SENATE BILL 855

Unofficial Copy 2000 Regular Session
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By: **Senators Dyson, Middleton, and Miller**
Introduced and read first time: February 23, 2000
Assigned to: Rules
Re-referred to: Finance, February 25, 2000

Committee Report: Favorable with amendments
Senate action: Adopted with floor amendments
Read second time: April 7, 2000

CHAPTER_____

AN ACT concerning

~~Public Health -~~ Senior Assistance - ~~Insurance Subsidy for Medicare Plus Choice~~ Short-Term Prescription Drug Subsidy Plan

FOR the purpose of establishing a certain ~~subsidy program under which a subsidy is to be paid to insurers for certain enrollees in Medicare plus Choice; establishing certain guidelines for enrollee eligibility; establishing the eligibility criteria for participating in the subsidy program; requiring certain benefits to be provided in order to be eligible for the subsidy; allowing a managed care organization to include certain deductibles and co-payments as part of its program; requiring the Secretary of Health and Mental Hygiene to make payments to certain managed care providers within a certain period of time, to provide a certain report, and to adopt certain regulations; providing for the termination of this Act; and generally relating to a subsidy program for insurers for certain enrollees in Medicare plus Choice~~ prescription drug plan for certain Medicare Plus Choice eligible individuals residing in certain medically underserved counties or portions of counties; requiring a certain carrier to provide the plan as a condition of receiving a certain hospital rate differential; requiring certain other carriers to pay a certain assessment into a certain fund as a condition of receiving that differential; creating the fund and providing for the use and administration of the fund; providing an exception to the insurance premium tax for the plan created under this Act; requiring that the carrier providing the plan meet certain conditions; requiring that the plan include a certain deductible and limitation on total benefits and certain co-pays and premiums; allowing the plan to exclude coverage for certain prescription drugs; requiring that enrollment be reserved for a certain period for a certain population of eligible individuals; requiring that the Secretary of Health and Mental Hygiene adopt certain regulations and issue a report jointly with the Maryland Insurance

Administration and the Health Services Cost Review Commission; prohibiting the Health Services Cost Review Commission from taking steps to eliminate or adjust the differential for substantial, affordable, and available coverage for a certain period; authorizing the Secretary to suspend the plan and certain provisions of this Act on certain notification by the Health Care Financing Administration; providing for the termination of this Act; defining certain terms; and generally relating to a short-term prescription drug plan for certain individuals in medically underserved counties or portions of counties and to the differential awarded carriers for providing substantial, affordable, and available coverage.

BY adding to
Article - Health - General
Section 15-601 through 15-605, inclusive, to be under the new subtitle "Subtitle ~~6. Maryland Medicare Plus Choice Insurance Subsidy Program"~~ 6. Short-Term Prescription Drug Subsidy Plan"
Annotated Code of Maryland
(1994 Replacement Volume and 1999 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 6-101 and 15-606
Annotated Code of Maryland
(1997 Volume and 1999 Supplement)

Preamble

WHEREAS, Residents in fourteen Maryland counties lack access to a Medicare plus Choice managed care plan; and

WHEREAS, Fifteen percent of seniors in Maryland do not have access to a Medicare plus Choice managed care plan that provides prescription drug benefits; and

~~WHEREAS, Seniors who cannot afford the higher premiums for a Medicare plus Choice managed care plan should not be deprived of access to the kind of care they need; and~~

WHEREAS, Maryland is among the states with the highest percentage of Medicare enrollees who lack a Medicare plus Choice managed care plan that provides prescription drug benefits; and

~~WHEREAS, Medicare plus Choice managed care can provide Maryland's senior citizens with benefits they do not get under the Federal Medicare program; and~~

~~WHEREAS, Medicare plus Choice managed care plans have benefits that are not included in the federal Medicare benefit package, including prescription drugs; and~~

WHEREAS, An increasing number of Maryland's senior citizens who live on fixed incomes are experiencing difficulties in meeting the cost of life-sustaining prescription drugs; and

WHEREAS, The cost of providing Medicare plus Choice managed care benefits that provided prescription drug coverage exceeded the income from premiums for these programs and thus caused managed care organizations to leave ~~fourteen counties and~~ medically underserved ~~areas~~ counties and portions of counties in Maryland; and

WHEREAS, The Maryland General Assembly recognizes the need to ~~encourage managed care organizations to return to those counties in Maryland that have no Medicare plus Choice managed care or are designated as medically underserved areas by the federal Health Care Financing Administration of the Department of Health and Human Services; and~~ ensure that all Maryland residents have access to prescription drugs in order to maintain the optimal level of health possible for Maryland citizens; and

WHEREAS, It is the intent of the Maryland General Assembly to ~~provide an incentive to Managed Care Organizations to provide Medicare plus Choice programs to seniors in those areas who have no Medicare managed care or are in medically underserved areas; and~~

~~WHEREAS, A subsidy to offset the premium cost for seniors who have no Medicare managed care~~ find a temporary means of providing prescription drug benefits to its senior citizens who have no prescription drug benefits in those counties or portions of counties that are medically underserved and have no managed care prescription drug benefits available; and

WHEREAS, It is the intent of the Maryland General Assembly to fund the prescription drug benefits plan with a portion of the approved purchaser differential received under § 15-606 of the Insurance Article by carriers who provide substantial, affordable, and available health care coverage programs; and

WHEREAS, Providing a short-term prescription drug program for Maryland's senior citizens will have a long term beneficial effect on the cost of public health in Maryland; now, therefore,

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

Article - Health - General

SUBTITLE 6. ~~MARYLAND MEDICARE PLUS CHOICE INSURANCE SUBSIDY PROGRAM~~ SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN.

15-601.

~~(A) THERE IS A MARYLAND MEDICARE PLUS CHOICE INSURANCE SUBSIDY PROGRAM IN THE DEPARTMENT TO BE PROVIDED FOR THOSE INDIVIDUALS WHO:~~

~~(1) ARE CITIZENS OF MARYLAND AND AT LEAST 65 YEARS OF AGE;~~

~~(2) ARE ELIGIBLE FOR MEDICARE PLUS CHOICE AS DEFINED BY TITLE XVIII OF THE SOCIAL SECURITY ACT, AS AMENDED;~~

~~(3) HAVE NO MEDICARE PLUS CHOICE IN THEIR COUNTY OR HAVE NO MEDICARE PLUS CHOICE IN AN AREA DESIGNATED AS MEDICALLY UNDERSERVED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES;~~

~~(4) PAY THE PREMIUM FOR MEDICARE PART "B" AS DETERMINED BY TITLE XVIII OF THE SOCIAL SECURITY ACT, AS AMENDED; AND~~

~~(5) PAY THE PREMIUM AND DEDUCTIBLES FOR A MEDICARE PLUS CHOICE MANAGED CARE PROGRAM.~~

~~15-602.~~

~~THE FIRST MANAGED CARE PROVIDER TO ESTABLISH A MEDICARE PLUS CHOICE MANAGED CARE INSURANCE PROGRAM IN A COUNTY OR MEDICALLY UNDERSERVED AREA THAT HAS NO MEDICARE PLUS CHOICE MANAGED CARE PROGRAM FOR CURRENT ELIGIBLE MEDICARE BENEFICIARIES OR NEW MEDICARE BENEFICIARIES SHALL BE PAID A $30 SUBSIDY PER ENROLLEE PER MONTH PROVIDED THAT:~~

~~(1) THE MANAGED CARE PROVIDER SIGNS A CONTRACT WITH THE SECRETARY GUARANTEEING THAT THEY WILL PROVIDE A MEDICARE PLUS CHOICE MANAGED CARE INSURANCE PROGRAM IN A COUNTY OR MEDICALLY UNDERSERVED AREA FOR A PERIOD OF AT LEAST 2 YEARS;~~

~~(2) THE MANAGED CARE PROVIDER APPLIES FOR AND RECEIVES APPROVAL FROM THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE MEDICARE PLUS CHOICE MANAGED CARE INSURANCE PROGRAM;~~

~~(3) THE PREMIUMS REMAIN THE SAME OR LESS FOR THE 2 YEAR CONTRACT PERIOD;~~

~~(4) THE REQUIRED MINIMUM BENEFITS ARE INCLUDED IN THE MEDICARE PLUS CHOICE MANAGED CARE BENEFIT PLAN;~~

~~(5) THE MANAGED CARE PROVIDER PROVIDES PROOF OF ENROLLMENT OF A BENEFICIARY ACCORDING TO REGULATIONS ADOPTED BY THE SECRETARY TO IMPLEMENT THIS SECTION;~~

~~(6) ALL PERFORMANCE REVIEW AND FINANCIAL RECORDS ARE AVAILABLE FOR REVIEW BY THE SECRETARY; AND~~

~~(7) THE MANAGED CARE PROVIDER MEETS ALL THE REQUIREMENTS OF THE MARYLAND INSURANCE COMMISSION.~~

~~15-603.~~

~~IN ORDER TO QUALIFY FOR THIS SUBSIDY A MANAGED CARE PROVIDER SHALL, AS A MINIMUM, PROVIDE THE FOLLOWING BENEFITS:~~

~~(1) ALL OF THE BENEFITS OF MEDICARE PART "A" PLUS MEDICARE PART "B" REQUIRED BY TITLE XVIII OF THE SOCIAL SECURITY ACT, AS AMENDED;~~

~~(2) A PRESCRIPTION BENEFIT OF $1,000 PER YEAR PER ENROLLEE;~~

~~(3) UNLIMITED HOSPITAL STAYS;~~

~~(4) UNLIMITED VISITS WITH A BENEFICIARY'S PRIMARY CARE PHYSICIAN OR PRIMARY HEALTH CARE PROVIDER;~~

~~(5) VISITS TO SPECIALISTS WITH A REFERRAL FROM THE BENEFICIARY'S PRIMARY CARE PHYSICIAN OR PRIMARY HEALTH CARE PROVIDER;~~

~~(6) PODIATRY TREATMENT;~~

~~(7) ONE ANNUAL PHYSICAL PER YEAR;~~

~~(8) OUTPATIENT HOSPITAL VISITS;~~

~~(9) OUTPATIENT HOSPITAL REHABILITATION;~~

~~(10) UP TO 190 DAYS OF INPATIENT MENTAL HEALTH TREATMENT PER YEAR;~~

~~(11) UP TO 100 DAYS OF SKILLED NURSING CARE PER YEAR;~~

~~(12) EMERGENCY AMBULANCE SERVICE;~~

~~(13) ONE ROUTINE EYE EXAM PER YEAR AND ONE PAIR OF EYEGLASSES PER YEAR;~~

~~(14) ALCOHOL AND DRUG ABUSE EDUCATION CLASSES AND OUTPATIENT TREATMENT;~~

~~(15) ANNUAL MAMMOGRAMS, PAP SMEARS, AND COLORECTAL SCREENING EXAMS FOR CANCER;~~

~~(16) HEPATITIS B AND FLU VACCINES;~~

~~(17) HEARING EXAMS;~~

~~(18) TWO PREVENTIVE DENTAL EXAMS PER YEAR; AND~~

~~(19) EMERGENCY MEDICAL OUTPATIENT TREATMENT.~~

~~15-604.~~

~~THE MANAGED CARE PROVIDER MAY:~~

~~(1) REQUIRE A DEDUCTIBLE TO APPLY TO PRESCRIPTION BENEFITS AND CO-PAYMENTS THAT ARE EQUAL OR LESS THAN THOSE REQUIRED BY THE MEDICARE PART "B" BENEFITS PROVIDED UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT, AS AMENDED;~~

~~(2) ESTABLISH A RESTRICTED FORMULARY OF EXPERIMENTAL DRUGS THAT WILL NOT BE REIMBURSED BY THE PROGRAM; AND~~

~~(3) ESTABLISH A CO-PAYMENT SYSTEM FOR PRESCRIPTION DRUGS BASED ON THE USE OF BRAND OR GENERIC DRUGS.~~

~~15-605.~~

~~THE SECRETARY SHALL:~~

~~(1) PAY A MANAGED CARE PROVIDER WITHIN 30 DAYS AFTER RECEIPT OF A CLAIM FOR PAYMENT OF SUBSIDIES;~~

~~(2) SUBMIT A REPORT TO THE GENERAL ASSEMBLY ON OR BEFORE JUNE 30, 2001, AND IN EACH SUCCESSIVE YEAR, THAT INCLUDES A SUMMARY OF THE PROGRAM ACTIVITIES FOR THE YEAR AND ANY RECOMMENDATIONS OR SUGGESTIONS FOR LEGISLATIVE CONSIDERATION; AND~~

~~(3) ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SECTION.~~

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

(B) "CARRIER" MEANS:

(1) AN AUTHORIZED INSURER;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION;

(4) A MANAGED CARE ORGANIZATION;

(5) A DENTAL PLAN ORGANIZATION; OR

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

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

(1) IS A RESIDENT OF MARYLAND AND AT LEAST 65 YEARS OF AGE;

(2) IS ELIGIBLE FOR MEDICARE PLUS CHOICE, AS DEFINED UNDER TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, AS AMENDED;

(3) RESIDES IN A MEDICALLY UNDERSERVED COUNTY OR PORTION OF A COUNTY;

(4) PAYS THE PREMIUM FOR MEDICARE PART "B", AS REQUIRED BY TITLE XVIII OF THE SOCIAL SECURITY ACT, AS AMENDED;

(5) IS NOT ENROLLED IN A MEDICARE PLUS CHOICE MANAGED CARE PROGRAM THAT PROVIDES PRESCRIPTION DRUG BENEFITS AT THE TIME THAT THE INDIVIDUAL APPLIES FOR ENROLLMENT IN THE PLAN; AND

(6) PAYS THE PREMIUM, CO-PAYMENTS, AND DEDUCTIBLES FOR THE PLAN.

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

(E) "FUND" MEANS THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN FUND CREATED UNDER § 15-604 OF THIS SUBTITLE.

(F) "MEDICALLY UNDERSERVED COUNTY" MEANS ANY OF THE FOLLOWING COUNTIES:

(1) ALLEGANY COUNTY;

(2) CALVERT COUNTY;

(3) CAROLINE COUNTY;

(4) CARROLL COUNTY;

(5) CECIL COUNTY;

(6) CHARLES COUNTY;

(7) DORCHESTER COUNTY;

(8) FREDERICK COUNTY;

(9) GARRETT COUNTY;

(10) KENT COUNTY;

(11) QUEEN ANNE'S COUNTY;

(12) ST. MARY'S COUNTY;

(13) SOMERSET COUNTY;

(14) TALBOT COUNTY;

(15) WASHINGTON COUNTY;

(16) WICOMICO COUNTY; OR

(17) WORCESTER COUNTY.

(G) "PORTION OF A COUNTY" MEANS A GEOGRAPHIC PART OF A COUNTY NOT LISTED IN SUBSECTION (F) OF THIS SECTION THAT WAS SERVED BY A MEDICARE PLUS CHOICE MANAGED CARE PROVIDER PRIOR TO JANUARY 1, 2000, AND IS NO LONGER SERVED.

(H) "PLAN" MEANS THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN ESTABLISHED UNDER THIS SUBTITLE.

15-602.

(A) A CARRIER THAT IS REQUIRED TO PROVIDE THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN UNDER § 15-606(C) OF THE INSURANCE ARTICLE SHALL:

(1) SIGN A CONTRACT WITH THE SECRETARY AGREEING TO PROVIDE PRESCRIPTION DRUG BENEFITS TO ELIGIBLE INDIVIDUALS FOR A PERIOD OF AT LEAST 2 YEARS;

(2) EXCEPT AS OTHERWISE REQUIRED UNDER STATE OR FEDERAL LAW, AGREE NOT TO ALTER THE LEVEL OR TYPES OF BENEFITS PROVIDED UNDER THE PLAN THROUGHOUT THE 2-YEAR PERIOD OF THE CONTRACT;

(3) AGREE TO HOLD ENROLLEE PREMIUMS AT THE SAME LEVEL THROUGHOUT THE 2-YEAR CONTRACT PERIOD;

(4) AGREE TO CONTINUE TO SERVE AT LEAST THE SAME MEDICALLY UNDERSERVED COUNTIES OR PORTIONS OF COUNTIES THROUGHOUT THE 2-YEAR CONTRACT PERIOD; AND

(5) MAKE ALL PERFORMANCE REVIEW AND FINANCIAL RECORDS AVAILABLE FOR REVIEW BY THE SECRETARY AND THE MARYLAND INSURANCE ADMINISTRATION.

(B) THE CARRIER IS NOT REQUIRED, IN PROVIDING THE PLAN, TO OFFER ANY OTHER BENEFIT OTHERWISE REQUIRED UNDER TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE OR TITLE 15, SUBTITLE 8 OF THE INSURANCE ARTICLE.

15-603.

(A) THE PLAN PROVIDED UNDER THIS SUBTITLE SHALL:

(1) THROUGHOUT THE 2-YEAR CONTRACT PERIOD, PROVIDE BENEFITS TO NOT MORE THAN 15,000 ENROLLEES AT ANY ONE TIME WHO ARE ELIGIBLE INDIVIDUALS AND WHO RESIDE IN ANY OF THE MEDICALLY UNDERSERVED COUNTIES OR PORTIONS OF COUNTIES;

(2) SET THE MONTHLY PREMIUM CHARGED AN ENROLLEE AT $40;

(3) SET THE DEDUCTIBLE CHARGED AN ENROLLEE AT $50 PER YEAR PER INDIVIDUAL;

(4) LIMIT THE CO-PAY CHARGED AN ENROLLEE TO:

(I) $10 FOR A PRESCRIPTION FOR A GENERIC DRUG;

(II) $20 FOR A PRESCRIPTION FOR A PREFERRED BRAND NAME DRUG; AND

(III) $35 FOR A PRESCRIPTION FOR A NONPREFERRED BRAND NAME DRUG; AND

(5) LIMIT THE TOTAL ANNUAL BENEFIT TO $1,000 PER INDIVIDUAL.

(B) THE PLAN MAY INCLUDE A RESTRICTED FORMULARY OF EXPERIMENTAL DRUGS NOT APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION FOR GENERAL USE THAT WILL NOT BE REIMBURSED.

(C) (1) DURING THE FIRST 180 DAYS OF THE OPERATION OF THE PLAN, THE CARRIER MAY ENROLL ONLY ELIGIBLE INDIVIDUALS WHO WERE:

(I) ENROLLED IN MEDICARE PLUS CHOICE MANAGED CARE PROGRAMS IN MEDICALLY UNDERSERVED COUNTIES OR PORTIONS OF COUNTIES ON OR BEFORE DECEMBER 31, 1999; AND

(II) AFTER DECEMBER 31, 1999, CEASED TO BE ENROLLED IN THOSE PLANS.

(2) ON AND AFTER THE 181ST DAY OF THE OPERATION OF THE PLAN, THE CARRIER MAY ENROLL ANY ELIGIBLE INDIVIDUAL.

(3) THE CARRIER SHALL WORK WITH THE SECRETARY AND THE MARYLAND DEPARTMENT OF AGING TO PROVIDE NOTICE, THROUGH THE WRITTEN AND ELECTRONIC MEDIA AND OTHER MEANS, TO THE ELIGIBLE INDIVIDUALS ELIGIBLE FOR ENROLLMENT IN THE FIRST 180 DAYS OF THE OPERATION OF THE PLAN, OF THE AVAILABILITY OF THE PLAN AND OF THE ENROLLMENT PREFERENCE TO BE GRANTED.

15-604.

(A) THERE IS A SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN FUND.

(B) THE FUND CONTAINS THE ASSESSMENT AGAINST CARRIERS MADE UNDER § 15-606(C) OF THE INSURANCE ARTICLE.

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

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

(E) (1) THE FUND SHALL BE INVESTED AND REINVESTED IN THE SAME MANNER AS OTHER STATE FUNDS.

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

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

(G) THE SECRETARY SHALL TRANSFER THE MONEYS IN THE FUND TO THE CARRIER PROVIDING THE PLAN AS THE MONEYS ARE NEEDED TO PROVIDE BENEFITS TO ENROLLEES IN THE PLAN.

15-605.

(A) ON OR BEFORE JUNE 30 OF EACH YEAR, THE SECRETARY, THE MARYLAND HEALTH SERVICES COST REVIEW COMMISSION, AND THE MARYLAND INSURANCE ADMINISTRATION SHALL SUBMIT A JOINT REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY, THAT INCLUDES A SUMMARY OF THE PROGRAM ACTIVITIES FOR THE YEAR AND ANY RECOMMENDATIONS FOR CONSIDERATION BY THE GENERAL ASSEMBLY.

(B) THE SECRETARY SHALL ADOPT REGULATIONS TO CARRY OUT THE PROVISIONS OF THIS SUBTITLE.

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 SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN CREATED UNDER TITLE 15, SUBTITLE 6 OF THE HEALTH - GENERAL ARTICLE.

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.

(C) (1) IN ADDITION TO THE REQUIREMENTS IMPOSED UNDER SUBSECTION (B) OF THIS SECTION, A CARRIER MAY NOT RECEIVE THE APPROVED PURCHASER DIFFERENTIAL UNLESS THE CARRIER CONTRIBUTES, AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, TO THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN CREATED UNDER TITLE 15, SUBTITLE 6 OF THE HEALTH - GENERAL ARTICLE.

(2) (I) THE TOTAL CONTRIBUTIONS TO BE MADE TO THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN BY ALL CARRIERS PARTICIPATING IN THE SUBSTANTIAL, AFFORDABLE, AND AVAILABLE COVERAGE DIFFERENTIAL PROGRAM SHALL BE $5.4 MILLION PER YEAR.

(II) 1. EACH CARRIER PARTICIPATING IN THE SUBSTANTIAL, AFFORDABLE, AND AVAILABLE COVERAGE DIFFERENTIAL PROGRAM SHALL CONTRIBUTE AN AMOUNT TO THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN THAT IS EQUAL TO THE TOTAL DERIVED BY MULTIPLYING $5.4 MILLION BY THE PERCENTAGE OF THE TOTAL BENEFIT TO ALL CARRIERS FROM THE SUBSTANTIAL, AFFORDABLE, AND AVAILABLE COVERAGE DIFFERENTIAL THAT THE CARRIER RECEIVES ON JANUARY 1, 2000.

2. ON JULY 1 OF EACH YEAR, THE HEALTH SERVICES COST REVIEW COMMISSION SHALL CALCULATE EACH CARRIER'S CONTRIBUTION AND ASSESS THE CONTRIBUTION AS PROVIDED IN THIS SUBSECTION.

(III) 1. THE ~~CARRIER WITH THE GREATEST MARKET SHARE PARTICIPATION IN THE SUBSTANTIAL, AFFORDABLE, AND AVAILABLE COVERAGE PROGRAM~~ LAST CARRIER TO PROVIDE MEDICARE PLUS CHOICE COVERAGE IN MEDICALLY UNDERSERVED COUNTIES OR PORTIONS OF COUNTIES SHALL USE AN AMOUNT EQUAL TO THE CONTRIBUTION DERIVED UNDER SUBPARAGRAPH (II) OF

THIS PARAGRAPH TO PROVIDE THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY PLAN CREATED UNDER TITLE 15, SUBTITLE 6 OF THE HEALTH - GENERAL ARTICLE.

2. THE CARRIER IS NOT REQUIRED, IN PROVIDING THE PLAN UNDER THIS SUBPARAGRAPH, TO OFFER ANY OTHER BENEFIT OTHERWISE REQUIRED UNDER TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE OR SUBTITLE 8 OF THIS TITLE.

(IV) THE HEALTH SERVICES COST REVIEW COMMISSION SHALL ANNUALLY ASSESS ANY CARRIER OTHER THAN THE CARRIER DESCRIBED UNDER SUBPARAGRAPH (III) OF THIS PARAGRAPH FOR THE CARRIER'S CONTRIBUTION AND SHALL TRANSFER THE CONTRIBUTION TO THE TREASURER OF THE STATE, FOR PAYMENT INTO THE SHORT-TERM PRESCRIPTION DRUG SUBSIDY FUND CREATED UNDER § 15-604 OF THE HEALTH - GENERAL ARTICLE.

(V) IF A CARRIER WITHDRAWS FROM THE SUBSTANTIAL, AFFORDABLE, AND AVAILABLE COVERAGE PROGRAM, THE COMMISSION SHALL RECALCULATE THE CONTRIBUTIONS TO THE PRESCRIPTION DRUG SUBSIDY PLAN FOR THE REMAINING CARRIERS.

SECTION 2. AND BE IT FURTHER ENACTED, That the Health Services Cost Review Commission may not take steps to eliminate or adjust the differential in hospital rates provided to carriers who provide a substantial, affordable, and available product in the nongroup market, under § 15-606 of the Insurance Article and the regulations of the Commission, as those rates were in effect on January 1, 2000, until the later of the termination of the Short-Term Prescription Drug Subsidy Plan created under this Act or the end of June 30, 2002.

SECTION 3. AND BE IT FURTHER ENACTED, That the Secretary of Health and Mental Hygiene shall study the cost of providing access to managed care for Medicare Plus Choice-eligible individuals residing in urban, suburban, and rural areas throughout the State and shall report the results of the study to the Governor and, in accordance with § 2-1246 of the State Government Article, to the General Assembly, on or before January 1, 2001.

SECTION 4. AND BE IT FURTHER ENACTED, That if the Secretary of Health and Mental Hygiene is notified by the federal Health Care Financing Administration that any provision of the Short-Term Prescription Drug Subsidy Plan or of this Act will invalidate the Maryland Medicare Waiver or cause a reduction in the State's eligibility for federal funding of Medicaid, the Secretary may suspend the provision of the Short-Term Prescription Drug Subsidy Plan or the provision of this Act that is the subject of the notification.

SECTION ~~2.~~ 5. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2000. ~~It shall remain effective for a period of 2 years and, at~~ On the earlier of the end of June 30, 2002, or the availability of comparable prescription pharmacy benefits provided by Medicare under Title XVIII of the Social Security Act, as amended, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect. If comparable prescription pharmacy

benefits are provided by Medicare under Title XVIII of the Social Security Act, the Secretary of Health and Mental Hygiene shall notify the Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401 not later than 90 days before prescription drug benefits are to be provided.