SB 772

Department of Legislative Services
Maryland General Assembly
2003 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 772 (Senator Middleton, *et al.*)
Finance Health and Government Operations

Health Insurance - Nonprofit Health Service Plans - Reform

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

Fiscal Summary

State Effect: Potentially significant general fund revenue increase in FY 2004 if CareFirst is required to pay premium taxes. Maryland Insurance Administration (MIA) special fund expenditures could increase by $39,500 in FY 2004. Future year estimates reflect annualization and inflation. Staffing the joint oversight committee could be handled with existing MIA and Department of Legislative Services (DLS) staff.

(in dollars)	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
GF Revenue	-	-	-	-	-
SF Expenditure	39,500	50,100	53,200	56,600	60,200
Net Effect	($39,500)	($50,100)	($53,200)	($56,600)	($60,200)

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill requires a nonprofit health service plan's mission to be: (1) providing affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan; (2)

assisting and supporting public and private health care initiatives for individuals without health insurance; and (3) promoting the integration of a statewide health care system that meets the health care needs of all Maryland citizens. A nonprofit health service plan must develop goals, objectives, and strategies for carrying out its statutory plan.

Premium Tax Exemption: In order for a nonprofit health service plan to be and remain exempt from premium taxation, it must meet certain public service requirements. These requirements may be met if the nonprofit health service plan has: (1) provided financial or in-kind support for public health programs; (2) employed underwriting standards in a manner that increases the availability of one or more health care services or products; or (3) employed pricing policies that enhance the affordability of health care services or products and result in a higher medical loss ratio than that established by a comparable for-profit health insurer. The bill exempts a nonprofit health service plan that insures between one and 10,000 covered lives or issues contracts for only one of the following services: (1) podiatric; (2) chiropractic; (3) pharmaceutical; (4) dental; (5) psychological; or (6) optometric.

In order to remain exempt from premium taxation, a nonprofit health service plan also must offer health care products in the individual market and the small employer group market.

If a nonprofit health service plan does not comply with these requirements, the Insurance Commissioner must issue an order requiring the plan to pay the 2% premium tax for a period of time beginning with the date the plan was determined to be noncompliant in an amount equal to the amount by which the plan's premium tax exemption exceeds the sum of the Senior Prescription Drug Program subsidy and other funds used by the plan to meet the public service requirement. Any premium tax revenue collected by MIA as a result of a nonprofit health service plan's noncompliance must be deposited into the Maryland Health Insurance Plan (MHIP) fund.

Certificate of Authority Requirements: A nonprofit health service plan must obtain a certificate of authority from the Insurance Commissioner to issue contracts in the State. An applicant for a certificate of authority must file a copy of the applicant's corporate mission statement, a list of the total compensation paid or proposed to be paid to each officer, director, or trustee of the corporation, and a list of the beginning and ending terms of membership for each board member. The Commissioner must issue a certificate of authority to an applicant if the Commissioner is satisfied the applicant has been organized in good faith for the purpose of operating a nonprofit health service plan that: (1) is committed to a nonprofit corporate structure; (2) seeks to provide individuals, businesses, and other groups 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 may disapprove a renewal of a certificate of authority if the Commissioner determines the nonprofit health service plan does not continue to meet these requirements.

Capital Improvement Projects: A certificate of authority to operate as a nonprofit health service plan authorizes a corporation: (1) to finance capital improvement projects through the Maryland Health and Higher Educational Facilities Authority (MHHEFA); (2) finance capital improvement projects through the Maryland Economic Development Corporation (MEDCO); and (3) partner with the State and other public or private entities to provide services or administer programs intended to address community health care needs.

Board Composition, Term Limits, and Compensation: The bill specifies that a nonprofit health service plan's board and its individual members are fiduciaries for the benefit of the corporation and its controlled affiliates or subsidiaries that offer health benefit plans and must act in a manner that is reasonably believed to be in the furtherance of the corporation's nonprofit mission. The principal functions of the board must include: (1) ensuring that the corporation effectively carries out the nonprofit mission; (2) selecting and evaluating the performance of corporate management; (3) ensuring to the extent practicable that resources are sufficient to meet corporate objectives; (4) nominating and selecting suitable individuals for the board; and (5) establishing a system of governance at the board level, including an annual evaluation of board performance.

The bill provides that a nonprofit health service plan's board must have no more than 23 members, changes certain board member term limitations, and specifies the makeup of the board. The board is composed of: (1) one nonvoting member (not a member of the General Assembly) appointed by the President of the Senate; (2) one nonvoting member (not a member of the General Assembly) appointed by the Speaker of the House of Delegates; and (3) 21 members selected by the board, including two consumer members.

A board member may not serve for more than two full terms or a total of more than six years. The bill also provides for the removal and replacement of board members by specified dates.

The board must establish: (1) an audit committee responsible for ensuring financial accountability; (2) a finance committee responsible for reviewing and making recommendations on the annual budget and for developing and recommending long-range financial objectives; (3) a compensation committee responsible for evaluating and recommending the compensation paid to officers and employees with annual compensation greater than $150,000, including any bonus or increase in compensation, and for comparing the compensation with officers and employees of comparable not-for-

profit entities in the United States; (4) a nominating committee responsible for identifying, evaluating, and recommending to the board individuals qualified to become board members; (5) a service and quality oversight committee responsible for ensuring that policies and systematic processes are in place and working to assess and improve the quality of health care services and products; (6) a mission oversight committee responsible for ensuring the officers of the corporation act in accordance with the nonprofit health service plan's mission; (7) a strategic planning committee responsible for examining long range planning objectives, assessing strategies that may be used to implement those objectives, and analyzing the nonprofit health service plan's role in the insurance marketplace; and (8) any other committee that the board determines is necessary to carry out its duties.

Each committee must have representatives from each corporation for which the nonprofit health service plan is the sole member. The compensation committee and the nominating committee must include either the appointee of the President of the Senate or the Speaker of the House. A decision by the board to convert to a for-profit entity may be rejected by any three members of the board.

The following actions by a nonprofit health service plan must be approved by the board: (1) modification to benefit levels; (2) material modification to provider networks or provider reimbursement; (3) modification of underwriting guidelines; (4) modification of rates or rating plans; (5) the withdrawal of a product from a line or type of business or geographic region; and (6) any other action that could impact the availability and affordability of health care in the State.

The bill prohibits board membership to any person who has been prohibited under federal securities law from acting as a director or officer of any corporation.

In general, an officer, director, trustee, or employee of a nonprofit corporation may receive fair and reasonable compensation in the form of salary, bonuses, or perquisites for work actually performed for the corporation's benefit. A board member may receive compensation not to exceed $12,000 annually; the chairman of the board, or a chairman of a committee, may receive up to $15,000. A nonprofit health service plan's compensation committee must submit compensation guidelines to the Commissioner for review and approval. If the Commissioner disapproves the proposed guidelines, the board must revise and submit new guidelines that meet the Commissioner's approval.

If the Attorney General has reason to believe that a nonprofit health service plan is engaging in an unsound or unsafe business practice, the Attorney General must notify the Insurance Commissioner. If the Commissioner fails to take action under State insurance law within 60 days after notification, the Attorney General may investigate the practice

and initiate an action in circuit court for an appropriate remedy, including the removal of an officer or director.

Joint Nonprofit Health Service Plan Oversight Committee: The bill creates a 17-member Joint Nonprofit Health Service Plan Oversight Committee. The committee is staffed by MIA and DLS. The committee must examine and evaluate the ability of the nonprofit health services plans that carry the BlueCross and BlueShield trademark to meet certain community benefit goals. The committee must submit its findings and recommendations in an annual report to the General Assembly by December 1 of each year. The bill's provisions related to the oversight committee take effect June 1, 2003 and terminate August 31, 2005.

Other Provisions: The Insurance Commissioner and the Attorney General each must determine whether any conduct identified in the Commissioner's denial of CareFirst's application for acquisition (MIA No: 2003-02-032) violates any provisions of the Insurance Article or other federal or State civil, criminal, or administrative law. The Commissioner must report by July 1, 2003 on the determinations made, if any, to the board of directors and the Governor and General Assembly. The Commissioner must make recommendations regarding whether any changes to Maryland law need to be made to ensure that the regulatory oversight of nonprofit health services plans is sufficient to protect the public interest. The Attorney General must report by September 1, 2003 to the Governor and General Assembly on the determinations made, if any, and make recommendations regarding any changes to State law that need to be made to ensure the public interest is protected.

The bill prohibits a person from filing an application for the acquisition of a nonprofit health service plan for a period of five years after the bill's effective date.

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 nonprofit health service plan has one year from the date the

Commissioner issued the order stating the plan was noncompliant to become compliant again. If the plan fails to become complaint, the Commissioner must report the determination to the House Economic Matters Committee and the Senate Finance Committee. The plan is subject to the premium tax if required by an act of the General Assembly.

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: Chapter 152 of 2002 expanded the types of facilities that MHHEFA could assist to include a nonprofit health service plan. A nonprofit health service plan has no express authority to finance capital projects through MEDCO.

MHHEFA was created in 1970 (Chapter 408 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.

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 BlueCross BlueShield 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, BlueCross BlueShield 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. (GHMSI), 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's premium tax exemption benefit was $18 million and GHMSI's benefit was $5 million in 2002.

CareFirst is the State's largest health insurer and by far its largest nonprofit health service plan. As a health insurer, CareFirst is exempt from the State corporate income tax, and as a nonprofit health service plan, it is exempt from the 2% tax on gross direct premiums that most other insurers are required to pay.

CareFirst Conversion: On November 20, 2001, CareFirst BlueCross BlueShield announced its intention to convert to a for-profit company and subsequently be acquired by WellPoint Health Networks, Inc. CareFirst is statutorily obligated to file a conversion application with all three jurisdictions to which its charitable assets would inure: Maryland, the District of Columbia, and Delaware. The application was filed with MIA on January 11, 2002. The $1.37 billion purchase price is one indication of the value of the company's charitable assets. Independent valuations have estimated a value between $1.7 billion to $1.8 billion. The Maryland Insurance Commissioner Steven B. Larsen announced on March 5, 2003 that he had denied the CareFirst BlueCross BlueShield application to convert to a for-profit company and be acquired by WellPoint Health Networks, Inc. The proposed transaction was not in the public interest because of several disqualifying factors.

In his order and accompanying 250-page report, Commissioner Larsen explained his rationale for the decision, including: (1) the auction to sell CareFirst was flawed and did not produce fair market value; (2) the original merger bonuses violated the anti-inurement requirements of the conversion statute; (3) the new, renegotiated "retention bonuses"

violated the anti-bonus provision in the conversion statute because they were not compensation for work performed with WellPoint; (4) the board breached its fiduciary obligations in deciding to convert because it failed to recognize the nonprofit mission of the company to offer insurance at "minimum cost and expense;" (5) the board permitted the use of selection criteria for bidders that largely benefited management, such as the willingness of the buyer to pay the merger incentive, and the role that the CEO would play in the successor organization; (6) although the board appeared to weigh certain factors in the selection process, such as the locations of corporate headquarters, possible job loss, "downside protection," and maintaining current benefit levels for CareFirst employees, on closer scrutiny, these factors appear to have little or no merit; (7) unbeknownst to the board, an attorney who previously represented the CEO in his employment negotiations with the board played a significant role in advising CareFirst management during negotiations with potential bidders; (8) CareFirst's investment bankers were asked by the board to issue an opinion on the "fairness" of WellPoint's purchase price and the bankers' compensation largely depended on the issuance of an opinion that the price they negotiated was fair; and (9) WellPoint did not make available to MIA and its experts pricing and underwriting information that would have permitted a complete "impact analysis."

State Expenditures: MIA special fund expenditures could increase by an estimated $39,488 in fiscal 2004, 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 the plan meets the nonprofit mission requirements necessary to maintain its premium tax exemption and report to the Governor and General Assembly as required. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salary and Fringe Benefits	$36,390
Operating Expenses	3,098
Total FY 2004 State Expenditures	**$39,488**

Future year expenditures reflect: (1) a full salary with 4.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

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 2004. As a point of reference, in 2002 the exemption was worth $23 million for CareFirst companies. The actual amount derived from the premium tax depends 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 transferred to MHIP to provide health insurance coverage to medically uninsurable 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.

Additional Information

Prior Introductions: A similar bill, HB 1207, was introduced in the 2002 session. It passed the House with amendments, but was reported unfavorably by the Senate Finance Committee.

Cross File: HB 1179 is listed as a cross file, but it is not identical.

Information Source(s): Maryland Insurance Administration, Department of Legislative Services

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