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By: **Chairman, Health and Government Operations Committee (By Request - Departmental - Health and Mental Hygiene)**
Introduced and read first time: February 25, 2004
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

AN ACT concerning

Health Reform Act of 2004

FOR the purpose of authorizing the Maryland Health Care Commission to establish a limited benefit plan to be offered to certain small employers; establishing the maximum actuarial value of the limited benefit plan; specifying certain conditions and limitations with respect to carriers that offer limited benefit plans under this Act; defining certain terms; and generally relating to health care insurance for small group employers.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 19-103 and 19-108
Annotated Code of Maryland
(2000 Replacement Volume and 2003 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-1201, 15-1207, 15-1209, and 15-1213
Annotated Code of Maryland
(2002 Replacement Volume and 2003 Supplement)

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

Article - Health - General

19-103.

(a) There is a Maryland Health Care Commission.

(b) The Commission is an independent commission that functions in the Department.

(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; AND

(III) A LIMITED BENEFIT PLAN;

(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.

(d) The Commission shall coordinate the exercise of its functions with the Department and the Health Services Cost Review Commission to ensure an integrated, effective health care policy for the State.

19-108.

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission shall adopt regulations:

(1) [specifying] SPECIFYING the comprehensive standard health benefit plan to apply under Title 15, Subtitle 12 of the Insurance Article; AND

(2) ON OR BEFORE JULY 1, 2005, SPECIFYING THE LIMITED BENEFIT PLAN TO APPLY UNDER TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE.

(b) In carrying out its duties under this section, the Commission shall comply with the provisions of § 15-1207 of the Insurance Article.

Article - Insurance

15-1201.

(a) In this subtitle the following words have the meanings indicated.

(b) "Board" means the Board of Directors of the Pool established under § 15-1216 of this subtitle.

(c) "Carrier" means a person that:

(1) offers health benefit plans in the State covering eligible employees of small employers; and

(2) is:

(i) an authorized insurer that provides health insurance in the State;

(ii) a nonprofit health service plan that is licensed to operate in the State;

(iii) a health maintenance organization that is licensed to operate in the State; or

(iv) any other person or organization that provides health benefit plans subject to State insurance regulation.

(d) "Commission" means the Maryland Health Care Commission established under Title 19, Subtitle 1 of the Health - General Article.

(e) (1) "Eligible employee" means:

(i) an individual who:

1. is an employee, sole proprietor, self-employed individual, partner of a partnership, or independent contractor who is included as an employee under a health benefit plan; and

2. works on a full-time basis and has a normal workweek of at least 30 hours; or

(ii) a sole employee of a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code who:

1. has a normal workweek of at least 20 hours; and

2. is not covered under a public or private plan for health insurance or other health benefit arrangement.

(2) "Eligible employee" does not include an individual who works:

(i) on a temporary or substitute basis; or

(ii) except for an individual described in paragraph (1)(ii) of this subsection, for less than 30 hours in a normal workweek.

(f) (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" includes a policy or certificate for hospital or medical benefits that covers residents of this State who are eligible employees and that is issued through:

(i) a multiple employer trust or association located in this State or another state; or

(ii) a professional employer organization, coemployer, or other organization located in this State or another state that engages in employee leasing.

(3) "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.

(g) "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.

(h) "Late enrollee" means:

(1) an eligible employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period provided under the health benefit plan; or

(2) a self-employed individual described in § 15-1203(c) or (d) of this subtitle or dependent who requests enrollment in a health benefit plan after an annual open enrollment period for self-employed individuals established by the carrier in accordance with regulations adopted by the Commissioner.

(I) "LIMITED BENEFIT PLAN" MEANS THE LIMITED BENEFIT PLAN ADOPTED BY THE COMMISSION IN ACCORDANCE WITH § 15-1207 OF THIS SUBTITLE AND TITLE 19, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

[(i)] (J) "Pool" means the Maryland Small Employer Health Reinsurance Pool established under this subtitle.

[(j)] (K) "Preexisting condition" means:

(1) a condition existing during a specified period immediately preceding the effective date of coverage, that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

[(k)] (L) "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

[(l)] (M) "Reinsuring carrier" means a carrier that participates in the Pool.

[(m)] (N) "Risk-assuming carrier" means a carrier that does not participate in the Pool.

[(n)] (O) "Small employer" means:

(1) an employer described in § 15-1203 of this subtitle; or

(2) an entity that leases employees from a professional employer organization, coemployer, or other organization engaged in employee leasing and that otherwise meets the description of § 15-1203 of this subtitle.

[(o)] (P) "Special enrollment period" means a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

[(p)] (Q) "Standard Plan" means the Comprehensive Standard Health Benefit Plan adopted by the Commission in accordance with § 15-1207 of this subtitle and Title 19, Subtitle 1 of the Health - General Article.

15-1207.

(a) In accordance with Title 19, Subtitle 1 of the Health - General Article, the Commission shall adopt regulations that specify:

(1) the Comprehensive Standard Health Benefit Plan to apply under this subtitle; [and]

(2) a modified health benefit plan for medical savings accounts that qualify under the federal Health Insurance Portability and Accountability Act of 1996, including:

(i) a waiver of deductibles as permitted under federal law;

(ii) minimum funding standards for medical savings accounts; and

(iii) authorization for offering the modified plan only by those persons who offer the Comprehensive Standard Health Benefit Plan adopted in accordance with item (1) of this subsection; AND

(3) A LIMITED BENEFIT PLAN, THE ACTUARIAL VALUE OF WHICH MAY NOT EXCEED 70% OF THE ACTUARIAL VALUE OF THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN.

(b) The Commission shall require that the minimum benefits allowed to be offered in the Standard Plan:

(1) by a health maintenance organization, shall include at least the actuarial equivalent of the minimum benefits required to be offered by a federally qualified health maintenance organization; and

(2) by an insurer or nonprofit health service plan on an expense-incurred basis, shall be actuarially equivalent to at least the minimum benefits required to be offered under item (1) of this subsection.

(c) (1) Subject to paragraph (2) of this subsection, the Commission shall exclude or limit benefits or adjust cost-sharing arrangements in the Standard Plan if the average rate for the Standard Plan exceeds 10% of the average annual wage in the State.

(2) The Commission annually shall determine the average rate for the Standard Plan by using the average rate submitted by each carrier that offers the Standard Plan.

(d) 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.

(e) The Commission may exclude FROM THE STANDARD PLAN OR THE LIMITED BENEFIT PLAN:

(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.

(f) The Standard Plan AND THE LIMITED BENEFIT PLAN shall include uniform deductibles and cost-sharing associated with its benefits, as determined by the Commission.

(g) In establishing cost-sharing as part of the Standard Plan AND LIMITED BENEFIT PLAN, the Commission shall:

(1) include cost-sharing and other incentives to help prevent consumers from seeking unnecessary services;

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

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

15-1209.

(a) This section does not apply to any insurance enumerated in § 15-1201(f)(3)(i) through (xiii) of this subtitle.

(b) A carrier shall issue its health benefit plans to each small employer that meets the requirements of this section.

(C) (1) A CARRIER THAT OFFERS INSURANCE IN THE SMALL GROUP HEALTH INSURANCE MARKET MUST OFFER THE COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN TO EACH SMALL EMPLOYER THAT MEETS THE REQUIREMENTS OF THIS SECTION.

(2) A CARRIER THAT OFFERS INSURANCE IN THE SMALL GROUP MARKET MUST OFFER THE LIMITED BENEFIT PLAN, BUT ONLY TO THOSE SMALL EMPLOYERS:

(I) THAT HAVE NOT BEEN COVERED BY A HEALTH CARE BENEFIT PLAN IN THE PREVIOUS 12 MONTHS; AND

(II) FOR WHICH THE AVERAGE ANNUAL WAGE OF THE EMPLOYER'S GROUP DOES NOT EXCEED 75% OF THE AVERAGE ANNUAL WAGE IN THE STATE.

(D) FOR SMALL EMPLOYERS THAT QUALIFY FOR AND CHOOSE THE LIMITED BENEFIT PLAN, A CARRIER:

(1) MUST OFFER COVERAGE FOR ALL ELIGIBLE EMPLOYEES AND DEPENDENTS UNDER THE LIMITED BENEFIT PLAN; AND

(2) MAY NOT OFFER COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN COVERAGE FOR ANY MEMBERS OF THE EMPLOYER'S GROUP.

[(c)] (E) (1) Nothing in this subsection requires a small employer to contribute to the premium payments for coverage of a dependent of an eligible employee.

(2) To be covered under a health benefit plan offered by a carrier, a small employer shall:

(i) elect to be covered;

(ii) agree to pay the premiums;

(iii) agree to offer coverage to any dependent of an eligible employee when coverage is sought by the eligible employee, in accordance with provisions governing late enrollees and any other provisions of this subtitle that apply to coverage;

(iv) agree to collect payments for premiums through payroll deductions for coverage of eligible employees and dependents and transmit those payments to the carrier; and

(v) satisfy other reasonable provisions of the health benefit plan as approved by the Commissioner.

[(d)] (F) (1) In determining whether a small employer satisfies the requirements of this section, a carrier shall apply its requirements uniformly among all small employers with the same number of eligible employees who apply for or receive coverage from the carrier, including a requirement that a minimum percentage of eligible employees of the small employer participate in the health benefit plan.

(2) A carrier may vary application of minimum participation of eligible employees only by the size of the group of the small employer.

[(e)] (G) A carrier may not require a small employer to contribute to payment of premiums for a health benefit plan.

15-1213.

(a) This section does not apply to any insurance enumerated in § 15-1201(f)(3)(i) through (xiii) of this subtitle.

(b) Each benefit offered in addition to the Standard Plan that increases access to care choices or lowers the cost-sharing arrangement in the Standard Plan OR THE LIMITED BENEFIT PLAN is subject to all of the provisions of this subtitle applicable to the Standard Plan, including:

(1) guaranteed issuance;

(2) guaranteed renewal;

(3) adjusted community rating; and

(4) the prohibition on preexisting condition limitations.

(c) (1) Each benefit offered in addition to the Standard Plan that increases the type of services available or the frequency of services is not subject to guaranteed issuance but is subject to all other provisions of this subtitle applicable to the Standard Plan, including:

(i) guaranteed renewal;

(ii) adjusted community rating; and

(iii) the prohibition on preexisting condition limitations.

(2) For each additional benefit offered under this subsection, a carrier shall accept or reject the application of the entire group.

(3) The Commissioner may prohibit a carrier from offering an additional benefit under this subsection if the Commissioner finds that the additional benefit will be sold in conjunction with the Standard Plan OR LIMITED BENEFIT PLAN in a manner designed to promote risk selection or underwriting practices otherwise prohibited by this subtitle.

(d) [(1)] A benefit offered in addition to the Standard Plan OR THE LIMITED BENEFIT PLAN to lower the cost-sharing arrangement in the Standard Plan OR THE LIMITED BENEFIT PLAN in accordance with § 15-301.1 of the Health - General Article is subject to:

(1) guaranteed issuance;

(2) guaranteed renewal;

(3) adjusted community rating; and

(4) the prohibition on preexisting condition limitations.

[(2) A carrier that offers a benefit under this subsection shall be required to guarantee issuance and guarantee renewal of the additional benefit only to employers who are participating in the MCHP private option plan established under § 15-301.1 of the Health - General Article.]

(E) A CARRIER MAY NOT OFFER ADDITIONAL BENEFITS TO THE LIMITED BENEFIT PLAN, EXCEPT FOR ADDITIONAL BENEFITS TO LOWER THE COST-SHARING ARRANGEMENTS IN THE LIMITED BENEFIT PLAN.

SECTION 2. AND BE IT FURTHER ENACTED, That health insurance carriers shall report to the Maryland Health Care Commission, at times and in a format specified by the Commission, the number of limited benefit plan policies they have sold and the number of lives covered by those policies.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2004.