SENATE BILL 515

C3, Q3 9lr1781
CF 9lr0428

By: **Senator Middleton**
Introduced and read first time: February 5, 2009
Assigned to: Finance and Budget and Taxation

A BILL ENTITLED

AN ACT concerning

Healthy Maryland Program

FOR the purpose of renaming the Maryland Health Insurance Plan to be the Healthy Maryland Program; establishing the status and purpose of the Program and the intent of the General Assembly with regard to the Program; repealing certain requirements for the operation of the Maryland Health Insurance Plan; establishing requirements for Program enrollment and coverage; establishing a Board of Directors for the Program; requiring the Program to operate subject to the supervision and control of the Board; providing for an Executive Director and staff for the Program; providing that the Program is not subject to certain provisions of law; requiring the Board to take certain actions; repealing certain obsolete provisions of law relating to the Senior Prescription Drug Assistance Program; renaming the Maryland Health Insurance Plan Fund to be the Healthy Maryland Program Fund; adding to the sources of revenue for the Fund collections from certain per–employee contributions and certain penalty revenue; repealing provisions of law pertaining to the Administrator of the Maryland Health Insurance Plan; requiring the Board to take certain steps relating to enrollment of individuals entitled to a subsidy; authorizing the Board to adopt regulations relating to the amount of subsidies; requiring the Board to maintain certain separate accounts; providing that a debt or obligation of the Program is not a debt of the State or a pledge of credit of the State; establishing certain requirements for the benefit package offered by the Program; establishing certain requirements for a certain master plan document and a certain certificate of coverage; establishing requirements for changes to and reports on the standard benefit package; requiring the Program, notwithstanding certain terms and conditions, to comply with the terms of a certain representation or authorization of coverage under certain circumstances; repealing provisions of law relating to certain premium rates; repealing a certain requirement for the Board to hire an administrator; establishing requirements for rates for Program coverage; establishing requirements for carriers to participate in the Program; providing that certain actions by certain entities are unlawful and a violation of the Insurance Article; requiring the

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

Program to be a certain alternative mechanism; prohibiting the Program from applying a certain exclusion to a certain individual; repealing a prohibition relating to a certain limit on participation; requiring the Insurance Commissioner to regulate the Program; establishing the applicability of certain provisions of law to the Program; providing that certain provisions do not limit certain authority of the Commissioner; establishing the authority of the Commissioner with regard to certain violations, fines, and penalties; altering requirements for carriers participating in the small group market; requiring a certain employer to pay a per–employee contribution at a certain time and in a certain manner; requiring the Maryland Health Care Commission to determine the amount of the per–employee contribution; requiring the Commissioner of Labor and Industry to determine and collect a certain contribution owed and assess a certain penalty; requiring certain amounts to be deposited in the Healthy Maryland Fund; imposing a penalty on the income tax of certain individuals unless the individual and certain dependents had certain health care coverage or are nonresidents; providing for certain exceptions; requiring the Maryland Health Care Commission to provide certain information to the Comptroller for a certain purpose; requiring the taxpayer to indicate on the income tax return the presence of health care coverage that meets certain requirements; requiring the revenues from the penalty to be distributed to the Healthy Maryland Program Fund; requiring the Comptroller to publicize the requirements of this Act for a certain purpose; providing for a delayed effective date for certain provisions of this Act; altering a certain definition; defining certain terms; and generally relating to the Healthy Maryland Program.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–501 through 14–505 and 14–507 through 14–509 to be under the amended part "Part I. Healthy Maryland Program"; and 15–1204(a) and 15–1301(f)(1)
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY adding to
Article – Insurance
Section 14–502.1, 14–506, and 14–506.1
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY repealing
Article – Insurance
Section 14–506
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY adding to
Article – Labor and Employment

Section 12–101 and 12–102 to be under the new title "Title 12. Employer Health Contribution"
Annotated Code of Maryland
(2008 Replacement Volume)

BY adding to
Article – Tax – General
Section 10–106.2
Annotated Code of Maryland
(2004 Replacement Volume and 2008 Supplement)

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

Article – Insurance

Part I. **[**Maryland Health Insurance Plan**]** **HEALTHY MARYLAND PROGRAM**.

14–501.

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

[(b) "Administrator" means:

(1) a person that is registered as an administrator under Title 8, Subtitle 3 of this article; or

(2) a carrier as defined under subsection (d) of this section.

(c)**]** **(B)** "Board" means the Board of Directors for the **[**Maryland Health Insurance Plan**]** **HEALTHY MARYLAND PROGRAM**.

[(d)**]** **(C)** "Carrier" means:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan that is licensed to operate in the State; or

(3) a health maintenance organization that is licensed to operate in the State.

[(e)**]** **(D)** "Creditable coverage" has the meaning stated in § 15–1301 of this article.

[(f)**]** **(E)** "Eligible individual" has the meaning stated in § 15–1301 of this article.

[(g)**] (F)** "Fund" means the **[**Maryland Health Insurance Plan**]** **HEALTHY MARYLAND PROGRAM** Fund.

[(h) (1) "Medically uninsurable individual" means an individual who is a resident of the State and who:

(i) provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual;

(ii) provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual, except at a rate that exceeds the Plan rate;

(iii) satisfies the definition of "eligible individual" under § 15–1301 of this article;

(iv) has a history of or suffers from a medical or health condition that is included on a list promulgated in regulation by the Board;

(v) is eligible for the tax credit for health insurance costs under § 35 of the Internal Revenue Code; or

(vi) is a dependent of an individual who is eligible for coverage under this subsection.

(2) "Medically uninsurable individual" does not include an individual who is eligible for coverage under:

(i) the federal Medicare program;

(ii) the Maryland Medical Assistance Program;

(iii) the Maryland Children's Health Program; or

(iv) an employer–sponsored group health insurance plan that includes benefits comparable to Plan benefits, unless the individual is eligible for the tax credit for health insurance costs under § 35 of the Internal Revenue Code.

(i)**] (G)** "Medicare Part D coverage gap" means the gap in coverage under Medicare Part D:

(1) above the initial coverage limit and before catastrophic coverage begins; and

(2) during which an individual enrolled in Medicare Part D is responsible for 100% coinsurance costs.

[(j) "Plan" means the Maryland Health Insurance Plan.**]**

(H) "PARTICIPATING CARRIER" MEANS A CARRIER THAT HAS RECEIVED APPROVAL FROM THE BOARD TO PROVIDE CREDITABLE COVERAGE TO PROGRAM ENROLLEES.

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

(J) "PROGRAM" MEANS THE HEALTHY MARYLAND PROGRAM.

(K) (1) "RESIDENT WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE" MEANS AN INDIVIDUAL OR A DEPENDENT WHO:

(I) IS A RESIDENT OF THE STATE; AND

(II) IS NOT EMPLOYED BY A CONTRIBUTING EMPLOYER, AS DEFINED UNDER TITLE 12 OF THE LABOR AND EMPLOYMENT ARTICLE.

(2) "RESIDENT WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE" INCLUDES AN INDIVIDUAL WHO IS ELIGIBLE FOR THE TAX CREDIT FOR HEALTH INSURANCE COSTS UNDER § 35 OF THE INTERNAL REVENUE CODE.

(3) "RESIDENT WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE" DOES NOT INCLUDE AN INDIVIDUAL WHO IS ELIGIBLE FOR COVERAGE UNDER:

(I) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT;

(II) A STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT; OR

(III) A STATE PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT.

14–502.

(a) There is a **[**Maryland Health Insurance Plan**]** **HEALTHY MARYLAND PROGRAM**.

(b) The **[**Plan**]** **PROGRAM** is an independent unit of the State government.

(c) The purpose of the **[**Plan**]** **PROGRAM** 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**]** **RESIDENTS WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE**.

(d) It is the intent of the General Assembly that**:**

(1) the **[**Plan**]** **PROGRAM** operate as a nonprofit entity**;**

(2) THE BOARD PROVIDES OVERSIGHT OF THE PROGRAM;

(3) THE UNDERWRITING RISK OF THE PROGRAM BE BORNE ENTIRELY BY THE PARTICIPATING CARRIERS WITHIN LIMITATIONS SET FORTH IN THIS SUBTITLE; and

(4) **[**that**]** Fund revenue, to the extent consistent with good business practices, be used to subsidize health insurance coverage for **[**medically uninsurable**]** individuals **WHO:**

(I) ARE RESIDENTS WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE; AND

(II) HAVE INCOME BELOW LEVELS ESTABLISHED BY THE BOARD.

[(e) (1) The operations of the Plan are subject to the provisions of this subtitle whether the operations are performed directly by the Plan itself or through an entity contracted with the Plan.

(2) The Plan shall ensure that any entity contracted with the Plan complies with the provisions of this subtitle when performing services that are subject to this subtitle on behalf of the Plan.**]**

14–502.1.

(A) (1) BEGINNING ON JULY 1, 2009, THE PROGRAM, THROUGH ITS PARTICIPATING CARRIERS, SHALL ENROLL ANY RESIDENT WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE WHO:

(I) MEETS THE ELIGIBILITY REQUIREMENTS OF THE PROGRAM; AND

(II) SEEKS TO ENROLL IN THE PROGRAM.

(2) COVERAGE SHALL BECOME EFFECTIVE:

(I) AT THE END OF THE MONTH IN WHICH A COMPLETED APPLICATION IS SUBMITTED, IF THE COMPLETED APPLICATION IS RECEIVED BY A PARTICIPATING CARRIER BY THE 15TH OF THAT MONTH; OR

(II) AT THE END OF THE NEXT CALENDAR MONTH, IF A COMPLETED APPLICATION IS RECEIVED BY A PARTICIPATING CARRIER AFTER THE 15TH OF THE PRIOR MONTH.

(B) (1) BEGINNING JANUARY 1, 2010, EACH RESIDENT WITHOUT ACCESS TO EMPLOYER–SPONSORED HEALTH CARE COVERAGE SHALL OBTAIN CREDITABLE COVERAGE THROUGH THE PROGRAM.

(2) COVERAGE UNDER THE PROGRAM SHALL BE THE EXCLUSIVE COVERAGE AVAILABLE TO RESIDENTS WITHOUT ACCESS TO EMPLOYER–SPONSORED COVERAGE.

(C) AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, AND A HEALTH MAINTENANCE ORGANIZATION MAY ONLY INSURE OR OFFER TO INSURE A RESIDENT WITHOUT ACCESS TO EMPLOYER–SPONSORED COVERAGE AS A PARTICIPATING CARRIER IN THE PROGRAM.

(D) A PARTICIPATING CARRIER:

(1) SHALL ACCEPT ON A GUARANTEED–ISSUE BASIS ANY ENROLLEE WHO CHOOSES COVERAGE FROM THE CARRIER;

(2) MAY ONLY OFFER THE COVERAGE APPROVED BY THE BOARD; AND

(3) MAY NOT IMPOSE A PRE–EXISTING CONDITION LIMITATION ON OR MEDICALLY UNDERWRITE COVERAGE.

14–503.

(a) There is a Board for the **[**Plan**]** **PROGRAM**.

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

(c) The Board consists of 10 members, of whom:

(1) one shall be the Executive Director of the Maryland Health Care Commission or the designee of the Executive Director of the Maryland Health Care Commission;

(2) one shall be the Executive Director of the Health Services Cost Review Commission or the designee of the Executive Director of the Health Services Cost Review Commission;

(3) one shall be the Secretary of Budget and Management or the designee of the Secretary of Budget and Management;

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

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

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

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

(8) one shall be the Secretary of Health and Mental Hygiene or the designee of the Secretary of Health and Mental Hygiene; and

(9) one shall be appointed by the Governor to represent hospitals in the State.

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

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

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

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

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

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

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

(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**]** **PROGRAM**.

(g) (1) The Executive Director may employ a staff for the **[**Plan**]** **PROGRAM** in accordance with the State budget.

(2) Staff for the **[**Plan**]** **PROGRAM** are in the executive service, management service, or are special appointments in the State Personnel Management System.

(3) The Executive Director, in consultation with the Department of Budget and Management, may determine the appropriate job classifications and grades for all staff.

(h) The **[**Board**]** **PROGRAM** is not subject to the provisions of the State Finance and Procurement Article.

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

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

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

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

(2) Regulations adopted by the Board may include:

(i) residency requirements for **[**Plan**]** **PROGRAM** enrollees;

(ii) **[**Plan**]** **PROGRAM** enrollment procedures; and

(iii) any other **[**Plan**]** **PROGRAM** requirements as determined by the Board.

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

(m)**]** (1) The Board shall report on or before December 1 of each year to the Governor and, subject to § 2–1246 of the State Government Article, to the General Assembly on:

(i) the number of members enrolled in the **[**Plan**]** **PROGRAM**;

(ii) any increase or decrease in the number of members enrolled in the **[**Plan**]** **PROGRAM** from the previous year;

(iii) any actions taken by the Board to increase enrollment or benefits offered through the **[**Plan**]** **PROGRAM**; and

(iv) the amount of any surplus in the Fund at the end of the previous fiscal year.

(2) For those members enrolled in the **[**Plan**]** **PROGRAM** whose eligibility in the **[**Plan**]** **PROGRAM** 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**]** **PROGRAM** and the costs to the **[**Plan**]** **PROGRAM** associated with providing insurance to those members.

14–504.

(a) (1) There is a **[**Maryland Health Insurance Plan**]** **HEALTHY MARYLAND PROGRAM** Fund.

(2) The Fund is a special nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The Treasurer shall separately hold and the Comptroller shall account for the Fund.

(4) The Fund shall be invested and reinvested at the direction of the Board in a manner that is consistent with the requirements of Title 5, Subtitle 6 of this article.

(5) Any investment earnings shall be retained to the credit of the Fund.

(6) On an annual basis, the Fund shall be subject to an independent actuarial review setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts.

(7) The Fund shall be used only to provide funding for the purposes authorized under this subtitle.

(b) The Fund shall consist of:

(1) **[**premiums for coverage that the Plan issues;

(2)**]** money collected in accordance with § 19–214(d) of the Health – General Article;

[(3)**] (2)** money deposited by a nonprofit health service plan in accordance with § 14–513 of this subtitle;

[(4)**] (3)** income from investments that the Board makes or authorizes on behalf of the Fund;

[(5)**] (4)** interest on deposits or investments of money from the Fund;

[(6)**] (5)** premium tax revenue collected under § 14–107 of this title;

[(7)**] (6)** money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Fund;

[(8)**] (7)** money donated to the Fund; **[**and

(9)**] (8)** money awarded to the Fund through grants**;**

(9) REVENUE COLLECTED FROM PER–EMPLOYEE CONTRIBUTIONS UNDER TITLE 12 OF THE LABOR AND EMPLOYMENT ARTICLE; AND

(10) PENALTY REVENUE COLLECTED UNDER § 10–106.2 OF THE TAX – GENERAL ARTICLE.

[(c) (1) The Board may allow the Administrator to use premiums collected by the Administrator from Plan enrollees to pay claims for Plan enrollees.

(2) The Administrator:

(i) shall deposit all premiums for Plan enrollees in a separate account, titled in the name of the State of Maryland, for the Maryland Health Insurance Plan; and

(ii) may use money in the account only to pay claims for Plan enrollees.

(3) The Administrator shall keep complete and accurate records of all transactions for the separate account.

(4) By the 15th of the following month, if monthly premiums collected by the Administrator exceed monthly claims received, the Administrator shall deposit the remaining balance, including interest, for that month in the Fund.

(d)**] (C)** (1) The Board shall take steps necessary to ensure that **[**Plan**]** enrollment **OF INDIVIDUALS ENTITLED TO A SUBSIDY** does not exceed the number **[**of enrollees**]** the **[**Plan**]** **PROGRAM** has the financial capacity to **[**insure**]** **SUBSIDIZE**.

(2) The Board may adopt regulations to **[**limit the enrollment of otherwise eligible medically uninsurable individuals whose premium is paid for by a pharmaceutical manufacturer or its affiliate if the Board determines that their enrollment would have an adverse financial impact on the Plan**]** **ENSURE THAT THE AMOUNT OF SUBSIDIES REQUIRED UNDER THE PROGRAM DOES NOT EXCEED THE REVENUE AVAILABLE FOR SUBSIDIES IN THE FUND**.

(e) (1) In addition to the operation and administration of the **[**Plan**]** **PROGRAM**, the Fund shall be used for the operation and administration of the Senior Prescription Drug Assistance Program established under Part II of this subtitle.

(2) The Board shall maintain separate accounts within the Fund for the Senior Prescription Drug Assistance Program and the **[**Maryland Health Insurance Plan**]** **HEALTHY MARYLAND PROGRAM**.

(3) Accounts within the Fund shall contain those moneys that are intended to support the operation of the **[**Program**]** **PROGRAM** for which the account is designated.

(f) A debt or obligation of the **[**Plan**]** **HEALTHY MARYLAND PROGRAM** is not a debt of the State or a pledge of credit of the State.

14–505.

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

(2) THE STANDARD BENEFIT PACKAGE SHALL BE BOTH AFFORDABLE AND COMPREHENSIVE.

[(2)**] (3) [**The**]** **TO ASSURE AFFORDABILITY AND ENCOURAGE ENROLLMENT IN THE PROGRAM, THE** Board may exclude from the benefit package:

(i) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(ii) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

(4) THE BENEFIT PACKAGE SHALL:

(I) INCLUDE INCENTIVES FOR HEALTHY BEHAVIOR; AND

(II) PROVIDE FIRST–DOLLAR COVERAGE FOR PREVENTIVE HEALTH SERVICES.

(5) INCENTIVES SHALL INCLUDE REDUCED PREMIUMS AND DEDUCTIBLES FOR ACTIVITIES SUCH AS:

(I) COMPLETING A HEALTH RISK ASSESSMENT OR HEALTH SCREENING;

(II) SELECTING A PROVIDER TO ACT AS THE MEMBER'S MEDICAL HOME; AND

(III) MEETING BENCHMARKS ESTABLISHED BY THE BOARD FOR ACHIEVING AND MAINTAINING GOOD HEALTH.

(b) (1) The Board shall **REQUIRE EACH PARTICIPATING CARRIER TO** develop**, IN ACCORDANCE WITH BOARD REQUIREMENTS,** a master plan document that sets forth in detail all of the terms and conditions of the standard benefit package required by subsection (a)(1) of this section, including:

(i) the benefits provided in the package;

(ii) any exclusions from coverage;

(iii) any conditions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service;

(iv) any conditions or limitations on the selection of a primary care provider or provider of specialty medical care;

(v) any cost–sharing requirements, including any premiums, deductibles, coinsurance, and copayment amounts for which a member may be responsible; and

(vi) the procedures to be followed in presenting a claim.

(2) The Board shall **REQUIRE EACH PARTICIPATING CARRIER TO**:

(I) OBTAIN BOARD APPROVAL FOR ITS MASTER PLAN DOCUMENT;

[(i)**] (II)** file the master plan document with the Commissioner; and

[(ii)**] (III)** provide a copy of the most recent version of the master plan document to a member, at no charge, on request of the member.

(c) (1) The Board shall **REQUIRE EACH PARTICIPATING CARRIER TO** develop a certificate of coverage that describes the essential features of the **[**Plan**]** **PROGRAM** and the standard benefit package.

(2) The certificate of coverage shall:

(i) be written in clear and easy to understand language; and

(ii) be sufficiently accurate and comprehensive to reasonably inform members of their rights and obligations under the standard benefit package.

(3) The Board shall **REQUIRE EACH PARTICIPATING CARRIER TO** update the certificate of coverage as necessary to reflect changes to the standard benefit package.

(4) The Board shall **REQUIRE EACH PARTICIPATING CARRIER TO**:

(i) within 30 days after a member's enrollment in the **[**Plan**]** **PROGRAM**, provide the most recent version of the certificate of coverage to:

1. the member; or

2. if dependents are included in the coverage, to the family unit;

(ii) make the most recent version of the certificate of coverage available on the **[**Plan**]** **PROGRAM** website; and

(iii) provide notice of any change to the standard benefit package to:

1. each member of the **[**Plan**]** **PROGRAM** to whom a certificate of coverage previously has been provided; or

2. if dependents are included in the coverage, to each family unit to which a certificate of coverage previously has been provided.

(d) The Board may make a change to the standard benefit package only if:

(1) the proposed change is submitted in writing to the Board at least 15 days before the meeting at which a vote on the proposed change will be taken;

(2) consideration of the proposed change is listed as an action item on the agenda for the meeting;

(3) the proposed change is set forth in a written motion that:

(i) identifies the specific changes to be made; and

(ii) is included in the minutes of the meeting of the Board at which the motion is made;

(4) the deliberations and vote on the proposed change occur during a public session of a meeting with the Board; and

(5) the vote approving the proposed change is reflected in the minutes of the meeting of the Board at which the vote is taken.

(e) **(1)** A change to the standard benefit package is not effective until **[**the later of:

(1) 30 days after the date the Board adopts the change;

(2) the date an updated master plan document reflecting the change is filed with the Commissioner; or

(3)**] 6 MONTHS AFTER ADOPTION OF THE CHANGE BY THE BOARD.**

(2) THE BOARD SHALL REQUIRE EACH PARTICIPATING CARRIER TO:

(I) POST NOTICE OF THE CHANGE ON THE CARRIER'S PROGRAM WEBSITE 15 DAYS IN ADVANCE OF THE EFFECTIVE DATE OF THE CHANGE; AND

(II) PROVIDE 15 days **[**after**]** **ADVANCE** notice of the change and the effective date of **THE** change **[**is:

(i) sent**]** to:

1. each member of the **[**Plan**]** **PROGRAM**; or

2. if dependents are included in the coverage, to the family unit**[**; and

(ii) posted on the Plan website**]**.

(f) On or before September 1 of each year, in accordance with § 2–1246 of the State Government Article, the Board shall report to the House Health and Government Operations Committee and the Senate Finance Committee on:

(1) the current standard benefit package offered by the **[**Plan**]** **PROGRAM**; and

(2) any changes to the standard benefit package implemented during the immediately preceding fiscal year.

(g) (1) If there is a conflict between a provision of the master plan document and a provision of the certificate of coverage, the provision that is most beneficial to the member shall control.

(2) Notwithstanding the terms and conditions of the standard benefit package, the master plan document, or the certificate of coverage, the **[**Plan**]** **PROGRAM** shall comply with the terms of any written representation or authorization of coverage made by or on behalf of the **[**Plan**]** **PROGRAM** to the extent that a member has incurred costs for health care services in reasonable reliance on the written representation or authorization.

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

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

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

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

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

(2) The premium rate for Plan coverage:

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

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

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

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

(j) (1) Notwithstanding the provisions of subsection (h) of this section, if the Board has implemented a preexisting condition limitation, the Board may offer members an optional endorsement to remove the preexisting condition limitation.

(2) The Board may charge an actuarially justified additional premium amount in addition to the premium rate for the standard benefit package for the optional endorsement under paragraph (1) of this subsection.

(3) An amount charged in addition to the premium rate for the standard benefit package for the optional endorsement under paragraph (1) of this subsection shall be subject to review and approval by the Commissioner.

(k) Losses incurred by the Plan shall be subsidized by the Fund.**]**

[14–506.

(a) (1) The Board shall select an Administrator to administer the Plan.

(2) The Administrator shall be selected based on criteria adopted by the Board in regulation, which shall include:

(i) the Administrator's proven ability to provide health insurance coverage to individuals;

(ii) the efficiency and timeliness of the Administrator's claim processing procedures;

(iii) an estimate of total charges for administering the Plan;

(iv) the Administrator's proven ability to apply effective cost containment programs and procedures; and

(v) the financial condition and stability of the Administrator.

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

(2) The contract between the Board and the Administrator shall require the Administrator to comply with the provisions of this subtitle to which the Plan is subject.

(c) The Administrator shall perform functions relating to the Plan as required by the Board, including:

(1) determination of eligibility;

(2) data collection;

(3) case management;

(4) financial tracking and reporting;

(5) payment of claims; and

(6) premium billing.

(d) (1) Each year, the Plan Administrator shall submit to the Commissioner an accounting of medical claims incurred, administrative expenses, and premiums collected.

(2) Plan losses shall be certified by the Commissioner in accordance with paragraph (3) of this subsection and returned to the Administrator by the Board.

(3) Administrative expenses and fees shall be paid as provided in the Administrator's contract with the Board.

(e) (1) The Board may contract with a qualified, independent third party for any service necessary to carry out the powers and duties of the Board.

(2) Unless permission is granted specifically by the Board, a third party hired by the Board may not release, publish, or otherwise use any information to which the third party had access under its contract.

(f) The Administrator shall submit regular reports to the Board regarding the operation of the Plan.

(g) The Administrator shall submit an annual report to the Board that includes:

(1) the net written and earned premiums for the year;

(2) the expense of the administration for the year; and

(3) the paid and incurred losses for the year.**]**

14–506.

(A) THE BOARD SHALL ESTABLISH A COMMUNITY RATE FOR PROGRAM COVERAGE.

(B) IN ESTABLISHING THE COMMUNITY RATE, THE BOARD SHALL USE A RATING METHODOLOGY, ACCORDING TO COMMONLY ACCEPTED ACTUARIAL PRINCIPLES, THAT IS BASED ON THE EXPERIENCE OF ALL RISKS COVERED BY THE PROGRAM WITHOUT REGARD TO HEALTH STATUS, OCCUPATION, OR ANY OTHER FACTOR NOT SPECIFICALLY AUTHORIZED UNDER THIS SECTION.

(C) THE COMMUNITY RATE MAY BE ADJUSTED ONLY FOR:

(1) AGE;

(2) FAMILY COMPOSITION; AND

(3) INCENTIVES FOR HEALTHY BEHAVIOR.

(D) BASED ON AGE, THE BOARD MAY ALLOW A RATE THAT IS 40% ABOVE THE COMMUNITY RATE OR 50% BELOW THE COMMUNITY RATE.

(E) IN ADDITION TO THE FACTORS PROVIDED UNDER SUBSECTIONS (B) THROUGH (D) OF THIS SECTION, THE BOARD SHALL ESTABLISH AND ALLOW A REASONABLE ADMINISTRATIVE FEE AND A MARGIN OF 2% FOR PARTICIPATING CARRIERS, TO BE INCLUDED IN RATES.

(F) IN ESTABLISHING AND PERIODICALLY ADJUSTING RATES, THE BOARD SHALL CONSULT WITH AN EXTERNAL EXPERT ACTUARIAL ADVISOR, WHO SHALL CERTIFY THAT RATES HAVE BEEN ESTABLISHED IN ACCORDANCE WITH THIS SECTION.

(G) EACH PARTICIPATING CARRIER SHALL CHARGE THE STANDARD PREMIUM RATES ESTABLISHED BY THE BOARD.

(H) ON OR BEFORE MARCH 31 OF EACH YEAR, EACH PARTICIPATING CARRIER SHALL REPORT, IN A FORM AND MANNER ESTABLISHED BY THE BOARD:

(1) THE ACTUAL MEDICAL COSTS EXPERIENCED BY PROGRAM ENROLLEES AND THE ACTUAL ADMINISTRATIVE COSTS ASSOCIATED WITH THE PROGRAM IN THE PREVIOUS YEAR; AND

(2) ANY REQUEST FOR AN ADJUSTMENT TO PROGRAM RATES AND THE ACTUARIAL BASIS FOR THE ADJUSTMENT.

14–506.1.

(A) EXCEPT AS PROVIDED UNDER SUBSECTION (C) OF THIS SECTION, A CARRIER MAY NOT BE REQUIRED TO PARTICIPATE IN THE PROGRAM.

(B) A CARRIER THAT SEEKS TO BE A PARTICIPATING CARRIER SHALL APPLY TO PARTICIPATE IN A FORM AND AT A TIME DETERMINED BY THE BOARD.

(C) A CARRIER THAT OFFERS A HEALTH BENEFIT PLAN TO SMALL EMPLOYERS UNDER TITLE 15, SUBTITLE 12 OF THIS ARTICLE SHALL PARTICIPATE IN THE PROGRAM.

(D) A CARRIER THAT IS A PARTICIPATING CARRIER AND LATER CEASES TO PARTICIPATE MAY NOT, FOR A PERIOD OF 5 CALENDAR YEARS AFTER THE DATE THE CARRIER CEASED PARTICIPATION IN THE PROGRAM:

(1) BECOME A PARTICIPATING CARRIER; OR

(2) EXCEPT AS PROVIDED UNDER SUBSECTION (E) OF THIS SECTION, OFFER A HEALTH BENEFIT PLAN TO SMALL EMPLOYERS UNDER TITLE 15, SUBTITLE 12 OF THIS ARTICLE.

(E) A CARRIER MAY ELECT TO CEASE PARTICIPATION IN THE PROGRAM AND CONTINUE TO OFFER A HEALTH BENEFIT PLAN TO SMALL EMPLOYERS UNDER TITLE 15, SUBTITLE 12 OF THIS ARTICLE IF THE CARRIER:

(1) EXPERIENCES CUMULATIVE LOSSES EXCEEDING $50,000,000 FROM THE TIME THE CARRIER BECAME A PARTICIPATING CARRIER; OR

(2) EXPERIENCES LOSSES EQUAL TO OR GREATER THAN 10% OF PREMIUM REVENUE IN 2 CONSECUTIVE OPERATING YEARS.

14–507.

It is unlawful and a violation of this article for a carrier, insurance producer, or third party administrator to refer an individual employee to the **[**Plan**]** **PROGRAM**, or arrange for an individual employee to apply to the **[**Plan**]** **PROGRAM**, for the purpose of separating that employee from the group health insurance coverage provided through the employee's employer.

14–508.

(a) The **[**Plan**]** **PROGRAM** shall be the alternative mechanism for eligible individuals under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. 148.128.

(b) The **[**Plan**]** **PROGRAM** may not apply a preexisting condition exclusion to an eligible individual who applies for coverage under the **[**Plan within 63 days of terminating prior creditable coverage**]** **PROGRAM**.

[(c) If the Board imposes a limit on the number of individuals who can participate in the Plan, the limit may not be applied to HIPAA eligible individuals.**]**

14–509.

(a) The Commissioner shall regulate the **[**Plan**]** **PROGRAM**.

(b) Except as otherwise provided in this subtitle, the **[**Plan**]** **PROGRAM** is not subject to the insurance laws of the State.

(c) Except as provided in subsection (d) of this section, the **[**Plan**]** **PROGRAM** shall be subject to:

(1) §§ 2–205, 2–207, 2–208, and 2–209 of this article;

(2) §§ 15–112, 15–112.1, 15–113, and 15–130 of this article;

(3) §§ 15–401, 15–402, 15–403, and 15–403.1 of this article;

(4) §§ 15–830, 15–831, and 15–833 of this article;

(5) §§ 15–1001, 15–1003, 15–1004, 15–1005, 15–1006, 15–1007, 15–1008, and 15–1009 of this article;

(6) Title 15, Subtitles 10A, 10B, and 10D of this article; and

(7) §§ 27–303 and 27–304 of this article.

(d) (1) The Plan is not subject to § 15–10B–12 of this article.

(2) This subsection does not limit the authority of the Commissioner to impose the penalty authorized under § 15–10B–12 of this article on a private review agent conducting utilization review on behalf of **A PARTICIPATING CARRIER UNDER** the **[**Plan**]** **PROGRAM**.

(e) (1) The Commissioner may not impose a fine or administrative penalty on the **[**Plan**]** **PROGRAM**.

(2) If the Commissioner finds that the **[**Plan**]** **PROGRAM** has violated a provision of this subtitle, the Commissioner may require the **[**Plan**]** **PROGRAM** to make restitution to each claimant who has suffered actual economic damages because of the violation.

(3) **[**Subject to the terms of the master plan document, the**]** **THE** restitution authorized under paragraph (2) of this subsection may not exceed the amount of actual economic damages sustained by the claimant.

(4) This subsection does not limit the authority of the Commissioner to take action against any person with respect to any provision of this article, other than this subtitle, that is applicable to that person.

(f) (1) The Commissioner shall:

(i) provide a copy of an adopted examination report or the results of any review conducted under this subtitle to the Board; and

(ii) make recommendations for corrective action to be taken by the Board.

(2) (i) Based on the Commissioner's recommendations provided under paragraph (1) of this subsection, the Board shall determine the steps necessary to implement corrective action to comply with the provisions of this subtitle, including whether to exercise any remedies available to the Board **[**under the contract between the Board and the Plan Administrator**]** **RELATING TO PARTICIPATING CARRIERS**.

(ii) If the Board exercises its right to impose fiscal sanctions or liquidated damages under the terms of a contract between the Board and **[**the Plan Administrator**]** **A PARTICIPATING CARRIER**, the moneys shall be deposited in the Fund.

[(3) This subsection does not limit the authority of the Commissioner to:

(i) impose the penalty under § 15–10B–12 of this article on a private review agent conducting utilization review on behalf of the Plan; or

(ii) impose the penalties under Title 8, Subtitle 3 of this article on a third party administrator operating on behalf of the Plan.**]**

15–1204.

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

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

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

(3) provide, in the case of individuals covered under more than one health benefit plan, for coordination of coverage under all of those health benefit plans in an equitable manner; **[**and**]**

(4) design policies to help ensure adequate access to providers of health care**; AND**

(5) BE A PARTICIPATING CARRIER IN THE HEALTHY MARYLAND PROGRAM, AS REQUIRED UNDER TITLE 14, SUBTITLE 5 OF THIS ARTICLE.

15–1301.

(f) (1) "Creditable coverage" means coverage of an individual under:

(i) an employer sponsored plan;

(ii) a health benefit plan;

(iii) Part A or Part B of Title XVIII of the Social Security Act;

(iv) Title XIX or Title XXI of the Social Security Act, other than coverage consisting solely of benefits under § 1928 of that Act;

(v) Chapter 55 of Title 10 of the United States Code;

(vi) a medical care program of the Indian Health Service or of a tribal organization;

(vii) a State health benefits risk pool;

(viii) a health plan offered under the Federal Employees Health Benefits Program (FEHBP), Title 5, Chapter 89 of the United States Code;

(ix) a public health plan as defined by federal regulations authorized by the Public Health Service Act, § 2701(c)(1)(i), as amended by P.L. 104–191; **[**or**]**

(x) a health benefit plan under § 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e)**; OR**

(XI) THE HEALTHY MARYLAND PROGRAM UNDER TITLE 14, SUBTITLE 5 OF THIS ARTICLE.

Article – Labor and Employment

TITLE 12. EMPLOYER HEALTH CONTRIBUTION.

12–101.

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

(B) "COMMISSIONER" MEANS THE COMMISSIONER OF LABOR AND INDUSTRY.

(C) "CONTRIBUTING EMPLOYER" MEANS AN EMPLOYER THAT OFFERS A GROUP HEALTH PLAN, AS DEFINED IN 26 U.S.C. 5000(B)(1), TO WHICH THE EMPLOYER MAKES A FAIR AND REASONABLE PREMIUM CONTRIBUTION, AS ESTABLISHED IN REGULATION BY THE MARYLAND HEALTH CARE COMMISSION.

(D) "EMPLOYEE" MEANS ANY INDIVIDUAL EMPLOYED BY AN EMPLOYER FOR AT LEAST 1 MONTH.

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

12–102.

(A) AN EMPLOYER THAT EMPLOYS NINE OR MORE FULL–TIME EQUIVALENT EMPLOYEES IN THE STATE AND IS NOT A CONTRIBUTING EMPLOYER SHALL PAY A PER–EMPLOYEE CONTRIBUTION AT A TIME AND IN A MANNER DETERMINED BY THE COMMISSIONER.

(B) THE MARYLAND HEALTH CARE COMMISSION SHALL ANNUALLY DETERMINE THE AMOUNT OF THE PER–EMPLOYEE CONTRIBUTION, BASED ON THE AVERAGE PREMIUM CONTRIBUTION MADE BY EMPLOYERS THAT OFFER INSURANCE IN THE SMALL GROUP MARKET.

(C) THE COMMISSIONER SHALL:

(1) DETERMINE AND COLLECT THE CONTRIBUTION OWED BY AN EMPLOYER AS REQUIRED UNDER SUBSECTION (A) OF THIS SECTION; AND

(2) ASSESS A PENALTY ON AN EMPLOYER THAT FAILS TO MAKE THE CONTRIBUTION REQUIRED UNDER SUBSECTION (A) OF THIS SECTION.

(D) ALL AMOUNTS COLLECTED UNDER THIS SECTION SHALL BE DEPOSITED IN THE HEALTHY MARYLAND PROGRAM FUND ESTABLISHED UNDER TITLE 14, SUBTITLE 5 OF THE INSURANCE ARTICLE.

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

Article – Tax – General

10–106.2.

(A) IN THIS SECTION, "CONTINUOUS HEALTH CARE COVERAGE" MEANS CREDITABLE COVERAGE AS DEFINED IN § 15–1301 OF THE INSURANCE ARTICLE WITH NO LAPSE IN COVERAGE EXCEEDING 63 DAYS IN ANY CALENDAR YEAR.

(B) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION AND SUBSECTIONS (C) AND (D) OF THIS SECTION, IN ADDITION TO THE STATE INCOME TAX UNDER § 10–105(A) OF THIS SUBTITLE, AN INDIVIDUAL SHALL BE SUBJECT TO A PENALTY OF $1,000, UNLESS THE INDIVIDUAL AND EACH DEPENDENT CHILD OF THE INDIVIDUAL MAINTAINED CONTINUOUS HEALTH CARE COVERAGE DURING THE TAXABLE YEAR.

(2) FOR A MARRIED COUPLE FILING A JOINT RETURN, THE PENALTY UNDER THIS SECTION EQUALS:

(I) $2,000 UNLESS EACH SPOUSE AND EACH DEPENDENT CHILD OF THE MARRIED COUPLE MAINTAINED CONTINUOUS HEALTH CARE COVERAGE; OR

(II) $1,000 IF EACH DEPENDENT CHILD OF THE MARRIED COUPLE AND EITHER THE HUSBAND OR WIFE, BUT NOT BOTH, MAINTAINED CONTINUOUS HEALTH CARE COVERAGE.

(C) THIS SECTION DOES NOT APPLY TO A NONRESIDENT, INCLUDING A NONRESIDENT SPOUSE OR A NONRESIDENT DEPENDENT.

(D) (1) THE COMPTROLLER SHALL PROVIDE FOR EXCEPTIONS TO SUBSECTION (B) OF THIS SECTION FOR AN INDIVIDUAL:

(I) WHOSE ANNUAL PREMIUM COSTS WOULD EXCEED 6% OF FEDERAL ADJUSTED GROSS INCOME;

(II) WHOSE ANNUAL HOUSEHOLD INCOME FALLS BELOW 300% OF THE FEDERAL POVERTY LEVEL; OR

(III) WHO OBJECTS TO HEALTH INSURANCE ON RELIGIOUS GROUNDS, PROVIDED THAT THE INDIVIDUAL FILES A SWORN AFFIDAVIT WITH THE TAX RETURN STATING THAT THE INDIVIDUAL'S SINCERELY HELD RELIGIOUS BELIEFS ARE THE BASIS OF THE INDIVIDUAL'S REFUSAL TO OBTAIN AND MAINTAIN HEALTH CARE COVERAGE.

(2) THE MARYLAND HEALTH CARE COMMISSION SHALL PROVIDE ANNUAL PREMIUM COSTS TO THE COMPTROLLER FOR THE PURPOSE OF MAKING THE CALCULATION UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION.

(E) THE TAXPAYER SHALL INDICATE ON THE INCOME TAX RETURN, IN THE FORM REQUIRED BY THE COMPTROLLER, THE PRESENCE OF HEALTH CARE COVERAGE THAT MEETS THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION FOR THE INDIVIDUAL, EACH SPOUSE IN THE CASE OF A MARRIED COUPLE, AND EACH DEPENDENT CHILD.

(F) NOTWITHSTANDING § 2–609 OF THIS ARTICLE, AFTER DEDUCTING A REASONABLE AMOUNT FOR ADMINISTRATIVE COSTS, THE COMPTROLLER SHALL DISTRIBUTE THE REVENUES FROM THE PENALTY TO THE HEALTHY MARYLAND PROGRAM FUND ESTABLISHED UNDER TITLE 14, SUBTITLE 5 OF THE INSURANCE ARTICLE.

SECTION 3. AND BE IT FURTHER ENACTED, That the Comptroller shall publicize the requirements of this Act to provide an adequate opportunity for individuals to obtain health care coverage and avoid a penalty.

SECTION 4. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect January 1, 2010, and shall be applicable to all taxable years beginning after December 31, 2009.

SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect July 1, 2009.