

SENATE BILL 427

C3

(7lr1831)

ENROLLED BILL

— Finance/Health and Government Operations —

Introduced by **Senators Middleton and Astle**

Read and Examined by Proofreaders:

Proofreader.

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this

_____ day of _____ at _____ o'clock, _____ M.

President.

CHAPTER _____

1 AN ACT concerning

2 **Health Insurance – Authorization of Additional Products and Small Group**
3 **Administrative Discounts and Study**

4 FOR the purpose of ~~making certain provisions of this Act applicable to health~~
5 ~~maintenance organizations; providing that certain insurance policies may~~
6 ~~provide for payment of services rendered by certain providers; requiring an~~
7 ~~insurer to establish payment in a certain manner under certain circumstances;~~
8 ~~requiring a certain policy to allow direct access to specialists; providing that the~~
9 Maryland Insurance Commissioner may authorize certain health insurance
10 carriers to offer a preferred provider insurance policy that conditions the
11 payment of benefits on the use of preferred providers if the health insurance

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Italics indicate opposite chamber / conference committee amendments.



1 carrier meets certain requirements; requiring certain insurers and nonprofit
 2 health service plans to offer an option to include preferred and nonpreferred
 3 providers as an additional benefit under certain circumstances; requiring
 4 certain insurers and nonprofit health service plans to provide certain
 5 disclosures under certain circumstances; authorizing certain entities to require
 6 a certain individual to pay a certain premium under certain circumstances;
 7 ~~providing that certain provisions of law do not apply to a small employer under~~
 8 ~~certain circumstances; requiring a small employer to provide a certain~~
 9 ~~certification under certain circumstances; authorizing a health insurance~~
 10 ~~carrier to offer a certain plan under certain circumstances; requiring certain~~
 11 carriers that use a provider panel and offer a certain preferred provider
 12 insurance policy to adhere to certain standards; authorizing a carrier to offer a
 13 certain administrative discount to a small employer under certain
 14 circumstances; providing for the intent of the General Assembly; authorizing a
 15 ~~carrier to offer a certain policy to certain employees; specifying what a certain~~
 16 ~~policy may exclude providing that a limited benefit group health insurance~~
 17 contract may be issued only by an insurer or nonprofit health service plan to an
 18 employer to provide health coverage only for certain employees; authorizing
 19 certain health insurance carriers to condition the sale of certain contracts on an
 20 employer taking certain actions; requiring a carrier certain health insurance
 21 carriers to make a certain disclosure under certain circumstances; requiring the
 22 Maryland Health Care Commission to conduct a certain study and report to
 23 certain committees of the General Assembly on or before a certain date; defining
 24 certain terms; and generally relating to the authorization of additional health
 25 insurance products and discounts.

26 ~~BY adding to~~

27 ~~Article – Health – General~~
 28 ~~Section 19–706(jjj)~~
 29 ~~Annotated Code of Maryland~~
 30 ~~(2005 Replacement Volume and 2006 Supplement)~~

31 BY repealing and reenacting, without amendments,

32 Article – Insurance
 33 Section 14–201 through 14–204
 34 Annotated Code of Maryland
 35 (2006 Replacement Volume and 2006 Supplement)

36 BY repealing and reenacting, with amendments,

37 Article – Insurance
 38 Section ~~14–205, 15–1202, 15–1204,~~ 15–112(b)(1) and 15–1205
 39 Annotated Code of Maryland
 40 (2006 Replacement Volume and 2006 Supplement)

1 BY adding to
 2 Article – Insurance
 3 Section ~~14-205.1; and 15-1701 through 15-1703 to be under the new subtitle~~
 4 ~~“Subtitle 17. Health Insurance Coverage for Part Time, Seasonal, and~~
 5 ~~Temporary Employees” 14-205.1 and 15-1104~~
 6 Annotated Code of Maryland
 7 (2006 Replacement Volume and 2006 Supplement)

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

10 ~~**Article – Health – General**~~

11 ~~19-706.~~

12 ~~(JJJ) THE PROVISIONS OF TITLE 15, SUBTITLE 17 OF THE INSURANCE~~
 13 ~~ARTICLE SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.~~

14 **Article – Insurance**

15 14-201.

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

17 (b) “Insured” means a person covered for benefits under a preferred provider
 18 insurance policy offered or administered by an insurer.

19 (c) “Nonpreferred provider” means a provider that is eligible for payment
 20 under a preferred provider insurance policy, but that is not a preferred provider under
 21 the applicable provider service contract.

22 (d) “Preferential basis” means an arrangement under which the insured or
 23 subscriber under a preferred provider insurance policy is entitled to receive health
 24 care services from preferred providers at no cost, at a reduced fee, or under more
 25 favorable terms than if the insured or subscriber received similar services from a
 26 nonpreferred provider.

27 (e) “Preferred provider” means a provider that has entered into a provider
 28 service contract.

29 (f) “Preferred provider insurance policy” means:

1 (1) a policy or insurance contract that is issued or delivered in the
2 State by an insurer, under which health care services are to be provided to the insured
3 by a preferred provider on a preferential basis; or

4 (2) another contract that is offered by an employer, third party
5 administrator, or other entity, under which health care services are to be provided to
6 the subscriber by a preferred provider on a preferential basis.

7 (g) "Provider" means a physician, hospital, or other person that is licensed or
8 otherwise authorized to provide health care services.

9 (h) "Provider service contract" means a contract between a provider and an
10 insurer, employer, third party administrator, or other entity, under which the provider
11 agrees to provide health care services on a preferential basis under specific preferred
12 provider insurance policies.

13 (i) "Subscriber" means a person covered for benefits under a preferred
14 provider insurance policy issued by a person that is not an insurer.

15 14–202.

16 (a) (1) This subtitle applies to insurers that issue or deliver individual or
17 group health insurance policies in the State.

18 (2) The provisions of this subtitle that apply to insurers also apply to
19 nonprofit health service plans that issue or deliver individual or group health
20 insurance policies in the State.

21 (b) Except as otherwise provided in § 14–206 of this subtitle, this subtitle
22 does not apply to an employee benefit plan to the extent that the plan is governed by
23 the Employee Retirement Income Security Act of 1974 (ERISA).

24 14–203.

25 The Commissioner may adopt regulations to enforce this subtitle.

26 14–204.

27 Subject to the approval of the Commissioner, an insurer may:

28 (1) offer or administer a health benefit program under which the
29 insurer offers preferred provider insurance policies that limit, through the use of

1 provider service contracts, the numbers and types of providers of health care services
 2 eligible for payment as preferred providers; and

3 (2) establish terms and conditions that providers must meet to qualify
 4 for payment as preferred providers.

5 ~~14-205.~~

6 ~~(a) If a preferred provider insurance policy offered by an insurer provides~~
 7 ~~benefits for a service that is within the lawful scope of practice of a health care~~
 8 ~~provider licensed under the Health Occupations Article, an insured covered by the~~
 9 ~~preferred provider insurance policy is entitled to receive the benefits for that service~~
 10 ~~either through direct payments to the health care provider or through reimbursement~~
 11 ~~to the insured.~~

12 ~~(B) A PREFERRED PROVIDER INSURANCE POLICY OFFERED BY AN~~
 13 ~~INSURER MAY PROVIDE FOR PAYMENT OF SERVICES RENDERED BY:~~

14 ~~(1) PREFERRED PROVIDERS AND NONPREFERRED PROVIDERS;~~
 15 ~~OR~~

16 ~~(2) PREFERRED PROVIDERS.~~

17 ~~[(b)] (C) (1) [A] IF A preferred provider insurance policy offered by an~~
 18 ~~insurer under this subtitle [shall provide] PROVIDES for payment of services rendered~~
 19 ~~by nonpreferred providers, THE INSURER SHALL ESTABLISH PAYMENT as provided~~
 20 ~~in this subsection.~~

21 ~~(2) Unless the insurer demonstrates to the satisfaction of the~~
 22 ~~Commissioner that an alternative level of payment is more appropriate, aggregate~~
 23 ~~payments made in a full calendar year to nonpreferred providers, after all deductible~~
 24 ~~and copayment provisions have been applied, on average may not be less than 80% of~~
 25 ~~the aggregate payments made in that full calendar year to preferred providers for~~
 26 ~~similar services, in the same geographic area, under their provider service contracts.~~

27 ~~(D) A PREFERRED PROVIDER INSURANCE POLICY SHALL ALLOW~~
 28 ~~DIRECT ACCESS TO SPECIALISTS.~~

29 ~~[(e)] (E) (1) In this subsection, "unfair discrimination" means an act,~~
 30 ~~method of competition, or practice engaged in by an insurer:~~

31 ~~(i) that is prohibited by Title 27, Subtitle 2 of this article; or~~

~~(ii) that, although not specified in Title 27, Subtitle 2 of this article, the Commissioner believes is unfair or deceptive and that results in the institution of an action by the Commissioner under § 27-104 of this article.~~

~~(2) If the rates for each institutional provider under a preferred provider insurance policy offered by an insurer vary based on individual negotiations, geographic differences, or market conditions and are approved by the Health Services Cost Review Commission, the rates do not constitute unfair discrimination under this article.~~

14-205.1.

(A) THE COMMISSIONER MAY AUTHORIZE AN INSURER OR NONPROFIT HEALTH SERVICE PLAN TO OFFER A PREFERRED PROVIDER INSURANCE POLICY THAT CONDITIONS THE PAYMENT OF BENEFITS ON THE USE OF PREFERRED PROVIDERS IF THE INSURER OR NONPROFIT HEALTH SERVICE PLAN:

(1) HAS DEMONSTRATED TO THE SECRETARY OF HEALTH AND MENTAL HYGIENE THAT THE PROVIDER PANEL OF THE INSURER OR NONPROFIT HEALTH SERVICE PLAN COMPLIES WITH THE REGULATIONS ADOPTED UNDER § 19-705.1(B)(1)(II) OF THE HEALTH - GENERAL ARTICLE; AND

(2) DOES NOT RESTRICT PAYMENT FOR COVERED SERVICES PROVIDED BY NONPREFERRED PROVIDERS:

(I) FOR EMERGENCY SERVICES, AS DEFINED IN § 19-701 OF THE HEALTH - GENERAL ARTICLE;

(II) FOR AN UNFORESEEN ILLNESS, INJURY, OR CONDITION REQUIRING IMMEDIATE CARE; OR

(III) AS REQUIRED UNDER § 15-830 OF THIS ARTICLE.

~~(A)~~ **(B) (1) IF AN EMPLOYER, ASSOCIATION, OR OTHER PRIVATE GROUP ARRANGEMENT OFFERS HEALTH BENEFIT PLAN COVERAGE TO EMPLOYEES OR INDIVIDUALS ONLY THROUGH PREFERRED PROVIDERS, THEN THE INSURER OR NONPROFIT HEALTH SERVICE PLAN WITH WHICH THE EMPLOYER, ASSOCIATION, OR OTHER PRIVATE GROUP ARRANGEMENT IS CONTRACTING FOR THE COVERAGE SHALL OFFER AN OPTION TO INCLUDE**

1 **PREFERRED AND NONPREFERRED PROVIDERS AS AN ADDITIONAL BENEFIT FOR**
 2 **AN EMPLOYEE OR INDIVIDUAL, AT THE EMPLOYEE'S OR INDIVIDUAL'S OPTION,**
 3 **TO ACCEPT OR REJECT.**

4 **(2) THE INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL**
 5 **PROVIDE TO EACH EMPLOYER, ASSOCIATION, OR OTHER PRIVATE GROUP**
 6 **ARRANGEMENT A DISCLOSURE STATEMENT ON THE GROUP APPLICATION THAT**
 7 **AN OPTION TO INCLUDE PREFERRED AND NONPREFERRED PROVIDERS IS**
 8 **AVAILABLE FOR THE INDIVIDUAL OR EMPLOYEE TO ACCEPT OR REJECT.**

9 ~~(B)~~ **(C) AN EMPLOYER, ASSOCIATION, OR OTHER PRIVATE GROUP**
 10 **ARRANGEMENT MAY REQUIRE AN EMPLOYEE OR INDIVIDUAL THAT ACCEPTS**
 11 **THE ADDITIONAL COVERAGE FOR PREFERRED AND NONPREFERRED PROVIDERS**
 12 **TO PAY A PREMIUM GREATER THAN THE AMOUNT OF THE PREMIUM FOR THE**
 13 **COVERAGE OFFERED FOR PREFERRED PROVIDERS ONLY.**

14 15-112.

15 (b) (1) A carrier that uses a provider panel shall:

16 (i) 1. if the carrier is an insurer, nonprofit health service
 17 plan, or dental plan organization, maintain standards in accordance with regulations
 18 adopted by the Commissioner for availability of health care providers to meet the
 19 health care needs of enrollees; [and]

20 2. if the carrier is a health maintenance organization,
 21 adhere to the standards for accessibility of covered services in accordance with
 22 regulations adopted under § 19-705.1(b)(1)(ii) of the Health – General Article; and

23 **3. IF THE CARRIER IS AN INSURER OR NONPROFIT**
 24 **HEALTH SERVICE PLAN THAT OFFERS A PREFERRED PROVIDER INSURANCE**
 25 **POLICY THAT CONDITIONS THE PAYMENT OF BENEFITS ON THE USE OF**
 26 **PREFERRED PROVIDERS, ADHERE TO THE STANDARDS FOR ACCESSIBILITY OF**
 27 **COVERED SERVICES IN ACCORDANCE WITH REGULATIONS ADOPTED UNDER §**
 28 **19-705.1(B)(1)(II) OF THE HEALTH – GENERAL ARTICLE AND AS ENFORCED BY**
 29 **THE SECRETARY OF HEALTH AND MENTAL HYGIENE; AND**

30 (ii) establish procedures to:

31 1. review applications for participation on the carrier's
 32 provider panel in accordance with this section;

1 2. notify an enrollee of:

2 A. the termination from the carrier's provider panel of
3 the primary care provider that was furnishing health care services to the enrollee; and

4 B. the right of the enrollee, on request, to continue to
5 receive health care services from the enrollee's primary care provider for up to 90 days
6 after the date of the notice of termination of the enrollee's primary care provider from
7 the carrier's provider panel, if the termination was for reasons unrelated to fraud,
8 patient abuse, incompetency, or loss of licensure status;

9 3. notify primary care providers on the carrier's provider
10 panel of the termination of a specialty referral services provider;

11 4. verify with each provider on the carrier's provider
12 panel, at the time of credentialing and recredentialing, whether the provider is
13 accepting new patients and update the information on participating providers that the
14 carrier is required to provide under subsection (j) of this section; and

15 5. notify a provider at least 90 days before the date of
16 the termination of the provider from the carrier's provider panel, if the termination is
17 for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

18 **15-1104.**

19 **(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE**
20 **MEANINGS INDICATED.**

21 **(2) "EMPLOYER SPONSORED HEALTH BENEFIT PLAN" MEANS ANY**
22 **PLAN, FUND, OR PROGRAM THAT:**

23 **(I) IS ESTABLISHED OR MAINTAINED BY AN EMPLOYER**
24 **UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974;**

25 **(II) OFFERS COVERAGE FOR HEALTH BENEFITS; AND**

26 **(III) IS TREATED BY THE EMPLOYER OR ANY ELIGIBLE**
27 **EMPLOYEE OR DEPENDENT AS PART OF A PLAN, FUND, OR PROGRAM UNDER**
28 **THE UNITED STATES INTERNAL REVENUE CODE, 26 U.S.C. § 106, § 125, OR §**
29 **162.**

1 **(3) "GROUP HEALTH INSURANCE" HAS THE MEANING STATED IN §**
2 **15-302 OF THIS TITLE.**

3 **(4) "LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT"**
4 **MEANS A GROUP HEALTH INSURANCE CONTRACT THAT PROVIDES HEALTH**
5 **INSURANCE BENEFITS, BUT IS NOT REQUIRED TO PROVIDE ALL THE BENEFITS**
6 **REQUIRED UNDER SUBTITLES 7 AND 8 OF THIS TITLE.**

7 **(5) "SPECIAL ELIGIBLE EMPLOYEE" MEANS AN EMPLOYEE WHO**
8 **IS:**

9 **(I) IS ELIGIBLE FOR HEALTH COVERAGE UNDER THE**
10 **TERMS OF AN EMPLOYER SPONSORED HEALTH BENEFIT PLAN;**

11 **(II) WORKS:**

12 **1. ON A TEMPORARY OR SUBSTITUTE BASIS; OR**

13 **2. LESS THAN 30 HOURS IN A NORMAL WORKWEEK;**

14 **AND**

15 **(III) IS NOT ELIGIBLE FOR COVERAGE UNDER ANY GROUP**
16 **HEALTH INSURANCE CONTRACT, NONPROFIT HEALTH SERVICE PLAN**
17 **CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION CONTRACT ISSUED TO**
18 **THE EMPLOYEE'S EMPLOYER BECAUSE THE EMPLOYEE MEETS THE CRITERIA OF**
19 **ITEM (II) OF THIS PARAGRAPH.**

20 **(B) A LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT MAY BE**
21 **ISSUED ONLY BY AN INSURER OR NONPROFIT HEALTH SERVICE PLAN TO AN**
22 **EMPLOYER IF THE LIMITED GROUP HEALTH INSURANCE CONTRACT IS ISSUED**
23 **TO PROVIDE HEALTH COVERAGE ONLY FOR:**

24 **(1) SPECIAL ELIGIBLE EMPLOYEES; OR**

25 **(2) SPECIAL ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS.**

26 **(C) AN INSURER OR NONPROFIT HEALTH SERVICE PLAN THAT SELLS A**
27 **LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT, AS A CONDITION OF**
28 **SALE, MAY REQUIRE THE EMPLOYER TO:**

1 **(1) COLLECT PAYMENT FOR PREMIUMS DUE UNDER THE LIMITED**
 2 **BENEFIT GROUP HEALTH INSURANCE CONTRACT THROUGH PAYROLL**
 3 **DEDUCTION;**

4 **(2) CONTRIBUTE TO THE PREMIUM PAYMENTS APPLICABLE TO**
 5 **THE COVERAGE OF A SPECIAL ELIGIBLE EMPLOYEE; AND**

6 **(3) OFFER COVERAGE TO ANY DEPENDENT OF A SPECIAL**
 7 **ELIGIBLE EMPLOYEE.**

8 **(D) A LIMITED BENEFIT GROUP HEALTH INSURANCE CONTRACT SHALL**
 9 **COMPLY WITH:**

10 **(1) ~~TITLE 15 OF THIS ARTICLE, EXCEPT SUBTITLES 7 AND 8; AND~~**

11 **(1) THIS TITLE, EXCEPT SUBTITLES 7 AND 8 OF THIS TITLE; AND**

12 **(2) NOTWITHSTANDING ITEM (1) OF THIS SUBSECTION, §§ 15-802,**
 13 **15-812, 15-815, 15-830, 15-831, 15-832, AND 15-833 OF THIS ~~ARTICLE~~ TITLE.**

14 **(E) AN INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL**
 15 **DISCLOSE IN THE GROUP CERTIFICATE AND IN ENROLLMENT MATERIAL**
 16 **PROVIDED TO EACH SPECIAL ELIGIBLE EMPLOYEE THAT THE LIMITED BENEFIT**
 17 **GROUP HEALTH INSURANCE CONTRACT DOES NOT PROVIDE COMPREHENSIVE**
 18 **HEALTH COVERAGE.**

19 ~~15-1202.~~

20 ~~(a) This subtitle applies only to a health benefit plan that:~~

21 ~~(1) covers eligible employees of small employers in the State; and~~

22 ~~(2) is issued or renewed on or after July 1, 1994, if:~~

23 ~~(i) any part of the premium or benefits is paid by or on behalf of~~
 24 ~~the small employer;~~

25 ~~(ii) any eligible employee or dependent is reimbursed, through~~
 26 ~~wage adjustments or otherwise, by or on behalf of the small employer for any part of~~
 27 ~~the premium;~~

1 ~~(iii) the health benefit plan is treated by the employer or any~~
2 ~~eligible employee or dependent as part of a plan or program under the United States~~
3 ~~Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or~~

4 ~~(iv) the small employer allows eligible employees to pay for the~~
5 ~~health benefit plan through payroll deductions.~~

6 ~~(b) A carrier is subject to the requirements of § 15-1403 of this title in~~
7 ~~connection with health benefit plans issued under this subtitle.~~

8 ~~(c) (1) THIS SUBTITLE DOES NOT APPLY TO A SMALL EMPLOYER~~
9 ~~WHOSE ONLY ROLE IN ADMINISTERING A HEALTH BENEFIT PLAN IS~~
10 ~~COLLECTING, THROUGH PAYROLL DEDUCTION, THE PREMIUMS OF AN~~
11 ~~INDIVIDUAL HEALTH BENEFIT PLAN OF AN EMPLOYEE, IF THE SMALL~~
12 ~~EMPLOYER HAS NOT OFFERED OR PROVIDED A HEALTH BENEFIT PLAN UNDER~~
13 ~~THIS SUBTITLE TO ITS EMPLOYEES DURING THE 6 MONTH PERIOD PRECEDING~~
14 ~~THE DATE OF THE PAYROLL DEDUCTION.~~

15 ~~(2) A SMALL EMPLOYER WHO COLLECTS PREMIUMS THROUGH~~
16 ~~PAYROLL DEDUCTION AS PROVIDED IN THIS SUBSECTION SHALL PROVIDE A~~
17 ~~CERTIFICATION TO A CARRIER PROVIDING AN INDIVIDUAL HEALTH BENEFIT~~
18 ~~PLAN TO AN EMPLOYEE OF THE SMALL EMPLOYER THAT THE SMALL EMPLOYER~~
19 ~~AND THE EMPLOYEE MEET THE REQUIREMENTS OF THIS SUBSECTION.~~

20 ~~15-1204.~~

21 ~~(a) In addition to any other requirement under this article, a carrier shall:~~

22 ~~(1) have demonstrated the capacity to administer the health benefit~~
23 ~~plan, including adequate numbers and types of administrative personnel;~~

24 ~~(2) have a satisfactory grievance procedure and ability to respond to~~
25 ~~enrollees' calls, questions, and complaints;~~

26 ~~(3) provide, in the case of individuals covered under more than one~~
27 ~~health benefit plan, for coordination of coverage under all of those health benefit plans~~
28 ~~in an equitable manner; and~~

29 ~~(4) design policies to help ensure adequate access to providers of~~
30 ~~health care.~~

1 ~~(b) A person may not offer a health benefit plan in the State unless the~~
2 ~~person offers at least the Standard Plan.~~

3 ~~(c) Except for the Limited Benefit Plan, a carrier may not offer a health~~
4 ~~benefit plan that has fewer benefits than those in the Standard Plan.~~

5 ~~(d) A carrier may offer benefits in addition to those in the Standard Plan if:~~

6 ~~(1) the additional benefits:~~

7 ~~(i) are offered and priced separately from benefits specified in~~
8 ~~accordance with § 15-1207 of this subtitle; and~~

9 ~~(ii) do not have the effect of duplicating any of those benefits;~~
10 ~~and~~

11 ~~(2) the carrier:~~

12 ~~(i) clearly distinguishes the Standard Plan from other offerings~~
13 ~~of the carrier;~~

14 ~~(ii) indicates the Standard Plan is the only plan required by~~
15 ~~State law; and~~

16 ~~(iii) specifies that all enhancements to the Standard Plan are not~~
17 ~~required by State law.~~

18 ~~(e) Notwithstanding subsection (b) of this section, a health maintenance~~
19 ~~organization may provide a point of service delivery system as an additional benefit~~
20 ~~through another carrier regardless of whether the other carrier also offers the~~
21 ~~Standard Plan.~~

22 ~~(f) A carrier may offer coverage for dental care and services as an additional~~
23 ~~benefit.~~

24 ~~(g) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SUBTITLE, A~~
25 ~~CARRIER MAY OFFER A HEALTH BENEFIT PLAN PREFERRED PROVIDER OPTION~~
26 ~~WITH IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES OR OUT-OF-POCKET~~
27 ~~MAXIMUMS THAT DIFFER FROM THE STANDARD PLAN IF:~~

28 ~~(1) THE ARITHMETIC TOTAL OF THE IN-NETWORK PLUS~~
29 ~~OUT-OF-NETWORK DEDUCTIBLE OR OUT-OF-POCKET MAXIMUMS IS GREATER~~

1 ~~THAN THE COMBINED IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLE OR~~
 2 ~~OUT-OF-POCKET MAXIMUMS OF THE STANDARD PLAN; AND~~

3 ~~(2) THE VALUE OF THE HEALTH BENEFIT PLAN EXCEEDS THE~~
 4 ~~VALUE OF THE STANDARD PLAN.~~

5 15-1205.

6 (a) (1) In establishing a community rate for a health benefit plan, a
 7 carrier shall use a rating methodology that is based on the experience of all risks
 8 covered by that health benefit plan without regard to health status or occupation or
 9 any other factor not specifically authorized under this subsection.

10 (2) A carrier may adjust the community rate only for:

11 (i) age; and

12 (ii) geography based on the following contiguous areas of the
 13 State:

14 1. the Baltimore metropolitan area;

15 2. the District of Columbia metropolitan area;

16 3. Western Maryland; and

17 4. Eastern and Southern Maryland.

18 (3) Rates for a health benefit plan may vary based on family
 19 composition as approved by the Commissioner.

20 (b) A carrier shall apply all risk adjustment factors under subsection (a) of
 21 this section consistently with respect to all health benefit plans that are issued,
 22 delivered, or renewed in the State.

23 (c) Based on the adjustments allowed under subsection (a)(2) of this section,
 24 a carrier may charge a rate that is 40% above or below the community rate.

25 (d) (1) A carrier shall base its rating methods and practices on commonly
 26 accepted actuarial assumptions and sound actuarial principles.

1 ~~(C) "ELIGIBLE EMPLOYEE" MEANS ANY EMPLOYEE, INCLUDING BUT~~
2 ~~NOT LIMITED TO PART-TIME, TEMPORARY, AND SEASONAL EMPLOYEES, WHO~~
3 ~~DOES NOT QUALIFY FOR GROUP HEALTH INSURANCE.~~

4 ~~(D) "GROUP HEALTH INSURANCE" HAS THE MEANING SPECIFIED IN §~~
5 ~~15-301 OF THIS ARTICLE.~~

6 ~~15-1702.~~

7 ~~IN ADOPTING THIS SUBTITLE, THE GENERAL ASSEMBLY INTENDS TO:~~

8 ~~(1) ENCOURAGE CARRIERS TO DEVELOP AFFORDABLE HEALTH~~
9 ~~INSURANCE PRODUCTS FOR EMPLOYEES WHO DO NOT QUALIFY FOR GROUP~~
10 ~~HEALTH INSURANCE; AND~~

11 ~~(2) GIVE EMPLOYEES WHO DO NOT QUALIFY FOR GROUP HEALTH~~
12 ~~INSURANCE ADDITIONAL OPTIONS FOR HEALTH INSURANCE.~~

13 ~~15-1703.~~

14 ~~(A) A CARRIER MAY OFFER A POLICY TO ELIGIBLE EMPLOYEES THAT~~
15 ~~INCLUDES, AT A MINIMUM, PHYSICIAN, HOSPITALIZATION, LABORATORY,~~
16 ~~X-RAY, AND PRESCRIPTION DRUG COVERAGE.~~

17 ~~(B) THE POLICY THAT A CARRIER OFFERS TO AN EMPLOYEE MAY~~
18 ~~EXCLUDE:~~

19 ~~(1) A HEALTH CARE SERVICE, BENEFIT, COVERAGE, OR~~
20 ~~REIMBURSEMENT FOR COVERED HEALTH CARE SERVICES THAT IS REQUIRED~~
21 ~~UNDER THIS ARTICLE OR THE HEALTH GENERAL ARTICLE TO BE PROVIDED~~
22 ~~OR OFFERED IN A POLICY THAT IS ISSUED OR DELIVERED IN THE STATE BY A~~
23 ~~CARRIER; OR~~

24 ~~(2) REIMBURSEMENT REQUIRED BY STATUTE FOR A SERVICE,~~
25 ~~WHEN THAT SERVICE IS PERFORMED BY A HEALTH CARE PROVIDER THAT IS~~
26 ~~LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE AND WHOSE SCOPE OF~~
27 ~~PRACTICE INCLUDES THAT SERVICE, IN A POLICY THAT IS ISSUED OR~~
28 ~~DELIVERED IN THE STATE BY A CARRIER.~~

1 ~~(C) A CARRIER SHALL DISCLOSE IN ITS POLICY DOCUMENTS TO THE~~
 2 ~~ELIGIBLE EMPLOYEE THAT THE POLICY DOES NOT PROVIDE COMPREHENSIVE~~
 3 ~~HEALTH COVERAGE.~~

4 SECTION 2. AND BE IT FURTHER ENACTED, That the Maryland Health
 5 Care Commission shall:

6 (1) conduct a study of the comprehensive standard health benefit plan
 7 for the small group health insurance market; and

8 (2) on or before December 1, 2007, report to the Senate Finance
 9 Committee and the House Health and Government Operations Committee, in
 10 accordance with § 2-1246 of the State Government Article, on options available,
 11 including modifying the comprehensive standard health benefit plan to specify a
 12 separate in-network deductible, out-of-network deductible, in-network out-of-pocket
 13 maximum, and out-of-network out-of-pocket maximum, to reform the comprehensive
 14 standard health benefit plan in a manner that will encourage more employers to enter
 15 the small group market.

16 SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take
 17 effect October 1, 2007.

Approved:

Governor.

President of the Senate.

Speaker of the House of Delegates.