HOUSE BILL 1540

C3 8lr2777

By: **Delegates Benson, Hucker, Bobo, Glenn, Heller, Holmes, Ivey, Levi, Love, Manno, Montgomery, Niemann, Ramirez, Taylor, F. Turner, V. Turner, Valderrama, and Vaughn**

Introduced and read first time: February 22, 2008
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

AN ACT concerning

Health Care Reform Act of 2008

FOR the purpose of establishing the Maryland Health Care Cost and Quality Transparency Commission in the Department of Health and Mental Hygiene; providing for the membership and staff of the Commission; requiring the Commission, on or before a certain date, to adopt a health care cost and quality transparency plan; establishing requirements for the plan; establishing the Health Care Cost and Quality Transparency Fund; establishing the purpose, administration, and sources of funds for the Fund; requiring the Commission to recover a certain cost from certain fees; requiring fees to be deposited in the Fund; requiring the Maryland Children's Health Program to provide certain health care services for certain parents and caretaker relatives; notwithstanding other provisions of law, making certain children eligible for the Maryland Children's Health Program; altering requirements for the family contribution in the Maryland Children's Health Program; requiring certain individuals to obtain health care coverage through the Maryland Cooperative Health Insurance Purchasing Program; requiring the Board of Directors of the Maryland Health Insurance Plan to establish a certain list of health conditions or diagnoses; requiring the Board to develop a certain questionnaire; prohibiting an insurer from denying coverage for an individual, with certain exceptions; establishing the Maryland Cooperative Health Insurance Purchasing Program; establishing the purpose, supervision, and control of the Program; establishing requirements for Program benefit plan designs, premiums, practices, and eligibility; establishing requirements relating to coverage of individuals eligible for the Maryland Medical Assistance Program and the Maryland Children's Health Program; establishing the Health Trust Fund; establishing the purpose, administration, sources of funds for, and expenditures from the Health Trust Fund; altering a certain loss ratio; altering the criteria specified for a small employer for health insurance purposes; providing that a carrier may only deny

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

coverage on the basis of medical underwriting in accordance with certain requirements; requiring the Insurance Commissioner to adopt regulations and make certain approvals of certain classes of individual health benefit plans; requiring carriers in the individual market to guarantee issuance of certain health benefit plans and discontinue offering and selling certain health benefit plans; authorizing individual purchase of certain health benefit plans; requiring certain carriers to use a certain questionnaire; prohibiting a carrier from excluding a potential enrollee from individual coverage on a certain basis, with a certain exception; prohibiting a carrier from using certain information for a certain purpose, with a certain exception; requiring a carrier to direct an individual to the Maryland Health Insurance Plan under certain circumstances; establishing the effective date for a health benefit plan; altering requirements for premium rates in the individual health insurance market; requiring the Commissioner to adopt certain regulations; requiring an employer to make a certain election; providing for the calculation of certain health expenditures; requiring a certain amount to be deposited into the Health Trust Fund; requiring certain employees to enroll in the Maryland Cooperative Health Insurance Purchasing Program; providing for certain exemptions; requiring certain employees to accept certain health expenditures; providing for certain exemptions; requiring an employer to notify the Department of Labor, Licensing, and Regulation and the employer's employees of a certain election; requiring an employer to adopt and retain a certain cafeteria plan; providing for certain penalties; requiring the Department to make certain deposits; requiring the Department to adopt certain regulations; defining certain terms; and generally relating to health care and health insurance reform.

BY adding to
Article – Health – General
Section 13–2701 through 13–2707 to be under the new subtitle "Subtitle 27. Maryland Health Care Cost and Quality Transparency Commission"; and 15–301.2
Annotated Code of Maryland
(2005 Replacement Volume and 2007 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–301 and 15–301.1
Annotated Code of Maryland
(2005 Replacement Volume and 2007 Supplement)

BY adding to
Article – Insurance
Section 14–509; 14–701 through 14–709 to be under the new subtitle "Subtitle 7. Maryland Cooperative Health Insurance Purchasing Program"; and 15–1304 through 15–1306 and 15–1312
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–605(c)(1)
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–605(c)(2), 15–1203, and 15–1303
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

BY repealing
Article – Insurance
Section 15–1312
Annotated Code of Maryland
(2006 Replacement Volume and 2007 Supplement)

BY adding to
Article – Labor and Employment
Section 12–101 through 12–109 to be under the new title "Title 12. Employer Health Expenditures"
Annotated Code of Maryland
(1999 Replacement Volume and 2007 Supplement)

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

Article – Health – General

SUBTITLE 27. MARYLAND HEALTH CARE COST AND QUALITY TRANSPARENCY COMMISSION.

13–2701.

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

(B) "COMMISSION" MEANS THE MARYLAND HEALTH CARE COST AND QUALITY TRANSPARENCY COMMISSION.

(C) "FUND" MEANS THE HEALTH CARE COST AND QUALITY TRANSPARENCY FUND.

13–2702.

THERE IS A MARYLAND HEALTH CARE COST AND QUALITY TRANSPARENCY COMMISSION IN THE DEPARTMENT.

13–2703.

(A) THE COMMISSION CONSISTS OF THE FOLLOWING MEMBERS, APPOINTED BY THE GOVERNOR:

(1) ONE REPRESENTATIVE FROM AN INSTITUTION OF HIGHER LEARNING WITH EXPERIENCE IN HEALTH CARE DATA AND COST EFFICIENCY RESEARCH;

(2) ONE REPRESENTATIVE OF HOSPITALS;

(3) ONE REPRESENTATIVE OF PHYSICIANS;

(4) ONE REPRESENTATIVE OF LARGE EMPLOYERS THAT PURCHASE GROUP HEALTH CARE COVERAGE FOR EMPLOYEES AND WHO IS NOT ALSO A SUPPLIER OR BROKER OF HEALTH CARE COVERAGE;

(5) ONE REPRESENTATIVE OF A LABOR UNION;

(6) ONE REPRESENTATIVE OF A NONPROFIT ORGANIZATION WITH EXPERIENCE WORKING WITH EMPLOYERS TO ENHANCE VALUE AND AFFORDABILITY OF HEALTH CARE COVERAGE;

(7) ONE REPRESENTATIVE OF CONSUMERS;

(8) ONE REPRESENTATIVE OF THE HEALTH INSURANCE INDUSTRY; AND

(9) ONE REPRESENTATIVE OF SMALL EMPLOYERS THAT PURCHASE HEALTH INSURANCE FOR EMPLOYEES.

(B) IN ADDITION TO THE MEMBERS APPOINTED BY THE GOVERNOR, THE FOLLOWING MEMBERS SHALL SERVE IN AN EX OFFICIO NONVOTING CAPACITY:

(1) THE SECRETARY OF HEALTH AND MENTAL HYGIENE, OR THE SECRETARY'S DESIGNEE;

(2) THE DIRECTOR OF THE OFFICE OF PERSONNEL SERVICES AND BENEFITS, OR THE DIRECTOR'S DESIGNEE;

(3) THE INSURANCE COMMISSIONER, OR THE COMMISSIONER'S DESIGNEE; AND

(4) THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH CARE COMMISSION, OR THE EXECUTIVE DIRECTOR'S DESIGNEE.

(C) EACH MEMBER APPOINTED BY THE GOVERNOR SHALL HAVE DEMONSTRATED KNOWLEDGE AND EXPERIENCE IN THE MEASUREMENT AND ANALYSIS OF HEALTH CARE QUALITY OR COST DATA, DEPLOYING HEALTH CARE QUALITY OR COST DATA ON BEHALF OF CONSUMERS AND PURCHASERS, OR HEALTH CARE OR OTHER AREAS RELEVANT TO THE COMMISSION'S RESPONSIBILITIES.

(D) THE GOVERNOR SHALL DESIGNATE THE CHAIR OF THE COMMISSION.

(E) THE TERM OF AN APPOINTED MEMBER IS 4 YEARS.

(F) A MEMBER OF THE COMMISSION:

(1) MAY RECEIVE A PER DIEM OF $100 FOR EACH DAY SPENT IN THE DISCHARGE OF OFFICIAL DUTIES; AND

(2) IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

13–2704.

(A) THE COMMISSION SHALL APPOINT AN EXECUTIVE DIRECTOR, WHO SHALL SERVE AT THE PLEASURE OF THE COMMISSION.

(B) UNDER THE DIRECTION OF THE COMMISSION, THE EXECUTIVE DIRECTOR SHALL PERFORM ANY DUTY OR FUNCTION THAT THE COMMISSION REQUIRES.

(C) THE EXECUTIVE DIRECTOR MAY EMPLOY STAFF NECESSARY TO CARRY OUT THE DUTIES AND FUNCTIONS OF THE COMMISSION.

13–2705.

(A) ON OR BEFORE DECEMBER 1, 2010, THE COMMISSION SHALL ADOPT A HEALTH CARE COST AND QUALITY TRANSPARENCY PLAN THAT WILL, WHEN IMPLEMENTED, RESULT IN THE TRANSPARENT PUBLIC REPORTING OF

SAFETY, QUALITY, AND COST EFFICIENCY INFORMATION AT ALL LEVELS OF THE HEALTH CARE SYSTEM.

(B) THE PLAN SHALL:

(1) (I) INCLUDE SPECIFIC STRATEGIES TO MEASURE AND COLLECT DATA RELATED TO HEALTH CARE SAFETY AND QUALITY, UTILIZATION, COST TO PAYERS, AND HEALTH OUTCOMES; AND

(II) FOCUS ON DATA ELEMENTS THAT FOSTER QUALITY IMPROVEMENT AND PEER GROUP COMPARISONS;

(2) FACILITATE VALUE–BASED, COST–EFFECTIVE PURCHASING OF HEALTH CARE SERVICES BY PUBLIC AND PRIVATE PURCHASERS;

(3) RESULT IN USABLE INFORMATION THAT ALLOWS HEALTH CARE PURCHASERS, CONSUMERS, AND DATA SOURCES TO IDENTIFY AND COMPARE HEALTH PLANS AND INSURERS AS WELL AS INDIVIDUAL HEALTH FACILITIES, PHYSICIANS, AND OTHER HEALTH CARE PROVIDERS, ON THE EXTENT TO WHICH THEY PROVIDE SAFE, COST–EFFECTIVE, HIGH QUALITY HEALTH CARE SERVICES;

(4) BE DESIGNED TO MEASURE EACH OF THE PERFORMANCE DOMAINS IDENTIFIED BY THE INSTITUTE OF MEDICINE: SAFETY, TIMELINESS, EFFECTIVENESS, EFFICIENCY, EQUITY, AND PATIENT–CENTEREDNESS;

(5) USE AND BUILD ON EXISTING DATA COLLECTION STANDARDS AND METHODS TO THE EXTENT POSSIBLE TO ACCOMPLISH THE GOALS OF THE COMMISSION IN A COST–EFFECTIVE MANNER, INCLUDING:

(I) COLLECTING AND DISSEMINATING ONE OR MORE NATIONALLY RECOGNIZED METHODOLOGIES FOR MEASURING AND QUANTIFYING PROVIDER QUALITY, COST, AND SERVICE EFFECTIVENESS; AND

(II) IMPLEMENTING SYSTEMWIDE MANDATORY COLLECTION OF DATA ELEMENTS OTHERWISE BEING COLLECTED IN EXISTING VOLUNTARY PUBLIC AND PRIVATE REPORTING PROGRAMS IN THE STATE; AND

(6) INCORPORATE AND UTILIZE:

(I) ADMINISTRATIVE CLAIMS DATA TO THE EXTENT IT IS THE MOST COST–EFFICIENT METHOD OF COLLECTING DATA TO MINIMIZE THE COST AND ADMINISTRATIVE BURDEN ON DATA SOURCES; AND

(II) OTHER DATA, PROVIDED IT IS NECESSARY TO MEASURE AND ANALYZE A SIGNIFICANT HEALTH CARE QUALITY, SAFETY, OR COST ISSUE THAT CANNOT BE ADEQUATELY MEASURED WITH THE USE OF ADMINISTRATIVE CLAIMS DATA.

13–2706.

(A) THE COMMISSION SHALL, TO THE EXTENT POSSIBLE, RECOVER THE COST OF IMPLEMENTING THIS SUBTITLE FROM FEES CHARGED TO DATA SOURCES AND DATA USERS.

(B) ALL FEES SHALL BE DEPOSITED IN THE HEALTH CARE COST AND QUALITY TRANSPARENCY FUND.

13–2707.

(A) THERE IS A HEALTH CARE COST AND QUALITY TRANSPARENCY FUND.

(B) THE PURPOSE OF THE FUND IS TO SUPPORT THE ACTIVITIES OF THE COMMISSION.

(C) THE COMMISSION SHALL ADMINISTER THE FUND.

(D) (1) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(E) THE STATE TREASURER SHALL HOLD THE FUND SEPARATELY, AND THE COMPTROLLER SHALL ACCOUNT FOR THE FUND.

(F) THE FUND CONSISTS OF:

(1) FEES CHARGED TO DATA SOURCES AND DATA USERS;

(2) GRANTS OR CONTRIBUTIONS FROM PRIVATE SOURCES; AND

(3) ANY OTHER MONEY FROM ANY OTHER SOURCE ACCEPTED FOR THE BENEFIT OF THE FUND.

(G) (1) THE FUND SHALL BE INVESTED AND REINVESTED IN THE SAME MANNER AS OTHER STATE FUNDS.

(2) ANY INVESTMENT EARNINGS SHALL BE CREDITED TO THE FUND.

(H) EXPENDITURES FROM THE FUND MAY BE MADE ONLY IN ACCORDANCE WITH THE STATE BUDGET.

15–301.

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

(b) **(1)** 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**[**,**]:**

(I) [comprehensive**] COMPREHENSIVE** medical care and other health care services to an individual who has a family income at or below 300 percent of the federal poverty guidelines and who is under the age of 19 years**; AND**

(II) MEDICAL CARE AND OTHER HEALTH CARE SERVICES FOR PARENTS AND CARETAKER RELATIVES:

1. WHO HAVE A DEPENDENT CHILD UNDER THE AGE OF 19 YEARS LIVING IN THE PARENTS' OR CARETAKER RELATIVES' HOME; AND

2. WHO HAVE A FAMILY INCOME AT OR BELOW 300 PERCENT OF THE FEDERAL POVERTY GUIDELINES.

(2) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, CHILDREN WHO, EXCEPT FOR THEIR IMMIGRATION STATUS, OTHERWISE MEET ELIGIBILITY REQUIREMENTS, ARE ELIGIBLE FOR THE MARYLAND CHILDREN'S HEALTH PROGRAM.

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

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

(2) For eligible individuals whose family income is above 200 percent, but at or below 300 percent 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.

(d) (1) The Department shall provide eligible individuals and health care providers with an accurate directory or other listing of all available providers:

(i) In written form, made available upon request; and

(ii) On an Internet database.

(2) The Department shall update the Internet database at least every 30 days.

(3) The written directory shall include a conspicuous reference to the Internet database.

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.

(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**]** **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) **[**(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 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.**]** **THE DEPARTMENT SHALL ESTABLISH A FAMILY CONTRIBUTION THAT:**

(1) VARIES WITH INCOME AND FAMILY SIZE; AND

(2) DOES NOT EXCEED 5 PERCENT OF THE FAMILY'S INCOME.

(d) The Department shall adopt regulations necessary to implement this section.

15–301.2.

(A) THIS SECTION APPLIES TO INDIVIDUALS WHO ARE:

(1) ENROLLED IN OR ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(2) ALSO ELIGIBLE FOR THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM UNDER § 14–707 OF THE INSURANCE ARTICLE.

(B) AN INDIVIDUAL SUBJECT TO THIS SECTION SHALL OBTAIN HEALTH CARE COVERAGE THROUGH THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM, IN ACCORDANCE WITH TITLE 14, SUBTITLE 7 OF THE INSURANCE ARTICLE.

Article – Insurance

14–509.

(A) (1) THE BOARD SHALL ESTABLISH A LIST OF SERIOUS HEALTH CONDITIONS OR DIAGNOSES MAKING AN APPLICANT AUTOMATICALLY ELIGIBLE FOR THE PROGRAM BASED ON THE STANDARDIZED HEALTH QUESTIONNAIRE DEVELOPED UNDER SUBSECTION (B) OF THIS SECTION.

(2) IN DEVELOPING THE LIST OF CONDITIONS, THE BOARD SHALL CONSULT WITH THE COMMISSIONER TO IDENTIFY COMMON HEALTH PLAN AND INSURER UNDERWRITING CRITERIA.

(B) (1) THE BOARD SHALL DEVELOP A STANDARDIZED HEALTH QUESTIONNAIRE TO BE USED BY ALL HEALTH PLANS AND INSURERS THAT OFFER AND SELL INDIVIDUAL COVERAGE.

(2) THE QUESTIONNAIRE SHALL PROVIDE FOR AN OBJECTIVE EVALUATION OF A PERSON'S HEALTH STATUS BY ASSIGNING A DISCRETE MEASURE, SUCH AS A SYSTEM OF POINT SCORING, TO EACH PERSON.

(3) THE QUESTIONNAIRE SHALL BE DESIGNED TO IDENTIFY THE 3% TO 5% OF PERSONS WHO ARE THE MOST EXPENSIVE TO TREAT IF COVERED UNDER AN INDIVIDUAL HEALTH BENEFIT PLAN, AND THE BOARD SHALL OBTAIN FROM AN ACTUARY A CERTIFICATION THAT THE STANDARDIZED HEALTH QUESTIONNAIRE MEETS THIS REQUIREMENT.

(4) THE QUESTIONNAIRE SHALL BE DESIGNED TO COLLECT ONLY THAT INFORMATION NECESSARY TO IDENTIFY IF A PERSON IS ELIGIBLE FOR COVERAGE IN THE PROGRAM.

(C) AN INSURER MAY NOT DENY COVERAGE FOR ANY INDIVIDUAL EXCEPT FOR THOSE WHO QUALIFY FOR AUTOMATIC ELIGIBILITY FOR THE PROGRAM AS DETERMINED BY THE BOARD IN ACCORDANCE WITH THIS SECTION.

SUBTITLE 7. MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM.

14–701.

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

(B) "BOARD" MEANS THE BOARD OF DIRECTORS FOR THE MARYLAND HEALTH INSURANCE PLAN.

(C) "PROGRAM" MEANS THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM.

14–702.

(A) THERE IS A MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM.

(B) THE PURPOSE OF THE PROGRAM IS TO PROVIDE ACCESS TO AFFORDABLE AND COMPREHENSIVE HEALTH INSURANCE FOR EMPLOYEES AND THEIR DEPENDENTS.

14–703.

(A) THE PROGRAM SHALL OPERATE SUBJECT TO THE SUPERVISION AND CONTROL OF THE BOARD.

(B) THE BOARD SHALL:

(1) DETERMINE ELIGIBILITY AND ENROLLMENT CRITERIA AND PROCESSES FOR THE PROGRAM;

(2) DETERMINE THE PARTICIPATION REQUIREMENTS FOR ENROLLEES;

(3) DETERMINE THE PARTICIPATION REQUIREMENTS AND THE STANDARDS AND SELECTION CRITERIA FOR PARTICIPATING HEALTH, DENTAL, AND VISION CARE PLANS, INCLUDING REASONABLE LIMITS ON A PLAN'S ADMINISTRATIVE COSTS TO ENSURE THAT A PLAN EXPENDS ON PATIENT CARE NOT LESS THAN 85% OF AGGREGATE DUES, FEES, AND OTHER PERIODIC PAYMENTS RECEIVED BY THE PLAN;

(4) DETERMINE WHEN AN ENROLLEE'S COVERAGE BEGINS AND THE EXTENT AND SCOPE OF COVERAGE;

(5) DETERMINE PREMIUM SCHEDULES, COLLECT THE PREMIUMS, AND ADMINISTER SUBSIDIES TO ELIGIBLE ENROLLEES;

(6) DETERMINE RATES PAID TO PARTICIPATING HEALTH, DENTAL, AND VISION CARE PLANS;

(7) PROVIDE, OR MAKE AVAILABLE, COVERAGE THROUGH HEALTH PLANS PARTICIPATING IN THE PROGRAM;

(8) PROVIDE, OR MAKE AVAILABLE, COVERAGE THROUGH DENTAL AND VISION CARE PLANS PARTICIPATING IN THE PROGRAM;

(9) PROVIDE FOR THE PROCESSING OF APPLICATIONS AND THE ENROLLMENT OF ENROLLEES;

(10) DETERMINE AND APPROVE THE BENEFIT DESIGNS AND COPAYMENTS FOR PARTICIPATING HEALTH, DENTAL, AND VISION CARE PLANS;

(11) ENTER INTO CONTRACTS;

(12) SUE AND BE SUED;

(13) EMPLOY NECESSARY STAFF;

(14) AUTHORIZE EXPENDITURES, AS NECESSARY, FROM THE FUND TO:

(I) PAY PROGRAM EXPENSES THAT EXCEED ENROLLEE CONTRIBUTIONS; AND

(II) ADMINISTER THE PROGRAM;

(15) ADOPT REGULATIONS, AS NECESSARY;

(16) (I) MAINTAIN ENROLLMENT AND EXPENDITURES TO ENSURE THAT EXPENDITURES DO NOT EXCEED THE AMOUNT OF REVENUE AVAILABLE IN THE FUND; AND

(II) IF SUFFICIENT REVENUE IS NOT AVAILABLE TO PAY THE ESTIMATED EXPENDITURES, INSTITUTE APPROPRIATE MEASURES TO ENSURE FISCAL SOLVENCY;

(17) ESTABLISH THE CRITERIA AND PROCEDURES THROUGH WHICH EMPLOYERS DIRECT EMPLOYEES' PREMIUM DOLLARS, WITHHELD UNDER THE TERMS OF CAFETERIA PLANS, TO THE PROGRAM TO BE CREDITED AGAINST THE EMPLOYEES' PREMIUM OBLIGATIONS;

(18) SHARE INFORMATION OBTAINED PURSUANT TO THIS SUBTITLE WITH THE DEPARTMENT OF LABOR, LICENSING, AND REGULATION, SOLELY FOR THE PURPOSE OF THE ADMINISTRATION AND ENFORCEMENT OF THIS SUBTITLE; AND

(19) EXERCISE ALL POWERS REASONABLY NECESSARY TO CARRY OUT THE POWERS AND RESPONSIBILITIES EXPRESSLY GRANTED OR IMPOSED BY THIS SUBTITLE.

14–704.

(A) THE BOARD SHALL DEVELOP AND OFFER A VARIETY OF BENEFIT PLAN DESIGNS, INCLUDING LOW–COST PLANS FOR PROGRAM ENROLLEES WHO ARE ADULTS WITH FAMILY INCOME BELOW 300% OF THE FEDERAL POVERTY LEVEL WHO ARE INELIGIBLE FOR COVERAGE THROUGH THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(B) IN ADDITION TO THESE BENEFIT PLAN DESIGNS, EACH PARTICIPATING HEALTH PLAN SHALL OFFER A MARYLAND MEDICAL ASSISTANCE PROGRAM PLAN AND A MARYLAND CHILDREN'S HEALTH PROGRAM PLAN, AND THE BOARD SHALL LIMIT ENROLLMENT IN THESE PLANS ONLY TO ELIGIBLE INDIVIDUALS.

(C) THE BENEFIT PLAN DESIGNS SHALL INCLUDE VARYING BENEFIT LEVELS, DEDUCTIBLES, COINSURANCE OR COPAYMENTS, AND ANNUAL LIMITS ON OUT–OF–POCKET EXPENSES.

(D) IN DEVELOPING THE BENEFIT PLAN DESIGNS, THE BOARD SHALL:

(1) TAKE INTO CONSIDERATION THE LEVELS OF HEALTH CARE COVERAGE PROVIDED IN THE STATE AND MEDICAL ECONOMIC FACTORS AS MAY BE DEEMED APPROPRIATE; AND

(2) INCLUDE COVERAGE AND DESIGN ELEMENTS THAT ARE REFLECTIVE OF AND COMMENSURATE WITH HEALTH INSURANCE COVERAGE PROVIDED THROUGH A REPRESENTATIVE NUMBER OF LARGE INSURED EMPLOYERS IN THE STATE.

(E) ALL BENEFIT PLAN DESIGNS SHALL INCLUDE PRESCRIPTION DRUG BENEFITS, COMBINED WITH ENROLLEE COST–SHARING LEVELS THAT PROMOTE PREVENTION AND HEALTH MAINTENANCE, INCLUDING APPROPRIATE COST SHARING FOR PHYSICIAN OFFICE VISITS, DIAGNOSTIC LABORATORY SERVICES, AND MAINTENANCE MEDICATIONS TO MANAGE CHRONIC DISEASES, SUCH AS ASTHMA, DIABETES, AND HEART DISEASE.

(F) IN DETERMINING ENROLLEE AND DEPENDENT DEDUCTIBLES, COINSURANCE, AND COPAYMENT REQUIREMENTS, THE BOARD SHALL CONSIDER WHETHER THOSE COSTS WOULD DETER AN ENROLLEE OR AN ENROLLEE'S DEPENDENTS FROM OBTAINING APPROPRIATE AND TIMELY CARE, INCLUDING THOSE ENROLLEES WITH A LOW OR MODERATE FAMILY INCOME.

(G) THE BOARD SHALL ALSO CONSIDER THE IMPACT OF THESE COSTS ON AN ENROLLEE'S ABILITY TO AFFORD HEALTH CARE SERVICES.

(H) THE BOARD SHALL ESTABLISH PREMIUMS FOR THE PROGRAM, TAKING INTO ACCOUNT THE COSTS OF HEALTH CARE TYPICALLY PAID FOR BY EMPLOYERS AND EMPLOYEES IN THE STATE.

(I) THE AMOUNT OF THE PREMIUM PAID BY AN EMPLOYEE WITH A HOUSEHOLD INCOME AT OR BELOW 300% OF THE FEDERAL POVERTY LEVEL MAY NOT EXCEED 5% OF THE HOUSEHOLD INCOME, DEPENDING ON THE INCOME, AFTER TAKING INTO ACCOUNT THE TAX SAVINGS THE EMPLOYEE IS ABLE TO REALIZE BY USING THE CAFETERIA PLAN MADE AVAILABLE BY THE EMPLOYEE'S EMPLOYER .

(J) AN EMPLOYER MAY PAY ALL, OR A PORTION OF, THE PREMIUM PAYMENT REQUIRED OF ITS EMPLOYEES ENROLLED IN THE PROGRAM.

(K) EMPLOYEES AND DEPENDENTS RECEIVING COVERAGE THROUGH THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM UNDER THIS SUBTITLE SHALL MAKE PREMIUM PAYMENTS, IF ANY, AS DETERMINED BY THE BOARD, AND PAY OTHER COST SHARING AMOUNTS THAT DO NOT EXCEED PREMIUM PAYMENTS AND COST SHARING LEVELS FOR ENROLLMENT IN THOSE PROGRAMS REQUIRED UNDER TITLE 15 OF THE HEALTH – GENERAL ARTICLE.

14–705.

(A) THE BOARD, IN ITS CONTRACT WITH A PARTICIPATING HEALTH PLAN, SHALL REQUIRE THAT THE PLAN UTILIZE EFFICIENT PRACTICES TO IMPROVE AND CONTROL COSTS.

(B) THESE PRACTICES SHALL INCLUDE:

(1) PREVENTIVE CARE;

(2) CARE MANAGEMENT FOR CHRONIC DISEASES;

(3) PROMOTION OF HEALTH INFORMATION TECHNOLOGY;

(4) STANDARDIZED BILLING PRACTICES;

(5) REDUCTION OF MEDICAL ERRORS;

(6) INCENTIVES FOR HEALTHY LIFESTYLES;

(7) PATIENT COST–SHARING TO ENCOURAGE THE USE OF PREVENTIVE AND APPROPRIATE CARE; AND

(8) RATIONAL USE OF NEW TECHNOLOGY.

14–706.

(A) THE BOARD SHALL NEGOTIATE WITH MEDICAID MANAGED CARE ORGANIZATIONS TO OBTAIN AFFORDABLE COVERAGE FOR ELIGIBLE ENROLLEES.

(B) THE BOARD SHALL:

(1) OBTAIN FROM EMPLOYERS THE APPLICABLE PREMIUM CONTRIBUTION FOR THEIR EMPLOYEES AND, IF APPLICABLE, DEPENDENTS ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(2) ENROLL THESE ELIGIBLE INDIVIDUALS IN A MARYLAND MEDICAL ASSISTANCE PROGRAM OR A MARYLAND CHILDREN'S HEALTH PROGRAM, AS APPLICABLE.

(C) THE BOARD, IN CONSULTATION WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, SHALL TAKE ALL REASONABLE STEPS NECESSARY TO MAXIMIZE FEDERAL FUNDING AND SUPPORT FEDERAL CLAIMING IN THE ADMINISTRATION OF THE PROGRAM.

14–707.

(A) TO BE ELIGIBLE TO ENROLL IN THE PROGRAM, AN INDIVIDUAL SHALL:

(1) BE A RESIDENT OF THE STATE; AND

(2) (I) BE AN EMPLOYEE OR A DEPENDENT OF AN EMPLOYEE OF AN EMPLOYER WHO ELECTED TO PAY INTO THE HEALTH TRUST FUND IN LIEU OF MAKING HEALTH EXPENDITURES UNDER § 12–102 OF THE LABOR AND EMPLOYMENT ARTICLE; AND

(II) TO THE EXTENT AN EMPLOYER ELECTS TO PAY INTO THE HEALTH TRUST FUND ONLY FOR EITHER THE EMPLOYER'S PART–TIME OR FULL–TIME EMPLOYEES, BE AN EMPLOYEE OR DEPENDENT IN THE CATEGORY OF EMPLOYEES FOR WHICH THE EMPLOYER HAS ELECTED TO PAY.

(B) (1) NOTWITHSTANDING SUBSECTION (A)(2)(II) OF THIS SECTION, ELIGIBLE EMPLOYEES AND, IF APPLICABLE, DEPENDENTS OF ELIGIBLE

EMPLOYEES ELIGIBLE FOR COVERAGE THROUGH A MARYLAND MEDICAL ASSISTANCE PROGRAM PLAN OR A MARYLAND CHILDREN'S HEALTH PROGRAM PLAN UNDER § 14–706 OF THIS SUBTITLE ARE ELIGIBLE FOR THE PROGRAM.

(2) THESE EMPLOYEES AND, IF APPLICABLE, THEIR DEPENDENTS SHALL BE LIMITED TO THE CHOICE OF A MARYLAND MEDICAL ASSISTANCE PROGRAM PLAN OR A MARYLAND CHILDREN'S HEALTH PROGRAM PLAN AND MAY NOT HAVE ACCESS TO OTHER BENEFIT PLAN OPTIONS AVAILABLE TO OTHER PROGRAM ENROLLEES.

14–708.

ON AND AFTER JULY 1, 2010, THE PROGRAM SHALL PROVIDE HEALTH COVERAGE AS REQUIRED UNDER THIS SUBTITLE.

14–709.

(A) THERE IS A HEALTH TRUST FUND.

(B) THE PURPOSE OF THE FUND IS TO SUPPORT THE ACTIVITIES OF THE PROGRAM.

(C) THE BOARD SHALL ADMINISTER THE FUND.

(D) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(E) THE STATE TREASURER SHALL HOLD THE FUND SEPARATELY, AND THE COMPTROLLER SHALL ACCOUNT FOR THE FUND.

(F) THE FUND CONSISTS OF:

(1) PAYMENTS FROM EMPLOYERS UNDER § 12–102 OF THE LABOR AND EMPLOYMENT ARTICLE;

(2) PREMIUM CONTRIBUTIONS FROM ENROLLEES;

(3) INVESTMENT EARNINGS; AND

(4) ANY OTHER MONEY FROM ANY OTHER SOURCE ACCEPTED FOR THE BENEFIT OF THE FUND.

(G) (1) THE STATE TREASURER SHALL INVEST AND REINVEST THE MONEYS OF THE FUND IN THE SAME MANNER AS OTHER STATE MONEYS MAY BE INVESTED.

(2) ANY INVESTMENT EARNINGS SHALL BE CREDITED TO THE FUND.

(H) EXPENDITURES FROM THE FUND MAY BE MADE ONLY IN ACCORDANCE WITH THE STATE BUDGET.

15–605.

(c) (1) For a health benefit plan that is issued under Subtitle 12 of this title, the Commissioner may require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than 75%.

(2) (i) Subject to subparagraph (ii) of this paragraph, for a health benefit plan that is issued to individuals the Commissioner **[**may**]** **SHALL** require the insurer, nonprofit health service plan, or health maintenance organization to file new rates if the loss ratio is less than **[**60%**]** **85%**.

(ii) Subparagraph (i) of this paragraph does not apply to an insurance product that:

1. is listed under § 15–1201(f)(3) of this title; or

2. is nonrenewable and has a policy term of no more than 6 months.

(iii) The Commissioner may establish a loss ratio for each insurance product described in subparagraph (ii)1 and 2 of this paragraph.

15–1203.

(a) A small employer under this subtitle is a person that meets the criteria specified in any subsection of this section.

(b) (1) A person is considered a small employer under this subtitle if the person:

(i) is an employer that on at least 50% of its working days during the preceding calendar quarter, employed at least two but not more than **[**50**]** **100** eligible employees, the majority of whom are employed in the State; and

(ii) is a person actively engaged in business or is the governing body of:

1. a charter home–rule county established under Article XI–A of the Maryland Constitution;

2. a code home–rule county established under Article XI–F of the Maryland Constitution;

3. a commission county established or operating under Article 25 of the Code; or

4. a municipal corporation established or operating under Article XI–E of the Maryland Constitution.

(2) Notwithstanding paragraph (1)(i) of this subsection:

(i) a person is considered a small employer under this subtitle if the employer did not exist during the preceding calendar year but on at least 50% of the working days during its first year the employer employs at least two but not more than **[**50**]** **100** eligible employees and otherwise satisfies the conditions of paragraph (1)(i) of this subsection; and

(ii) if the federal Employee Retirement Income Security Act (ERISA) is amended to exclude employee groups under a specific size, this subtitle shall apply to any employee group size that is excluded from that Act.

(3) In determining the group size specified under paragraph (1)(i) of this subsection:

(i) companies that are affiliated companies or that are eligible to file a consolidated federal income tax return shall be considered one employer; and

(ii) an employee may not be counted who is a part–time employee as described in § 15–1210(a)(2) of this subtitle.

(4) A carrier may request documentation to verify that a person meets the criteria under this subsection to be considered a small employer under this subtitle.

(5) Notwithstanding paragraph (1)(i) of this subsection, a person is considered to continue to be a small employer under this subtitle if the person met the conditions of paragraph (1)(i) of this subsection and purchased a health benefit plan in accordance with this subtitle, and subsequently eliminated all but one employee.

(c) A person is considered a small employer under this subtitle if the person is a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code and has at least one eligible employee.

15–1303.

(a) In addition to any other requirements under this article, a carrier that offers individual health benefit plans in this State shall:

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

(2) have a satisfactory grievance procedure and ability to respond to calls, questions, and complaints from enrollees or insureds; and

(3) design policies to help ensure that enrollees or insureds have adequate access to providers of health care.

(b) (1) For each calendar quarter, a carrier that offers individual health benefit plans in the State shall submit to the Commissioner a report that includes:

(i) the number of applications submitted to the carrier for individual coverage; and

(ii) the number of declinations issued by the carrier for individual coverage.

(2) The report required under paragraph (1) of this subsection shall be filed with the Commissioner no later than 30 days after the last day of the quarter for which the information is provided.

(c) **A CARRIER MAY ONLY DENY COVERAGE ON THE BASIS OF MEDICAL UNDERWRITING IN ACCORDANCE WITH § 15–1305 OF THIS SUBTITLE.**

(D) (1) If a carrier denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market, the carrier shall provide the individual with specific information regarding the availability of coverage under the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of this article.

(2) A notice issued by a carrier under this subsection shall be provided in a manner and form required by the Commissioner.

15–1304.

(A) (1) ON OR BEFORE OCTOBER 1, 2009, THE COMMISSIONER SHALL ADOPT REGULATIONS GOVERNING FIVE CLASSES OF INDIVIDUAL HEALTH BENEFIT PLANS THAT CARRIERS SHALL MAKE AVAILABLE IN THE INDIVIDUAL MARKET.

(2) WITHIN 90 DAYS OF THE ADOPTION OF THE REGULATIONS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COMMISSIONER SHALL APPROVE FIVE CLASSES OF INDIVIDUAL HEALTH BENEFIT PLANS FOR

EACH CARRIER PARTICIPATING IN THE INDIVIDUAL MARKET, WITH EACH CLASS HAVING AN INCREASED LEVEL OF BENEFITS BEGINNING WITH THE LOWEST CLASS.

(3) WITHIN EACH CLASS, THE COMMISSIONER SHALL APPROVE ONE BASELINE HEALTH MAINTENANCE ORGANIZATION AND ONE BASELINE PREFERRED PROVIDER ORGANIZATION, TO BE ISSUED BY CARRIERS IN THE INDIVIDUAL MARKET.

(4) ON AND AFTER JANUARY 1, 2010, CARRIERS IN THE INDIVIDUAL MARKET SHALL, EXCEPT AS PROVIDED IN § 14–509 OF THIS ARTICLE, GUARANTEE ISSUANCE OF THE FIVE CLASSES OF APPROVED HEALTH BENEFIT PLANS AND DISCONTINUE OFFERING AND SELLING HEALTH BENEFIT PLANS OTHER THAN THOSE WITHIN THE FIVE APPROVED CLASSES OF BENEFIT PLANS IN THE INDIVIDUAL MARKET.

(B) (1) INDIVIDUALS MAY PURCHASE A HEALTH BENEFIT PLAN FROM ONE OF THE FIVE CLASSES OF APPROVED PLANS ON A GUARANTEED ISSUE BASIS.

(2) AFTER SELECTING AND PURCHASING A HEALTH BENEFIT PLAN WITHIN A CLASS OF BENEFITS, AN INDIVIDUAL MAY CHANGE PLANS ONLY AS ESTABLISHED BY THE COMMISSIONER IN REGULATION.

15–1305.

(A) ON AND AFTER JULY 1, 2009, EACH CARRIER THAT OFFERS INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE AND CONDUCTS MEDICAL UNDERWRITING TO DETERMINE WHETHER TO ISSUE COVERAGE TO A SPECIFIC INDIVIDUAL SHALL USE A STANDARDIZED HEALTH QUESTIONNAIRE DEVELOPED BY THE BOARD OF DIRECTORS OF THE MARYLAND HEALTH INSURANCE PLAN.

(B) A CARRIER MAY NOT EXCLUDE A POTENTIAL ENROLLEE FROM ANY INDIVIDUAL COVERAGE ON THE BASIS OF AN ACTUAL OR EXPECTED HEALTH CONDITION, TYPE OF ILLNESS, TREATMENT, MEDICAL CONDITION, ACCIDENT, OR PREEXISTING CONDITION, EXCEPT AS PROVIDED UNDER § 14–509 OF THIS ARTICLE.

(C) A CARRIER MAY NOT USE INFORMATION PROVIDED ON THE QUESTIONNAIRE TO DECLINE COVERAGE OR LIMIT AN INDIVIDUAL'S CHOICE OF HEALTH BENEFIT PLAN, EXCEPT AS PROVIDED IN § 14–509 OF THIS ARTICLE.

(D) IF A CARRIER IDENTIFIES, ON THE BASIS OF THE QUESTIONNAIRE SUBMITTED BY AN APPLICANT, THAT AN INDIVIDUAL MEETS THE

REQUIREMENTS OF § 14–509 OF THIS ARTICLE, THE CARRIER MAY DECLINE COVERAGE AND DIRECT THE INDIVIDUAL TO THE MARYLAND HEALTH INSURANCE PLAN FOR COVERAGE.

15–1306.

A HEALTH BENEFIT PLAN SHALL BECOME EFFECTIVE WITHIN 31 DAYS OF RECEIPT OF THE INDIVIDUAL'S APPLICATION, STANDARDIZED HEALTH STATUS QUESTIONNAIRE, AND PREMIUM PAYMENT.

[15–1312.

A carrier that issued a high level or low level policy form prior to July 1, 2004, may not charge a rate to eligible individuals under the high level or low level policy form that is greater than 200% of the rate the carrier normally would charge for the same or similar policy forms to other individuals.**]**

15–1312.

(A) PREMIUM RATES FOR HEALTH BENEFIT PLANS SUBJECT TO THIS SUBTITLE ARE SUBJECT TO THE FOLLOWING PROVISIONS:

(1) THE INDIVIDUAL CARRIER SHALL DEVELOP ITS RATES BASED ON AN ADJUSTED COMMUNITY RATE AND MAY ONLY VARY THE ADJUSTED COMMUNITY RATE FOR:

(I) GEOGRAPHIC AREA;

(II) FAMILY COMPOSITION; AND

(III) AGE; AND

(2) THE ADJUSTMENTS TO THE RATES FOR A HEALTH BENEFIT PLAN PERMITTED IN ITEM(1)(III) OF THIS SUBSECTION MAY NOT RESULT IN A RATE PER ENROLLEE FOR THE HEALTH BENEFIT PLAN OF MORE THAN 200% OF THE LOWEST RATE FOR ALL ADULT AGE GROUPS.

(B) THE PREMIUM CHARGED FOR A HEALTH BENEFIT PLAN MAY NOT BE ADJUSTED MORE FREQUENTLY THAN ANNUALLY EXCEPT THAT THE RATES MAY BE CHANGED TO REFLECT:

(1) CHANGES TO THE FAMILY COMPOSITION OF THE ELIGIBLE PERSON; OR

(2) CHANGES TO THE HEALTH BENEFIT PLAN REQUESTED BY THE ELIGIBLE PERSON.

(C) RATING FACTORS SHALL PRODUCE PREMIUMS FOR IDENTICAL ELIGIBLE PERSONS THAT DIFFER ONLY BY THE AMOUNTS ATTRIBUTABLE TO PLAN DESIGN AND DO NOT REFLECT DIFFERENCES DUE TO THE NATURE OF THE ELIGIBLE PERSONS ASSUMED TO SELECT PARTICULAR HEALTH BENEFIT PLANS.

(D) THE COMMISSIONER SHALL ADOPT REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SECTION AND TO ASSURE THAT RATING PRACTICES USED BY INDIVIDUAL CARRIERS ARE CONSISTENT WITH THE PURPOSES OF THIS SUBTITLE.

Article – Labor and Employment

TITLE 12. EMPLOYER HEALTH EXPENDITURES.

12–101.

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

(B) "EMPLOYER" HAS THE MEANING STATED IN § 3–301 OF THIS ARTICLE.

(C) "FUND" MEANS THE HEALTH TRUST FUND ESTABLISHED UNDER § 14–709 OF THE INSURANCE ARTICLE.

(D) (1) "HEALTH EXPENDITURES" MEANS ANY AMOUNT PAID BY AN EMPLOYER TO, OR ON BEHALF OF, ITS EMPLOYEES AND THEIR DEPENDENTS, IF APPLICABLE, TO PROVIDE HEALTH CARE OR HEALTH–RELATED SERVICES OR TO REIMBURSE THE COSTS OF THOSE SERVICES, INCLUDING:

(I) CONTRIBUTIONS TO A HEALTH SAVINGS ACCOUNT AS DEFINED BY § 223 OF THE INTERNAL REVENUE CODE OR ANY OTHER ACCOUNT HAVING SUBSTANTIALLY THE SAME PURPOSE OR EFFECT;

(II) REIMBURSEMENT BY THE EMPLOYER TO ITS EMPLOYEES, AND THEIR DEPENDENTS, IF APPLICABLE, FOR INCURRED HEALTH CARE EXPENSES, IF THOSE RECIPIENTS HAVE NO ENTITLEMENT TO THAT REIMBURSEMENT UNDER ANY PLAN, FUND, OR PROGRAM MAINTAINED BY THE EMPLOYER;

(III) PROGRAMS TO ASSIST EMPLOYEES TO ATTAIN AND MAINTAIN HEALTHY LIFESTYLES, INCLUDING ONSITE WELLNESS PROGRAMS, REIMBURSEMENT FOR ATTENDING OFFSITE WELLNESS PROGRAMS, ONSITE HEALTH FAIRS AND CLINICS, AND FINANCIAL INCENTIVES FOR PARTICIPATING IN HEALTH SCREENINGS AND OTHER WELLNESS ACTIVITIES;

(IV) DISEASE MANAGEMENT PROGRAMS;

(V) PHARMACY BENEFIT MANAGEMENT PROGRAMS;

(VI) CARE RENDERED TO EMPLOYEES AND THEIR DEPENDENTS BY HEALTH CARE PROVIDERS EMPLOYED BY OR UNDER CONTRACT TO EMPLOYERS, SUCH AS EMPLOYER–SPONSORED PRIMARY CARE CLINICS;

(VII) CONTRIBUTIONS MADE IN ACCORDANCE WITH § 302(C)(5) OF THE LABOR MANAGEMENT RELATIONS ACT, UNDER A COLLECTIVE BARGAINING AGREEMENT; OR

(VIII) HEALTH INSURANCE PREMIUMS.

(2) "HEALTH EXPENDITURES" DOES NOT INCLUDE A PAYMENT MADE DIRECTLY OR INDIRECTLY FOR WORKERS' COMPENSATION, MEDICARE BENEFITS, OR ANY OTHER HEALTH BENEFIT COST OR TAXES, PENALTIES, OR ASSESSMENT THAT THE EMPLOYER IS REQUIRED TO PAY BY STATE OR FEDERAL LAW.

12–102.

(A) (1) EACH EMPLOYER SHALL ELECT TO:

(I) 1. MAKE HEALTH EXPENDITURES AS PROVIDED IN PARAGRAPH (2)(I) OF THIS SUBSECTION FOR THE EMPLOYER'S FULL–TIME EMPLOYEES AND, IF APPLICABLE, THEIR DEPENDENTS; OR

2. PAY AN EQUIVALENT AMOUNT INTO THE FUND; AND

(II) 1. MAKE HEALTH EXPENDITURES AS PROVIDED IN PARAGRAPH (2)(II) OF THIS SUBSECTION FOR THE EMPLOYER'S PART–TIME EMPLOYEES AND, IF APPLICABLE, THEIR DEPENDENTS; OR

2. PAY AN EQUIVALENT AMOUNT INTO THE FUND.

(2) (I) AN EMPLOYER'S CUMULATIVE AMOUNT OF HEALTH EXPENDITURES FOR THE EMPLOYER'S FULL–TIME EMPLOYEES WORKING 120 OR MORE HOURS PER MONTH SHALL BE EQUIVALENT TO AT LEAST 7.5% OF WAGES PAID BY THE EMPLOYER TO ITS FULL–TIME EMPLOYEES.

(II) AN EMPLOYER'S CUMULATIVE AMOUNT OF HEALTH EXPENDITURES FOR THE EMPLOYER'S PART–TIME EMPLOYEES WORKING LESS THAN 120 HOURS PER MONTH SHALL BE EQUIVALENT TO AT LEAST 7.5% OF WAGES PAID BY THE EMPLOYER TO ITS PART–TIME EMPLOYEES.

(III) IN COMPUTING THE AMOUNT UNDER SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH, WAGES PAID TO AN EMPLOYEE THAT EXCEED THE APPLICABLE CONTRIBUTION AND BENEFIT BASE, AS DETERMINED UNDER § 230 OF THE SOCIAL SECURITY ACT (42 U.S.C. § 430) FOR THE CALENDAR YEAR SHALL BE EXCLUDED.

(B) THE AMOUNT PAYABLE TO THE FUND BY AN EMPLOYER ELECTING TO PAY SHALL BE DEPOSITED INTO THE FUND.

12–103.

(A) AN EMPLOYEE OF AN EMPLOYER THAT ELECTS, UNDER § 12–102 OF THIS TITLE, TO PAY AN EMPLOYER FEE IN LIEU OF MAKING HEALTH EXPENDITURES SHALL ENROLL IN THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM TO RECEIVE HEALTH CARE COVERAGE.

(B) NOTWITHSTANDING SUBSECTION (A) OF THIS SECTION, AN EMPLOYEE IS EXEMPT FROM ENROLLING IN THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM IF:

(1) THE EMPLOYEE PROVIDES EVIDENCE OF OTHER HEALTH CARE COVERAGE; OR

(2) THE COST OF HEALTH CARE COVERAGE UNDER THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM EXCEEDS 5% OF WAGES PAID BY THE ELECTING EMPLOYER FOR COVERAGE WITH A MAXIMUM OUT–OF–POCKET COST OF $1,500.

(C) (1) AN EMPLOYEE OF AN EMPLOYER THAT ELECTS, UNDER § 12–102 OF THIS TITLE, TO MAKE HEALTH EXPENDITURES SHALL ACCEPT THE HEALTH EXPENDITURES MADE BY THE EMPLOYER.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, AN EMPLOYEE IS EXEMPT FROM THE REQUIREMENT TO ACCEPT HEALTH EXPENDITURES FROM AN EMPLOYER IF:

(I) ACCEPTING THE HEALTH EXPENDITURES WOULD RESULT IN ANNUAL HEALTH EXPENDITURES BY THE EMPLOYEE IN EXCESS OF 5% OF THE EMPLOYEE'S WAGES PAID BY THE ELECTING EMPLOYER; OR

(II) THE EMPLOYEE PROVIDES EVIDENCE OF OTHER COVERAGE UNDER AN INDIVIDUAL OR GROUP HEALTH BENEFIT PLAN.

12–104.

(A) EACH EMPLOYER, ON OR BEFORE JULY 1, 2010, SHALL MAKE AN ELECTION UNDER § 12–102 OF THIS TITLE FOR ITS FULL–TIME EMPLOYEES AND PART–TIME EMPLOYEES AND NOTIFY THE DEPARTMENT OF ITS ELECTION.

(B) AN EMPLOYER THAT FAILS TO MAKE AN ELECTION BY JULY 1, 2010, SHALL BE DEEMED TO BE AN EMPLOYER ELECTING TO PAY AN EMPLOYER FEE INTO THE FUND.

(C) AFTER JANUARY 1, 2011, EACH EMPLOYER SHALL NOTIFY THE DEPARTMENT ON OR BEFORE SEPTEMBER 15 OF EACH YEAR OF ITS ELECTION UNDER § 12–102 OF THIS TITLE FOR THE SUBSEQUENT CALENDAR YEAR, IF DIFFERENT FROM THE CURRENT YEAR, ON A FORM AND IN A MANNER REQUIRED BY THE DEPARTMENT.

12–105.

AN EMPLOYER SHALL NOTIFY ITS EMPLOYEES OF:

(1) ITS ELECTION UNDER § 12–102 OF THIS TITLE WITHIN 5 BUSINESS DAYS OF MAKING THE ELECTION; AND

(2) THE REQUIREMENT FOR EMPLOYEES TO ACCEPT HEALTH EXPENDITURES OR ENROLL IN THE MARYLAND COOPERATIVE HEALTH INSURANCE PURCHASING PROGRAM, DEPENDING ON THE EMPLOYER'S ELECTION.

12–106.

EACH EMPLOYER SHALL ADOPT AND RETAIN A CAFETERIA PLAN, WITHIN THE MEANING OF § 125 OF THE INTERNAL REVENUE CODE, TO ALLOW EMPLOYEES TO PAY PREMIUMS FOR HEALTH CARE COVERAGE THAT ARE

EXCLUDABLE FROM THE GROSS INCOME OF THE EMPLOYEE UNDER § 106 OF THE INTERNAL REVENUE CODE.

12–107.

AN EMPLOYER THAT, WITHOUT GOOD CAUSE AS DETERMINED BY THE DEPARTMENT, FAILS TO COMPLY WITH THIS TITLE SHALL BE SUBJECT TO A FINE NOT TO EXCEED:

(1) FOR A FIRST VIOLATION, $1,000 PER EMPLOYEE;

(2) FOR A SECOND VIOLATION, $2,000 PER EMPLOYEE; AND

(3) FOR ALL SUBSEQUENT VIOLATIONS, $3,000 PER EMPLOYEE.

12–108.

THE DEPARTMENT SHALL DEPOSIT:

(1) ALL EMPLOYER FEES AND EMPLOYEE PREMIUM PAYMENTS INTO THE FUND; AND

(2) ALL FINES COLLECTED INTO A SEPARATE ACCOUNT WITHIN THE FUND.

12–109.

THE DEPARTMENT SHALL ADOPT REGULATIONS TO CARRY OUT THIS TITLE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2008.