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By: **Senators Neall, Astle, Baker, Blount, Colburn, Collins, Conway, Currie, DeGrange, Della, Dorman, Dyson, Exum, Ferguson, Forehand, Frosh, Green, Hafer, Haines, Harris, Hoffman, Hogan, Hollinger, Hooper, Hughes, Jacobs, Jimeno, Kasemeyer, Kelley, Kittleman, Lawlah, McFadden, Middleton, Mitchell, Mooney, Munson, Pinsky, Roesser, Ruben, Schrader, Sfikas, Stoltzfus, Stone, Teitelbaum, and Van Hollen**

Introduced and read first time: January 30, 2002
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance - Substantial, Available, and Affordable Coverage Products - Reform

FOR the purpose of requiring the Maryland Insurance Commissioner to notify the State Health Services Cost Review Commission of certain health insurance carriers that apply for approval of a Substantial, Available, and Affordable Coverage (SAAC) product, or have a SAAC product that has been approved, under certain provisions of law; making a certain tax exemption for nonprofit health service plans subject to a certain requirement; requiring certain nonprofit health service plans to submit an annual report by a certain date; authorizing the Insurance Commission to permit a certain report to be filed as a part of another report; providing that certain nonprofit health service plans have a certain amount of time to comply with a certain order; providing that an applicant for a certificate of authority as a nonprofit health service plan shall satisfy the Commission that the nonprofit health service plan offers or will offer a SAAC product that has been approved under certain provisions of law; specifying procedures for applying for approval of a SAAC product; specifying the requirements a SAAC product must meet to qualify for approval; requiring the State Health Services Cost Review Commission to grant a certain differential to a carrier that has an approved SAAC product; specifying the circumstances under which a carrier must submit a corrective plan to the Commission; authorizing a corrective plan to provide for certain actions; requiring a carrier to pay a certain amount to the Commission or the Commission's designee if the carrier stops offering a SAAC product; requiring a carrier that sends a letter of declination to an applicant for medically underwritten health insurance in the nongroup market to send the applicant certain information about the availability of SAAC products in the nongroup market; authorizing the Commissioner and the Commission to adopt certain regulations; providing for the application of certain provisions of this Act; defining certain terms; providing for the effective date of certain provisions of

this Act; providing for the termination of certain provisions of this Act; and generally relating to Substantial, Available, and Affordable Coverage products in the nongroup health insurance market.

BY adding to
Article - Health - General
Section 19-214.1 and 19-706(ww)
Annotated Code of Maryland
(2000 Replacement Volume and 2001 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 6-101(b)(1)
Annotated Code of Maryland
(1997 Volume and 2001 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 14-106, 14-107, 14-110, and 15-606
Annotated Code of Maryland
(1997 Volume and 2001 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-606
Annotated Code of Maryland
(1997 Volume and 2001 Supplement)
(As enacted by Chapters 134 and 135 of the Acts of the General Assembly of 2001)

BY adding to
Article - Insurance
Section 15-131; and 15-6A-01 through 15-6A-03 and 15-6A-05 to be under the new subtitle "Subtitle 6A. Substantial, Available, and Affordable Coverage Products"
Annotated Code of Maryland
(1997 Volume and 2001 Supplement)

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

Article - Health - General

19-214.1.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

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

(3) "COMMISSIONER" MEANS THE MARYLAND INSURANCE COMMISSIONER.

(4) "SAAC PRODUCT" HAS THE MEANING STATED IN § 15-6A-01 OF THE INSURANCE ARTICLE.

(5) "SUBSIDY" MEANS THE AMOUNT OF HEALTH CARE EXPENDITURES PAID BY A CARRIER THAT EXCEEDS 70% OF THE PREMIUM EARNED FOR THE SAAC PRODUCT BY THE CARRIER.

(6) "VALUE OF THE DIFFERENTIAL" MEANS THE DIFFERENCE BETWEEN WHAT THE CARRIER WOULD HAVE PAID FOR HOSPITAL SERVICES WITHOUT THE DIFFERENTIAL, AND WHAT THE CARRIER PAID FOR HOSPITAL SERVICES WITH THE DIFFERENTIAL.

(B) THE COMMISSIONER SHALL NOTIFY THE COMMISSION OF EACH CARRIER THAT:

(1) APPLIES FOR APPROVAL OF A SAAC PRODUCT UNDER § 15-6A-03 OF THE INSURANCE ARTICLE; OR

(2) HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THE INSURANCE ARTICLE.

(C) (1) THE COMMISSION SHALL GRANT UP TO A 4% DIFFERENTIAL TO A CARRIER THAT HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THE INSURANCE ARTICLE.

(2) IF THE VALUE OF THE DIFFERENTIAL IS EQUAL TO OR LESS THAN 62.5% OF THE SUBSIDY, THE CARRIER HAS EARNED THE DIFFERENTIAL.

(3) IF THE VALUE OF THE DIFFERENTIAL IS GREATER THAN 62.5% OF THE SUBSIDY, THE CARRIER SHALL SUBMIT A CORRECTIVE PLAN TO THE COMMISSION, FOR APPROVAL BY THE COMMISSION, IN CONSULTATION WITH THE COMMISSIONER.

(D) A CORRECTIVE PLAN UNDER SUBSECTION (C)(3) OF THIS SECTION MAY PROVIDE FOR:

(1) PAYMENT BY THE CARRIER TO THE COMMISSION OR THE COMMISSION'S DESIGNEE IN THE AMOUNT BY WHICH THE VALUE OF THE DIFFERENTIAL EXCEEDS THE SUBSIDY;

(2) A REDUCTION IN THE DIFFERENTIAL GIVEN TO THE CARRIER; OR

(3) ANY OTHER ACTION APPROVED BY THE COMMISSION, IN CONSULTATION WITH THE COMMISSIONER.

(E) IF A CARRIER STOPS OFFERING A SAAC PRODUCT, THE CARRIER SHALL PAY TO THE COMMISSION OR THE COMMISSION'S DESIGNEE THE AMOUNT BY WHICH THE VALUE OF THE DIFFERENTIAL EXCEEDS 62.5% OF THE SUBSIDY.

(F) THE COMMISSION MAY ADOPT REGULATIONS TO IMPLEMENT THIS SECTION.

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

Article - Health - General

19-706.

(WW) THE PROVISIONS OF § 15-131 AND TITLE 15, SUBTITLE 6A OF THE INSURANCE ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article - Insurance

6-101.

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

(1) a nonprofit health service plan corporation that meets the requirements established under §§ 14-106 and 14-107 of this article;

14-106.

(a) It is the public policy of this State that the exemption from taxation for nonprofit health service plans under § 6-101(b)(1) of this article is granted so that funds which would otherwise be collected by the State and spent for a public purpose shall be used in a like manner and amount by the nonprofit health service plan.

(b) This section does not apply to a nonprofit health service plan that insures fewer than 10,000 covered lives in Maryland.

(c) By March 1 of each year or a deadline otherwise imposed by the Commissioner for good cause, each nonprofit health service plan shall file with the Commissioner a premium tax exemption report that:

(1) is in a form approved by the Commissioner; and

(2) demonstrates that the plan has used funds equal to the value of the premium tax exemption provided to the plan under § 6-101(b) of this article, in a manner that serves the public interest in accordance with subsection (d) of this section.

(d) (1) BY MARCH 1 OF EACH YEAR OR A DEADLINE OTHERWISE IMPOSED BY THE COMMISSIONER FOR GOOD CAUSE, EACH NONPROFIT HEALTH SERVICE PLAN SHALL FILE WITH THE COMMISSIONER A PREMIUM TAX EXEMPTION REPORT THAT DEMONSTRATES THAT THE NONPROFIT HEALTH SERVICE PLAN HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THIS ARTICLE.

(2) THE COMMISSIONER MAY AUTHORIZE A NONPROFIT HEALTH SERVICE PLAN TO FILE THE REPORT REQUIRED UNDER THIS SUBSECTION AS PART OF THE REPORT FILED UNDER SUBSECTION (C) OF THIS SECTION.

(E) Except as provided in subsection [(e)] (F) of this section, a nonprofit health service plan may satisfy the public service requirement in subsection (c)(2) of this section by establishing that the plan has:

(1) increased access to, or the affordability of, one or more health care products or services by offering and selling health care products or services that are not required or provided for by law; or

(2) served the public interest by any method or practice approved by the Commissioner.

[(e)] (F) The Commissioner may not consider the fact that a nonprofit health service plan offers a product through the substantial, available, affordable coverage program when determining whether the plan has satisfied the requirements of subsection (c)(2) of this section.

[(f)] (G) Each report filed with the Commissioner under [subsection] SUBSECTIONS (c) AND (D) of this section is a public record.

14-107.

(a) By November 1 of each year, the Commissioner shall issue an order notifying each nonprofit health service plan that is required to file [a report] THE REPORTS REQUIRED under § 14-106 of this subtitle of whether the plan has satisfied the requirements of § 14-106 of this subtitle.

(b) (1) If the Commissioner determines that a nonprofit health service plan has not satisfied the requirements of § 14-106 of this subtitle, the nonprofit health service plan shall have 1 year from the date the Commissioner issued the order under subsection (a) of this section to comply with the requirements of § 14-106 of this subtitle.

(2) If after the time period provided under paragraph (1) of this subsection the Commissioner determines that a nonprofit health service plan has not satisfied the requirements of § 14-106 of this subtitle[:

(i) the Commissioner shall report the determination to the House Economic Matters Committee and the Senate Finance Committee, including the reasons for the determination; and

(ii) if required by an act of the General Assembly], the nonprofit health service plan shall be subject to the premium tax under Title 6, Subtitle 1 of this article FOR THE TAXABLE YEAR IN WHICH THE COMMISSIONER MAKES THE DETERMINATION.

(c) A nonprofit health service plan that fails to timely file the [report] REPORTS required under § 14-106 of this subtitle:

(1) shall pay the penalties under § 14-121 of this subtitle; AND

(2) MAY BE SUBJECT TO AN ORDER REQUIRING THE PLAN TO PAY THE PREMIUM TAX.

(d) A party aggrieved by an order of the Commissioner issued under this section has a right to a hearing in accordance with §§ 2-210 through 2-215 of this article.

14-110.

The Commissioner shall issue a certificate of authority to an applicant if:

(1) the applicant has paid the applicable fee required by § 2-112 of this article; and

(2) the Commissioner is satisfied:

(i) that the applicant has been organized in good faith for the purpose of establishing, maintaining, and operating a nonprofit health service plan;

(ii) that:

1. each contract executed or proposed to be executed by the applicant and a health care provider to furnish health care services to subscribers to the nonprofit health service plan, obligates or, when executed, will obligate each health care provider party to the contract to render the health care services to which

each subscriber is entitled under the terms and conditions of the various contracts issued or proposed to be issued by the applicant to subscribers to the plan; and

2. each subscriber is entitled to reimbursement for podiatric, chiropractic, psychological, or optometric services, regardless of whether the service is performed by a licensed physician, licensed podiatrist, licensed chiropractor, licensed psychologist, or licensed optometrist;

(iii) that:

1. each contract issued or proposed to be issued to subscribers to the plan is in a form approved by the Commissioner; and

2. the rates charged or proposed to be charged for each form of each contract are fair and reasonable; [and]

(iv) that the applicant has a surplus, as defined in § 14-117 of this subtitle, of the greater of:

1. $100,000; and

2. an amount equal to that required under § 14-117 of this subtitle; AND

(V) THAT EXCEPT FOR A NONPROFIT HEALTH SERVICE PLAN THAT INSURES FEWER THAN 10,000 COVERED LIVES IN THE STATE, THE NONPROFIT HEALTH SERVICE PLAN OFFERS OR WILL OFFER A SAAC PRODUCT, AS DEFINED IN § 15-6A-01 OF THIS ARTICLE, THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THIS ARTICLE.

15-131.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

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

(3) "SAAC PRODUCT" HAS THE MEANING STATED IN § 15-6A-01 OF THIS TITLE.

(B) THIS SECTION APPLIES TO CARRIERS THAT OFFER MEDICALLY UNDERWRITTEN HEALTH INSURANCE IN THE NONGROUP MARKET IN THE STATE.

(C) (1) A CARRIER SUBJECT TO THIS SECTION THAT SENDS A LETTER OF DECLINATION TO AN APPLICANT FOR MEDICALLY UNDERWRITTEN HEALTH INSURANCE IN THE NONGROUP MARKET SHALL SEND TO THE APPLICANT INFORMATION ABOUT THE AVAILABILITY OF SAAC PRODUCTS IN THE NONGROUP MARKET.

(2) THE INFORMATION SHALL BE IN THE FORM, AND SHALL BE SENT IN THE MANNER, THAT THE COMMISSIONER REQUIRES.

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

Article - Insurance

SUBTITLE 6A. SUBSTANTIAL, AVAILABLE, AND AFFORDABLE COVERAGE PRODUCTS.

15-6A-01.

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

(B) "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.

(C) "COMMISSION" MEANS THE STATE HEALTH SERVICES COST REVIEW COMMISSION.

(D) "SUBSTANTIAL, AVAILABLE, AND AFFORDABLE COVERAGE PRODUCT" OR "SAAC PRODUCT" MEANS A HEALTH BENEFIT PLAN THAT:

(1) IS OFFERED IN THE NONGROUP MARKET;

(2) IS OFFERED ON AN OPEN ENROLLMENT BASIS;

(3) INCLUDES BENEFITS IN ACCORDANCE WITH THE PLAN ESTABLISHED UNDER § 15-6A-04 OF THIS SUBTITLE; AND

(4) IS PRICED AT LEAST 5% HIGHER THAN THE PREMIUMS OF THE GREATER OF:

(I) ANY COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ISSUED BY THE CARRIER PURSUANT TO § 15-1207 OF THIS TITLE; OR

(II) A BENEFIT-EQUIVALENT MEDICALLY UNDERWRITTEN INDIVIDUAL PRODUCT OFFERED BY THE CARRIER.

(E) "VALUE OF THE DIFFERENTIAL" MEANS THE DIFFERENCE BETWEEN WHAT THE CARRIER WOULD HAVE PAID FOR HOSPITAL SERVICES WITHOUT THE DIFFERENTIAL, AND WHAT THE CARRIER PAID FOR HOSPITAL SERVICES WITH THE DIFFERENTIAL.

15-6A-02.

THE COMMISSIONER SHALL NOTIFY THE COMMISSION OF EACH CARRIER THAT:

(1) APPLIES FOR APPROVAL OF A SAAC PRODUCT UNDER § 15-6A-03 OF THIS SUBTITLE; OR

(2) HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THIS SUBTITLE.

15-6A-03.

(A) TO APPLY FOR APPROVAL OF A SAAC PRODUCT, A CARRIER SHALL SUBMIT TO THE COMMISSIONER AN APPLICATION ON THE FORM THE COMMISSIONER REQUIRES AND EVIDENCE THAT THE CARRIER'S SAAC PRODUCT COMPLIES WITH THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION.

(B) TO QUALIFY FOR APPROVAL, A SAAC PRODUCT SHALL:

(1) BE ADVERTISED BY THE CARRIER DURING AT LEAST TWO OPEN ENROLLMENT PERIODS PER YEAR, FOR A DURATION OF 1 MONTH PER OPEN ENROLLMENT PERIOD;

(2) HAVE AGE OR GEOGRAPHY BANDING OF ITS COMMUNITY RATE THAT IS CONSISTENT WITH § 15-1205 OF THIS TITLE; AND

(3) COMPLY WITH ANY REGULATIONS ADOPTED BY THE COMMISSIONER AND THE COMMISSION.

[15-606.] 15-6A-04.

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

(1) an insurer;

(2) a nonprofit health service plan;

(3) a health maintenance organization; or

(4) 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 COMPREHENSIVE HEALTH BENEFITS 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 § 19-214.1 OF THE HEALTH - GENERAL ARTICLE AND regulations adopted by the [Health Services Cost Review] COMMISSIONER AND THE Commission.

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

[(i)] (1) their effectiveness in improving the health of individuals;

[(ii)] (2) their impact on maintaining and improving health and encouraging consumers to use only the health care services they need; and

[(iii)] (3) their impact on the affordability of health care coverage.

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

[(i)] (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

[(ii)] (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.

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

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

[(i)] (1) include cost-sharing and other incentives to help consumers use only the health care services they need;

[(ii)] (2) balance the effect of cost-sharing in reducing premiums and in affecting utilization of appropriate services; and

[(iii)] (3) limit the total cost-sharing that may be incurred by an individual in a year.

[(c) (1)] (F) (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)] (2) The total contributions to be made to the Short-Term Prescription Drug Subsidy Plan by all carriers participating in the substantial, available, and affordable coverage differential program shall be equal to 37.5 percent of the value of the differential provided to all carriers that offer substantial, available, and affordable coverage in the nongroup insurance market.

[(ii) 1.] (3) (I) Each carrier participating in the substantial, available, and affordable coverage differential program shall contribute an amount to the Short-Term Prescription Drug Subsidy Plan that is equal to 37.5 percent of the value of the differential provided to that carrier during the previous year.

[2.] (II) On or before 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.] (4) (I) The last carrier to provide Medicare Plus Choice coverage in medically underserved 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.] (II) 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)] (5) The Health Services Cost Review Commission shall annually assess each carrier 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.

15-6A-05.

THE COMMISSIONER MAY ADOPT REGULATIONS TO IMPLEMENT THIS SUBTITLE.

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

Article - Health - General

19-214.1.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

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

(3) "COMMISSIONER" MEANS THE MARYLAND INSURANCE COMMISSIONER.

(4) "SAAC PRODUCT" HAS THE MEANING STATED IN § 15-6A-01 OF THE INSURANCE ARTICLE.

(5) "SUBSIDY" MEANS THE AMOUNT OF HEALTH CARE EXPENDITURES PAID BY A CARRIER THAT EXCEEDS 70% OF THE PREMIUM EARNED FOR THE SAAC PRODUCT BY THE CARRIER.

(6) "VALUE OF THE DIFFERENTIAL" MEANS THE DIFFERENCE BETWEEN WHAT THE CARRIER WOULD HAVE PAID FOR HOSPITAL SERVICES WITHOUT THE DIFFERENTIAL, AND WHAT THE CARRIER PAID FOR HOSPITAL SERVICES WITH THE DIFFERENTIAL.

(B) THE COMMISSIONER SHALL NOTIFY THE COMMISSION OF EACH CARRIER THAT:

(1) APPLIES FOR APPROVAL OF A SAAC PRODUCT UNDER § 15-6A-03 OF THE INSURANCE ARTICLE; OR

(2) HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THE INSURANCE ARTICLE.

(C) (1) THE COMMISSION SHALL GRANT UP TO A 2% DIFFERENTIAL TO A CARRIER THAT HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THE INSURANCE ARTICLE.

(2) IF THE VALUE OF THE DIFFERENTIAL IS EQUAL TO OR LESS THAN THE SUBSIDY, THE CARRIER HAS EARNED THE DIFFERENTIAL.

(3) IF THE VALUE OF THE DIFFERENTIAL IS GREATER THAN THE SUBSIDY, THE CARRIER SHALL SUBMIT A CORRECTIVE PLAN TO THE COMMISSION, FOR APPROVAL BY THE COMMISSION, IN CONSULTATION WITH THE COMMISSIONER.

(D) A CORRECTIVE PLAN UNDER SUBSECTION (C)(3) OF THIS SECTION MAY PROVIDE FOR:

(1) PAYMENT BY THE CARRIER TO THE COMMISSION OR THE COMMISSION'S DESIGNEE IN THE AMOUNT BY WHICH THE VALUE OF THE DIFFERENTIAL EXCEEDS THE SUBSIDY;

(2) A REDUCTION IN THE DIFFERENTIAL GIVEN TO THE CARRIER; OR

(3) ANY OTHER ACTION APPROVED BY THE COMMISSION, IN CONSULTATION WITH THE COMMISSIONER.

(E) IF A CARRIER STOPS OFFERING A SAAC PRODUCT, THE CARRIER SHALL PAY TO THE COMMISSION OR THE COMMISSION'S DESIGNEE THE AMOUNT BY WHICH THE VALUE OF THE DIFFERENTIAL EXCEEDS THE SUBSIDY.

(F) THE COMMISSION MAY ADOPT REGULATIONS TO IMPLEMENT THIS SECTION.

Article - Insurance

SUBTITLE 6A. SUBSTANTIAL, AVAILABLE, AND AFFORDABLE COVERAGE PRODUCTS.

15-6A-01.

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

(B) "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.

(C) "COMMISSION" MEANS THE STATE HEALTH SERVICES COST REVIEW COMMISSION.

(D) "SUBSTANTIAL, AVAILABLE, AND AFFORDABLE COVERAGE PRODUCT" OR "SAAC PRODUCT" MEANS A HEALTH BENEFIT PLAN THAT:

(1) IS OFFERED IN THE NONGROUP MARKET;

(2) IS OFFERED ON AN OPEN ENROLLMENT BASIS;

(3) INCLUDES BENEFITS IN ACCORDANCE WITH THE PLAN ESTABLISHED UNDER § 15-6A-04 OF THIS SUBTITLE; AND

(4) IS PRICED AT LEAST 5% HIGHER THAN THE PREMIUMS OF THE GREATER OF:

(I) ANY COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN ISSUED BY THE CARRIER PURSUANT TO § 15-1207 OF THIS TITLE; OR

(II) A BENEFIT-EQUIVALENT MEDICALLY UNDERWRITTEN INDIVIDUAL PRODUCT OFFERED BY THE CARRIER.

(E) "VALUE OF THE DIFFERENTIAL" MEANS THE DIFFERENCE BETWEEN WHAT THE CARRIER WOULD HAVE PAID FOR HOSPITAL SERVICES WITHOUT THE DIFFERENTIAL, AND WHAT THE CARRIER PAID FOR HOSPITAL SERVICES WITH THE DIFFERENTIAL.

15-6A-02.

THE COMMISSIONER SHALL NOTIFY THE COMMISSION OF EACH CARRIER THAT:

(1) APPLIES FOR APPROVAL OF A SAAC PRODUCT UNDER § 15-6A-03 OF THIS SUBTITLE; OR

(2) HAS A SAAC PRODUCT THAT HAS BEEN APPROVED UNDER § 15-6A-03 OF THIS SUBTITLE.

15-6A-03.

(A) TO APPLY FOR APPROVAL OF A SAAC PRODUCT, A CARRIER SHALL SUBMIT TO THE COMMISSIONER AN APPLICATION ON THE FORM THE COMMISSIONER REQUIRES AND EVIDENCE THAT THE CARRIER'S SAAC PRODUCT COMPLIES WITH THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION.

(B) TO QUALIFY FOR APPROVAL, A SAAC PRODUCT SHALL:

(1) BE ADVERTISED BY THE CARRIER DURING AT LEAST TWO OPEN ENROLLMENT PERIODS PER YEAR, FOR A DURATION OF 1 MONTH PER OPEN ENROLLMENT PERIOD;

(2) HAVE AGE OR GEOGRAPHY BANDING OF ITS COMMUNITY RATE THAT IS CONSISTENT WITH § 15-1205 OF THIS TITLE; AND

(3) COMPLY WITH ANY REGULATIONS ADOPTED BY THE COMMISSIONER AND THE COMMISSION.

[15-606.] 15-6A-04.

(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 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.]

15-6A-05.

THE COMMISSIONER MAY ADOPT REGULATIONS TO IMPLEMENT THIS SUBTITLE.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 4 of this Act shall take effect on the taking effect of the termination provisions specified in Section 12 of Chapters 134 and 135 of the Acts of the General Assembly of 2001. If these termination provisions take effect, Sections 1 and 3 of this Act shall be abrogated and of no further force and effect. This Act may not be interpreted to have any effect on those termination provisions.

SECTION 6. AND BE IT FURTHER ENACTED, That, subject to the provisions of Section 5 of this Act, this Act shall take effect July 1, 2002.