SENATE BILL 893

C3 7lr3183

By: **Senator Astle**
Introduced and read first time: February 21, 2007
Assigned to: Rules

A BILL ENTITLED

AN ACT concerning

Maryland Health Insurance Plan – Plan Independence, Board Composition, and Regulation

FOR the purpose of removing the Maryland Health Insurance Plan from the Maryland Insurance Administration; providing that the Plan is an independent unit of the State government; altering the composition of the Board of Directors of the Plan; authorizing the Executive Director of the Plan to employ certain staff; repealing a certain exemption of the Board from certain State personnel laws; requiring the Board to develop a certain master plan document; requiring the Board to file the master plan document with the Maryland Insurance Commissioner and provide the document to a member, at no charge, on request of the member; requiring the Board to develop a certain certificate of coverage; requiring the Board to update the certificate of coverage under certain circumstances; requiring the Board to provide the most recent version of the certificate of coverage to certain persons under certain circumstances; requiring the Board to make the most recent version of the certificate of coverage available on the Plan's website; requiring the Board to provide notice of a change to the certificate of coverage to certain persons; specifying the circumstances under which the Board may make changes to a certain benefit package; providing for the effective date of a change to a certain benefit package; requiring the Board to submit a certain report to certain committees of the General Assembly on or before a certain date each year; providing that if there is a conflict between a provision of the master plan document and a provision of the certificate of coverage a certain provision will control; requiring the Plan to comply with the terms of certain written representations or authorizations under certain circumstances; requiring the contract between the

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

Board and the Plan Administrator to require the Administrator to comply with certain provisions of law; providing that the Plan is not subject to certain laws; requiring the Commissioner to regulate the Plan; requiring the Plan and the Board of Directors of the Plan to comply with certain provisions of law; providing that certain provisions of this Act do not limit the authority of the Commissioner to impose certain penalties or take certain action under certain circumstances; authorizing the Commissioner to require the Plan to make certain restitution to certain individuals under certain circumstances; prohibiting the Commissioner from imposing a fine or administrative penalty on the Plan; requiring an entity contracted with the Plan and certain health care providers to comply with certain provisions of law under certain circumstances; requiring the Commissioner to provide a copy of an adopted examination report or the results of certain reviews to the Board and to make recommendations for any corrective action to be taken by the Board; requiring the Board to determine the steps necessary to implement corrective action; requiring certain moneys to be deposited into the Maryland Health Insurance Plan Fund; requiring the Maryland Insurance Administration to provide fiscal and personnel services to the Plan at no charge during a certain fiscal year; making a certain stylistic change; providing for the application of this Act; and generally relating to the Maryland Health Insurance Plan.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–502, 14–503, 14–505, and 14–506(b)
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY adding to
Article – Insurance
Section 14–509
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 – Insurance

14–502.

(a) There is a Maryland Health Insurance Plan.

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

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

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

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

(2) THE PLAN SHALL ENSURE THAT ANY ENTITY CONTRACTED WITH THE PLAN COMPLIES WITH THE PROVISIONS OF THIS SUBTITLE WHEN PERFORMING SERVICES THAT ARE SUBJECT TO THIS SUBTITLE ON BEHALF OF THE PLAN.

14–503.

(a) There is a Board for the Plan.

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

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

(1) **[**one shall be the Commissioner;

(2)**]** one shall be the Executive Director of the Maryland Health Care Commission**, OR THE EXECUTIVE DIRECTOR'S DESIGNEE**;

[(3)**] (2)** one shall be the Executive Director of the Health Services Cost Review Commission**, OR THE EXECUTIVE DIRECTOR'S DESIGNEE**;

[(4)**] (3)** one shall be the Secretary of **[**the Department of**]** Budget and Management**, OR THE SECRETARY'S DESIGNEE**;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(G) (1) THE EXECUTIVE DIRECTOR MAY EMPLOY A STAFF FOR THE PLAN IN ACCORDANCE WITH THE STATE BUDGET.

(2) STAFF FOR THE PLAN ARE IN THE EXECUTIVE SERVICE, MANAGEMENT SERVICE, OR ARE SPECIAL APPOINTMENTS IN THE STATE PERSONNEL MANAGEMENT SYSTEM.

(3) THE EXECUTIVE DIRECTOR, IN CONSULTATION WITH THE DEPARTMENT OF BUDGET AND MANAGEMENT, MAY DETERMINE THE APPROPRIATE JOB CLASSIFICATIONS AND GRADES FOR ALL STAFF.

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

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

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

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

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

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

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

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

(2) Regulations adopted by the Board may include:

(i) residency requirements for Plan enrollees;

(ii) Plan enrollment procedures; and

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

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

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

14–505.

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

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

(i) 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

(ii) 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.

(B) (1) THE BOARD SHALL DEVELOP A MASTER PLAN DOCUMENT THAT SETS FORTH IN DETAIL ALL OF THE TERMS AND CONDITIONS OF THE STANDARD BENEFIT PACKAGE, INCLUDING:

(I) THE BENEFITS PROVIDED IN THE PACKAGE;

(II) ANY EXCLUSIONS FROM COVERAGE;

(III) ANY CONDITIONS REQUIRING PREAUTHORIZATION OR UTILIZATION REVIEW AS A CONDITION TO OBTAINING A BENEFIT OR SERVICE;

(IV) ANY CONDITIONS OR LIMITATIONS ON THE SELECTION OF A PRIMARY CARE PROVIDER OR PROVIDER OF SPECIALTY MEDICAL CARE;

(V) ANY COST–SHARING REQUIREMENTS, INCLUDING ANY PREMIUMS, DEDUCTIBLES, COINSURANCE, AND COPAYMENT AMOUNTS FOR WHICH A MEMBER MAY BE RESPONSIBLE; AND

(VI) THE PROCEDURES TO BE FOLLOWED IN PRESENTING A CLAIM.

(2) THE BOARD SHALL:

(I) FILE THE MASTER PLAN DOCUMENT WITH THE COMMISSIONER; AND

(II) PROVIDE A COPY OF THE MOST RECENT VERSION OF THE MASTER PLAN DOCUMENT TO A MEMBER, AT NO CHARGE, ON REQUEST OF THE MEMBER.

(C) (1) THE BOARD SHALL DEVELOP A CERTIFICATE OF COVERAGE THAT DESCRIBES THE ESSENTIAL FEATURES OF THE PLAN AND THE STANDARD BENEFIT PACKAGE.

(2) THE CERTIFICATE OF COVERAGE SHALL:

(I) BE WRITTEN IN CLEAR AND EASY TO UNDERSTAND LANGUAGE; AND

(II) BE SUFFICIENTLY ACCURATE AND COMPREHENSIVE TO REASONABLY INFORM MEMBERS OF THEIR RIGHTS AND OBLIGATIONS UNDER THE STANDARD BENEFIT PACKAGE.

(3) THE BOARD SHALL UPDATE THE CERTIFICATE OF COVERAGE AS NECESSARY TO REFLECT CHANGES TO THE STANDARD BENEFIT PACKAGE.

(4) THE BOARD SHALL:

(I) WITHIN 30 DAYS AFTER A MEMBER'S ENROLLMENT IN THE PLAN, PROVIDE THE MOST RECENT VERSION OF THE CERTIFICATE OF COVERAGE TO:

1. THE MEMBER; OR

2. IF DEPENDENTS ARE INCLUDED IN THE COVERAGE, THE FAMILY UNIT;

(II) MAKE THE MOST RECENT VERSION OF THE CERTIFICATE OF COVERAGE AVAILABLE ON THE PLAN'S WEBSITE; AND

(III) PROVIDE NOTICE OF ANY CHANGE TO THE STANDARD BENEFIT PACKAGE TO:

1. EACH MEMBER OF THE PLAN TO WHOM A CERTIFICATE OF COVERAGE PREVIOUSLY HAS BEEN PROVIDED; OR

2. IF DEPENDENTS ARE INCLUDED IN THE COVERAGE, EACH FAMILY UNIT TO WHICH A CERTIFICATE OF COVERAGE PREVIOUSLY HAS BEEN PROVIDED.

(D) THE BOARD MAY MAKE A CHANGE TO THE STANDARD BENEFIT PACKAGE ONLY IF:

(1) THE PROPOSED CHANGE IS SUBMITTED IN WRITING TO THE BOARD AT LEAST 15 DAYS BEFORE THE MEETING AT WHICH A VOTE ON THE PROPOSED CHANGE WILL BE TAKEN;

(2) CONSIDERATION OF THE PROPOSED CHANGE IS LISTED AS AN ACTION ITEM ON THE AGENDA FOR THE MEETING;

(3) THE PROPOSED CHANGE IS SET FORTH IN A WRITTEN MOTION THAT:

(I) IDENTIFIES THE SPECIFIC CHANGE TO BE MADE; AND

(II) IS INCLUDED IN THE MINUTES OF THE MEETING OF THE BOARD AT WHICH THE MOTION IS MADE;

(4) THE DELIBERATIONS AND VOTE ON THE PROPOSED CHANGE OCCUR DURING A PUBLIC SESSION OF A MEETING OF THE BOARD;

(5) THE PROPOSED CHANGE RECEIVES AT LEAST FIVE AFFIRMATIVE VOTES; AND

(6) THE VOTE APPROVING THE PROPOSED CHANGE IS REFLECTED IN THE MINUTES OF THE MEETING OF THE BOARD AT WHICH THE VOTE IS TAKEN.

(E) A CHANGE TO THE STANDARD BENEFIT PACKAGE IS NOT EFFECTIVE UNTIL THE LATER OF:

(1) 30 DAYS AFTER THE DATE THE BOARD ADOPTS THE CHANGE;

(2) THE DATE AN UPDATED MASTER PLAN DOCUMENT REFLECTING THE CHANGE IS FILED WITH THE COMMISSIONER; OR

(3) 15 DAYS AFTER NOTICE OF THE CHANGE AND THE EFFECTIVE DATE OF THE CHANGE IS:

(I) SENT TO:

1. EACH MEMBER OF THE PLAN; OR

2. IF DEPENDENTS ARE INCLUDED IN THE COVERAGE, THE FAMILY UNIT; AND

(II) POSTED ON THE PLAN'S WEBSITE.

(F) ON OR BEFORE SEPTEMBER 1 OF EACH YEAR, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE BOARD SHALL REPORT TO THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE AND THE SENATE FINANCE COMMITTEE ON:

(1) THE CURRENT STANDARD BENEFIT PACKAGE OFFERED BY THE PLAN; AND

(2) ANY CHANGES TO THE STANDARD BENEFIT PACKAGE IMPLEMENTED DURING THE PREVIOUS FISCAL YEAR.

(G) (1) IF THERE IS A CONFLICT BETWEEN A PROVISION OF THE MASTER PLAN DOCUMENT AND A PROVISION OF THE CERTIFICATE OF COVERAGE, THE PROVISION THAT IS MOST BENEFICIAL TO THE MEMBER WILL CONTROL.

(2) NOTWITHSTANDING THE TERMS AND CONDITIONS OF THE STANDARD BENEFIT PACKAGE, THE MASTER PLAN DOCUMENT, OR THE CERTIFICATE OF COVERAGE, THE PLAN SHALL COMPLY WITH THE TERMS OF ANY WRITTEN REPRESENTATION OR AUTHORIZATION OF COVERAGE MADE BY OR ON BEHALF OF THE PLAN TO THE EXTENT THAT A MEMBER HAS INCURRED COSTS FOR HEALTH CARE SERVICES IN REASONABLE RELIANCE ON THE WRITTEN REPRESENTATION OR AUTHORIZATION.

[(b)**] (H)** (1) The Board shall establish a premium rate for Plan coverage subject to review and approval by the Commissioner.

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

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

(4) The Board may charge different premiums based on the benefit package delivery system when more than one benefit package delivery system is offered.

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

(2) The premium rate for Plan coverage:

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

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

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

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

[(d)**]** **(J)** Losses incurred by the Plan shall be subsidized by the Fund.

14–506.

(b) **(1)** The Administrator shall serve for a period of time specified in its contract with the Plan subject to removal for cause and any other terms, conditions, and limitations contained in the contract.

(2) THE CONTRACT BETWEEN THE BOARD AND THE ADMINISTRATOR SHALL REQUIRE THE ADMINISTRATOR TO COMPLY WITH THE PROVISIONS OF THIS SUBTITLE TO WHICH THE PLAN IS SUBJECT.

14–509.

(A) THE COMMISSIONER SHALL REGULATE THE PLAN.

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

(C) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, THE PLAN SHALL BE SUBJECT TO:

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

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

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

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

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

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

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

(D) (1) THE PLAN IS NOT SUBJECT TO § 15–10B–12 OF THIS ARTICLE.

(2) THIS SUBSECTION DOES NOT LIMIT THE AUTHORITY OF THE COMMISSIONER TO IMPOSE THE PENALTY AUTHORIZED UNDER § 15–10B–12 OF THIS ARTICLE ON A PRIVATE REVIEW AGENT CONDUCTING UTILIZATION REVIEW ON BEHALF OF THE PLAN.

(E) (1) THE COMMISSIONER MAY NOT IMPOSE A FINE OR ADMINISTRATIVE PENALTY ON THE PLAN.

(2) IF THE COMMISSIONER FINDS THAT THE PLAN HAS VIOLATED A PROVISION OF THIS SUBTITLE, THE COMMISSIONER MAY REQUIRE THE PLAN TO MAKE RESTITUTION TO EACH CLAIMANT WHO HAS SUFFERED ACTUAL ECONOMIC DAMAGES BECAUSE OF THE VIOLATION.

(3) SUBJECT TO THE TERMS OF THE MASTER PLAN DOCUMENT, THE RESTITUTION AUTHORIZED UNDER PARAGRAPH (2) OF THIS SUBSECTION MAY NOT EXCEED THE AMOUNT OF ACTUAL ECONOMIC DAMAGES SUSTAINED BY THE CLAIMANT.

(4) THIS SUBSECTION DOES NOT LIMIT THE AUTHORITY OF THE COMMISSIONER TO TAKE ACTION AGAINST ANY PERSON WITH RESPECT TO ANY PROVISION OF THIS ARTICLE, OTHER THAN THIS SUBTITLE, THAT IS APPLICABLE TO THAT PERSON.

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

(I) A HEALTH MAINTENANCE ORGANIZATION; OR

(II) A DELIVERY SYSTEM UNDER WHICH:

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

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

(2) THE PLAN SHALL COMPLY WITH THE PROVISIONS OF §§ 19–710(I) AND 19–710.1 OF THE HEALTH – GENERAL ARTICLE, EXCEPT FOR § 19–710.1(E) OF THE HEALTH – GENERAL ARTICLE.

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

(G) (1) THE COMMISSIONER SHALL:

(I) PROVIDE A COPY OF AN ADOPTED EXAMINATION REPORT OR THE RESULTS OF ANY REVIEW CONDUCTED UNDER THIS SUBTITLE TO THE BOARD; AND

(II) MAKE RECOMMENDATIONS FOR CORRECTIVE ACTION TO BE TAKEN BY THE BOARD.

(2) (I) BASED ON ANY RECOMMENDATIONS OF THE COMMISSIONER PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE BOARD SHALL DETERMINE THE STEPS NECESSARY TO IMPLEMENT CORRECTIVE ACTION TO COMPLY WITH THE PROVISIONS OF THIS SUBTITLE, INCLUDING WHETHER TO EXERCISE ANY REMEDIES AVAILABLE TO THE BOARD UNDER THE CONTRACT BETWEEN THE BOARD AND THE PLAN ADMINISTRATOR.

(II) IF THE BOARD EXERCISES ITS RIGHT TO IMPOSE FISCAL SANCTIONS OR LIQUIDATED DAMAGES UNDER THE TERMS OF A CONTRACT BETWEEN THE BOARD AND THE PLAN ADMINISTRATOR, THE MONEYS SHALL BE DEPOSITED IN THE FUND.

(3) THIS SUBSECTION DOES NOT LIMIT THE AUTHORITY OF THE COMMISSIONER TO:

(I) IMPOSE THE PENALTY UNDER § 15–10B–12 OF THIS ARTICLE ON A PRIVATE REVIEW AGENT CONDUCTING UTILIZATION REVIEW ON BEHALF OF THE PLAN; OR

(II) IMPOSE THE PENALTIES UNDER TITLE 8, SUBTITLE 3 OF THIS ARTICLE ON A THIRD PARTY ADMINISTRATOR OPERATING ON BEHALF OF THE PLAN.

SECTION 2. AND BE IT FURTHER ENACTED, That during fiscal year 2008, the Maryland Insurance Administration shall provide fiscal and personnel services to the Maryland Health Insurance Plan at no charge.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall apply to any contract that becomes effective, is entered into, or is modified on or after the effective date of this Act.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2007.