
By: **Chairman, Finance Committee (By Request - Departmental - Health and Mental Hygiene)**

Introduced and read first time: March 3, 2004

Assigned to: Rules

A BILL ENTITLED

1 AN ACT concerning

2 **Health Reform Act of 2004**

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

9 BY repealing and reenacting, with amendments,
10 Article - Health - General
11 Section 19-103 and 19-108
12 Annotated Code of Maryland
13 (2000 Replacement Volume and 2003 Supplement)

14 BY repealing and reenacting, with amendments,
15 Article - Insurance
16 Section 15-1201, 15-1207, 15-1209, and 15-1213
17 Annotated Code of Maryland
18 (2002 Replacement Volume and 2003 Supplement)

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

21 **Article - Health - General**

22 19-103.

23 (a) There is a Maryland Health Care Commission.

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

26 (c) The purpose of the Commission is to:

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

- 4 (2) Promote the development of a health regulatory system that
5 provides, for all Marylanders, financial and geographic access to quality health care
6 services at a reasonable cost by:
 - 7 (i) Advocating policies and systems to promote the efficient
8 delivery of and improved access to health care services; and
 - 9 (ii) Enhancing the strengths of the current health care service
10 delivery and regulatory system;

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

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

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

- 19 (6) In accordance with Title 15, Subtitle 12 of the Insurance Article,
20 develop:
 - 21 (i) A uniform set of effective benefits to be included in the
22 Comprehensive Standard Health Benefit Plan; [and]
 - 23 (ii) A modified health benefit plan for medical savings accounts;
24 AND
 - 25 (III) A LIMITED BENEFIT PLAN;

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

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

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

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

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

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

5 (13) Oversee and administer the Maryland Trauma Physician Services
6 Fund in conjunction with the Health Services Cost Review Commission.

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

10 19-108.

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

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

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

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

19

Article - Insurance

20 15-1201.

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

22 (b) "Board" means the Board of Directors of the Pool established under §
23 15-1216 of this subtitle.

24 (c) "Carrier" means a person that:

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

27 (2) is:

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

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

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

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

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

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

6 (i) an individual who:

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

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

12 (ii) a sole employee of a nonprofit organization that has been
13 determined by the Internal Revenue Service to be exempt from taxation under §
14 501(c)(3), (4), or (6) of the Internal Revenue Code who:

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

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

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

19 (i) on a temporary or substitute basis; or

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

22 (f) (1) "Health benefit plan" means:

23 (i) a policy or certificate for hospital or medical benefits;

24 (ii) a nonprofit health service plan; or

25 (iii) a health maintenance organization subscriber or group master
26 contract.

27 (2) "Health benefit plan" includes a policy or certificate for hospital or
28 medical benefits that covers residents of this State who are eligible employees and
29 that is issued through:

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

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

- 1 (3) "Health benefit plan" does not include:
- 2 (i) accident-only insurance;
- 3 (ii) fixed indemnity insurance;
- 4 (iii) credit health insurance;
- 5 (iv) Medicare supplement policies;
- 6 (v) Civilian Health and Medical Program of the Uniformed Services
7 (CHAMPUS) supplement policies;
- 8 (vi) long-term care insurance;
- 9 (vii) disability income insurance;
- 10 (viii) coverage issued as a supplement to liability insurance;
- 11 (ix) workers' compensation or similar insurance;
- 12 (x) disease-specific insurance;
- 13 (xi) automobile medical payment insurance;
- 14 (xii) dental insurance; or
- 15 (xiii) vision insurance.
- 16 (g) "Health status-related factor" means a factor related to:
- 17 (1) health status;
- 18 (2) medical condition;
- 19 (3) claims experience;
- 20 (4) receipt of health care;
- 21 (5) medical history;
- 22 (6) genetic information;
- 23 (7) evidence of insurability including conditions arising out of acts of
24 domestic violence; or
- 25 (8) disability.
- 26 (h) "Late enrollee" means:

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

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

8 (I) "LIMITED BENEFIT PLAN" MEANS THE LIMITED BENEFIT PLAN ADOPTED
9 BY THE COMMISSION IN ACCORDANCE WITH § 15-1207 OF THIS SUBTITLE AND TITLE
10 19, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

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

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

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

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

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

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

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

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

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

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

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

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

1 15-1207.

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

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

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

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

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

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

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

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

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

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

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

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

32 (d) In establishing benefits, the Commission shall judge preventive services,
33 medical treatments, procedures, and related health services based on:

34 (1) their effectiveness in improving the health status of individuals;

35 (2) their impact on maintaining and improving health and on reducing
36 the unnecessary consumption of health care services; and

1 (3) their impact on the affordability of health care coverage.

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

4 (1) a health care service, benefit, coverage, or reimbursement for covered
5 health care services that is required under this article or the Health - General Article
6 to be provided or offered in a health benefit plan that is issued or delivered in the
7 State by a carrier; or

8 (2) reimbursement required by statute, by a health benefit plan for a
9 service when that service is performed by a health care provider who is licensed under
10 the Health Occupations Article and whose scope of practice includes that service.

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

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

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

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

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

22 15-1209.

23 (a) This section does not apply to any insurance enumerated in §
24 15-1201(f)(3)(i) through (xiii) of this subtitle.

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

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

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

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

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

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

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

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

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

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

12 (i) elect to be covered;

13 (ii) agree to pay the premiums;

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

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

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

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

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

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

33 15-1213.

34 (a) This section does not apply to any insurance enumerated in §
35 15-1201(f)(3)(i) through (xiii) of this subtitle.

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

- 5 (1) guaranteed issuance;
- 6 (2) guaranteed renewal;
- 7 (3) adjusted community rating; and
- 8 (4) the prohibition on preexisting condition limitations.

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

- 13 (i) guaranteed renewal;
- 14 (ii) adjusted community rating; and
- 15 (iii) the prohibition on preexisting condition limitations.

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

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

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

- 27 (1) guaranteed issuance;
- 28 (2) guaranteed renewal;
- 29 (3) adjusted community rating; and
- 30 (4) the prohibition on preexisting condition limitations.

31 [(2)] A carrier that offers a benefit under this subsection shall be required
32 to guarantee issuance and guarantee renewal of the additional benefit only to
33 employers who are participating in the MCHP private option plan established under
34 § 15-301.1 of the Health - General Article.]

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

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

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