C3 6lr0040

By: **Chairman, Finance Committee (By Request - Departmental - Insurance Administration, Maryland)**
Introduced and read first time: January 25, 2006
Rules suspended
Assigned to: Finance

A BILL ENTITLED

1 AN ACT concerning

2 **Maryland Health Insurance Plan - Plan Independence, Board Composition,**
3 **and Regulation**

4 FOR the purpose of removing the Maryland Health Insurance Plan from the
5 Maryland Insurance Administration; providing that the Plan is an independent
6 unit of the State government; providing that the Plan is part of the
7 Administration for certain purposes; altering the composition of the Board of
8 Directors of the Plan; permitting the use of a proxy by certain members of the
9 Board of Directors; requiring the Plan to establish a certain benefit package by
10 regulation; providing that the Plan is not subject to certain laws; requiring the
11 Maryland Insurance Commissioner to regulate the Plan; requiring the Plan and
12 the Board of Directors of the Plan to comply with certain provisions of law;
13 requiring an entity contracted with the Plan and certain health care providers to
14 comply with certain provisions of law under certain circumstances; making a
15 certain stylistic change; and generally relating to the Maryland Health
16 Insurance Plan.

17 BY repealing and reenacting, with amendments,
18 Article - Insurance
19 Section 14-502, 14-503, and 14-505
20 Annotated Code of Maryland
21 (2002 Replacement Volume and 2005 Supplement)

22 BY adding to
23 Article - Insurance
24 Section 14-509
25 Annotated Code of Maryland
26 (2002 Replacement Volume and 2005 Supplement)

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

1 **Article - Insurance**

2 14-502.

3 (a) There is a Maryland Health Insurance Plan.

4 (b) (1) The Plan is an independent unit [that operates within the
5 Administration] OF THE STATE GOVERNMENT.

6 (2) THE PLAN IS PART OF THE ADMINISTRATION FOR BUDGETARY AND
7 ADMINISTRATIVE PURPOSES.

8 (c) The purpose of the Plan is to decrease uncompensated care costs by
9 providing access to affordable, comprehensive health benefits for medically
10 uninsurable residents of the State by July 1, 2003.

11 (d) It is the intent of the General Assembly that the Plan operate as a
12 nonprofit entity and that Fund revenue, to the extent consistent with good business
13 practices, be used to subsidize health insurance coverage for medically uninsurable
14 individuals.

15 (E) (1) THE OPERATIONS OF THE PLAN ARE SUBJECT TO THE PROVISIONS
16 OF THIS SUBTITLE WHETHER THE OPERATIONS ARE PERFORMED DIRECTLY BY THE
17 PLAN ITSELF OR THROUGH AN ENTITY CONTRACTED WITH THE PLAN.

18 (2) AN ENTITY CONTRACTED WITH THE PLAN SHALL COMPLY WITH THE
19 PROVISIONS OF THIS SUBTITLE WHEN PERFORMING SERVICES THAT ARE SUBJECT
20 TO THIS SUBTITLE ON BEHALF OF THE PLAN.

21 14-503.

22 (a) There is a Board for the Plan.

23 (b) The Plan shall operate subject to the supervision and control of the Board.

24 (c) The Board consists of nine members, of whom:

25 (1) [one shall be the Commissioner;

26 (2)] one shall be the Executive Director of the Maryland Health Care
27 Commission;

28 [(3)] (2) one shall be the Executive Director of the Health Services Cost
29 Review Commission;

30 [(4)] (3) one shall be the Secretary of [the Department of] Budget and
31 Management;

32 [(5)] (4) two shall be appointed by the Director of the Health, Education,
33 and Advocacy Unit in the Office of the Attorney General in accordance with
34 subsection (d) of this section;

1 [(6)] (5) one shall be appointed by the Commissioner to represent
2 carriers operating in the State;

3 [(7)] (6) one shall be appointed by the Commissioner to represent
4 insurance producers selling insurance in the State; [and]

5 [(8)] (7) one shall be an individual who is an owner or employee of a
6 minority-owned business in the State, appointed by the Governor; AND

7 (8) ONE SHALL BE APPOINTED BY THE GOVERNOR TO REPRESENT
8 HEALTH CARE PROVIDERS IN THE STATE.

9 (d) (1) (i) Each Board member appointed under subsection [(c)(5)] (C)(4)
10 of this section shall be a consumer who does not have a substantial financial interest
11 in a person regulated under this article or under Title 19, Subtitle 7 of the Health -
12 General Article.

13 (ii) One of the Board members appointed under subsection [(c)(5)]
14 (C)(4) of this section shall be a member of a racial minority.

15 (2) The term of an appointed member is 4 years.

16 (3) At the end of a term, an appointed member continues to serve until a
17 successor is appointed and qualifies.

18 (4) An appointed member who is appointed after a term has begun
19 serves only for the rest of the term and until a successor is appointed and qualifies.

20 (E) EACH BOARD MEMBER DESIGNATED UNDER SUBSECTION (C)(1), (2), AND
21 (3) OF THIS SECTION MAY HAVE A PROXY WHO:

22 (1) (I) IS DESIGNATED IN WRITING;

23 (II) IS NOT A MEMBER OF THE BOARD; AND

24 (III) IS AN EMPLOYEE OF THE MEMBER'S UNIT OF STATE
25 GOVERNMENT; AND

26 (2) MAY VOTE AT BOARD MEETINGS IN THE MEMBER'S ABSENCE.

27 [(e)] (F) Each member of the Board is entitled to reimbursement for expenses
28 under the Standard State Travel Regulations, as provided in the State budget.

29 [(f)] (G) (1) The Board shall appoint an Executive Director who shall be the
30 chief administrative officer of the Plan.

31 (2) The Executive Director shall serve at the pleasure of the Board.

32 (3) The Board shall determine the appropriate compensation for the
33 Executive Director.

1 (4) Under the direction of the Board, the Executive Director shall
2 perform any duty or function that is necessary for the operation of the Plan.

3 [(g)] (H) The Board is not subject to:

4 (1) the provisions of the State Finance and Procurement Article;

5 (2) the provisions of Division I of the State Personnel and Pensions
6 Article that govern the State Personnel Management System; or

7 (3) the provisions of Divisions II and III of the State Personnel and
8 Pensions Article.

9 [(h)] (I) (1) The Board shall adopt a plan of operation for the Plan.

10 (2) The Board shall submit the plan of operation and any amendment to
11 the plan of operation to the Commissioner for approval.

12 [(i)] (J) On an annual basis, the Board shall submit to the Commissioner an
13 audited financial report of the Fund prepared by an independent certified public
14 accountant.

15 [(j)] (K) (1) The Board shall adopt regulations necessary to operate and
16 administer the Plan.

17 (2) Regulations adopted by the Board may include:

18 (i) residency requirements for Plan enrollees;

19 (ii) Plan enrollment procedures; and

20 (iii) any other Plan requirements as determined by the Board.

21 [(k)] (L) In order to maximize volume discounts on the cost of prescription
22 drugs, the Board may aggregate the purchasing of prescription drugs for enrollees in
23 the Plan and enrollees in the Senior Prescription Drug Program established under
24 Part II of this subtitle.

25 [(l)] (M) For those members enrolled in the Plan whose eligibility in the Plan
26 is subject to the requirements of the federal tax credit for health insurance costs
27 under Section 35 of the Internal Revenue Code, the Board shall report on or before
28 December 1, 2003, and annually thereafter, to the Governor, and subject to § 2-1246
29 of the State Government Article, to the General Assembly on the number of members
30 enrolled in the Plan and the costs to the Plan associated with providing insurance to
31 those members.

32 14-505.

33 (a) (1) The Board shall establish BY REGULATION a standard benefit
34 package to be offered by the Plan.

1 (2) The Board may exclude from the benefit package:

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

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

10 (3) THE BOARD SHALL COMPLY WITH THE PROVISIONS OF § 12-203 OF
11 THIS ARTICLE FOR ALL FORMS RELATING TO THE STANDARD BENEFIT PACKAGE.

12 (b) (1) The Board shall establish a premium rate for Plan coverage subject to
13 review and approval by the Commissioner.

14 (2) The premium rate may vary on the basis of family composition.

15 (3) If the Board determines that a standard risk rate would create
16 market dislocation, the Board may adjust the premium rate based on member age.

17 (c) (1) The Board shall determine a standard risk rate by considering the
18 premium rates charged by carriers in the State for coverage comparable to that of the
19 Plan.

20 (2) The premium rate for Plan coverage:

21 (i) may not be less than 110% of the standard risk rate established
22 under paragraph (1) of this subsection; and

23 (ii) may not exceed 200% of the standard risk rate.

24 (3) Premium rates shall be reasonably calculated to encourage
25 enrollment in the Plan.

26 (4) The Board may subsidize premiums, deductibles, and other policy
27 expenses, based on a member's income.

28 (d) Losses incurred by the Plan shall be subsidized by the Fund.

29 14-509.

30 (A) THE COMMISSIONER SHALL REGULATE THE PLAN.

31 (B) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, THE PLAN IS NOT
32 SUBJECT TO THE INSURANCE LAWS OF THE STATE.

33 (C) THE PLAN SHALL BE SUBJECT TO:

1 (1) §§ 2-205, 2-207, 2-208, AND 2-209 OF THIS ARTICLE;

2 (2) §§ 15-112, 15-112.1, 15-113, AND 15-130 OF THIS ARTICLE;

3 (3) §§ 15-401, 15-402, 15-403, AND 15-403.1 OF THIS ARTICLE;

4 (4) §§ 15-830, 15-831, AND 15-833 OF THIS ARTICLE;

5 (5) §§ 15-1001, 15-1003, 15-1004, 15-1005, 15-1006, 15-1007, 15-1008, AND
6 15-1009 OF THIS ARTICLE;

7 (6) TITLE 15, SUBTITLES 10A, 10B, AND 10D OF THIS ARTICLE; AND

8 (7) §§ 27-303 AND 27-304 OF THIS ARTICLE.

9 (D) (1) IN ADDITION TO THE INSURANCE LAWS TO WHICH THE PLAN IS
10 SUBJECT, THE PROVISIONS OF PARAGRAPHS (2) AND (3) OF THIS SUBSECTION SHALL
11 APPLY IF THE PLAN DELIVERS SERVICES THROUGH:

12 (I) A HEALTH MAINTENANCE ORGANIZATION; OR

13 (II) A DELIVERY SYSTEM UNDER WHICH:

14 1. EXCEPT FOR APPLICABLE COPAYMENTS, MOST SERVICES
15 ARE PAID IN FULL IF THE MEMBER SEES A NETWORK PROVIDER; AND

16 2. EXCEPT FOR EMERGENCY AND URGENT CARE, SERVICES
17 FOR NONNETWORK PROVIDERS ARE NOT PAID.

18 (2) THE PLAN SHALL COMPLY WITH THE PROVISIONS OF §§ 19-710(I) AND
19 19-710.1 OF THE HEALTH - GENERAL ARTICLE.

20 (3) A HEALTH CARE PROVIDER WHO IS NOT A CONTRACTING PROVIDER
21 WITH THE PLAN OR ITS ADMINISTRATOR SHALL COMPLY WITH THE REQUIREMENTS
22 OF § 19-710(P) OF THE HEALTH - GENERAL ARTICLE.

23 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take
24 effect October 1, 2006.