT IT DETERMINES.

(C) (1) EACH MEMBER OF THE BOARD, EXCEPT FOR AN EX OFFICIO MEMBER, IS ENTITLED TO COMPENSATION IN ACCORDANCE WITH THE STATE BUDGET.

(2) EACH MEMBER OF THE BOARD IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(D) (1) THE BOARD MAY EMPLOY A STAFF IN ACCORDANCE WITH THE STATE BUDGET.

(2) STAFF HIRED ARE IN THE EXECUTIVE SERVICE, MANAGEMENT SERVICE, OR ARE SPECIAL APPOINTMENTS IN THE STATE PERSONNEL MANAGEMENT SYSTEM.

(3) THE BOARD, IN CONSULTATION WITH THE COMMISSIONER, SHALL DETERMINE THE APPROPRIATE JOB CLASSIFICATIONS AND GRADES FOR ALL STAFF.

(E) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL:

(1) ADOPT REGULATIONS THAT RELATE TO ITS MEETINGS, MINUTES, AND TRANSACTIONS;

(2) KEEP MINUTES OF EACH MEETING; AND

(3) PREPARE ANNUALLY A BUDGET PROPOSAL THAT INCLUDES THE ESTIMATED INCOME OF THE BOARD AND PROPOSED EXPENSES FOR ITS ADMINISTRATION AND OPERATION.

15-1607.

(A) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, THE BOARD SHALL ASSESS A FEE ON HOSPITALS ~~AND AMBULATORY SURGICAL CENTERS~~ EQUAL TO 1% OF ANNUAL GROSS REVENUE.

(2) THE BOARD, IN CONSULTATION WITH THE HEALTH SERVICES COST REVIEW COMMISSION, SHALL REDETERMINE THE ASSESSMENT ON HOSPITALS IF THE BOARD FINDS THAT A 1% ASSESSMENT SIGNIFICANTLY INCREASES COSTS TO MEDICARE OR WILL RESULT IN THE LOSS OF MARYLAND'S MEDICARE WAIVER UNDER § 1814(B) OF THE SOCIAL SECURITY ACT.

(B) THE BOARD SHALL ASSESS EACH ~~FACILITY~~ HOSPITAL ON OR BEFORE JUNE 30 OF EACH YEAR.

(C) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, EACH ~~FACILITY~~ HOSPITAL ASSESSED UNDER THIS SECTION SHALL MAKE PAYMENT TO THE BOARD.

(D) (1) THERE IS A MARYLAND HEALTH INSURANCE GOVERNING BOARD FUND.

(2) THE FUND IS A SPECIAL, CONTINUING, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7-302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(3) THE TREASURER SHALL SEPARATELY HOLD, AND THE COMPTROLLER SHALL ACCOUNT FOR, THE FUND.

(4) THE FUND SHALL BE INVESTED AND REINVESTED IN THE SAME MANNER AS OTHER STATE FUNDS.

(5) ANY INVESTMENT EARNINGS SHALL BE RETAINED TO THE CREDIT OF THE FUND.

(6) THE FUND SHALL BE SUBJECT TO AN AUDIT BY THE OFFICE OF LEGISLATIVE AUDITS AS PROVIDED FOR IN § 2-1220 OF THE STATE GOVERNMENT ARTICLE.

(7) THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT THE FUND FROM RECEIVING FUNDS FROM ANY OTHER SOURCE.

(8) THE FUND SHALL BE USED ONLY TO PROVIDE FUNDING FOR THE BOARD AND FOR THE PURPOSES AUTHORIZED UNDER THIS SUBTITLE.

15-1608. RESERVED.

15-1609. RESERVED.

PART II. MARYLAND HEALTH INSURANCE ASSISTANCE PROGRAM.

15-1610.

(A) IN PART II OF THIS SUBTITLE, THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "BASIC PLAN" MEANS THE BASIC INDIVIDUAL HEALTH BENEFIT PLAN ESTABLISHED BY THE BOARD IN ACCORDANCE WITH § 15-1613 OF THIS SUBTITLE TO BE OFFERED TO INDIVIDUALS UNDER THE PROGRAM.

(C) "BOARD" MEANS THE MARYLAND HEALTH INSURANCE GOVERNING BOARD.

(D) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL WHO:

(1) IS A RESIDENT OF THE STATE;

(2) IS NOT ELIGIBLE FOR MEDICARE;

(3) HAS A HOUSEHOLD INCOME EQUAL TO OR LESS THAN 200% OF THE FEDERAL POVERTY GUIDELINES;

(4) HAS BEEN WITHOUT HEALTH INSURANCE COVERAGE, EXCEPT MEDICAID COVERAGE, FOR AT LEAST 6 MONTHS PRIOR TO OBTAINING COVERAGE UNDER THE PROGRAM;

(5) HAS INVESTMENTS AND SAVINGS LESS THAN THE LIMIT ESTABLISHED BY THE BOARD; AND

(6) MEETS ANY OTHER ELIGIBILITY CRITERIA ESTABLISHED BY THE BOARD.

(E) "ENROLLEE" MEANS AN INDIVIDUAL ENROLLED IN THE MARYLAND HEALTH INSURANCE ASSISTANCE PROGRAM.

(F) (1) "HEALTH BENEFIT PLAN" MEANS:

(I) A POLICY OR CERTIFICATE FOR HOSPITAL OR MEDICAL BENEFITS;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER OR GROUP MASTER CONTRACT.

(2) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

(I) ACCIDENT-ONLY INSURANCE;

(II) FIXED INDEMNITY INSURANCE;

(III) CREDIT HEALTH INSURANCE;

(IV) MEDICARE SUPPLEMENT POLICIES;

(V) CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) SUPPLEMENT POLICIES;

(VI) LONG-TERM CARE INSURANCE;

(VII) DISABILITY INCOME INSURANCE;

(VIII) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

(IX) WORKERS' COMPENSATION OR SIMILAR INSURANCE;

(X) DISEASE-SPECIFIC INSURANCE;

(XI) AUTOMOBILE MEDICAL PAYMENT INSURANCE;

(XII) DENTAL INSURANCE; OR

(XIII) VISION INSURANCE.

(J) "PROGRAM" MEANS THE MARYLAND HEALTH INSURANCE ASSISTANCE PROGRAM.

(K) "THIRD PARTY ADMINISTRATOR" MEANS A PERSON THAT IS REGISTERED AS AN ADMINISTRATOR UNDER TITLE 8, SUBTITLE 3 OF THIS ARTICLE.

15-1611.

(A) THERE IS A MARYLAND HEALTH INSURANCE ASSISTANCE PROGRAM.

(B) THE PURPOSE OF THE PROGRAM IS TO PROVIDE FINANCIAL ASSISTANCE FOR THE PURCHASE OF HEALTH INSURANCE COVERAGE TO LOW-INCOME INDIVIDUALS IN ORDER TO:

(I) IMPROVE THE HEALTH STATUS OF RESIDENTS OF THE STATE; AND

(II) DECREASE HOSPITAL UNCOMPENSATED CARE COSTS.

15-1612.

(A) THE BOARD SHALL FORMULATE POLICY FOR AND MANAGE THE PROGRAM.

(B) (1) THE BOARD MAY ENTER INTO A CONTRACT WITH A THIRD PARTY ADMINISTRATOR TO PERFORM ADMINISTRATIVE FUNCTIONS.

(2) DUTIES OF A THIRD PARTY ADMINISTRATOR MAY INCLUDE:

(I) ELIGIBILITY DETERMINATION;

(II) DATA COLLECTION;

(III) SUBSIDY PAYMENT;

(IV) FINANCIAL TRACKING AND REPORTING; AND

(V) ANY OTHER SERVICE THAT THE BOARD DEEMS NECESSARY FOR THE ADMINISTRATION OF THE PROGRAM.

15-1613.

(A) THE BOARD SHALL DEVELOP A UNIFORM SET OF BENEFITS, INCLUDING COST-SHARING ARRANGEMENTS TO BE OFFERED UNDER THE BASIC INDIVIDUAL HEALTH BENEFIT PLAN.

(B) THE BOARD SHALL REQUIRE THAT THE MINIMUM BENEFITS ALLOWED TO BE OFFERED IN THE BASIC PLAN:

(1) BY A HEALTH MAINTENANCE ORGANIZATION, SHALL INCLUDE AT LEAST THE ACTUARIAL EQUIVALENT OF THE MINIMUM BENEFITS REQUIRED TO BE OFFERED BY A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION; AND

(2) BY AN INSURER OR NONPROFIT HEALTH SERVICE PLAN ON AN EXPENSE-INCURRED BASIS, SHALL BE ACTUARIALLY EQUIVALENT TO AT LEAST THE MINIMUM BENEFITS REQUIRED TO BE OFFERED UNDER ITEM (1) OF THIS SUBSECTION.

(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, THE BOARD SHALL EXCLUDE OR LIMIT BENEFITS OR ADJUST COST-SHARING ARRANGEMENTS IN THE BASIC PLAN IF THE AVERAGE RATE FOR THE BASIC PLAN EXCEEDS 10% OF THE AVERAGE ANNUAL WAGE IN THE STATE.

(2) THE BOARD SHALL ANNUALLY DETERMINE THE AVERAGE RATE FOR THE BASIC PLAN BY USING THE AVERAGE RATE SUBMITTED BY EACH CARRIER THAT OFFERS THE BASIC PLAN.

(D) IN ESTABLISHING BENEFITS, THE BOARD SHALL JUDGE PREVENTIVE SERVICES, MEDICAL TREATMENTS, PROCEDURES, AND RELATED HEALTH SERVICES BASED ON:

(1) THEIR EFFECTIVENESS IN IMPROVING THE HEALTH STATUS OF INDIVIDUALS;

(2) THEIR IMPACT ON MAINTAINING AND IMPROVING HEALTH AND ON REDUCING THE UNNECESSARY CONSUMPTION OF HEALTH CARE SERVICES; AND

(3) THEIR IMPACT ON THE AFFORDABILITY OF HEALTH CARE COVERAGE.

(E) THE BOARD MAY EXCLUDE:

(1) 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

(2) 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.

(F) THE BASIC PLAN SHALL INCLUDE UNIFORM DEDUCTIBLES AND COST-SHARING ASSOCIATED WITH ITS BENEFITS, AS DETERMINED BY THE BOARD.

(G) IN ESTABLISHING COST-SHARING AS PART OF THE BASIC PLAN, THE BOARD SHALL:

(1) INCLUDE COST-SHARING AND OTHER INCENTIVES TO HELP PREVENT CONSUMERS FROM SEEKING UNNECESSARY SERVICES;

(2) BALANCE THE EFFECT OF COST-SHARING IN REDUCING PREMIUMS AND IN EFFECTING UTILIZATION OF APPROPRIATE SERVICES; AND

(3) LIMIT THE TOTAL COST-SHARING THAT MAY BE INCURRED BY AN INDIVIDUAL IN A YEAR.

15-1614.

(A) TO APPLY FOR COVERAGE UNDER THE PROGRAM, AN INDIVIDUAL SHALL SUBMIT A WRITTEN APPLICATION TO THE BOARD OR A THIRD PARTY ADMINISTRATOR WITH WHICH THE BOARD HAS CONTRACTED, AS DETERMINED BY THE BOARD.

(B) AN ELIGIBLE INDIVIDUAL SHALL EITHER BE ENROLLED IN THE PROGRAM OR PLACED ON A WAITING LIST.

(C) SUBJECT TO SUBSECTION (D) OF THIS SECTION, THE BOARD OR THIRD PARTY ADMINISTRATOR SHALL ISSUE ASSISTANCE VOUCHERS IN AN AMOUNT DETERMINED UNDER § 15-1615 OF THIS SUBTITLE TO:

(1) AN ENROLLEE; OR

(2) A HEALTH INSURANCE CARRIER DESIGNATED BY THE ENROLLEE.

(D) (1) ASSISTANCE VOUCHERS MAY NOT EXCEED THE AMOUNT CONTRIBUTED BY AN ENROLLEE TO AN EMPLOYER-SPONSORED HEALTH BENEFIT PLAN OR THE PREMIUM PAID BY AN ENROLLEE FOR AN INDIVIDUAL HEALTH BENEFIT PLAN.

(2) ASSISTANCE VOUCHERS MAY NOT BE USED TO PAY DEDUCTIBLES OR COPAYMENT EXPENSES.

(3) ASSISTANCE VOUCHERS MAY NOT BE USED TO SUBSIDIZE PREMIUMS FOR A HEALTH BENEFIT PLAN WHERE PREMIUMS ARE WHOLLY PAID BY THE ELIGIBLE INDIVIDUAL'S EMPLOYER.

(E) THE BOARD MAY ISSUE ASSISTANCE VOUCHERS TO AN ENROLLEE IN ADVANCE OF A PURCHASE OF A HEALTH BENEFIT PLAN.

(F) AN ENROLLEE MUST ENROLL IN A GROUP HEALTH BENEFIT PLAN IF:

(1) THE ENROLLEE IS ELIGIBLE FOR PARTICIPATION IN THE PLAN THROUGH THE ENROLLEE'S EMPLOYER; AND

(2) THE ENROLLEE'S EMPLOYER CONTRIBUTES TO THE PREMIUM COST OF THE PLAN.

(G) THE BOARD SHALL ASSIST AN ENROLLEE WHO IS NOT ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH BENEFIT PLAN IN SELECTING A CARRIER THAT OFFERS THE BASIC PLAN BY:

(1) PROVIDING EACH ENROLLEE WITH A LIST OF CARRIERS THAT OFFER THE BASIC PLAN; AND

(2) DEVELOPING MATERIAL THAT EXPLAINS THE DIFFERENCES IN BENEFITS, COST-SHARING, AND PREMIUMS AMONG THE CARRIERS THAT OFFER THE BASIC PLAN.

(H) AN ENROLLEE WHO IS ELIGIBLE FOR COVERAGE UNDER THE MARYLAND HEALTH INSURANCE PLAN IN ACCORDANCE WITH PART III OF THIS SUBTITLE, SHALL OBTAIN COVERAGE THROUGH THE MARYLAND HEALTH INSURANCE PLAN.

(I) AN ENROLLEE SHALL REMAIN ELIGIBLE FOR THE PROGRAM IN ACCORDANCE WITH CRITERIA ESTABLISHED BY THE BOARD.

15-1615.

(A) THE BOARD SHALL ESTABLISH SUBSIDY LEVELS ON A SLIDING SCALE BASED ON:

(1) HOUSEHOLD INCOME;

(2) NUMBER OF DEPENDENTS; AND

(3) ANY OTHER FACTOR THAT THE BOARD DETERMINES IS RELEVANT.

(B) THE SUBSIDIES SHALL BE REASONABLY CALCULATED TO ENCOURAGE PARTICIPATION IN THE PROGRAM.

15-1616.

(A) NOTWITHSTANDING THE ELIGIBILITY CRITERIA ESTABLISHED UNDER THIS SUBTITLE AND ANY REGULATIONS ADOPTED IN ACCORDANCE WITH THIS SUBTITLE, ELIGIBLE INDIVIDUALS SHALL BE ENROLLED IN THE PROGRAM ONLY TO THE EXTENT ALLOWED BY THE FUND AS DETERMINED BY THE BOARD.

(B) THE BOARD SHALL LIMIT ENROLLMENT IN THE PROGRAM TO ENSURE THAT THE FUND BALANCE IS ADEQUATE TO COVER EXPENSES AND PREMIUM COSTS.

(C) AN ENROLLEE SHALL BE PLACED ON A WAITING LIST IF FUNDS ARE NOT AVAILABLE AT THE TIME THE ENROLLEE IS DETERMINED TO BE ELIGIBLE FOR THE PROGRAM.

15-1617.

(A) THE BOARD SHALL ADOPT REGULATIONS NECESSARY TO MANAGE THE PROGRAM, INCLUDING REGULATIONS ESTABLISHING:

(1) ELIGIBILITY REQUIREMENTS;

(2) APPLICATION PROCEDURES;

(3) MINIMUM BENEFIT REQUIREMENTS AND COST-SHARING ARRANGEMENTS FOR THE BASIC PLAN;

(4) SUBSIDY LEVELS; AND

(5) CARRIER PARTICIPATION.

15-1618.

(A) THE BOARD SHALL SUBMIT AN ANNUAL REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE.

(B) THE REPORT REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL INCLUDE THE FOLLOWING INFORMATION:

(1) NUMBER OF INDIVIDUALS ENROLLED IN THE PROGRAM DURING THE YEAR IN QUESTION;

(2) NUMBER OF INDIVIDUALS PLACED ON THE WAITING LIST DURING THE YEAR IN QUESTION;

(3) TOTAL NUMBER OF INDIVIDUALS ENROLLED IN THE PROGRAM;

(4) TOTAL NUMBER OF APPLICANTS ON THE WAITING LIST;

(5) NUMBER OF ENROLLEES COVERED UNDER THE BASIC PLAN;

(6) NUMBER OF INDIVIDUALS COVERED UNDER AN EMPLOYER-SPONSORED HEALTH BENEFIT PLAN;

(7) A LIST OF CARRIERS THAT OFFER THE BASIC PLAN;

(8) THE NUMBER OF INDIVIDUALS COVERED BY EACH CARRIER UNDER THE BASIC PLAN;

(9) THE AVERAGE COST OF THE BASIC PLAN;

(10) THE AVERAGE COST OF THE EMPLOYER-SPONSORED HEALTH BENEFIT PLANS THAT COVER ENROLLEES;

(11) THE AVERAGE SUBSIDY PAID FOR THE BASIC PLAN; AND

(12) THE AVERAGE SUBSIDY PAID FOR THE EMPLOYER-SPONSORED HEALTH BENEFIT PLANS THAT COVER ENROLLEES.

15-1619. RESERVED.

15-1620. RESERVED.

PART III. MARYLAND HEALTH INSURANCE PLAN.

15-1621.

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

(B) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL WHO IS ELIGIBLE FOR COVERAGE UNDER THE PLAN IN ACCORDANCE WITH § 15-1624 OF THIS SUBTITLE.

(C) "ENROLLEE" MEANS AN INDIVIDUAL ENROLLED IN THE PLAN.

(D) "PLAN" MEANS THE MARYLAND HEALTH INSURANCE PLAN.

15-1622.

(A) THERE IS A MARYLAND HEALTH INSURANCE PLAN.

(B) THE PURPOSE OF THE PLAN IS TO PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE TO INDIVIDUALS WITH PREEXISTING HEALTH PROBLEMS IN ORDER TO IMPROVE THE HEALTH STATUS OF SUCH INDIVIDUALS AND TO REDUCE HOSPITAL UNCOMPENSATED CARE COSTS.

15-1623.

(A) THE PLAN SHALL HAVE THE GENERAL POWERS AND AUTHORITY GRANTED TO HEALTH INSURERS THAT HOLD A CERTIFICATE OF AUTHORITY UNDER THIS ARTICLE.

(B) THE PLAN SHALL OPERATE UNDER THE SUPERVISION AND CONTROL OF THE BOARD.

(C) THE BOARD SHALL:

(1) ESTABLISH PROCEDURES OF OPERATION FOR THE PLAN;

(2) ESTABLISH PROCEDURES FOR SELECTING AN ADMINISTRATOR IN ACCORDANCE WITH § 15-1626 OF THIS SUBTITLE;

(3) ESTABLISH PROCEDURES FOR THE HANDLING, ACCOUNTING, AND AUDITING OF ASSETS, FUNDS, AND CLAIMS OF THE PLAN AND THE PLAN ADMINISTRATOR;

(4) DEVELOP, IMPLEMENT, AND MAINTAIN A PROGRAM TO PUBLICIZE THE EXISTENCE OF THE PLAN, THE ELIGIBILITY REQUIREMENTS FOR THE PLAN, AND PROCEDURES FOR ENROLLMENT UNDER THE PLAN; AND

(5) PROVIDE FOR ANY OTHER MATTERS AS MAY BE NECESSARY FOR THE EXECUTION OF THE BOARD'S POWERS, DUTIES, AND OBLIGATIONS UNDER PART III OF THIS SUBTITLE.

(D) THE BOARD SHALL HAVE THE AUTHORITY TO:

(1) ENTER INTO CONTRACTS NECESSARY TO CARRY OUT THE PROVISIONS AND PURPOSES OF PART III OF THIS SUBTITLE INCLUDING A CONTRACT FOR THE PERFORMANCE OF THE ADMINISTRATIVE FUNCTIONS OF THE PLAN.

(2) TAKE SUCH LEGAL ACTION AS NECESSARY:

(I) TO AVOID THE PAYMENT OF IMPROPER CLAIMS AGAINST THE PLAN;

(II) TO RECOVER MONEY ERRONEOUSLY OR IMPROPERLY PAID BY THE PLAN; AND

(III) TO RECOVER ANY OTHER MONEY DUE TO THE PLAN;

(3) ESTABLISH AND MODIFY RATES AND RATE SCHEDULES;

(4) ISSUE POLICIES OF INSURANCE IN ACCORDANCE WITH PART III OF THIS SUBTITLE; AND

(5) PROVIDE FOR REINSURANCE OF RISKS INCURRED BY THE PLAN.

15-1624.

(A) AN INDIVIDUAL IS ELIGIBLE FOR COVERAGE UNDER THE PLAN IF:

(1) FOR HEALTH REASONS, AN INSURER HAS REFUSED TO ISSUE SUBSTANTIALLY SIMILAR INSURANCE TO THE INDIVIDUAL WITHIN A TIME FRAME DETERMINED BY THE BOARD;

(2) THE INDIVIDUAL HAS A HISTORY OF, OR SUFFERS FROM, A MEDICAL OR HEALTH CONDITION THAT IS INCLUDED ON A LIST DEVELOPED BY THE BOARD IN ACCORDANCE WITH SUBSECTION (B) OF THIS SECTION; OR

(3) THE INDIVIDUAL IS THE SPOUSE OR DEPENDENT OF AN INDIVIDUAL WHO IS ELIGIBLE UNDER THIS SECTION.

(B) THE BOARD SHALL, BY REGULATION, ADOPT A LIST OF MEDICAL OR HEALTH CONDITIONS FOR WHICH AN INDIVIDUAL IS ELIGIBLE FOR PLAN COVERAGE WITHOUT FIRST APPLYING FOR INSURANCE.

(C) AN INDIVIDUAL IS NOT ELIGIBLE FOR COVERAGE UNDER THE PLAN IF:

(1) THE INDIVIDUAL IS ELIGIBLE FOR MEDICARE;

(2) THE INDIVIDUAL HAS OR CAN OBTAIN HEALTH INSURANCE COVERAGE SUBSTANTIALLY SIMILAR TO, OR MORE COMPREHENSIVE THAN, A PLAN POLICY;

(3) THE INDIVIDUAL HAS TERMINATED PLAN COVERAGE WITHIN THE LAST 12 MONTHS;

(4) THE INDIVIDUAL IS AN INMATE OR PATIENT IN A PUBLIC INSTITUTION; OR

(5) THE BOARD HAS PAID OUT $1,000,000 IN BENEFITS ON BEHALF OF THE INDIVIDUAL.

(D) AN INDIVIDUAL WHO CEASES TO MEET THE ELIGIBILITY REQUIREMENTS OF THIS SECTION MAY BE TERMINATED AT THE END OF THE POLICY PERIOD FOR WHICH THE NECESSARY PREMIUMS HAVE BEEN PAID.

15-1625.

IT IS UNLAWFUL FOR AN INSURER, INSURANCE AGENT, INSURANCE BROKER, OR THIRD PARTY ADMINISTRATOR TO REFER AN INDIVIDUAL EMPLOYEE TO THE PLAN, OR ARRANGE FOR AN INDIVIDUAL EMPLOYEE TO APPLY TO THE PLAN, FOR THE PURPOSE OF SEPARATING THAT EMPLOYEE FROM THE GROUP HEALTH INSURANCE COVERAGE PROVIDED IN CONNECTION WITH THE EMPLOYEE'S EMPLOYMENT.

15-1626.

(A) THE BOARD SHALL SELECT A PLAN ADMINISTRATOR TO ADMINISTER THE PLAN.

(B) THE PLAN ADMINISTRATOR SHALL PERFORM FUNCTIONS RELATING TO THE PLAN AS REQUIRED BY THE BOARD, INCLUDING:

(1) DETERMINATION OF ELIGIBILITY;

(2) PAYMENT OF CLAIMS; AND

(3) ESTABLISHING A PREMIUM BILLING PROCEDURE.

(C) THE ADMINISTRATOR SHALL SUBMIT REGULAR REPORTS TO THE BOARD REGARDING THE OPERATION OF THE PLAN.

(D) AFTER THE END OF EACH CALENDAR YEAR, THE ADMINISTRATOR SHALL REPORT TO THE BOARD THE NET WRITTEN AND EARNED PREMIUMS, THE EXPENSE OF THE ADMINISTRATION, AND THE PAID AND INCURRED LOSSES FOR THE YEAR.

15-1627.

(A) (1) THE BOARD SHALL ESTABLISH PREMIUM RATES FOR PLAN COVERAGE.

(2) THE BOARD MAY ADOPT SEPARATE PREMIUM RATE SCHEDULES BASED ON:

(I) AGE; AND

(II) GEOGRAPHY BASED ON THE FOLLOWING CONTIGUOUS AREAS OF THE STATE:

1. THE BALTIMORE METROPOLITAN AREA;

2. THE DISTRICT OF COLUMBIA METROPOLITAN AREA;

3. WESTERN MARYLAND; AND

4. EASTERN AND SOUTHERN MARYLAND.

(3) PREMIUM RATES SHALL BE FILED WITH THE COMMISSIONER FOR APPROVAL PRIOR TO USE.

(B) (1) THE BOARD SHALL DETERMINE A STANDARD RISK RATE BY CALCULATING THE AVERAGE RATE CHARGED BY INSURERS OFFERING COVERAGES COMPARABLE TO THAT OF THE PLAN.

(2) IN DETERMINING A STANDARD RISK RATE, THE BOARD SHALL CONSIDER THE RATES THAT APPLY TO THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ESTABLISHED UNDER § 15-1207 OF THIS TITLE.

(3) THE PREMIUM RATES FOR COVERAGE UNDER THE PLAN MAY NOT EXCEED 110% OF RATES ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(C) (1) LOSSES INCURRED BY THE PLAN SHALL BE SUBSIDIZED BY THE STATE THROUGH THE ASSESSMENT PROVIDED FOR IN § 15-1607 OF THIS SUBTITLE.

(2) THE BOARD SHALL OPERATE THE PLAN IN A MANNER SO THAT THE ESTIMATED COST OF PROVIDING HEALTH INSURANCE COVERAGE DURING ANY FISCAL YEAR WILL NOT EXCEED TOTAL INCOME THE PLAN EXPECTS TO RECEIVE FROM POLICY PREMIUMS AND ASSESSMENTS.

(3) AFTER DETERMINING THE AMOUNT OF FUNDS AVAILABLE TO IT FOR A FISCAL YEAR, THE BOARD SHALL ESTIMATE THE NUMBER OF NEW POLICIES THE PLAN HAS THE FINANCIAL CAPACITY TO INSURE DURING THAT YEAR SO THAT COSTS DO NOT EXCEED INCOME.

(4) THE BOARD SHALL TAKE STEPS NECESSARY TO ENSURE THAT PLAN ENROLLMENT DOES NOT EXCEED THE NUMBER OF ENROLLEES THE PLAN HAS THE FINANCIAL CAPACITY TO INSURE.

15-1628.

(A) THE PLAN SHALL OFFER COMPREHENSIVE HEALTH INSURANCE COVERAGE.

(B) THE BOARD MAY ADOPT ONE OF THE FOLLOWING AS THE UNIFORM SET OF BENEFITS TO BE OFFERED UNDER THE PLAN:

(1) THE BASIC INDIVIDUAL HEALTH BENEFIT PLAN DEVELOPED IN ACCORDANCE WITH § 15-1613 OF THIS SUBTITLE; OR

(2) THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ESTABLISHED UNDER § 15-1207 OF THIS TITLE.

(C) PLAN COVERAGE SHALL EXCLUDE CHARGES OR EXPENSES INCURRED DURING THE FIRST 6 MONTHS FOLLOWING THE EFFECTIVE DATE OF COVERAGE FOR ANY CONDITION FOR WHICH MEDICAL ADVICE, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE 6-MONTH PERIOD IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.

15-1629. RESERVED.

15-1630. RESERVED.

**Article - Health - General**

19-219.

(a) The Commission may review costs and rates and make any investigation that the Commission considers necessary to assure each purchaser of health care facility services that:

(1) The total costs of all hospital services offered by or through a facility are reasonable;

(2) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility; and

(3) The rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

(b) (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate that a facility sets or requests.

(2) A facility shall charge for services only at a rate set in accordance with this subtitle.

(3) In determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(c) To promote the most efficient and effective use of health care facility services and, if it is in the public interest and consistent with this subtitle, the Commission may promote and approve alternate methods of rate determination and payment that are of an experimental nature.

(D) (1) THE COMMISSION SHALL ADJUST HOSPITAL RATES TO TAKE INTO ACCOUNT THE ASSESSMENT REQUIRED UNDER § 15-1607 OF THE INSURANCE ARTICLE.

(2) THE COMMISSION MAY NOT CONSIDER THE ASSESSMENT REQUIRED UNDER TITLE 15, SUBTITLE 16 OF THE INSURANCE ARTICLE IN DETERMINING:

(I) THE REASONABLENESS OF RATES UNDER THIS SUBTITLE; OR

(II) HOSPITAL FINANCIAL PERFORMANCE.

SECTION ~~2.~~ 4. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission shall continue to offer a differential in hospital rates to carriers that provide a substantial, available, and affordable coverage product in the nongroup market in accordance with regulations adopted by the Commission until October 1, 2001.

SECTION ~~3.~~ 5. AND BE IT FURTHER ENACTED, That the terms of the initial members of the Maryland Health Insurance Governing Board appointed by the Governor shall expire as follows:

(1) 2 members in 2002;

(2) 2 members in 2003; and

(3) 2 members in 2004.

SECTION ~~4.~~ 6. AND BE IT FURTHER ENACTED, That the Maryland Health Insurance Governing Board may not enroll any individual in the Maryland Health Insurance Assistance Program or the Maryland Health Insurance Plan until October 1, 2001.

SECTION 7. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect at the end of September 30, 2001.

SECTION ~~5.~~ 8. AND BE IT FURTHER ENACTED, That, except as provided in Section 7 of this Act, subject to Section ~~4~~ 6 of this Act, this Act shall take effect October 1, 2000.