Part J
Health

Public Health – Generally

Medicaid

Managed Care Pilot Program for Long-term Care

Senate Bill 819 ***(passed)*** requires the Department of Health and Mental Hygiene (DHMH) to apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to establish the Community Choice Program (program), a managed care system that will operate in two areas of the State and provide long-term care services to eligible Medicaid enrollees. Prior to submitting the waiver to CMS, DHMH must submit the proposed waiver to the Legislative Policy Committee for its review and comment.

Individuals eligible for the program include (1) adults who are dually-eligible for Medicare and Medicaid; (2) adult Medicaid recipients who meet the nursing home level-of-care standard; and (3) Medicaid recipients over 65 years of age. Program recipients are required to enroll in a community care organization (CCO), which promotes the delivery of services in the most appropriate, cost-effective setting, including nursing facilities and community-based services. If an enrollee requires nursing home level of care, the enrollee may choose to receive services in a nursing home or in the community if community placement is cost effective. In addition, DHMH must make capitation payments to each CCO at a level that is actuarially adjusted for the benefits provided. DHMH must use the savings realized under the program to increase reimbursement rates to community providers and develop a statewide single point-of-entry system to accept applications, make eligibility determinations, enroll individuals, and provide coordinated services. The program terminates in May 2008.

The bill also requires DHMH to seek permission from CMS to alter the level-of-care standard for individuals to be medically eligible to receive services through the Waiver for Older Adults. An individual will be medically eligible if the individual requires (1) skilled nursing facility care or other related services; (2) rehabilitation services; or (3) health-related services above the level of room and board that are available only through nursing facilities, including individuals who have severe cognitive impairments.

Dental Services

Children enrolled in Medicaid have historically received very little dental care. In fiscal 1997, the final year that most Medicaid enrollees received dental care on a fee-for-service basis, only about 20 percent of children who were enrolled for most of the year used dental services. The General Assembly sought to address this trend by setting utilization targets that increased from 30 percent in calendar 2000 to 70 percent for calendar 2004. Despite enhanced funding for dental care and modest increases in visits, the utilization rate for HealthChoice managed care organization (MCO) enrollees still trails the statutory target. Utilization of restorative care (fillings) is especially low at only about 10 percent.

***House Bill 1134* (passed)** requires a Medicaid MCO, in coordination with participating dentists, enrollees, and families of enrollees, to develop a process to arrange to provide dental therapeutic treatment to individuals under 21 years old that requires (1) a participating dentist to notify an MCO when an enrollee needs therapeutic treatment and the dentist is unable to provide that treatment; (2) an MCO to provide an enrollee with a list of participating providers who offer therapeutic treatment services; and (3) an MCO to notify an enrollee that the MCO will provide further assistance if the enrollee has difficulty obtaining an appointment to receive therapeutic treatment.

Developmental Disabilities Administration

Funding Increase

The Developmental Disabilities Administration (DDA) provides services to individuals with mental or physical impairments that result in substantial functional limitations and are likely to continue indefinitely. Services are provided in four State residential centers and through a coordinated service delivery system that supports the integration of these individuals into the community.

The DDA budget grows $44 million in fiscal 2005, a result of several recent initiatives intended to increase access to and quality of community services. Of the increase, $18 million is dedicated to the third year of the initiative to increase wages for community direct service workers. Concern that direct care workers employed by community providers were not being compensated at the rate of employees in State residential centers led to legislation, enacted in 2001, to eliminate the wage disparity over a five-year period. The initiative is expected to increase the hourly wage and fringe benefits of community direct service workers 8.5 percent in fiscal 2005, from $13.01 to $14.12.

The fiscal 2005 budget also includes funds for expansion of community services. The transitioning youth program, which provides supported employment and day services for students graduating from the school system, will provide services to an additional 475 students in fiscal 2005 at a cost of $7 million. Residential, day, and support services will also be expanded to an estimated 400 individuals on an emergency basis at a cost of $5 million in fiscal 2005. The remainder of the increase provides funds for the annualization of fiscal 2004 community placements, inflation in community services costs, and deinstitutionalization.

Respite Care

House Bill 475 ***(passed)*** requires State residential centers to provide respite care for families caring for individuals with developmental disabilities in their homes. Beginning in fiscal 2006, the Holly Center, the Potomac Center, and the Brandenburg Center must each reserve not more than 4 percent of its total beds for respite care. The Rosewood Center must reserve at least 2 percent but not more than 4 percent of its total beds for respite care, as required under current law. The bill requires families caring for individuals with developmental disabilities in their homes to have a choice of obtaining respite care in a State residential center or a community setting.

Under the bill, DHMH must study the demand for respite care beds in State residential centers and determine how many beds could be reserved for respite care.

Mental Health

Specialty Mental Health Services

When DHMH implemented Medicaid managed care in 1998, specialty mental health services were carved out of the managed care structure and funded through the public mental health system. Specialty mental health services are defined as meeting certain medical necessity criteria utilizing accepted diagnostic tools.

Concerned that ongoing budget deficits in the specialty mental health services budget might result in an executive decision to end the carve-out, ***Senate Bill 754/House Bill 943*** ***(both passed)*** provide that, without the legislative approval of the General Assembly (1) the Secretary of Health and Mental Hygiene may not end the exclusion of specialty mental health services from the Medicaid HealthChoice managed care program; and (2) DHMH may not contract with a behavioral managed care organization to provide specialty mental health services.

Emergency Evaluations

Senate Bill 873 ***(passed)*** adds a clinical nurse specialist in psychiatric and mental health nursing and a psychiatric nurse practitioner to the list of individuals who may petition for an emergency evaluation of an individual if the nurse specialist or practitioner has examined the person and has reason to believe that the individual has a mental disorder and that the individual presents a danger to the life or safety of the individual or a another person. In addition, any licensed health care professional who petitions for an emergency evaluation must include the professional's license number on the petition.

Group Homes

House Bill 416 ***(passed)*** requires the Office for Children, Youth, and Families (OCYF), in coordination with DHMH, the Department of Human Resources, and the Department of Juvenile Services, to analyze and recommend how the Subcabinet Resources Directory may be used (1) to notify State and local elected officials about newly licensed children's group homes

in their jurisdictions and (2) by State and local elected officials, law enforcement agents, and other appropriate individuals to quickly identify the owner and agency that licenses a particular group home. By October 1, 2004, OCYF must report its results and recommendations to the Senate Finance Committee, the House Health and Government Operations Committee, and the Joint Committee on Children, Youth, and Families.

Health Care Decisions

Advance Directives

The legislature passed two pieces of legislation relating to advance directives. Advance directives are forms that allow an individual to express his or her preferences for the types of medical treatment and care he or she wishes to receive if the individual becomes incapacitated or unable to make informed medical decisions by illness or injury.

There is a gap between patients' preferences about end-of-life care and the interventions actually performed in health care facilities because the wishes expressed by an advance directive may in some cases not be honored due to the unavailability of completed forms or a provider's lack of understanding of how to translate the document into treatment of specific medical conditions. ***Senate Bill 352*/*House Bill 556* (both passed)** require the Office of the Attorney General to develop a "Patient's Plan of Care" form suitable for reflecting an individual's preferences for treatment and care, including the use of life-sustaining procedures and the transfer to a hospital from a nonhospital setting. The form will include a statement that the form can be modified at any time and will designate under which conditions the form must be reviewed. The form will travel with an individual upon transfer, and health care providers must review these forms as part of an individual's plan of care.

***House Bill 557* (passed)** requires DHMH, in consultation with the Office of the Attorney General, to develop an information sheet that provides information regarding advance directives and to develop a plan to widely distribute the information sheet to the general public.

Medical Decision Making Act of 2004

***House Bill 1284* (failed)** would have established a Life Partnership Registry in DHMH for same sex and opposite sex couples for the purpose of conferring rights to make medical decisions in certain circumstances.

Community Health

Health and Human Services Referral System

***House Bill 981* (passed)** establishes a Health and Human Services Referral Board within DHMH to oversee four self-funded pilot programs that currently utilize the 2-1-1 telephone service on a regional basis. The 2-1-1 service provides an automatic connection to an established information and referral source. The board must determine how to implement the 2-1-1 telephone service statewide and how to integrate emergency and nonemergency numbers. The

bill also establishes 2-1-1 as the primary information and referral telephone number for health and human services in Maryland.

Minority Health and Health Disparities

Senate Bill 177*/*House Bill 86* *(both passed) establish the Office of Minority Health and Health Disparities within DHMH (see the subpart "State Agencies, Offices, and Officials" within Part C – State Government of this *90 Day Report*).

Disease Prevention

Cervical Cancer: ***Senate Bill 499*/*House Bill 1067* *(passed)*** establish a Cervical Cancer Committee of the Maryland Comprehensive Cancer Control Plan (committee). The committee's duties include (1) collaborating with DHMH and the State Council on Cancer Control to promote public awareness on the causes, nature, detection, treatment, and prevention of cervical cancer; (2) identifying and examining the limitations of existing programs with respect to cervical cancer awareness and the availability of health insurance coverage and public services for cervical cancer diagnosis and treatment; (3) developing a statewide Cervical Cancer Prevention Plan; and (4) facilitating coordination and communication among State and local agencies and organizations to achieve the plan's goals. The committee will terminate in five years.

Fetal Alcohol Syndrome: ***House Bill 1274* *(passed)*** requires the Secretary of Health and Mental Hygiene, working with other State agencies and to the extent funds are available, to establish and promote a statewide public education campaign on fetal alcohol syndrome and other effects of prenatal alcohol exposure.

Umbilical Cord Blood: Umbilical cord blood contains blood stem cells that could be used to treat various life-threatening diseases such as leukemia and sickle cell anemia. The stem cells in frozen cord blood remain available for transplantation for many years. A certified public cord blood bank makes cord blood available to any patient in need of a transplant, for research, and is not reserved for a family's private use. ***Senate Bill 332*/*House Bill 398* *(passed)*** require hospitals to allow pregnant patients to arrange for the donation of the cord blood from the umbilical cord of a newborn child to a certified public cord blood bank. A patient that arranges cord blood donation is prohibited from being charged for the costs associated with the donation. No hospital personnel may be required to collect cord blood for donation if it conflicts with a bona fide religious belief.

Prescription Drugs

Reducing medication errors has been identified as a means of reducing health care costs and increasing patient safety. Medication errors include dispensing the wrong drug or wrong dosage due to the illegibility of the original prescription from the health care provider. ***House Bill 433* *(passed)*** requires a written prescription to be legible. This bill also requires the Secretary of Health and Mental Hygiene, in conjunction with various other groups, to convene a

workgroup to study the issue of legibility of prescriptions and to make recommendations for any statutory or regulatory changes to improve patient safety.

Food Safety and Regulation

House Bill 1397 ***(passed)*** requires the Secretary of Health and Mental Hygiene to impound a milk product that is a threat to the public health because it is handled improperly, is not kept at the required temperature, is injurious to health if consumed, or is otherwise unsafe. If the Secretary impounds a milk product, the Secretary may order the milk be disposed of or rendered unusable, or impose a civil monetary penalty.

Senate Bill 839/***House Bill 1468*** ***(both passed)*** exempt bed and breakfast establishments (lodging or rooming houses with eight rooms or less for rent) from any regulation governing food service facilities adopted by DHMH or a local government relating to the construction or installation of commercial grade kitchen equipment. Each establishment that intends to serve hot meals to renters must be licensed to operate a food establishment and is subject to State and local health regulations that govern food safety and contamination. The county health officer must inspect each establishment for regulatory compliance.

House Bill 780 ***(passed)*** amends the definition of "excluded organization" to allow a volunteer fire company to serve food to the public for up to 30 consecutive days once a year, up from the current maximum of 14 consecutive days once a year, without requiring the company to be licensed to operate a food establishment.

Laboratories

House Bill 580 ***(passed)***, specifies that the director of a medical laboratory outside Maryland that tests a human specimen from a person in Maryland must submit a report to the Secretary of Health and Mental Hygiene within 48 hours after an examination that shows evidence of specified diseases or conditions. The Secretary will notify the health officer of the jurisdiction where the patient resides of such a laboratory examination report. The bill adds all types of arbovirus infection, pesticide-related illness, and severe acute respiratory syndrome to the list of diseases and conditions required to be reported.

Biological Agents

Chapter 361 of 2002 established the Biological Agents Registry Program in DHMH to identify specified biological agents possessed and maintained by any person in the State. ***House Bill 666*** ***(Ch. 59)*** requires DHMH to adopt regulations providing for the release of specified information in the Biological Agents Registry to the Maryland Emergency Management Agency and the Maryland Department of the Environment for purposes of planning.

The registry may also release information to the Maryland Institute for Emergency Medical Services Systems (MIEMSS) so that MIEMSS can provide certain specified information to a police officer responding to an emergency and to a fire or emergency medical services entity performing emergency services, proceeding to a fire or other emergency, or dispatched on a call

for emergency services. Local jurisdictions must be informed of the location and nature of each biological agent in the registry that is within their jurisdiction.

Health Occupations

Altering Grounds for Discipline and Penalties Imposed

Several pieces of legislation amend the grounds for discipline of licensees or penalties to be imposed for a violation of the particular title that relates to the particular health occupation. Specifically, ***House Bill 944*** ***(passed)*** adds acts of gross negligence and misconduct as grounds for denial, suspension, or revocation of an acupuncturist's license and raises the fines and imprisonment terms for a violation. ***House Bill 671*** ***(passed)*** adds the commission of an immoral act or the failure to cooperate with an investigation of the Board of Professional Counselors and Therapists to the grounds for which a professional counselor or therapist's license may be denied, suspended, or revoked. ***House Bill 799*** ***(passed)*** adds discipline by any branch of the U.S. Uniformed Services or Veterans Administration as grounds for discipline of a physical therapist and raises the fines and imprisonment terms for a violation.

Senate Bill 330 ***(failed)*** was an omnibus bill that would have standardized for a majority of the health occupations boards the maximum fine imposed for a violation of the applicable health occupations laws at $5,000 and the maximum imprisonment term for a first offense imposed for a violation of these laws at three years. The bill was referred to interim study by the Senate Education, Health, and Environmental Affairs Committee.

Board of Pharmacy – Administration of the Influenza Vaccination

The scope of practice of pharmacists is expanded through ***Senate Bill 389***/***House Bill 384*** ***(both passed),*** which authorize a licensed pharmacist to administer an influenza vaccination in accordance with regulations adopted jointly by the Board of Pharmacy, the Board of Physicians, and the Board of Nursing. The regulations must establish a reasonable fee that may be charged for the administration of the vaccination and must provide for patient safety.

Board of Nursing – Certification of Medication Technicians

Senate Bill 405/***House Bill 602*** ***(both passed)*** require the Board of Nursing to certify medication technicians and require the board to consult with interested groups when developing regulations. The creation of a certification scheme for medication technicians seeks to address concerns regarding proper qualifications, training, and discipline of these individuals.

Board of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists – Altering Board Membership

Although the Senate voted to override the Governor's veto of a bill to remove the physician members of the Board of Audiologists, Hearing Aid Dispensers, and Speech-Language

Pathologists, the House took no action on the matter. ***Senate Bill 281*/*House Bill 427* *(both passed)*** do not remove the physician members of the board but rather limit the voting powers of the physician members of the board in order that they may not vote on proposals that expand or restrict the practice of audiology or speech pathology.

Sunset Review of the Board of Dietetic Practice

The Department of Legislative Services recommended extending the Board of Dietetic Practice in its sunset review of the board in 2003. ***Senate Bill 110*/*House Bill 353* *(both passed)*** extend the board's termination date until July 1, 2015, and create a single dietitian-nutritionist license for the practice of dietetics rather than continuing separate licenses with virtually identical qualifications and scopes of practice.

Sunset Review of the Respiratory Care Professional Standards Committee

The Department of Legislative Services also recommended extending the termination date of the Respiratory Care Professional Standards Committee, which is a subunit of the Board of Physicians, as a result of its sunset review of the committee in 2003. ***Senate Bill 72*/*House Bill 1081* *(both passed)*** continue the committee until July 1, 2012.

Miscellaneous

Legislation was also introduced on behalf of the Board of Acupuncture and the Board of Dental Examiners. ***House Bill 627* *(passed)*** repeals a termination provision over the authority of substance abuse counselors and nurses, in addition to licensed acupuncturists, to practice auricular detoxification – an acupuncture technique applied to the ear that alleviates substance abuse. ***Senate Bill 361*/*House Bill 558* *(both passed)*** broaden the authority of the Board of Dental Examiners to regulate sedation and limit the authority of the board to require a permit in specified instances of sedation administration.

Health Care Facilities and Regulation

Crownsville Hospital

For the past several years, the General Assembly has encouraged the Department of Health and Mental Hygiene (DHMH) to consider closing a State mental health facility due to declining utilization of inpatient mental health services. Over the past 21 years, utilization has decreased from 4,390 beds to 1,204 in the State's various psychiatric facilities. However, in that time the State closed only one hospital, Highland Health in 1998. In 2003, at the request of the General Assembly, DHMH explored the feasibility of closing one of three large (over 200 beds) regional facilities (Crownsville, Spring Grove, or Springfield) and ultimately decided to close Crownsville Hospital Center located in Anne Arundel County.

Crownsville Budgetary Considerations

As submitted by the Governor, the fiscal 2005 operating and capital budgets contained several actions implementing DHMH's October 2003 *Joint Chairmen's Report* response consolidating State-run psychiatric beds utilizing a system of two rather than three large regional hospitals and recommending the closure of Crownsville Hospital in Anne Arundel County. Those actions and the final status of those proposals are summarized in **Exhibit J-1**.

Exhibit J-1
State-run Psychiatric Hospital Consolidation and the Fiscal 2005 Operating and Capital Budget

Item	Funding	Comment and Legislative Action
Deficiency appropriation	$916,000	Renovation of two buildings at both Spring Grove and Springfield hospitals to accommodate patients transferred from Crownsville. Approved by the General Assembly.
Operating budget savings	($11,800,000)	Operating savings from the closure of Crownsville. Of this amount, $6.8 million is removed from the base budget and thus not subject to legislative action.
Operating budget expenditures	$5,000,000	Reinvestment of savings into expansion of community mental health services. The General Assembly attached budget bill language directing $4 million of these savings to be used for regional service expansion in Anne Arundel, Prince George's, Calvert, Charles, and St. Mary's counties; and $1 million to move patients currently at Crownsville who are ready for discharge into the community.
Recycling of fiscal 2004 operating funds and capital budget expenditures	$150,000 (GF) $9,625,000 (GO)	Design and construct a 48-bed addition to the maximum-security wing at Perkins in order to expand overall capacity in the State-run psychiatric hospital system. Overall, the consolidated system will have a net gain of 34 beds. Approved by the General Assembly.

Source: Department of Legislative Services

DHMH is proceeding with the closure of Crownsville, having begun to transfer patients. While most employees at Crownsville will be transferred to other hospitals, 133.3 positions will be abolished as a result of the hospital closure, and the Governor's budget requires the abolition of these positions by the end of fiscal 2005. Of these positions, approximately 109 are currently filled. At the time of writing, it is not certain how many of these 109 employees will be laid-off as a result of closure. DHMH has committed to work to find them alternative positions in State government.

In a matter related to the closing of Crownsville Hospital, ***House Bill 1351*** ***(passed)*** provides that a cemetery owned by the State and located on the grounds of certain State facilities, primarily State-run hospitals, may not be sold if the facility is closed or sold. In addition, the cemetery must be maintained by the State and marked with a monument commemorating the individuals interred in the cemetery. Any easement to a State-owned cemetery that has been recorded with a county on or before October 1, 2004, may not be transferred or sold, unless the deed includes a restrictive covenant requiring any future owner to maintain the cemetery.

Community-based Services

Bills were introduced this session that attempted to use the savings achieved by the closure of Crownsville or another Mental Hygiene Administration (MHA) facility to increase access to community-based mental health services. ***Senate Bill 706*** ***(passed)*** requires that if any MHA facility is downsized, consolidated, or closed, all State property associated with the facility that is not transferred to another governmental entity must be sold or leased at fair market value, and the net proceeds of the sale or lease must be deposited into the Community-Based Services Fund. Proceeds in this fund are to be used to provide community-based services to the mentally ill. The bill only applies prospectively. The bill also requires the Waiting List Equity Fund, which is currently funded by the Community Services Trust Fund, to provide community-based services to individuals eligible for but not receiving services from the Developmental Disabilities Administration.

In addition, DHMH, the University of Maryland Medical System (UMMS), and the University of Maryland, Baltimore, must report to the legislature on any developments related to the proposed transfer of the Walter P. Carter Center to UMMS.

Other legislation, ***Senate Bill 620***/***House Bill 946*** ***(both passed)***, is intended to facilitate the transfer of nursing home residents to home- and community-based services by providing residents with additional information about those services.

Continuing Care Facilities

Senate Bill 785/***House Bill 1001*** ***(both passed)*** require a continuing care facility to establish an internal grievance procedure for addressing complaints. A facility must include in its disclosure statement to the Maryland Department of Aging a description of its internal grievance procedure. The facility must also provide a description of the grievance procedure to applicants and subscribers.

Nursing Facilities and Assisted Living Programs

Several bills were considered this session to strengthen consumer protection in nursing homes and assisted living programs. ***Senate Bill 343*/*House Bill 484* *(both passed)*** address family councils at nursing homes. A family council is a group of individuals who work together to protect the rights and improve the quality of life of residents in a nursing home. In the past, some nursing homes that directed family councils discouraged council autonomy. The bills attempt to correct any possible conflict of interest by specifying that a family council may consist of a resident's family members, or an individual appointed by the resident, or, if the resident is incapable of appointing an individual, an individual appointed by the resident's family. In order to facilitate the development of a family council, the owner, operator, or staff of a nursing home may lead the family council for no longer than six months, at which time the council must be led by a council member.

Last session, legislation failed that would have required notification of family members by a nursing home of a resident's change in condition. In response, DHMH issued regulations in late 2003 that embodied the intent of the failed legislation. ***Senate Bill 297* *(passed)*** codifies the regulations by requiring a nursing home to notify a resident and the resident's representative or family member of any changes in condition, events that resulted in a change of condition, unanticipated consequences of care, and any corrective actions.

Senate Bill 810*/*House Bill 1190* *(both passed) strengthen quality of care in assisted living homes by imposing education requirements on assisted living managers. The bills require an assisted living manager who is employed by an assisted living program that is licensed for 17 or more beds to complete an approved manager training course, including an examination. Managers must meet these licensure requirements by 2006. In addition, the managers must also meet continuing education requirements.

Nursing Referral Agencies

Whereas residential service agencies require a doctor's order or a doctor's referral for the provision of specific services such as an IV antibiotic, nursing referral service agencies screen and refer licensed health professionals for the provision of skilled nursing services, home health aid services, or other home health care services at the request of a particular client. ***Senate Bill 550*/*House Bill 1425* *(both passed)*** establish a licensure scheme for nursing referral service agencies, formerly known as nurse registries, within DHMH.

Health Insurance

Nonprofit Health Service Plans

Regulation

In the wake of CareFirst BlueCross BlueShield's failed attempt to convert to a for-profit entity in 2002, the General Assembly strengthened State regulation of nonprofit health service plans in the 2003 session. Chapters 386 and 387 of 2003 made changes to the governance of nonprofit health service plans, specified a variety of public service requirements a nonprofit health service plan must meet to maintain its premium tax exemption, and established a Joint Oversight Committee to monitor compliance with the new requirements. The 2003 laws also required the Maryland Insurance Commissioner and the Attorney General to review the Commissioner's order denying the for-profit conversion and make recommendations regarding whether any changes to Maryland law were needed to ensure that regulatory oversight was sufficient to protect the public interest.

Senate Bill 4*/*House Bill 341* *(both passed) incorporate the recommendations of the Commissioner and the Attorney General by:

- prohibiting a member of the board of directors of a nonprofit health service plan from using board membership for personal or financial enrichment;

- requiring the board to ensure that adequate consideration is given to an independent valuation of the plan before considering any bid or offer to acquire the plan and convert to a for-profit entity;

- holding plan officers to fiduciary standards similar to those to which board members are held;

- giving the Commissioner authority to impose a civil penalty on a plan officer or director in response to an unsound or unsafe business practice; and

- enhancing the due diligence standard required when the appropriate regulating entity considers an application for acquisition of a nonprofit health entity.

The bills also address concerns of the District of Columbia's Insurance Commissioner that the 2003 law usurped the Commissioner's authority over the CareFirst affiliate domiciled in the District of Columbia. To address these concerns, the bills specify that while a nonprofit health service plan doing business in the State must meet public service requirements established under Maryland law, to the extent these requirements conflict with the plan's legislatively enacted charter or any law, rule, or regulation of the jurisdiction in which the plan is domiciled, the charter and the laws, rules, and regulations of the jurisdiction of domicile control.

Authority of Insurance Commissioner over Compensation

In response to a federal court order and consent judgment that resolved several legal issues among the national BlueCross BlueShield Association, CareFirst, Inc., and the State, ***Senate Bill 29***/***House Bill 350*** ***(both passed)*** repeal the Maryland Insurance Commissioner's authority to approve compensation guidelines for all officers and executives of a nonprofit health service plan. Instead, a nonprofit health service plan's board is required to annually provide a copy of the board-approved compensation guidelines to the Commissioner. The Commissioner retains the authority under current law to ensure that compensation guidelines are developed in the manner required by statute and are implemented and followed

Expanding Health Care Coverage to the Uninsured

Two significant bills introduced in the 2004 session addressed the growing number of uninsured in the State. ***Senate Bill 737***/***House Bill 1008*** ***(both failed)*** were reintroductions of the Public-Private Partnership for Health Coverage for All Marylanders. The bills would have provided universal health care coverage for State residents by changing eligibility requirements in the Medicaid program, the Maryland Children's Health Program (MCHP), the Maryland Pharmacy Discount Program, the Maryland Health Insurance Plan, and the small group health insurance market. The program would have been funded by an increased tobacco tax and a new payroll tax on employers.

House Bill 1271 ***(failed)*** would have established the Maryland Community Health Resources Commission to increase access to health care for lower-income individuals and provide funding for community health resources around the State. As passed by the House, the bill would have expanded Medicaid coverage to provide primary care and office-based specialty care to individuals with incomes up to 116 percent of the federal poverty level guidelines (FPG) and to parents of MCHP enrollees with family incomes up to 200 percent of the FPG. These initiatives would have been funded by a 1 percent premium tax imposed on health maintenance organizations and Medicaid managed care organizations and, beginning fiscal 2008, with funds from the Cigarette Restitution Fund. The Senate Finance Committee amended the bill to provide comprehensive coverage to parents of MCHP enrollees with family incomes up to 150 percent of the FPG, funded by a 2 percent premium tax.

Maryland Health Insurance Plan

The Maryland Health Insurance Plan (MHIP), the State's high-risk insurance pool that covers medically uninsurable individuals, began implementation on July 1, 2003. While implementation was generally smooth, as of February 2004, 6,137 individuals were enrolled, well below the level of enrollment anticipated. Several statutory changes were proposed to address transitional issues and improve the effectiveness of the program.

House Bill 125 ***(passed)*** corrects a problem caused by the transfer of Medicare-eligible individuals from MHIP's predecessor, the Substantial, Available, and Affordable Coverage program, into MHIP. While these individuals technically were ineligible for MHIP because of

their Medicare eligibility, they were allowed to remain in MHIP until July 1, 2004. To ensure that these individuals will be able to purchase supplementary medical coverage when MHIP coverage terminates, the bill requires a health insurance carrier to issue a Medicare supplement policy to an individual who is eligible for Medicare due to age if the individual (1) transferred from a substantial, available, and affordable coverage plan to MHIP on July 1, 2003; (2) is terminated from MHIP as a result of Medicare eligibility; and (3) applies for the policy within six months after termination from MHIP. The Maryland Insurance Administration (MIA) is required to notify carriers of this requirement, and MHIP must provide notice of the availability of Medicare supplement coverage to eligible MHIP enrollees. These provisions terminate on July 1, 2005.

The bill also requires a carrier to make available both a Medicare supplement policy plan C and plan I to an individual who (1) is enrolled in MHIP; (2) is under the age of 65 but is eligible for Medicare due to a disability; (3) is terminated from MHIP due to Medicare eligibility; and (4) applies for the policy within six months after termination from MHIP.

House Bill 667 ***(passed)*** expands the size of the MHIP board and the board's authority over enrollment and premium rate setting. The bill adds two minority members to the board and allows the board to subsidize premiums, deductibles, and other policy expenses based on a member's income. The bill also allows the MHIP board to limit enrollment of otherwise eligible individuals whose premiums are paid for by a pharmaceutical manufacturer or its affiliate where the board determines that enrollment capacity is adversely impacted. Finally, the bill expands the types of funds that can be deposited into the MHIP fund to include donations and grant awards.

Small Group Health Insurance Market

In January 2004, the Maryland Health Care Commission (MHCC) reported to the General Assembly on a variety of options for covering the uninsured. One proposal included a limited benefit plan to be offered in the small group market. The primary advantage of this type of plan is its affordability.

Senate Bill 570 ***(passed)*** establishes a limited health benefit plan to be offered in the small group health insurance market. Certain prominent carriers, which are defined in the bill, must offer the limited benefit plan to a small employer that has not provided comprehensive insurance in the last 12 months and whose employees are paid an average annual wage not exceeding 75 percent of the average annual wage in the State. Benefits under the limited benefit plan may not exceed 70 percent of the actuarial value of the Comprehensive Standard Health Benefit Plan currently sold in the small group market. MHCC must report to the Governor and specified legislative committees on the number of limited benefit plans sold and other related data by January 1, 2008. The bill's provisions terminate June 30, 2008.

Other Initiatives

Reimbursement Rates for Podiatrists

Senate Bill 437*/*House Bill 411* *(both passed) require health insurers, nonprofit health service plans, and health maintenance organizations to reimburse a licensed podiatrist for services provided at the same rate as the carriers would reimburse a physician for those same services. In 2003, MHCC studied payor differentials between physicians and other licensed health care providers. The study concluded that in 2002, on average, carriers reimbursed podiatrists at 91 percent of the rate that carriers reimbursed physicians for the same services.

Underwriting Standards

House Bill 127* *(passed) requires a nonprofit health service plan and a health maintenance organization, at the request of the Maryland Insurance Commissioner, to file with the Commissioner a copy of its underwriting standards, including any amendments or supplements. The bill is intended to help the State monitor changes that affect people's ability to obtain private health insurance. If a large insurance carrier changes its underwriting standards, fewer people may be eligible for private coverage and may be required to enroll in MHIP.

Study of Affordable Health Insurance Coverage

Senate Bill 131*/*House Bill 845* *(both passed) require MHCC and MIA to conduct studies of a variety of factors that affect the cost of health insurance in Maryland. Based on the studies, MHCC and MIA must develop recommendations on ways to make private health insurance more affordable for State residents and present an interim report on their findings and recommendations by January 1, 2005, and a final report by January 1, 2006.

Surgical Treatment of Morbid Obesity – Utilization Review

Senate Bill 868*/*House Bill 1410* *(both passed) clarify that a health insurance carrier that is required to provide coverage for the surgical treatment of morbid obesity may require an insured or enrollee to satisfy guidelines approved by the National Institutes of Health (NIH) to qualify for the mandated benefit. The bills also establish a Task Force to Study Utilization Review of the Surgical Treatment of Morbid Obesity and require the task force to (1) review utilization review procedures currently used by health insurance carriers; (2) review NIH guidelines and any other nationally recognized guidelines or criteria for the surgical treatment of morbid obesity; and (3) recommend a set of guidelines or criteria that are appropriate for the utilization review of the surgical treatment and reasonable procedures for documenting patient compliance with the guidelines or criteria. The task force must report its findings and recommendations to specified legislative committees by December 1, 2004.

Review of Adverse Decisions of Health Insurance Carriers – Burden of Persuasion

A health insurance carrier must have an internal grievance process for a member to appeal a denial of coverage. A member subsequently may file a complaint with the Maryland

Insurance Commissioner to review a carrier's adverse decision. During the review of a complaint by the Commissioner, the carrier has the burden of persuasion to prove its adverse decision is correct. ***House Bill 1361*** ***(passed)*** clarifies that the carrier also has the burden of persuasion to prove its adverse decision is correct in a review conducted by an administrative law judge.