HOUSE BILL 132

C3, J1, Q3 7lr0181
CF 7lr0180

By: **The Speaker (By Request – Administration) and Delegates Busch, Haynes, Howard, Hubbard, Hucker, Kaiser, Kullen, McIntosh, Morhaim, Rosenberg, and F. Turner**

Introduced and read first time: January 24, 2007
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Maryland Health Care Access Act of 2007

FOR the purpose of altering certain eligibility requirements for participation in the Maryland Children's Health Program; requiring the Department of Health and Mental Hygiene to establish a certain annual family contribution; requiring the Department to adopt certain regulations; establishing the Maryland Institute for Health Care Quality as an independent, nonprofit organization; establishing the purpose, duties, and membership of the Institute; requiring the State Health Services Cost Review Commission to adopt certain regulations and make a certain report on or before a certain date; requiring the Commission to establish certain standards and benchmarks in conjunction with certain entities; establishing the Maryland Health Insurance Exchange as a body corporate and independent of all State units; providing for the governance, purpose, and duties of the Exchange; establishing the Board of Directors of the Exchange; establishing the composition, terms of members, duties, and authority of the Board; establishing eligibility requirements for participation in health benefit plans offered by the Exchange; requiring each employer in the State with a certain number of employees to adopt and maintain a certain cafeteria plan; providing certain penalties for a violation of certain provisions of this Act; requiring each group or individual health benefit plan issued or delivered in the State by certain carriers to permit a child to continue coverage under the plan under certain circumstances and for a certain period of time; authorizing certain carriers in the small group insurance market to offer a discounted rate for participation in certain wellness activities; providing that

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

the Maryland Health Insurance Plan is within the Exchange; altering the purpose of the Plan; repealing certain provisions of law that establish and govern the Board of Directors for the Plan; repealing certain provisions of law that authorize the Board of Directors for the Plan to aggregate the purchasing of prescription drugs for certain enrollees; repealing certain reporting requirements; requiring the Board of Directors of the Exchange to make certain annual reports to the Governor and the General Assembly; requiring the Secretary of Health and Mental Hygiene to develop a certain plan to improve the quality and cost–effectiveness of care for certain individuals and to make a certain report on the plan; requiring the Department of Budget and Management and the Department of Health and Mental Hygiene to jointly develop a certain wellness incentive pilot program; requiring the Departments to implement the plan on or before a certain date; requiring the Maryland Health Care Commission and the State Health Services Cost Review Commission to collaborate in seeking a proposal to establish a certain regional health information exchange; establishing a Task Force on Expanding Access to Affordable Health Care; providing for the membership, chair, staff, compensation of members, and duties of the Task Force; defining certain terms; altering certain definitions; providing for the application of certain provisions of this Act; providing for a delayed effective date for certain provisions of this Act; providing for the termination of certain provisions of this Act; and generally relating to the Maryland Health Care Access Act of 2007.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 15–301(a) and 19–219(a)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–301(b) and (c), 15–301.1, and 19–219(b)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY adding to
Article – Health – General
Section 19–140 and 19–706(jjj)
Annotated Code of Maryland
(2005 Replacement Volume and 2006 Supplement)

BY adding to
Article – Insurance

Section 15–418, 15–1201(r); and 15–1601 through 15–1614 to be under the new subtitle "Subtitle 16. Maryland Health Insurance Exchange"
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY adding to
Article – Labor and Employment
Section 12–101 through 12–103 to be under the new title "Title 12. Cafeteria Plan"
Annotated Code of Maryland
(1999 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 14–501(a), (g), (i), and (j) and 15–1201(a)
Annotated Code of Maryland
(2006 Replacement Volume and 2006 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–501(c), 14–502, 14–503, and 15–1205
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

15–301.

(a) There is a Maryland Children's Health Program.

(b) The Maryland Children's Health Program shall provide, subject to the limitations of the State budget and any other requirements imposed by the State and as permitted by federal law or waiver, comprehensive medical care and other health care services to an individual who has a family income at or below **[**300 percent**]** **400%** of the federal poverty guidelines and who is under the age of 19 years.

(c) The Maryland Children's Health Program shall be administered:

(1) **[**Except as provided in item (3) of this subsection, for**]** **FOR** individuals whose family income is at or below **[**200 percent**]** **200%** of the federal poverty guidelines, through the program under Subtitle 1 of this title requiring individuals to enroll in managed care organizations; **OR**

(2) For eligible individuals whose family income is above **[**200 percent**]** **200%**, but at or below **[**300 percent**]** **400%** of the federal poverty guidelines, through the MCHP premium plan under § 15–301.1 of this subtitle**[**; or

(3) In fiscal year 2004 only, for eligible individuals whose family income is above 185 percent, but at or below 300 percent of the federal poverty guidelines, through the MCHP premium plan under § 15–301.1 of this subtitle**]**.

15–301.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Eligible individual" means an individual who qualifies to participate in the Maryland Children's Health Program under § 15–301(b) of this subtitle **AND WHOSE FAMILY INCOME IS ABOVE 200% BUT AT OR BELOW 400% OF THE FEDERAL POVERTY GUIDELINES**.

(3) "Family contribution" means the portion of the premium cost paid for an eligible individual to enroll and participate in the Maryland Children's Health Program.

(4) "MCHP premium plan" means the plan established under this section to provide access to health insurance coverage to eligible individuals through managed care organizations under the Maryland Children's Health Program.

[(b) Except as provided in subsection (c) of this section, this section applies only to individuals whose family income is above 200 percent, but at or below 300 percent of the federal poverty guidelines.**]**

[(c)**]** **(B)** (1) As a requirement of enrollment and participation in the MCHP premium plan, the parent or guardian of an eligible individual shall agree to pay **[**the following**]** **AN** annual family contribution**[**:

(i) In fiscal year 2004 only, for an eligible individual whose family income is above 185 percent, but at or below 200 percent of the federal poverty guidelines, an amount equal to 2 percent of the annual income of a family of two at 185 percent of the federal poverty guidelines;

(ii) For an eligible individual whose family income is above 200 percent, but at or below 250 percent of the federal poverty guidelines, an amount equal to 2 percent of the annual income of a family of two at 200 percent of the federal poverty guidelines; and

(iii) For an eligible individual whose family income is above 250 percent, but at or below 300 percent of the federal poverty guidelines, an amount equal to 2 percent of the annual income of a family of two at 250 percent of the federal poverty guidelines.

(2) The family contribution amounts required under paragraph (1) of this subsection apply on a per family basis regardless of the number of eligible individuals each family has enrolled in the MCHP premium plan**]**.

(2) THE DEPARTMENT SHALL ESTABLISH AN ANNUAL FAMILY CONTRIBUTION THAT:

(I) IS REASONABLE, ACCORDING TO THE FAMILY INCOME; AND

(II) ENCOURAGES ENROLLMENT OF ALL ELIGIBLE INDIVIDUALS.

[(d)**] (C) (1)** The Department shall adopt regulations necessary to implement this section.

(2) THE REGULATIONS MAY PROVIDE INCENTIVES FOR ELIGIBLE INDIVIDUALS TO ENROLL IN ANY EMPLOYER SPONSORED INSURANCE THAT MAY BE AVAILABLE TO THEM.

19–140.

(A) THERE IS A MARYLAND INSTITUTE FOR HEALTH CARE QUALITY.

(B) THE PURPOSE OF THE INSTITUTE IS TO PROMOTE HEALTH CARE QUALITY AND ACCELERATE IMPROVEMENT IN THE VALUE OF HEALTH CARE DELIVERED IN THE STATE.

(C) THE INSTITUTE IS AN INDEPENDENT, NONPROFIT ORGANIZATION GOVERNED BY A BOARD OF DIRECTORS.

(D) THE INSTITUTE SHALL:

(1) FACILITATE COLLABORATION ON HEALTH CARE QUALITY IMPROVEMENT BY MEDICAL GROUPS, HOSPITALS, AND HEALTH PLANS THAT OPERATE IN THE STATE;

(2) SURVEY SCIENTIFIC LITERATURE AND DRAFT HEALTH CARE GUIDELINES BASED ON SCIENTIFIC EVIDENCE;

(3) PROVIDE SCIENTIFIC APPRAISALS OF THE SAFETY AND EFFICACY OF EMERGING AND LEADING EDGE MEDICAL TECHNOLOGY;

(4) EVALUATE THE IMPACT OF HEALTH INFORMATION TECHNOLOGY PRODUCTS AND SYSTEMS ON HEALTH CARE QUALITY;

(5) ORGANIZE ACTION GROUPS FOR TOPICS OF SIGNIFICANT INTEREST, SUCH AS CHRONIC DISEASE CARE, PREVENTIVE SERVICES, AND PATIENT SAFETY;

(6) PROVIDE QUALITY IMPROVEMENT EDUCATION AND TRAINING; AND

(7) PARTICIPATE IN COMMUNITY HEALTH CARE QUALITY DISCUSSIONS.

(E) FUNDING FOR THE INSTITUTE SHALL BE DERIVED FROM MEMBER DUES.

(F) MEMBERSHIP IN THE INSTITUTE SHALL BE COMPRISED OF:

(1) HOSPITALS;

(2) OTHER HEALTH CARE FACILITIES;

(3) HEALTH CARE PROVIDER GROUPS;

(4) HEALTH INSURERS, HEALTH MAINTENANCE ORGANIZATIONS, NONPROFIT HEALTH SERVICE PLANS, AND MANAGED CARE ORGANIZATIONS; AND

(5) INDIVIDUALS.

19–219.

(a) The Commission may review costs and rates and make any investigation that the Commission considers necessary to assure each purchaser of health care facility services that:

(1) The total costs of all hospital services offered by or through a facility are reasonable;

(2) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility; and

(3) The rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

(b) (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate that a facility sets or requests.

(2) A facility shall charge for services only at a rate set in accordance with this subtitle.

(3) In determining the reasonableness of rates, the Commission may take into account objective standards of efficiency and effectiveness.

(4) (I) ON OR BEFORE JULY 1, 2008, THE COMMISSION SHALL:

1. ADOPT REGULATIONS THAT PROVIDE INCENTIVES WITHIN HOSPITAL PAYMENT STANDARDS FOR ADHERENCE TO QUALITY STANDARDS AND ACHIEVEMENT OF PERFORMANCE BENCHMARKS; AND

2. REPORT TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, A PLAN TO ANALYZE DATA COLLECTED UNDER THE COMMISSION'S QUALITY–BASED

REIMBURSEMENT PROJECT THAT INDICATE WHETHER THERE ARE RACIAL AND ETHNIC DISPARITIES IN ADHERENCE TO QUALITY STANDARDS AND PERFORMANCE BENCHMARKS.

(II) THE COMMISSION SHALL ESTABLISH QUALITY STANDARDS AND PERFORMANCE BENCHMARKS IN CONJUNCTION WITH THE MARYLAND HEALTH CARE COMMISSION, THE OFFICE OF HEALTH CARE QUALITY, AND THE MARYLAND INSTITUTE FOR HEALTH CARE QUALITY.

Article – Insurance

SUBTITLE 16. MARYLAND HEALTH INSURANCE EXCHANGE.

15–1601.

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

(B) "ADMINISTRATOR" HAS THE MEANING STATED IN THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT, 29 U.S.C. § 1002.

(C) "BOARD" MEANS THE BOARD OF DIRECTORS OF THE MARYLAND HEALTH INSURANCE EXCHANGE.

(D) "EXCHANGE" MEANS THE MARYLAND HEALTH INSURANCE EXCHANGE.

(E) "SMALL EMPLOYER" HAS THE MEANING STATED IN § 15–1201 OF THIS TITLE.

15–1602.

(A) THERE IS A MARYLAND HEALTH INSURANCE EXCHANGE.

(B) THE EXCHANGE IS GOVERNED BY A BOARD OF DIRECTORS.

(C) THE PURPOSE OF THE EXCHANGE IS TO FACILITATE THE AVAILABILITY, CHOICE, AND PURCHASE OF PRIVATE HEALTH INSURANCE PLANS TO AND BY INDIVIDUALS AND SMALL EMPLOYERS IN THE STATE.

15–1603.

(A) THE EXCHANGE IS A BODY CORPORATE THAT IS INDEPENDENT OF ALL STATE UNITS.

(B) THE EXCHANGE IS EXEMPT FROM:

(1) TAXATION BY THE STATE AND LOCAL GOVERNMENT;

(2) THE REQUIREMENTS OF § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE; AND

(3) EXCEPT AS PROVIDED IN TITLE 14, SUBTITLE 3 (MINORITY BUSINESS PARTICIPATION), THE REQUIREMENTS OF DIVISION II (GENERAL PROCUREMENT LAW) OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

15–1604.

(A) THERE IS A BOARD OF DIRECTORS FOR THE EXCHANGE, WITH DUTIES AND POWERS ESTABLISHED BY THIS SUBTITLE.

(B) (1) THE BOARD CONSISTS OF 9 MEMBERS APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE.

(2) OF THE 9 MEMBERS:

(I) AT LEAST 2 SHALL REPRESENT SMALL BUSINESS INTERESTS; AND

(II) AT LEAST 2 SHALL REPRESENT CONSUMER INTERESTS.

(3) THE GOVERNOR SHALL CONSIDER RACIAL, GENDER, AND GEOGRAPHIC DIVERSITY IN MAKING APPOINTMENTS TO THE BOARD.

(C) (1) THE TERM OF A MEMBER IS 3 YEARS.

(2) THE TERMS OF MEMBERS ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS OF THE BOARD ON JULY 1, 2007.

(3) AT THE END OF A TERM A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(4) A 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.

(5) THE GOVERNOR MAY REMOVE A MEMBER FOR NEGLECT OF DUTY, INCOMPETENCE, OR MISCONDUCT.

(6) A MEMBER MAY NOT SERVE MORE THAN TWO CONSECUTIVE TERMS.

(D) FROM AMONG ITS MEMBERS, THE BOARD ANNUALLY SHALL ELECT A CHAIR AND A VICE–CHAIR.

(E) THE BOARD SHALL MEET AT LEAST 6 TIMES A YEAR, AT PLACES AND DATES DETERMINED BY THE BOARD.

(F) 5 MEMBERS OF THE BOARD SHALL CONSTITUTE A QUORUM, AND THE AFFIRMATIVE VOTE OF A MAJORITY OF THE QUORUM SHALL BE NECESSARY AND SUFFICIENT FOR ANY ACTION TAKEN BY THE BOARD.

(G) MEETINGS OF THE BOARD ARE SUBJECT TO THE STATE OPEN MEETINGS LAW.

15–1605.

(A) THE BOARD SHALL APPOINT AN EXECUTIVE DIRECTOR TO SUPERVISE THE ADMINISTRATIVE AFFAIRS AND GENERAL MANAGEMENT AND OPERATIONS OF THE EXCHANGE.

(B) THE EXECUTIVE DIRECTOR SHALL RECEIVE A SALARY COMMENSURATE WITH THE DUTIES OF THE POSITION.

(C) THE EXECUTIVE DIRECTOR MAY HIRE OTHER EMPLOYEES AS NECESSARY FOR THE FUNCTIONING OF THE EXCHANGE.

15–1606.

(A) THE BOARD SHALL DEVELOP A PLAN OF OPERATION FOR THE EXCHANGE, INCLUDING:

(1) PROCEDURES FOR THE OPERATION OF THE EXCHANGE;

(2) PROCEDURES FOR SELECTING AND APPROVING HEALTH BENEFIT PLANS TO BE OFFERED THROUGH THE EXCHANGE;

(3) A PLAN FOR PUBLICIZING THE EXISTENCE, ELIGIBILITY REQUIREMENTS, AND ENROLLMENT PROCEDURES OF THE EXCHANGE;

(4) A STANDARD APPLICATION FORM FOR ELIGIBLE INDIVIDUALS AND SMALL EMPLOYERS;

(5) PROCEDURES FOR DETERMINING ELIGIBILITY OF INDIVIDUALS AND SMALL EMPLOYERS FOR ENROLLMENT IN THE EXCHANGE;

(6) PROCEDURES FOR ENROLLING ELIGIBLE INDIVIDUALS AND SMALL EMPLOYERS IN THE EXCHANGE;

(7) A PLAN FOR OPERATING A HEALTH INSURANCE SERVICE CENTER TO PROVIDE ELIGIBLE INDIVIDUALS AND SMALL EMPLOYERS WITH INFORMATION ON THE EXCHANGE; AND

(8) A SYSTEM FOR:

(I) COLLECTING ALL PREMIUM PAYMENTS MADE BY, OR ON BEHALF OF, INDIVIDUALS OBTAINING HEALTH INSURANCE COVERAGE THROUGH THE EXCHANGE; AND

(II) REMITTING PREMIUM PAYMENTS TO INSURANCE CARRIERS.

(B) THE BOARD MAY:

(1) ADOPT BY–LAWS FOR THE REGULATION OF ITS AFFAIRS AND THE CONDUCT OF ITS BUSINESS;

(2) ENTER INTO CONTRACTS WITH PUBLIC OR PRIVATE ENTITIES TO CARRY OUT THE DUTIES OF THE EXCHANGE UNDER THIS TITLE, INCLUDING CONTRACTS TO ADMINISTER APPLICATIONS, ELIGIBILITY VERIFICATION, ENROLLMENT, AND PREMIUM PAYMENTS FOR SPECIFIC GROUPS OR POPULATIONS;

(3) TAKE ANY LEGAL ACTION NECESSARY OR PROPER ON BEHALF OF THE EXCHANGE;

(4) HIRE OR CONTRACT WITH APPROPRIATE LEGAL, ACTUARIAL, AND OTHER ADVISORS TO PROVIDE TECHNICAL ASSISTANCE IN THE MANAGEMENT AND OPERATION OF THE EXCHANGE;

(5) ESTABLISH AND EXECUTE A LINE OF CREDIT, AND ESTABLISH ONE OR MORE CASH AND INVESTMENT ACCOUNTS TO CARRY OUT THE DUTIES OF THE EXCHANGE;

(6) ESTABLISH AND COLLECT FEES FROM ENROLLED INDIVIDUALS, ENROLLED SMALL EMPLOYERS, AND CARRIERS SUFFICIENT TO SUPPORT THE COSTS OF ADMINISTERING THE EXCHANGE;

(7) APPLY FOR GRANTS FROM PUBLIC AND PRIVATE ENTITIES; AND

(8) CONTRACT WITH SMALL EMPLOYERS TO ACT AS THE ADMINISTRATOR OF THE EMPLOYER'S EMPLOYER–SUBSIDIZED PLAN AND UNDERTAKE THE OBLIGATIONS REQUIRED OF THE ADMINISTRATOR FOR THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN.

(C) THE ACCOUNTS OF THE EXCHANGE ARE NOT ACCOUNTS OF THE STATE, AND THE MONEY IN THE ACCOUNTS IS NOT PART OF THE GENERAL FUND OF THE STATE.

(D) ALL DEBTS, CLAIMS, OBLIGATIONS, AND LIABILITIES OF THE EXCHANGE SHALL BE THE DEBTS, CLAIMS, OBLIGATIONS, AND LIABILITIES OF

THE EXCHANGE ONLY AND NOT OF THE STATE OR THE AGENCIES, INSTRUMENTALITIES, OFFICERS, OR EMPLOYEES OF THE STATE.

15–1607.

(A) THE EXCHANGE SHALL OFFER HEALTH BENEFIT PLANS TO INDIVIDUALS AND SMALL EMPLOYERS BEGINNING JULY 1, 2008.

(B) (1) THE EXCHANGE MAY ONLY OFFER HEALTH BENEFIT PLANS TO INDIVIDUALS AND SMALL EMPLOYERS.

(2) TO PARTICIPATE IN THE EXCHANGE, INDIVIDUALS AND SMALL EMPLOYERS SHALL MEET THE REQUIREMENTS OF THIS SUBTITLE.

(C) (1) THE EXCHANGE MAY ONLY OFFER TO ELIGIBLE INDIVIDUALS AND SMALL EMPLOYERS HEALTH BENEFIT PLANS APPROVED BY THE EXCHANGE.

(2) THE EXCHANGE SHALL ESTABLISH STANDARDS FOR APPROVAL OF HEALTH BENEFIT PLANS TO BE OFFERED THROUGH THE EXCHANGE.

(3) THE STANDARDS SHALL INCLUDE VERIFICATION THAT THE HEALTH BENEFIT PLAN:

(I) HAS BEEN AUTHORIZED BY THE COMMISSIONER AND UNDERWRITTEN BY A CARRIER;

(II) OFFERS HIGH QUALITY SERVICES; AND

(III) PROVIDES GOOD VALUE.

(D) EACH HEALTH BENEFIT PLAN OFFERED THROUGH THE EXCHANGE SHALL CONTAIN A DETAILED DESCRIPTION OF BENEFITS OFFERED, INCLUDING ANY LIMITATIONS, EXCLUSIONS, AND MAXIMUM BENEFITS.

(E) IN ACCORDANCE WITH §§ 15–1212 AND 15–1309 OF THIS TITLE, A CARRIER SHALL RENEW A HEALTH BENEFIT PLAN OFFERED THROUGH THE

EXCHANGE, AT THE OPTION OF THE SMALL EMPLOYER OR THE ELIGIBLE INDIVIDUAL.

15–1608.

(A) A SMALL EMPLOYER THAT SEEKS TO PARTICIPATE IN THE EXCHANGE SHALL, AS A CONDITION OF PARTICIPATION, ENTER INTO A BINDING AGREEMENT WITH THE EXCHANGE WHICH PROVIDES THAT THE SMALL EMPLOYER:

(1) FOR THE TERM OF THE AGREEMENT, WILL NOT OFFER TO ITS EMPLOYEES ANY HEALTH BENEFIT PLAN SEPARATE FROM OR COMPETING WITH THE HEALTH BENEFIT PLANS OFFERED THROUGH THE EXCHANGE;

(2) RESERVES THE RIGHT TO DETERMINE, SUBJECT TO APPLICABLE LAW:

(I) THE CRITERIA FOR ELIGIBILITY, ENROLLMENT, AND PARTICIPATION IN THE EXCHANGE; AND

(II) THE AMOUNTS OF THE EMPLOYER CONTRIBUTION, IF ANY, TO A HEALTH BENEFIT PLAN OFFERED THROUGH THE EXCHANGE;

(3) WILL PARTICIPATE IN A PAYROLL DEDUCTION PROGRAM TO FACILITATE THE PAYMENT OF HEALTH BENEFIT PLAN PREMIUM CONTRIBUTIONS BY EMPLOYEES UNDER 26 U.S.C. 104, 105, 106, AND 125; AND

(4) AGREES TO MAKE AVAILABLE, IN A TIMELY MANNER, FOR CONFIDENTIAL REVIEW BY THE AUTHORITY, ANY OF THE SMALL EMPLOYER'S DOCUMENTS, RECORDS, OR INFORMATION THAT THE AUTHORITY REASONABLY DETERMINES IS NECESSARY FOR THE AUTHORITY TO:

(I) VERIFY THAT THE SMALL EMPLOYER IS IN COMPLIANCE WITH APPLICABLE FEDERAL AND STATE LAWS RELATING TO EMPLOYER–SPONSORED PLANS; AND

(II) VERIFY THE ELIGIBILITY FOR THE EXCHANGE OF INDIVIDUALS ENROLLED IN THE SMALL EMPLOYER'S EMPLOYER–SPONSORED PLAN.

(B) ALL OF THE REQUIREMENTS UNDER SUBTITLE 12 OF THIS TITLE SHALL APPLY TO INSURANCE PURCHASED BY A SMALL EMPLOYER THROUGH THE EXCHANGE.

15–1609.

(A) AN INDIVIDUAL MAY ONLY PURCHASE A NON–GROUP PLAN THROUGH THE EXCHANGE IF THE INDIVIDUAL:

(1) IS A RESIDENT OF THE STATE;

(2) IS NOT A MEDICARE BENEFICIARY; AND

(3) AGREES TO MEET THE REQUIREMENTS, INCLUDING REQUIREMENTS FOR MAKING PREMIUM PAYMENTS, ESTABLISHED BY THE EXCHANGE.

(B) ALL OF THE REQUIREMENTS OF THIS TITLE PERTAINING TO NON–GROUP PLANS SHALL APPLY TO INSURANCE PURCHASED BY AN INDIVIDUAL THROUGH THE EXCHANGE.

15–1610.

WHEN AN INDIVIDUAL OR SMALL EMPLOYER IS ENROLLED IN THE EXCHANGE BY A PRODUCER LICENSED IN THE STATE, THE HEALTH BENEFIT PLAN CHOSEN BY THE INDIVIDUAL OR SMALL EMPLOYER SHALL PAY THE PRODUCER A COMMISSION THAT SHALL BE DETERMINED BY THE BOARD.

15–1611.

THE BOARD MAY APPLY A SURCHARGE TO ALL HEALTH BENEFIT PLANS APPROVED TO BE OFFERED THROUGH THE EXCHANGE TO BE USED ONLY FOR THE PURPOSE OF SUPPORTING THE EXPENSES OF ADMINISTERING AND OPERATING THE EXCHANGE.

15–1612.

THE BOARD MAY ADOPT REGULATIONS IN ACCORDANCE WITH THE ADMINISTRATIVE PROCEDURE ACT TO CARRY OUT THE REQUIREMENTS OF THIS SUBTITLE.

15–1613.

ON OR BEFORE JANUARY 1, 2008, AND ON OR BEFORE JANUARY 1 OF EACH SUBSEQUENT YEAR, THE BOARD SHALL REPORT ON ITS ACTIVITIES FOR THE PRIOR FISCAL YEAR TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE – GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY.

15–1614.

(A) (1) THE ACCOUNTS OF THE EXCHANGE SHALL BE AUDITED ANNUALLY.

(2) THE AUDITS SHALL BE CONDUCTED IN ACCORDANCE WITH GENERALLY ACCEPTED AUDITING STANDARDS BY INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS.

(3) A REPORT OF THE ANNUAL AUDIT SHALL BE FILED WITH THE GOVERNOR AND, SUBJECT TO § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY AND SHALL BE AVAILABLE FOR PUBLIC INSPECTION DURING BUSINESS HOURS AT THE PRINCIPAL OFFICE OF THE EXCHANGE.

(B) (1) IN ADDITION TO THE ANNUAL AUDIT REQUIRED BY SUBSECTION (A) OF THIS SECTION, THE FINANCIAL TRANSACTIONS OF THE EXCHANGE MAY BE AUDITED BY THE LEGISLATIVE AUDITOR.

(2) (I) THE LEGISLATIVE AUDITOR SHALL HAVE ACCESS TO ALL BOOKS, ACCOUNTS, FINANCIAL RECORDS, REPORTS, FILES, AND OTHER PAPERS OR PROPERTY BELONGING TO OR IN USE BY THE EXCHANGE AND NECESSARY TO FACILITATE THE AUDIT.

(II) FULL FACILITIES FOR VERIFYING TRANSACTIONS WITH THE BALANCES AND SECURITIES HELD BY DEPOSITORIES, FISCAL AGENTS, AND CUSTODIANS SHALL BE AVAILABLE TO THE AUDITOR.

(III) ALL BOOKS, ACCOUNTS, FINANCIAL RECORDS, REPORTS, FILES, AND OTHER PAPERS OR PROPERTY OF THE EXCHANGE SHALL REMAIN IN THE POSSESSION AND CUSTODY OF THE EXCHANGE FOR A PERIOD OF 3 YEARS, BUT THE LEGISLATIVE AUDITOR MAY REQUIRE A LONGER PERIOD OF RETENTION.

Article – Labor and Employment

TITLE 12. CAFETERIA PLAN.

12–101.

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

(B) "EMPLOYEE" MEANS ANY INDIVIDUAL EMPLOYED FULL TIME OR PART TIME DIRECTLY BY AN EMPLOYER.

(C) "EMPLOYER" HAS THE MEANING STATED IN § 10–905 OF THE TAX–GENERAL ARTICLE.

(D) "EXCHANGE" MEANS THE MARYLAND HEALTH INSURANCE EXCHANGE, ESTABLISHED UNDER § 15–1602 OF THE INSURANCE ARTICLE.

12–102.

(A) EACH EMPLOYER WITH MORE THAN 10 EMPLOYEES IN THE STATE SHALL:

(1) ADOPT AND MAINTAIN A CAFETERIA PLAN THAT SATISFIES 26 U.S.C. 125 AND THE RULES AND REGULATIONS ADOPTED BY THE EXCHANGE; AND

(2) FILE A COPY OF THE CAFETERIA PLAN WITH THE EXCHANGE.

(B) THE EXCHANGE SHALL PROVIDE EDUCATION AND, ON REQUEST, TECHNICAL ASSISTANCE TO EMPLOYERS TO CARRY OUT THE REQUIREMENTS OF THIS SECTION.

12–103.

IF AN EMPLOYER VIOLATES THIS TITLE, AN EMPLOYEE MAY:

(1) SUBMIT A WRITTEN COMPLAINT TO THE EXCHANGE; OR

(2) BRING AN ACTION FOR INJUNCTIVE RELIEF, DAMAGES, OR OTHER RELIEF.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Health – General

19–706.

(JJJ) THE PROVISIONS OF § 15–418 OF THE INSURANCE ARTICLE APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

Article – Insurance

15–418.

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

(2) "CARRIER" MEANS:

(I) AN INSURER;

(II) A NONPROFIT HEALTH SERVICE PLAN; OR

(III) A HEALTH MAINTENANCE ORGANIZATION.

(3) "CONTINUOUS COVERAGE" MEANS COVERAGE FOR A CHILD UNDER ONE OR MORE OF A PARENT'S HEALTH BENEFIT PLANS WITHOUT A BREAK IN COVERAGE THAT EXCEEDS 63 DAYS.

(4) (I) "HEALTH BENEFIT PLAN" MEANS:

1. A HOSPITAL OR MEDICAL POLICY, CONTRACT, OR CERTIFICATE, INCLUDING THOSE ISSUED UNDER MULTIPLE EMPLOYER TRUSTS OR ASSOCIATIONS;

2. A HOSPITAL OR MEDICAL POLICY, CONTRACT, OR CERTIFICATE ISSUED BY A NONPROFIT HEALTH SERVICE PLAN; OR

3. A HEALTH MAINTENANCE ORGANIZATION CONTRACT.

(II) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

1. A CONTRACT COVERING ONE OR MORE, OR ANY COMBINATION OF THE FOLLOWING:

A. COVERAGE ONLY FOR LOSS CAUSED BY AN ACCIDENT;

B. DISABILITY COVERAGE;

C. CREDIT–ONLY INSURANCE; OR

D. LONG–TERM CARE COVERAGE; OR

2. THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A SEPARATE CONTRACT:

A. DENTAL COVERAGE;

B. VISION COVERAGE;

C. MEDICARE SUPPLEMENT INSURANCE;

D. COVERAGE LIMITED TO BENEFITS FOR A SPECIFIED DISEASE OR DISEASES; AND

E. TRAVEL ACCIDENT OR SICKNESS COVERAGE.

(B) EACH GROUP OR INDIVIDUAL HEALTH BENEFIT PLAN ISSUED OR DELIVERED IN THE STATE BY A CARRIER SHALL PERMIT A CHILD TO CONTINUE TO BE COVERED UNDER THE HEALTH BENEFIT PLAN AFTER THE CHILD MEETS THE LIMITING AGE SPECIFIED IN THE HEALTH BENEFIT PLAN IF THE CHILD HAS HAD CONTINUOUS COVERAGE FOR AT LEAST 2 YEARS IMMEDIATELY PRIOR TO REACHING THE LIMITING AGE.

(C) THE CONTINUATION OF COVERAGE PROVIDED IN SUBSECTION (B) OF THIS SECTION SHALL END ON THE EARLIER OF:

(1) THE END OF THE MONTH IN WHICH THE CHILD ATTAINS AGE 25;

(2) THE DATE ON WHICH THE CHILD ACCEPTS COVERAGE UNDER ANOTHER INDIVIDUAL HEALTH BENEFIT PLAN;

(3) THE DATE ON WHICH THE CHILD BECOMES ELIGIBLE FOR COVERAGE UNDER AN EMPLOYER–SPONSORED HEALTH BENEFIT PLAN AS OTHER THAN A DEPENDENT CHILD;

(4) THE DATE ON WHICH THE PARENT ELECTS TO TERMINATE COVERAGE FOR THE CHILD UNDER THE PARENT'S HEALTH BENEFIT PLAN; OR

(5) THE DATE ON WHICH THE PARENT TERMINATES COVERAGE.

(D) THE CONTINUATION RIGHT PROVIDED UNDER THIS SECTION MAY NOT BE USED TO TERMINATE COVERAGE FOR AN INCAPACITATED CHILD AS PROVIDED UNDER § 15–402 OF THIS SUBTITLE.

15–1201.

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

(R) "WELLNESS ACTIVITY" MEANS AN EXPLICIT PROGRAM OR ACTIVITY, CONSISTENT WITH GUIDELINES DEVELOPED BY THE COMMISSION, SUCH AS SMOKING CESSATION, INJURY AND ACCIDENT PREVENTION, REDUCTION OF ALCOHOL MISUSE, APPROPRIATE WEIGHT REDUCTION, EXERCISE, AUTOMOBILE AND MOTORCYCLE SAFETY, BLOOD CHOLESTEROL REDUCTION, AND NUTRITION EDUCATION, FOR THE PURPOSE OF IMPROVING HEALTH STATUS AND REDUCING HEALTH CARE COSTS.

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.

(4) A CARRIER MAY OFFER A DISCOUNTED RATE FOR PARTICIPATION IN WELLNESS ACTIVITIES.

(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.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

14–501.

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

(c) "Board" means the Board of Directors for the Maryland Health Insurance **[**Plan**]** **EXCHANGE**.

(g) "Fund" means the Maryland Health Insurance Plan Fund.

(i) "Plan" means the Maryland Health Insurance Plan.

(j) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with § 14–503 of this subtitle.

14–502.

(a) There is a Maryland Health Insurance Plan **WITHIN THE MARYLAND HEALTH INSURANCE EXCHANGE**.

(b) **[**The Plan is an independent unit that operates within the Administration.

(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)**]** **(C)** 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.

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;

(3) one shall be the Executive Director of the Health Services Cost Review Commission;

(4) one shall be the Secretary of the Department of Budget and Management;

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

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

(8) one shall be an individual who is an owner or employee of a minority–owned business in the State, appointed by the Governor.

(d) (1) (i) Each Board member appointed under subsection (c)(5) 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) 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)**](B)**(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) 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)**](C)**(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)**] (D)** 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)**](E)**(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) 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)**] (F) [**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.**] THE BOARD SHALL REPORT ON OR BEFORE DECEMBER 1, 2008, AND ANNUALLY THEREAFTER, TO THE GOVERNOR, AND SUBJECT TO § 2–1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY ON THE ENROLLMENT, COSTS, AND ACTIVITIES OF THE PLAN.**

SECTION 4. AND BE IT FURTHER ENACTED, That :

(a) The Secretary of Health and Mental Hygiene shall develop a statewide plan to improve the quality and cost–effectiveness of care for individuals with, and at risk for, chronic health care conditions.

(b) The plan shall include:

(1) patient self–management, in collaboration with a health care team;

(2) incentives for provision of care consistent with evidence–based standards;

(3) ways to engage communities to fight physical inactivity and obesity;

(4) identification of information technology that supports care management;

(5) linkages between financing mechanisms and performance measures; and

(6) a chronic care management program, that incorporates all elements of the plan, for enrollees in the Maryland Medical Assistance Program.

(c) The Secretary shall involve representatives of stakeholder groups, including health care providers, payors, consumers, and other State and local agencies, in developing the plan.

(d) On or before January 1, 2008, the Secretary shall report on the plan to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly.

SECTION 5. AND BE IT FURTHER ENACTED, That:

(a) The Department of Budget and Management and the Department of Health and Mental Hygiene shall jointly develop a wellness incentive pilot program for State employees.

(b) The purpose of the program is to provide incentives for State employees, their dependents, and other enrollees to maintain their health and prevent chronic illness.

(c) The program shall:

(1) provide incentives for activities such as smoking cessation, injury and accident prevention, reduction of drug and alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education; and

(2) include performance measures, including savings in health care costs.

(d) On or before January 1, 2008, the Departments shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on the components of and implementation plans for the program.

(e) The Departments shall implement the program beginning July 1, 2008.

SECTION 6. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission and the Health Services Cost Review Commission shall collaborate in seeking a proposal or proposals leading to the establishment of:

(1) a regional health information exchange, to include:

(i) the design and development of the technical architecture;

(ii) the implementation of a pilot project or projects; and

(iii) the identification of a sustainable and expandable business model; and

(2) a unique patient identifier for electronic medical records in the State.

SECTION 7. AND BE IT FURTHER ENACTED, That:

(a) There is a Task Force on Expanding Access to Affordable Health Care.

(b) The Task Force consists of the following 15 members:

(1) four members of the Senate, appointed by the President of the Senate;

(2) four members of the House of Delegates, appointed by the Speaker of the House;

(3) the Secretary of Health and Mental Hygiene;

(4) the Secretary of Budget and Management;

(5) one representative of the Maryland Health Care Commission, appointed by the Secretary of Health and Mental Hygiene; and

(6) four individuals appointed by the Governor.

(c) The Secretary of Health and Mental Hygiene shall serve as Chair of the Task Force.

(d) (1) The Department of Health and Mental Hygiene shall provide staff for the Task Force.

(2) The Maryland Health Care Commission and the Health Services Cost Review Commission shall provide additional staff and technical assistance to the Task Force.

(e) A member of the Task Force may not receive compensation but is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(f) The Task Force shall study and make recommendations regarding expanding access to health insurance and reducing the amount of uncompensated care in the State, including:

(1) expanding Medicaid coverage for parents of Medicaid and Maryland Children's Health Program–eligible children, above the current level of 42% of federal poverty guidelines;

(2) expanding Medicaid to cover childless adults;

(3) providing premium assistance to individuals below a certain level of the federal poverty guidelines to assist in the purchase of health insurance;

(4) providing incentives to small businesses to offer health insurance coverage for employees;

(5) developing a cost–effective reinsurance fund;

(6) imposing requirements on individuals in families above a certain level of the federal poverty guidelines to purchase health insurance;

(7) implementing a chronic care management program; and

(8) implementing a health insurance exchange, including the legal, logistical, and tax implications for such an approach to distributing health coverage to individuals and groups.

(g) In making its recommendations, the Task Force shall:

(1) consider initiatives used in other states to reduce the number of uninsured individuals;

(2) solicit testimony, data, and other information from all interested parties on issues to be studied by the Task Force;

(3) provide an estimate of the number of additional individuals that could be insured through each initiative, and an estimated cost for pursuing the initiative;

(4) evaluate alternatives for phasing–in some of the initiatives; and

(5) evaluate potential funding sources for recommended initiatives, including:

(i) federal funds;

(ii) State funds that can be reallocated from existing State and federal programs that would no longer be necessary if one or more new initiatives were implemented;

(iii) savings from reducing the amount of uncompensated care that must be provided in the State; and

(iv) any other source of funds.

(h) The Task Force shall report its findings and recommendations to the Governor and, subject to § 2–1246 of the State Government Article, to the General Assembly, by December 31, 2007.

SECTION 8. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall apply to all policies and contracts issued, delivered, or renewed in the State on or after October 1, 2007. Any policy or contract in effect before October 1, 2007, shall comply with the provisions of this Act no later than October 1, 2008.

SECTION 9. AND BE IT FURTHER ENACTED, That Section 4 shall take effect July 1, 2008.

SECTION 10. AND BE IT FURTHER ENACTED, That, except as provided in Section 9 of this Act, this Act shall take effect July 1, 2007. Section 7 of this Act shall remain effective for a period of 1 year and, at the end of June 30, 2008, with no further action required by the General Assembly, Section 7 of this Act shall be abrogated and of no further force and effect.