SENATE BILL 427

C3 7lr1831
CF 7lr2285

By: **Senators Middleton and Astle**
Introduced and read first time: February 2, 2007
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Health Insurance – Authorization of Additional Products and Small Group Administrative Discounts

FOR the purpose of making certain provisions of this Act applicable to health maintenance organizations; providing that certain insurance policies may provide for payment of services rendered by certain providers; requiring an insurer to establish payment in a certain manner under certain circumstances; requiring a certain policy to allow direct access to specialists; requiring certain insurers to offer an option to include preferred and nonpreferred providers as an additional benefit under certain circumstances; requiring certain insurers to provide certain disclosures under certain circumstances; authorizing certain entities to require a certain individual to pay a certain premium under certain circumstances; providing that certain provisions of law do not apply to a small employer under certain circumstances; requiring a small employer to provide a certain certification under certain circumstances; authorizing a health insurance carrier to offer a certain plan under certain circumstances; authorizing a carrier to offer a certain administrative discount to a small employer under certain circumstances; providing for the intent of the General Assembly; authorizing a carrier to offer a certain policy to certain employees; specifying what a certain policy may exclude; requiring a carrier to make a certain disclosure under certain circumstances; defining certain terms; and generally relating to the authorization of additional health insurance products and discounts.

BY adding to
Article – Health – General

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.
[Brackets**]** indicate matter deleted from existing law.

Section 19–706(jjj)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 14–201 through 14–204
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–205, 15–1202, 15–1204, and 15–1205
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY adding to
Article – Insurance
Section 14–205.1; and 15–1701 through 15–1703 to be under the new subtitle "Subtitle 17. Health Insurance Coverage for Part–Time, Seasonal, and Temporary Employees"
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

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

Article – Health – General

19–706.

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

Article – Insurance

14–201.

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

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

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

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

(e) "Preferred provider" means a provider that has entered into a provider service contract.

(f) "Preferred provider insurance policy" means:

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

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

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

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

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

14–202.

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

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

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

14–203.

The Commissioner may adopt regulations to enforce this subtitle.

14–204.

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

(1) offer or administer a health benefit program under which the insurer offers preferred provider insurance policies that limit, through the use of provider service contracts, the numbers and types of providers of health care services eligible for payment as preferred providers; and

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

14–205.

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

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

(1) PREFERRED PROVIDERS AND NONPREFERRED PROVIDERS; OR

(2) PREFERRED PROVIDERS.

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

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

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

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

(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) (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 WITH WHICH THE EMPLOYER, ASSOCIATION, OR OTHER PRIVATE GROUP ARRANGEMENT IS CONTRACTING FOR THE COVERAGE SHALL OFFER AN OPTION TO INCLUDE PREFERRED AND NONPREFERRED PROVIDERS AS AN ADDITIONAL BENEFIT FOR AN EMPLOYEE OR INDIVIDUAL, AT THE EMPLOYEE'S OR INDIVIDUAL'S OPTION, TO ACCEPT OR REJECT.

(2) THE INSURER SHALL PROVIDE TO EACH EMPLOYER, ASSOCIATION, OR OTHER PRIVATE GROUP ARRANGEMENT A DISCLOSURE STATEMENT ON THE GROUP APPLICATION THAT AN OPTION TO INCLUDE

PREFERRED AND NONPREFERRED PROVIDERS IS AVAILABLE FOR THE INDIVIDUAL OR EMPLOYEE TO ACCEPT OR REJECT.

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

15–1202.

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

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

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

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

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

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

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

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

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

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

15–1204.

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

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

(2) have a satisfactory grievance procedure and ability to respond to enrollees' 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 person may not offer a health benefit plan in the State unless the person offers at least the Standard Plan.

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

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

(1) the additional benefits:

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

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

(2) the carrier:

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

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

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

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

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

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

(1) THE ARITHMETIC TOTAL OF THE IN–NETWORK PLUS OUT–OF–NETWORK DEDUCTIBLE OR OUT–OF–POCKET MAXIMUMS IS GREATER THAN THE COMBINED IN–NETWORK AND OUT–OF–NETWORK DEDUCTIBLE OR OUT–OF–POCKET MAXIMUMS OF THE STANDARD PLAN; AND

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

15–1205.

(a) (1) In establishing a community rate for a 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 community 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 health benefit plans that are issued, delivered, or renewed in the State.

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

(d) (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.

(E) (1) A CARRIER MAY OFFER AN ADMINISTRATIVE DISCOUNT TO A SMALL EMPLOYER IF THE SMALL EMPLOYER ELECTS TO PURCHASE ADDITIONAL EMPLOYEE BENEFITS THROUGH THE CARRIER.

(2) THE ADMINISTRATIVE DISCOUNT SHALL BE OFFERED UNDER THE SAME TERMS AND CONDITIONS FOR ALL QUALIFYING SMALL EMPLOYERS.

SUBTITLE 17. HEALTH INSURANCE COVERAGE FOR PART–TIME, SEASONAL, AND TEMPORARY EMPLOYEES.

15–1701.

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

(B) "CARRIER" MEANS:

(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; OR

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

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

(D) "GROUP HEALTH INSURANCE" HAS THE MEANING SPECIFIED IN § 15–301 OF THIS ARTICLE.

15–1702.

IN ADOPTING THIS SUBTITLE, THE GENERAL ASSEMBLY INTENDS TO:

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

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

15–1703.

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

(B) THE POLICY THAT A CARRIER OFFERS TO AN EMPLOYEE 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 POLICY THAT IS ISSUED OR DELIVERED IN THE STATE BY A CARRIER; OR

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

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

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