Unofficial Copy 2004 Regular Session
C3 4lr0834

By: **Delegate Costa**
Introduced and read first time: January 28, 2004
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance - Association Health Benefit Plan

FOR the purpose of establishing an Association Health Benefit Plan to provide health insurance to certain entities; altering the purposes of the Maryland Health Care Commission; requiring the Commission to adopt regulations that specify the Plan; specifying the persons to whom an association may offer the Plan; establishing certain requirements for carriers that offer the Plan; prohibiting carriers from offering to an association a health benefit plan with fewer benefits than those in the Plan; authorizing carriers to offer additional benefits under certain conditions; requiring an association to have a certain amount of member participation in the Plan within a certain time; requiring employers to have a certain amount of employee participation in the Plan within a certain time; requiring the Commission, in establishing benefits, to judge certain services based on certain criteria; authorizing the Commission to exclude certain benefits and reimbursements for certain services; requiring the Plan to include a pharmacy discount card option; establishing the amount of certain co-payments and deductibles under the Plan; prohibiting a carrier from limiting coverage for a preexisting condition except under certain circumstances; requiring a carrier to issue the Plan to each association that meets certain requirements; requiring a carrier to offer coverage to certain persons; exempting health maintenance organizations from providing coverage under certain circumstances; requiring carriers to use a certain rating methodology in establishing a rate for the Plan; authorizing carriers to adjust the rate under certain circumstances; requiring carriers to consistently apply certain risk adjustment factors; requiring carriers to file an actuarial certification with the Maryland Insurance Commissioner by a certain time each year; 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 the Association Health Benefit Plan.

BY adding to
Article - Insurance
Section 15-1701 through 15-1710, inclusive, to be under the new subtitle "Subtitle 17. Association Health Benefit Plan"
Annotated Code of Maryland

(2002 Replacement Volume and 2003 Supplement)

BY repealing and reenacting, without amendments,
Article - Health - General
Section 19-103(a)
Annotated Code of Maryland
(2000 Replacement Volume and 2003 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-103(c)
Annotated Code of Maryland
(2000 Replacement Volume and 2003 Supplement)

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-103(c)
Annotated Code of Maryland
(2000 Replacement Volume and 2003 Supplement)
(As enacted by Chapter 385 of the Acts of the General Assembly of 2003)

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

Article - Insurance

SUBTITLE 17. ASSOCIATION HEALTH BENEFIT PLAN.

15-1701.

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

(B) "ASSOCIATION" MEANS AN ASSOCIATION THAT:

(1) HAS BEEN ACTIVELY IN EXISTENCE FOR AT LEAST 5 YEARS;

(2) HAS BEEN FORMED AND MAINTAINED IN GOOD FAITH FOR PURPOSES OTHER THAN OBTAINING INSURANCE;

(3) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON THE PURCHASE OF ASSOCIATION-SPONSORED INSURANCE;

(4) DOES NOT CONDITION MEMBERSHIP IN THE ASSOCIATION ON ANY HEALTH STATUS-RELATED FACTOR RELATING TO AN INDIVIDUAL AND STATES THIS CLEARLY IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

(5) MAKES HEALTH INSURANCE COVERAGE OFFERED THROUGH THE ASSOCIATION AVAILABLE TO ALL MEMBERS REGARDLESS OF ANY HEALTH STATUS-RELATED FACTOR RELATING TO THE MEMBERS OR INDIVIDUALS ELIGIBLE FOR COVERAGE THROUGH A MEMBER AND STATES THIS CLEARLY IN ALL MEMBERSHIP AND APPLICATION MATERIALS;

(6) DOES NOT MAKE HEALTH INSURANCE COVERAGE OFFERED THROUGH THE ASSOCIATION AVAILABLE OTHER THAN IN CONNECTION WITH MEMBERSHIP IN THE ASSOCIATION AND STATES THIS CLEARLY IN ALL MARKETING AND APPLICATION MATERIALS;

(7) IS ORGANIZED AND EXISTING UNDER THE LAWS OF THE STATE;

(8) (I) HAS MORE THAN 50 MEMBERS; OR

(II) EMPLOYS MORE THAN 50 ELIGIBLE EMPLOYEES; AND

(9) (I) HAS AN AFFILIATION WITH A PROFESSION, INDUSTRY, OR TRADE;

(II) IS A CHAMBER OF COMMERCE; OR

(III) IS AN ASSOCIATION OF NONPROFIT ENTITIES.

(C) "ASSOCIATION HEALTH BENEFIT PLAN" MEANS THE ASSOCIATION HEALTH BENEFIT PLAN ADOPTED BY THE COMMISSION UNDER § 19-103(C) OF THE HEALTH - GENERAL ARTICLE.

(D) "CARRIER" MEANS A PERSON THAT IS:

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

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

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

(4) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

(E) "COMMISSION" MEANS THE MARYLAND HEALTH CARE COMMISSION ESTABLISHED UNDER TITLE 19, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

(F) (1) "ELIGIBLE EMPLOYEE" MEANS AN INDIVIDUAL WHO WORKS ON A FULL-TIME BASIS AND HAS A NORMAL WORKWEEK OF AT LEAST 30 HOURS.

(2) "ELIGIBLE EMPLOYEE" DOES NOT INCLUDE AN INDIVIDUAL WHO WORKS ON A TEMPORARY OR SUBSTITUTE BASIS.

(G) "EMPLOYER" MEANS AN EMPLOYER THAT:

(1) IS A MEMBER OF THE ASSOCIATION; OR

(2) HAS A PARTNER, OFFICER, OR DIRECTOR THAT IS:

(I) AN INDIVIDUAL MEMBER OF THE ASSOCIATION; AND

(II) AN ACTIVE PARTICIPANT IN THE EMPLOYER'S BUSINESS.

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

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

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

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

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

(I) ACCIDENT-ONLY INSURANCE;

(II) FIXED INDEMNITY INSURANCE;

(III) CREDIT HEALTH INSURANCE;

(IV) MEDICARE SUPPLEMENT POLICIES;

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

(VI) LONG-TERM CARE INSURANCE;

(VII) DISABILITY INCOME INSURANCE;

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

(IX) WORKERS' COMPENSATION OR SIMILAR INSURANCE;

(X) DISEASE-SPECIFIC INSURANCE;

(XI) AUTOMOBILE MEDICAL PAYMENT INSURANCE;

(XII) DENTAL INSURANCE; OR

(XIII) VISION INSURANCE.

(I) "HEALTH STATUS-RELATED FACTOR" MEANS A FACTOR RELATED TO:

(1) HEALTH STATUS;

(2) MEDICAL CONDITION;

(3) CLAIMS EXPERIENCE;

(4) RECEIPT OF HEALTH CARE;

(5) MEDICAL HISTORY;

(6) GENETIC INFORMATION;

(7) EVIDENCE OF INSURABILITY INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE; OR

(8) DISABILITY.

(J) "LATE ENROLLEE" MEANS AN INDIVIDUAL ELIGIBLE FOR COVERAGE UNDER § 15-1702 OF THIS SUBTITLE WHO REQUESTS ENROLLMENT IN A HEALTH BENEFIT PLAN AFTER THE INITIAL ENROLLMENT PERIOD PROVIDED UNDER THE HEALTH BENEFIT PLAN.

(K) "MEMBER" MEANS A PERSON WHO HAS QUALIFIED AND BEEN ACCEPTED FOR MEMBERSHIP IN AN ASSOCIATION IN ACCORDANCE WITH ITS BYLAWS.

15-1702.

AN ASSOCIATION MAY OFFER THE ASSOCIATION HEALTH BENEFIT PLAN ONLY TO A PERSON THAT IS:

(1) LICENSED BY OR DOMICILED IN THE STATE; AND

(2) (I) AN EMPLOYEE OF THE ASSOCIATION;

(II) A MEMBER;

(III) AN ACTIVE OR RETIRED PARTNER, OFFICER, DIRECTOR, OR ELIGIBLE EMPLOYEE OF A PARTICIPATING EMPLOYER; OR

(IV) A DEPENDENT OF AN INDIVIDUAL DESCRIBED IN ITEM (I), (II), OR (III) OF THIS ITEM.

15-1703.

(A) IN ADDITION TO ANY OTHER REQUIREMENT UNDER THIS ARTICLE, A CARRIER SHALL:

(1) HAVE DEMONSTRATED THE CAPACITY TO ADMINISTER THE ASSOCIATION HEALTH BENEFIT PLAN, INCLUDING ADEQUATE NUMBERS AND TYPES OF ADMINISTRATIVE PERSONNEL;

(2) HAVE A SATISFACTORY GRIEVANCE PROCEDURE AND ABILITY TO RESPOND TO CALLS, QUESTIONS, AND COMPLAINTS;

(3) PROVIDE, IN THE CASE OF INDIVIDUALS COVERED UNDER MORE THAN ONE HEALTH BENEFIT PLAN, FOR COORDINATION OF COVERAGE UNDER ALL OF THOSE HEALTH BENEFIT PLANS IN AN EQUITABLE MANNER; AND

(4) DESIGN POLICIES TO HELP ENSURE ADEQUATE ACCESS TO PROVIDERS OF HEALTH CARE.

(B) A CARRIER MAY NOT OFFER TO AN ASSOCIATION A HEALTH BENEFIT PLAN THAT HAS FEWER BENEFITS THAN THOSE IN THE ASSOCIATION HEALTH BENEFIT PLAN.

(C) A CARRIER MAY OFFER BENEFITS IN ADDITION TO THOSE IN THE ASSOCIATION HEALTH BENEFIT PLAN IF THE CARRIER:

(1) CLEARLY DISTINGUISHES THE ASSOCIATION HEALTH BENEFIT PLAN FROM OTHER OFFERINGS OF THE CARRIER; AND

(2) SPECIFIES THAT ALL ENHANCEMENTS TO THE ASSOCIATION HEALTH BENEFIT PLAN ARE NOT REQUIRED BY STATE LAW.

15-1704.

(A) AN ASSOCIATION SHALL HAVE AT LEAST 50% PARTICIPATION OF THOSE PERSONS DESCRIBED IN § 15-1702 OF THIS SUBTITLE WITHIN 1 YEAR AFTER THE ASSOCIATION HEALTH BENEFIT PLAN IS OFFERED.

(B) AN ASSOCIATION SHALL MAINTAIN AT LEAST 70% PARTICIPATION OF THOSE PERSONS DESCRIBED IN § 15-1702 OF THIS SUBTITLE AFTER THE FIFTH YEAR THAT THE ASSOCIATION HEALTH BENEFIT PLAN IS OFFERED.

(C) EMPLOYERS SHALL HAVE AT LEAST 70% EMPLOYEE PARTICIPATION WITHIN 1 YEAR OF PARTICIPATION IN THE ASSOCIATION HEALTH BENEFIT PLAN.

15-1705.

(A) IN ACCORDANCE WITH TITLE 19, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE, THE COMMISSION SHALL ADOPT REGULATIONS THAT SPECIFY THE ASSOCIATION HEALTH BENEFIT PLAN TO APPLY UNDER THIS SUBTITLE.

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

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

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

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

(C) THE COMMISSION MAY EXCLUDE:

(1) A HEALTH CARE SERVICE, BENEFIT, COVERAGE, OR REIMBURSEMENT FOR COVERED HEALTH CARE SERVICES THAT IS REQUIRED UNDER THIS ARTICLE OR THE HEALTH - GENERAL ARTICLE TO BE PROVIDED OR OFFERED IN A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED IN THE STATE BY A CARRIER; OR

(2) REIMBURSEMENT REQUIRED BY STATUTE, BY A HEALTH BENEFIT PLAN FOR A SERVICE WHEN THAT SERVICE IS PERFORMED BY A HEALTH CARE PROVIDER WHO IS LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE AND WHOSE SCOPE OF PRACTICE INCLUDES THAT SERVICE.

(D) THE ASSOCIATION HEALTH BENEFIT PLAN SHALL INCLUDE A PHARMACY DISCOUNT CARD OPTION.

(E) SUBJECT TO SUBSECTION (F) OF THIS SECTION, THE ASSOCIATION HEALTH BENEFIT PLAN SHALL INCLUDE UNIFORM DEDUCTIBLES AND COST-SHARING ASSOCIATED WITH ITS BENEFITS, AS DETERMINED BY THE COMMISSION.

(F) THE ASSOCIATION HEALTH BENEFIT PLAN SHALL INCLUDE:

(1) A CO-PAYMENT OF $200 FOR EMERGENCY ROOM SERVICES;

(2) A CO-PAYMENT OF $50 FOR PRIMARY CARE SERVICES AND SPECIALTY CARE SERVICES FOR A CARRIER THAT IS A HEALTH MAINTENANCE ORGANIZATION;

(3) CO-PAYMENTS FOR THE FOLLOWING SERVICES THAT ARE THE SAME AS CO-PAYMENTS FOR SPECIALTY SERVICES:

(I) OUTPATIENT LABORATORY AND DIAGNOSTIC SERVICES;

(II) SKILLED NURSING FACILITIES;

(III) OUTPATIENT REHABILITATIVE AND CHIROPRACTIC SERVICES; AND

(IV) OUTPATIENT SERVICES OR SURGERY; AND

(4) AN ANNUAL DEDUCTIBLE OF $2,000 FOR CARRIERS THAT PROVIDE AN INDEMNITY, PREFERRED PROVIDER, OR POINT OF SERVICE DELIVERY SYSTEM.

15-1706.

(A) (1) A CARRIER MAY NOT LIMIT COVERAGE UNDER THE ASSOCIATION HEALTH BENEFIT PLAN FOR A PREEXISTING CONDITION.

(2) AN EXCLUSION OF COVERAGE FOR PREEXISTING CONDITIONS MAY NOT BE APPLIED TO HEALTH CARE SERVICES FURNISHED FOR PREGNANCY OR NEWBORNS.

(B) (1) THIS SUBSECTION DOES NOT APPLY TO A LATE ENROLLEE IF:

(I) THE INDIVIDUAL REQUESTS ENROLLMENT WITHIN 30 DAYS AFTER BECOMING ELIGIBLE FOR COVERAGE UNDER THE ASSOCIATION HEALTH BENEFIT PLAN;

(II) A COURT HAS ORDERED COVERAGE TO BE PROVIDED FOR A SPOUSE OR MINOR CHILD OF AN INDIVIDUAL COVERED UNDER THE ASSOCIATION HEALTH BENEFIT PLAN; OR

(III) A REQUEST FOR ENROLLMENT IS MADE WITHIN 30 DAYS AFTER THE MARRIAGE, OR THE BIRTH OR ADOPTION OF A CHILD, OF AN INDIVIDUAL COVERED UNDER THE ASSOCIATION HEALTH BENEFIT PLAN.

(2) NOTWITHSTANDING SUBSECTION (A) OF THIS SECTION, A LATE ENROLLEE MAY BE SUBJECT TO A 12-MONTH PREEXISTING CONDITION PROVISION OR A WAITING PERIOD UNTIL THE NEXT OPEN ENROLLMENT PERIOD NOT TO EXCEED A 12-MONTH PERIOD.

(C) FOR A PERIOD NOT TO EXCEED 6 MONTHS AFTER THE DATE AN INDIVIDUAL BECOMES ELIGIBLE FOR COVERAGE, THE ASSOCIATION HEALTH BENEFIT PLAN MAY REQUIRE DEDUCTIBLES AND COST-SHARING FOR BENEFITS FOR A PREEXISTING CONDITION OF THE INDIVIDUAL IN AMOUNTS NOT EXCEEDING 1.5 TIMES THE AMOUNT OF THE STANDARD DEDUCTIBLES AND COST-SHARING OF OTHER INDIVIDUALS ELIGIBLE FOR COVERAGE IF THE INDIVIDUAL WAS NOT PREVIOUSLY COVERED BY A PUBLIC OR PRIVATE PLAN OF HEALTH INSURANCE OR ANOTHER HEALTH BENEFIT ARRANGEMENT.

5-1707.

(A) A CARRIER SHALL ISSUE THE ASSOCIATION HEALTH BENEFIT PLAN TO EACH ASSOCIATION THAT MEETS THE REQUIREMENTS OF THIS SECTION.

(B) (1) NOTHING IN THIS SUBSECTION REQUIRES AN ASSOCIATION TO CONTRIBUTE TO THE PREMIUM PAYMENTS FOR COVERAGE OF A DEPENDENT OF AN INDIVIDUAL COVERED UNDER THE ASSOCIATION HEALTH BENEFIT PLAN.

(2) TO BE COVERED UNDER A HEALTH BENEFIT PLAN OFFERED BY A CARRIER, AN ASSOCIATION SHALL:

(I) ELECT TO BE COVERED;

(II) AGREE TO PAY THE PREMIUMS;

(III) AGREE TO OFFER COVERAGE TO ANY DEPENDENT OF AN INDIVIDUAL COVERED UNDER THE ASSOCIATION HEALTH BENEFIT PLAN, IN

ACCORDANCE WITH PROVISIONS GOVERNING LATE ENROLLEES AND ANY OTHER PROVISIONS OF THIS SUBTITLE THAT APPLY TO COVERAGE; AND

(IV) SATISFY OTHER REASONABLE PROVISIONS OF THE ASSOCIATION HEALTH BENEFIT PLAN AS APPROVED BY THE COMMISSIONER.

(C) A CARRIER MAY NOT REQUIRE AN ASSOCIATION TO CONTRIBUTE TO PAYMENT OF PREMIUMS FOR THE ASSOCIATION HEALTH BENEFIT PLAN.

15-1708.

(A) A CARRIER THAT OFFERS COVERAGE TO AN ASSOCIATION SHALL OFFER COVERAGE TO ALL OF THE PERSONS DESCRIBED UNDER § 15-1702 OF THIS SUBTITLE, REGARDLESS OF WHETHER THE PERSONS ARE COVERED UNDER ANOTHER PUBLIC OR PRIVATE PLAN OF HEALTH INSURANCE OR ANOTHER HEALTH BENEFIT ARRANGEMENT.

(B) (1) A HEALTH MAINTENANCE ORGANIZATION NEED NOT OFFER COVERAGE:

(I) TO AN ASSOCIATION THAT IS OUTSIDE THE HEALTH MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREAS;

(II) TO AN INDIVIDUAL WHO RESIDES OUTSIDE THE HEALTH MAINTENANCE ORGANIZATION'S APPROVED SERVICE AREAS; OR

(III) WITHIN AN AREA WHERE THE HEALTH MAINTENANCE ORGANIZATION REASONABLY ANTICIPATES AND DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER THAT IT WILL NOT HAVE THE CAPACITY IN ITS NETWORK OF PROVIDERS TO DELIVER SERVICE ADEQUATELY BECAUSE OF OBLIGATIONS TO EXISTING GROUP CONTRACT HOLDERS AND ENROLLEES.

(2) A HEALTH MAINTENANCE ORGANIZATION THAT DOES NOT OFFER COVERAGE UNDER PARAGRAPH (1)(III) OF THIS SUBSECTION MAY NOT OFFER COVERAGE IN THE APPLICABLE AREA TO AN ASSOCIATION UNTIL THE LATER OF:

(I) 180 DAYS AFTER A REFUSAL TO DO SO; OR

(II) THE DATE ON WHICH THE HEALTH MAINTENANCE ORGANIZATION NOTIFIES THE COMMISSIONER THAT IT HAS REGAINED CAPACITY TO DELIVER SERVICES TO ASSOCIATIONS IN THAT AREA.

(C) A CARRIER MAY NOT BE REQUIRED TO OFFER COVERAGE UNDER § 15-1705 OF THIS SUBTITLE FOR AS LONG AS THE COMMISSIONER FINDS THAT THE COVERAGE WOULD PLACE THE CARRIER IN A FINANCIALLY IMPAIRED CONDITION.

15-1709.

(A) (1) IN ESTABLISHING A RATE FOR THE ASSOCIATION HEALTH BENEFIT PLAN, A CARRIER SHALL USE A RATING METHODOLOGY THAT IS BASED ON THE

EXPERIENCE OF ALL RISKS COVERED BY THAT HEALTH BENEFIT PLAN WITHOUT REGARD TO HEALTH STATUS OR OCCUPATION OR ANY OTHER FACTOR NOT SPECIFICALLY AUTHORIZED UNDER THIS SUBSECTION.

(2) A CARRIER MAY ADJUST THE RATE ONLY FOR:

(I) AGE; AND

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

1. THE BALTIMORE METROPOLITAN AREA;

2. THE DISTRICT OF COLUMBIA METROPOLITAN AREA;

3. WESTERN MARYLAND; AND

4. EASTERN AND SOUTHERN MARYLAND.

(3) RATES FOR A HEALTH BENEFIT PLAN MAY VARY BASED ON FAMILY COMPOSITION AS APPROVED BY THE COMMISSIONER.

(B) A CARRIER SHALL APPLY ALL RISK ADJUSTMENT FACTORS UNDER SUBSECTION (A) OF THIS SECTION CONSISTENTLY WITH RESPECT TO ALL ASSOCIATION HEALTH BENEFIT PLANS THAT ARE ISSUED, DELIVERED, OR RENEWED IN THE STATE.

(C) (1) A CARRIER SHALL BASE ITS RATING METHODS AND PRACTICES ON COMMONLY ACCEPTED ACTUARIAL ASSUMPTIONS AND SOUND ACTUARIAL PRINCIPLES.

(2) A CARRIER THAT IS A HEALTH MAINTENANCE ORGANIZATION AND THAT INCLUDES A SUBROGATION PROVISION IN ITS CONTRACT AS AUTHORIZED UNDER § 19-713.1(D) OF THE HEALTH - GENERAL ARTICLE SHALL:

(I) USE IN ITS RATING METHODOLOGY AN ADJUSTMENT THAT REFLECTS THE SUBROGATION; AND

(II) IDENTIFY IN ITS RATE FILING WITH THE ADMINISTRATION, AND ANNUALLY IN A FORM APPROVED BY THE COMMISSIONER, ALL AMOUNTS RECOVERED THROUGH SUBROGATION.

15-1710.

(A) ON OR BEFORE MARCH 15 OF EACH YEAR, EACH CARRIER SHALL FILE AN ACTUARIAL CERTIFICATION WITH THE COMMISSIONER.

(B) THE ACTUARIAL CERTIFICATION SHALL BE WRITTEN IN A FORM THAT THE COMMISSIONER APPROVES BY A MEMBER OF THE AMERICAN ACADEMY OF ACTUARIES OR ANOTHER PERSON ACCEPTABLE TO THE COMMISSIONER AND SHALL

STATE THAT THE CARRIER IS IN COMPLIANCE WITH THIS SUBTITLE AND HAS FOLLOWED THE RATING PRACTICES IMPOSED UNDER § 15-1709 OF THIS SUBTITLE.

(C) THE ACTUARIAL CERTIFICATION SHALL BE BASED ON AN EXAMINATION THAT INCLUDES A REVIEW OF APPROPRIATE RECORDS AND ACTUARIAL ASSUMPTIONS AND METHODS USED BY THE CARRIER.

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

Article - Health - General

19-103.

(a) There is a Maryland Health Care Commission.

(c) The purpose of the Commission is to:

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by:

(i) Advocating policies and systems to promote the efficient delivery of and improved access to health care services; and

(ii) Enhancing the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;

(4) Establish and develop a medical care data base on health care services rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services;

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop:

(i) A uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan; and

(ii) A modified health benefit plan for medical savings accounts;

(7) Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;

(8) Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

(9) Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;

(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

(11) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article;

(12) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; [and]

(13) Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Health Services Cost Review Commission; AND

(14) IN ACCORDANCE WITH TITLE 15, SUBTITLE 17 OF THE INSURANCE ARTICLE, DEVELOP A UNIFORM SET OF EFFECTIVE BENEFITS TO BE INCLUDED IN THE ASSOCIATION HEALTH BENEFIT PLAN.

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

Article - Health - General

19-103.

(c) The purpose of the Commission is to:

(1) Develop health care cost containment strategies to help provide access to appropriate quality health care services for all Marylanders, after consulting with the Health Services Cost Review Commission;

(2) Promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost by:

(i) Advocating policies and systems to promote the efficient delivery of and improved access to health care services; and

(ii) Enhancing the strengths of the current health care service delivery and regulatory system;

(3) Facilitate the public disclosure of medical claims data for the development of public policy;

(4) Establish and develop a medical care data base on health care services rendered by health care practitioners;

(5) Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services;

(6) In accordance with Title 15, Subtitle 12 of the Insurance Article, develop:

(i) A uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan; and

(ii) A modified health benefit plan for medical savings accounts;

(7) Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;

(8) Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;

(9) Establish standards for the operation and licensing of medical care electronic claims clearinghouses in Maryland;

(10) Reduce the costs of claims submission and the administration of claims for health care practitioners and payors;

(11) Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article; [and]

(12) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; AND

(13) IN ACCORDANCE WITH TITLE 15, SUBTITLE 17 OF THE INSURANCE ARTICLE, DEVELOP A UNIFORM SET OF EFFECTIVE BENEFITS TO BE INCLUDED IN THE ASSOCIATION HEALTH BENEFIT PLAN.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect on the taking effect of the termination provision specified in Section 3 of Chapter 385 of the Acts of the General Assembly of 2003. If that termination provision takes effect, Section 2 of this Act shall be abrogated and of no further force and effect. This Act may not be interpreted to have any effect on that termination provision.

SECTION 5. AND BE IT FURTHER ENACTED, That, subject to the provisions of Section 4 of this Act, this Act shall take effect October 1, 2004.