Department of Legislative Services

Maryland General Assembly
2008 Session

FISCAL AND POLICY NOTE
Revised

House Bill 872 (Delegate Pendergrass, *et al.*)
Health and Government Operations Finance

Health Insurance - Public-Private Health Care Programs

This bill establishes a regulatory framework for the establishment and operation of "public-private health care programs."

The bill takes effect June 1, 2008 and terminates May 31, 2013.

Fiscal Summary

State Effect: To the extent that only a few public-private health care programs apply for certification, the bill's requirements could be handled with existing budgeted resources. Revenues would not be significantly affected by the bill's monetary civil penalty provisions.

Local Effect: To the extent that local governments are partners in or provide funding for public-private health care programs, local revenues and expenditures could increase. Any potential impact on the circuit courts is anticipated to be minimal.

Small Business Effect: Minimal to none.

Analysis

Bill Summary: A "public-private health care program" is a program established and operated by a nonprofit corporation that ● is certified by the Maryland Insurance Commissioner; ● has entered into a written agreement with each county in which the program proposed to operate; and ● provides for or arranges health care services for participants for a fee.

A public-private health care program may not approve an application for enrollment if the individual for whom the application was submitted voluntarily terminated coverage under a small group market health benefit plan within six months of the date of application.

A person must be certified before operating a public-private health care program. Applicants for certification must be nonprofit corporations organized for the purpose of establishing and operating a public-private health care program. Applicants must file with the Commissioner ● an application; ● specific documents certified by at least two of the executive officers of the corporation; ● specified information on the board of directors; ● the written agreement with each county in which the applicant plans to operate; ● a description of the public-private health care program; ● all forms, agreements, advertising, or other documents that will be provided to participants; and ● any other information required by the Commissioner.

The Commissioner must certify an applicant that ● has been organized in good faith for the purpose of establishing and operating a public-private health care program; ● is committed to a nonprofit corporate structure; and ● has sufficient funds to meet its obligations. A certification expires after three years and may be renewed if the applicant otherwise is entitled to certification. Subject to hearing provisions, the Commissioner may deny a certification or refuse to renew, suspend, or revoke the certification under specified circumstances.

All documents provided by a certified nonprofit corporation to public-private health care program participants must be truthful and not misleading in fact or by implication and be made available to the Commissioner on request.

A certified nonprofit corporation will be subject to specified unfair claim settlement practices under current law and the associated civil monetary penalties. To enforce the bill or any regulations adopted under the bill, the Commissioner may issue an order that requires the violator to ● cease and desist; ● take specific affirmative corrective action; or ● make restitution of money, property, or other assets to a person who has suffered financial injury because of the violation. An order must be served in a specified manner. The Commissioner may file a petition in the circuit court of any county to enforce an order issued under the bill. If the Commissioner prevails, the Commissioner may recover for the State reasonable attorney's fees and the cost of the action.

The Commissioner may also impose a monetary civil penalty of up to $10,000 for each violation of the bill and a monetary civil penalty of up to $1,000 per day for each day that a person operates a public-private health care program without certification.

The Maryland Insurance Administration, on or before December 31, 2010, has to report to specified standing committees on its recommendations for the continuation of public-private health care programs in the State.

Current Law/Background: The Comprehensive Standard Health Benefit Plan is the standard health benefit plan that carriers sell to small businesses (2 to 50 employees) in the small group health insurance market. Carriers must offer CSHBP to all small businesses but may sell additional benefits or enhancements through riders. Any riders must be offered and priced separately. CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and no preexisting condition limitations. In order to maintain affordability, the average CSHBP premium rate per employee must remain below 10% of Maryland's average annual wage. In calendar 2006, CSHBP covered 51,022 employer groups and 429,431 covered lives. The overall cost of CSHBP was at 91% of the affordability cap.

Howard County has proposed establishing a public-private partnership to offer health care coverage to uninsured county adults with incomes up to 300% of federal poverty guidelines. The program would be run by a newly created nonprofit organization, Healthy Howard. To be eligible for the program, individuals must have been both uninsured and resided in the county for at least one year. Benefits will include primary care services, hospital care at Howard County General Hospital only, discounted prescription drugs, some specialty services, and health coaching. Participation fees will be based on income and range from $50 per month for an individual with an income under 200% FPG to $115 per month for an individual plus one with income between 201% and 300% FPG. Howard County indicates that legislation is required because the program does not fit the traditional definition of health insurance, nor could the program meet the financial requirements currently placed on health insurance carriers such as capital reserves.

Healthy Howard is similar to the Healthy San Francisco Program implemented in April 2007. Healthy San Francisco offers preventive/routine care, emergency and hospital care at San Francisco General Hospital only, prescriptions, and some specialty care to residents regardless of immigration status, employment status, or preexisting conditions. To be eligible, individuals must be aged 18-64, have incomes at or below 300% FPG, have been uninsured for at least 90 days, and reside in San Francisco. Individuals with incomes under 100% FPG pay no participation fee, while fees for those with incomes between 101% and 300% FPG range based on income from $60 to $150 per family member per quarter. As of February 2008, the program serves 11,374 individuals

Additional Information

Prior Introductions: None.

Cross File: SB 852 (Senator Kasemeyer, *et al.*) – Finance.

Information Source(s): Howard County Department of Health, San Francisco Department of Public Health, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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