HB 1207

Department of Legislative Services

Maryland General Assembly
2002 Session

FISCAL NOTE
Revised

House Bill 1207 (Delegate Taylor, *et al.*)
Economic Matters Finance and Budget and Taxation

Health Insurance - Nonprofit Health Service Plans and Rate Making - Reform

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This bill modifies the regulatory scheme for certain nonprofit health service plans.

The bill's provisions changing a nonprofit health service plan's board composition, term limits, and compensation take effect upon: (1) a determination by the Insurance Commission or an Act of the General Assembly that the application for acquisition filed on January 11, 2002 by CareFirst of Maryland, Inc. is denied; or (2) termination by either party of the proposed acquisition agreement between CareFirst, Inc. and WellPoint Health Networks, Inc. The remaining provisions take effect June 1, 2002.

Fiscal Summary

State Effect: Potentially significant general fund revenue increase in FY 2003 if CareFirst is required to pay premium taxes. Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2003. MIA special fund expenditures could increase by $40,100 in FY 2003. Future year estimates reflect annualization and inflation.

(in dollars)	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
GF Revenue	-	-	-	-	-
SF Revenue	-	0	0	0	0
SF Expenditure	40,100	49,800	52,100	54,600	57,200
Net Effect	($40,100)	($49,800)	($52,100)	($54,600)	($57,200)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Premium Tax Exemption: This bill specifies the public purpose requirements a nonprofit health service plan must satisfy in order to qualify for exemption from the State's 2% insurance premium tax. The bill exempts, from an annual reporting requirement, a nonprofit health service plan that contracts to provide only one of the following services: (1) podiatric; (2) chiropractic; (3) pharmaceutical; (4) dental; (5) psychological; or (6) optometric. A nonprofit health service plan required to file the annual report must demonstrate the plan has used funds to: (1) increase 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; (2) provide financial or in-kind support for public health programs; (3) employ underwriting standards in a manner that increases the availability of health care services or products; (4) employ pricing policies that enhance the affordability of health care services or products and result in a higher medical loss ratio than comparable for-profit health insurers; or (5) serve the public interest by any method approved by the Commissioner.

In addition, a nonprofit health service plan must: (1) offer a comprehensive benefit open enrollment product in the individual market; (2) offer an open enrollment product in the small employer group market; and (3) administer the Short-Term Prescription Drug Subsidy Plan. If a nonprofit health service plan fails to meets these requirements, the Insurance Commissioner must issue an order requiring the plan to pay the premium tax until such time as the plan demonstrates to the Commissioner that the plan is complying with the public purpose requirements. Any premium tax revenue collected as the result of a noncompliance order issued by the Commissioner against a nonprofit health service plan must be used to provide health insurance coverage to medically uninsurable or underinsured people.

The Attorney General may bring an action in a court of competent jurisdiction to: (1) enforce the nonprofit mission of a nonprofit health service plan; and (2) preserve and protect the assets of a nonprofit health service plan from waste, mismanagement, or abuse.

Certificate of Authority Requirements: The bill specifies that a nonprofit health service plan, when applying for a certificate of authority, must include its mission statement and a list of total compensation paid to board members. The Insurance Commissioner must issue a certificate of authority to a nonprofit health service plan if the Commissioner is satisfied that the plan: (1) is committed to a nonprofit corporate structure; (2) seeks to provide individuals and businesses with the most affordable and accessible health

insurance possible; and (3) recognizes a responsibility to contribute to the improvement of the overall health status of Maryland residents. The Commissioner cannot renew the certificate of authority unless the Commissioner determines the plan continues to satisfy the public purpose requirements.

Capital Improvement Projects: A certificate of authority permits a nonprofit health service plan to finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority and the Maryland Economic Development Corporation, and partner with the State and other public and private entities to provide services or administer programs intended to address community health care needs.

Board Composition, Term Limits, and Compensation: For nonprofit health service plans that insure more than 10,000 covered lives, the bill alters a plan's board composition by: (1) limiting the board to no more than 17 members; (2) providing that the Governor, with the advice and consent of the General Assembly, must appoint eight members; (3) providing that each board member must be a State resident; and (4) providing that of the board members selected by the board, four must be selected from certain nominating lists submitted by various health care associations and public interest groups, and five must be consumer members. In addition a member cannot serve more than two full terms or a total of six years. The compensation for directors and officers of a nonprofit health service plan must be reasonable. The chairman of the board's compensation may not exceed $40,000 annually and other board members' compensation may not exceed $24,000 annually.

Rates: The bill prohibits life and health insurance carriers, including nonprofit health service plans, from charging a premium that appears excessive in consideration of funds available or intended to subsidize rates or offset losses. If a nonprofit health service plan files contract or rate amendments with the Insurance Commissioner, the Commissioner must disapprove or modify the proposed changes if the table of rates appears by statistical analysis and reasonable assumptions to be excessive in consideration of funds available or intended to subsidize rates or offset losses.

Current Law:

Premium Tax Exemption: A 2% tax is imposed on all direct insurance premiums written in the State. An exemption is given certain types of carriers, including nonprofit health service plan corporations that meet certain requirements. In order to maintain the premium tax exemption, a nonprofit health service plan with more than 10,000 covered lives must file an annual premium tax exemption report with the Insurance Commissioner demonstrating the plan has used funds equal to the value of the premium tax exemption in a manner that serves the public interest. A nonprofit health service plan must demonstrate in its premium tax exemption report that it has increased access to, or the affordability of, one or more health care products or services. If the Insurance Commissioner determines that a nonprofit health service plan is not meeting its public

purpose requirements, the Commissioner must report the determination to the House Economic Matters Committee and the Senate Finance Committee, and if required by an act of the General Assembly, the nonprofit health service plan will be subject to the premium tax.

Certificate of Authority: A nonprofit health service plan cannot issue contracts for health care services unless the Insurance Commissioner has issued a certificate of authority to the plan. When applying for a certificate of authority, a nonprofit health service plan must file certain documents with the Insurance Commissioner, including its articles of incorporation, bylaws, health care services contracts, table of rates, financial statement, and a list of the names and addresses of board members. The Commissioner must issue a certificate of authority if the plan has paid the required fee and the Commissioner is satisfied the plan has been organized in good faith for the purpose of establishing, maintaining, and operating a nonprofit health service plan. The Commissioner may revoke a certificate of authority.

Capital Improvement Projects: A nonprofit health service plan cannot finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority (MHHEFA) and has no express authority to do so through the Maryland Economic Development Corporation (MEDCO).

MHHEFA was created in 1970 (Chapter 408, Acts of 1970). MHHEFA assists hospitals and educational institutions with financing for construction, site acquisition, and capital equipment. Private nonprofit health and higher educational facilities may use MHHEFA as a vehicle to issue tax-exempt bonds and thereby pay a lower rate of interest.

MEDCO is a nonbudgeted entity created in 1984 to allow the State the ability to directly own or develop property for economic development purposes. MEDCO's mission is to assist in the expansion, modernization, and retention of existing Maryland business and to attract new business to the State. MEDCO purchases or develops property that is leased to others under favorable terms. MEDCO also makes direct loans to companies requiring financing to maintain or develop facilities throughout the State.

Board Composition, Term Limits, and Compensation: There is no limit on the number of members permitted on a nonprofit health service plan's board. The board must appoint two additional members to serve as voting consumer members. Current board terms are three years and must be staggered over three-year periods. A board member is limited to serving three full terms or a total of nine years. There is no limitation placed on the compensation of directors and officers of a nonprofit health service plan.

Rates: A form for a life or health insurance policy cannot be delivered or issued for delivery in the State unless the form has been filed with and approved by the Commissioner. A nonprofit health service plan cannot amend contracts issued to subscribers or modify rates without prior approval by the Insurance Commissioner.

Background: Historically, nonprofit health service plans have received favorable tax treatment and other benefits from both federal and state governments that were not accorded their for-profit counterparts. Prior to 1987, these plans had tax-exempt status because they performed public services that, absent the organization, would have to be provided by the government. Spurred by complaints from commercial insurers that such tax treatment represented an unfair competitive advantage, Congress repealed the full tax-exempt status of Blue Cross Blue Shield plans under the federal Tax Reform Act of 1986. However, Congress created a special tax class for the plans in recognition of the unique community service they provide. Beginning January 1, 1987, Blue Cross Blue Shield plans throughout the nation became subject to a corporate tax rate that is significantly lower than the prevailing corporate tax rate.

In 2001, nine nonprofit health service plans were registered with MIA, eight of which wrote premiums in Maryland. Only two nonprofit health service plans, CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., would be subject to the bill's premium tax exemption report requirements. Both of these plans are wholly-owned subsidiaries of CareFirst, Inc. According to MIA, CareFirst, Inc. received a premium tax exemption of $16,597,709 for calendar 2000. Information regarding CareFirst's premium tax exemption for calendar 2001 will not be available to MIA until CareFirst files its 2001 annual statement on March 1, 2002. CareFirst advises that its premium tax exemption was approximately $19 million for calendar 2001.

State Expenditures: MIA special fund expenditures could increase by an estimated $40,091 in fiscal 2003, which accounts for a 90-day start-up delay. This estimate reflects the cost of hiring one company analyst to conduct annual reviews of qualifying nonprofit health service plans to determine whether: (1) the plan is committed to a nonprofit corporate structure and public service requirements of the bill; (2) the board of directors is composed and has acted in accordance with the bill's requirements; and (3) the compensation of the directors and officers is reasonable in comparison to the compensation paid to board members and officers of comparable nonprofit health plans. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salary and Fringe Benefits	$36,919
Operating Expenses	3,172
Total FY 2003 State Expenditures	**$40,091**

Future year expenditures reflect: (1) full salary with 3.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Additional reviews of rate filings to ensure that premiums are not excessive could be handled with existing MIA resources.

State Revenues: If CareFirst fails to meet its premium tax exemption requirements, general fund revenues from premium taxes imposed on CareFirst could increase by a significant amount in fiscal 2003. The actual amount of general fund revenues derived from the premium tax would depend on the actual direct premiums written by CareFirst during the time period the Insurance Commissioner determines CareFirst did not meet its public purpose requirements. These funds must be used to provide health insurance coverage to medically uninsurable or underinsured people. Future year estimates depend on whether CareFirst meets its public purpose requirements and maintains its premium tax exemption and the amount of direct premiums written in any given fiscal year.

Special fund revenues for the MIA from the $125 rate and form filing fee could increase in fiscal 2003. The number of filings cannot be accurately estimated at this time.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene (Maryland Health Care Commission, AIDS Administration, Health Services Cost Review Commission); Maryland Insurance Administration; CareFirst, Inc.; Department of Legislative Services

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