Part J
Health and Human Services

Public Health – Generally

Medicaid

Fiscal 2010 Budget Actions

The fiscal 2010 budget increases funding for Medicaid, the Maryland Children's Health Program (MCHP), and the Primary Adult Care program (PAC) by $180.9 million or 3.2%. The Medicaid expansion to parents (enacted under Chapter 7 of the special session of 2007) accounts for $54.7 million of that increase. General fund support declines by $222.3 million or 11.2% due to additional federal funds provided under the federal American Recovery and Reinvestment Act of 2009 (ARRA) and increased availability of special funds.

Under ARRA, each state receives a temporary, across-the-board 6.2% increase to its federal medical assistance percentage (FMAP) – the federal government's share of Medicaid expenses. Also, an unemployment-related FMAP bonus is available to states that experience increased unemployment rates. Both of these provisions are available for the period of October 1, 2008, through December 31, 2010. For Maryland, ARRA funds are expected to total $1.4 billion, $891.8 million from the across-the-board increase and $544.1 million from projected increases in the unemployment rate.

Most medical care program providers do not receive a rate increase in the fiscal 2010 budget, with the exception of providers in the Older Adults, Living at Home, and Medical Day Care waiver programs, and managed care organizations (MCOs). Although enhancements for physician and dental rates were expected for fiscal 2010, dental rates were level funded and physician rates were reduced by about 1.5%.

As introduced, the fiscal 2010 budget included contingent language assuming savings of $24.0 million with the passage of the Maryland False Health Claims Act of 2009, ***Senate Bill 272***/***House Bill 304*** ***(both failed)***, and the Health Program Integrity and Recovery Act of 2009, ***House Bill 1476*** ***(failed)***. Supplemental Budget No. 2 included additional language that reinstituted hospital medical day limits and reduced physician rates contingent on the failure

of ***Senate Bill 272***/***House Bill 304***. As these bills failed, the Medicaid budget is reduced by $29.0 million, $20.0 million to reflect hospital medical day limits and $9.0 million in physician rate reductions.

False Claims

The federal Deficit Reduction Act of 2005 established incentives for states to enact certain antifraud legislation modeled after the federal False Claims Act. States that enact qualifying legislation are eligible to receive an increase of 10% of the recovery of funds (by a corresponding 10% reduction in the federal share).

Senate Bill 272/***House Bill 304*** ***(both failed)*** would have established a State false claims act, anticipated to qualify for enhanced recoveries. The bills would have prohibited a person from making a false or fraudulent claim for payment or approval under a State health plan or program. The bills also would have authorized the State to file a civil action against a person who makes a false health claim, established civil penalties for making a false health claim, permitted a private citizen to file a civil action on behalf of the State against a person who has made a false health claim, and required the court to award a certain percentage of the proceeds of the action to the private citizen initiating the action.

Coverage of Independent Foster Care Adolescents

Youth in State foster care receive medical care through Medicaid. However, this coverage often terminates when the youth turns 18 and leaves the foster care system. Many continue to qualify for Medicaid or MCHP through their nineteenth or twenty-first birthdays. ***House Bill 580*** ***(passed)*** requires Medicaid to provide coverage for independent foster care adolescents who are not otherwise eligible for Medicaid benefits and who have annual household incomes up to 300% of federal poverty guidelines. Independent foster care adolescents are individuals younger than age 21 who, on their eighteenth birthday, were in State foster care.

Substance Abuse

Senate Bill 952/***House Bill 739*** ***(both passed)*** require substance abuse services equivalent to those provided to adults under the Medicaid program to be provided to adults covered under PAC. In fiscal 2010, the bills authorize the Governor to transfer $3.3 million in general or special funds from the Alcohol and Drug Abuse Administration (ADAA) to Medicaid to provide substance abuse services under PAC and to increase the rates paid to providers for substance abuse services provided through PAC and Medicaid. Beginning in fiscal 2011, the bills require the Governor to include sufficient funding to provide these services. Separate budget action restricted fiscal 2010 funds in the Alcohol and Drug Abuse Administration budget for these same purposes. In addition, the bills require MCOs to submit specific information regarding substance abuse treatment services. The Department of Health and Mental Hygiene (DHMH) has to collaborate with MCOs to establish a process and criteria to qualify certified addiction treatment programs as paneled providers.

Long-term Care

Senate Bill 761*/*House Bill 113* *(both passed) require DHMH to study the feasibility of creating a coordinated care program to reform the provision of Medicaid long-term care services in a manner that improves and integrates the care of individuals to meet the differing needs of seniors and adults with disabilities in the State. DHMH must submit an interim report by September 1, 2009, and a final report by December 1, 2010. The bills require the Secretary of Health and Mental Hygiene to convene specified stakeholders to evaluate and make recommendations related to a Coordinated Care Program. The stakeholder process must include a review of long-term plans, consensus reports, experiences, and best practices in the State and in other states relating to the management and coordination of long-term care supports and services, as well as DHMH's plan for evaluating the existing home- and community-based services infrastructure. If the General Assembly passes legislation that requires the submission of a federal waiver, DHMH must submit the waiver by June 1, 2011.

Outreach and Enrollment in Baltimore City Public School System

House Bill 500* *(passed) requires the Baltimore City Public School System and DHMH to increase outreach for Medicaid and MCHP to parents and guardians in Baltimore City whose students are enrolled in the National School Lunch Program.

Electronic Health Records

In 2007, the Task Force to Study Electronic Health Records found that health information technology (IT) dissemination, including adoption and use of electronic health records (EHR) has not occurred rapidly in Maryland in part due to the high costs for health care providers.

House Bill 706* *(passed) requires the Maryland Health Care Commission (MHCC) to adopt regulations requiring the State Employee and Retiree Health and Welfare Benefits Program and carriers that issue or deliver health benefit plans in the State ("State-regulated payors") to provide incentives to providers to promote the adoption and meaningful use of EHR. Any incentives must have monetary value, facilitate the use of EHR, recognize and be consistent with existing payor incentives, and take into account certain federal incentives. MHCC and the Health Services Cost Review Commission (HSCRC) must designate a State health information exchange (HIE), while MHCC has to designate one or more management service organizations to offer EHR services. Beginning the later of January 1, 2015, or the date established for the imposition of penalties under ARRA, each provider using EHR that seeks payment from a State-regulated payor must use EHR that are certified by a national certification organization designated by MHCC and capable of connecting to and exchanging data with the State HIE. State-regulated payors may reduce payments to health care providers for noncompliance with these requirements.

House Bill 706 also requires HSCRC, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services (CMS), to assure that hospitals receive payments provided under ARRA and implement any changes in hospital rates required by CMS to ensure compliance with ARRA. DHMH, in consultation with MHCC, has to develop a

mechanism to assure that health care providers that participate in Medicaid receive the payments provided for adoption and use of EHR technology under ARRA.

Mental Health

***Senate Bill 874/House Bill 415* (both passed)** allow an individual in a mental health facility to designate an advocate to participate in the treatment and discharge planning process except when the individual is a child or disabled adult whose parent or legal guardian has requested that a specific advocate not participate. The bills require an individual in a mental health facility to receive treatment in accordance with his or her advance directive and clarify use of restraints. Finally, the bills place conditions on advocate participation and prohibit the bills' provisions from being construed to grant certain authority not otherwise in law or limit authority established elsewhere in law.

Autism

Autism Spectrum Disorders can cause severe and pervasive impairment in thinking, feeling, language, and the ability to relate to others. In the past decade, the number of children identified with characteristics of Autism Spectrum Disorders has increased significantly in nearly every jurisdiction in the State. ***Senate Bill 963*/*House Bill 503* (both passed)** establish the Maryland Commission on Autism, staffed by DHMH and the Maryland State Department of Education, to make recommendations regarding services for individuals with autism spectrum disorders; develop a statewide plan for a system of training, treatment, and services for individuals with autism; evaluate ways to promote autism spectrum disorder awareness; and review the findings of any summit or conference convened by the State regarding autism spectrum disorders. The commission must report its preliminary findings and recommendations to the General Assembly by June 1, 2011, and its final report by September 30, 2012.

Behavioral Health Services for Veterans

Chapters 555 and 556 of 2008 established a new program for behavioral health services for Maryland veterans of the Afghanistan and Iraq conflicts. Although the program's call center has received 267 calls since its inception, very few veterans have actually been provided program-funded behavioral health services through the Mental Hygiene Administration. Instead, veterans have been connected to services through the U.S Department of Veterans Affairs (VA) or through other available, pro-bono services outside of the program.

***House Bill 1475* (passed)** extends behavioral health services benefits to *all* Maryland veterans of foreign wars who have been discharged or released from service under conditions other than dishonorable and are not receiving services from the VA, rather than to veterans only of the Iraq and Afghanistan conflicts. In addition, the bill broadens the geographic coverage area for short-term behavioral services provided to these veterans, where existing federal and State services are determined by DHMH to be inadequate, from rural areas to any area in the State.

Miscellaneous Public Health Issues

Oral Health

Chapter 527 of 2007 established an Oral Health Safety Net Program within DHMH's Office of Oral Health to award grants to local health departments, federally qualified health centers, and entities providing dental services within State facilities to increase dental provider capacity for the underserved. ***Senate Bill 63*** ***(passed)*** repeals the September 30, 2011 termination date for the program which results in general fund expenditures of $1.3 million in fiscal 2012 and future years to continue issuing grants at the current funding level.

Environmental Health

State law prohibits a person from manufacturing, selling, offering for sale, importing, or distributing a lead-containing children's product. ***House Bill 119*** ***(Ch. 129)*** is an emergency bill which alters the definition of a child, for purposes of regulating lead-containing children's products, to include individuals younger than age 13. The bill also incorporates the federal Consumer Product Safety Act of 2008 into the State's framework for the regulation of children's products containing lead.

Bisphenol-A (BPA) is a compound found in many plastics. Some studies have shown that BPA may have hormone-like effects on the developing reproductive system and result in neurobehavioral changes on the offspring of laboratory test animals. ***House Bill 15*** ***(failed)*** would have prohibited the sale, manufacture, or distribution of child care articles that contain BPA on or after January 1, 2011.

Health Occupations

Athletic Trainers

Senate Bill 247/***House Bill 173*** ***(both passed)*** require that on or after October 1, 2011, an individual be licensed by the State Board of Physicians before practicing athletic training in the State. The practice of athletic training is defined as applying the principles and methods of prevention, clinical evaluation and assessment, immediate care, and treatment, rehabilitation, and reconditioning to the management of athletic injuries for athletes in good overall health under the direction of a licensed physician. The bills establish an Athletic Trainer Advisory Committee within the board to develop and recommend regulations, continuing education requirements, and practice protocols for athletic trainers.

Dental Hygienists

Senate Bill 602/***House Bill 576*** ***(both passed)*** expand the scope of practice for a licensed dental hygienist to include specified manual curettage (removal of dead tissue from gums) and the administration of local anesthesia. The bills authorize the Board of Dental Examiners to adopt regulations governing the education, training, evaluation, examination, and administration

associated with this expanded scope of practice. The bills also allow more flexibility in the unsupervised clinical hours that dental hygienists may work by making the 60% threshold currently applicable to any given calendar week applicable to a three-month period instead.

Massage Therapists

Chapter 243 of 2008 renamed the Board of Chiropractic Examiners as the Board of Chiropractic and Massage Therapy Examiners and repealed the Massage Therapy Advisory Committee. Three licensed massage therapists and one chiropractor were added to the board's membership, which previously had no massage therapist members. While the Massage Therapy Advisory Committee was repealed with the bill's October 1, 2008 effective date, the terms of the massage therapy board members do not begin until July 1, 2009. ***Senate Bill 789*/*House Bill 1460* (both passed)** authorize the massage therapy members of the board to begin their terms two months earlier on May 1, 2009.

Nursing Home Administrators

***Senate Bill 471* (Ch. 71)** expands the membership of the State Board of Nursing Home Administrators by adding an additional nursing home administrator member and a representative of the Office of Health Care Quality as an *ex officio* member. The bill also establishes new requirements for board members and the executive director including that:

- one of the nursing home administrator members have experience with the Eden Alternative Green House or a similar program, if practicable;
- of the two required non-nursing home professional members, one be a doctor or nurse who specializes in geriatrics and the other be a geriatric social worker;
- one of the consumer members have or have had a family member living in a nursing home; and
- the executive director possess, at a minimum, a bachelor's degree.

Pharmacists

Dispensation of Prescription Medications

Regulations of the State Board of Pharmacy require a pharmacy permit holder to provide patients with information regarding the patient's role and responsibility in preventing medication errors and how to report medication errors. ***Senate Bill 242* (Ch. 45)** requires pharmacy permit holders to inform consumers of the process for resolving incorrectly filled prescriptions by posting a readable sign in a conspicuous location at the point where prescriptions are dispensed to consumers or by including that information with each filled prescription. Licensed dentists, physicians, or podiatrists who prepare and dispense their own prescriptions must comply with

these requirements; however, an exemption exists for a pharmacy to which the public does not have access that is owned or operated by specified facilities, such as a hospital.

Administration of Vaccinations

Under current law, a pharmacist may administer an influenza vaccination to any person or a pneumococcal pneumonia or herpes zoster vaccination to an adult who has a prescription from a physician, in accordance with regulations set jointly by the Board of Pharmacy, Board of Physicians, and Board of Nursing. ***Senate Bill 700*** ***(passed)*** expands the types of vaccinations that may be administered by a pharmacist to any vaccination that the Board of Pharmacy, Board of Physicians, and Board of Nursing determines is in the best interest of the community and is administered in accordance with regulations adopted jointly by the three boards. The vaccinations may only be administered by a pharmacist who has verified successful completion of a certification course that included instruction in the Centers for Disease Control and Prevention's guidelines and recommendations regarding vaccinations and who is certified in basic cardiopulmonary resuscitation.

Drug Therapy Management

The Drug Therapy Management Program, established by Chapter 249 of 2002, authorizes a physician and a pharmacist to enter into a therapy management contract that specifies treatment protocols that may be used to provide disease specific care to a patient. ***Senate Bill 791***/***House Bill 725*** ***(both passed)*** exempt group model health maintenance organizations from this law and set standards for licensed physicians and licensed pharmacists who wish to provide drug therapy management to patients in a group model health maintenance organization. For a further discussion of ***Senate Bill 791***/***House Bill 725***, see the subpart "Health Insurance" within this part of this *90 Day Report.*

Pharmacy Permits

Senate Bill 309/***House Bill 252*** ***(both passed)*** extend the term of a pharmacy permit from one to two years and require the State Board of Pharmacy to send each permit holder a renewal notice by October 1 of the year in which the permit expires. The bills also remove the requirement that, along with a renewal notice, the board send a renewal application to a permit holder.

Polysomnographic Technologists

Chapter 595 of 2006 required the State Board of Physicians to license and regulate the practice of polysomnography – the monitoring and recording of physiologic data during sleep, including sleep-related respiratory disturbances. ***Senate Bill 433***/***House Bill 597*** ***(both passed)*** delay the date by which a polysomnographic technologist must be licensed by the State Board of Physicians in order to practice in the State until October 1, 2011, and extend the date by which licensure applicants can fulfill the requirements for a waiver of education requirements.

Psychologists

Senate Bill 951*/*House Bill 654* *(both passed) alter the definition of a doctoral degree in psychology to expand the types of doctoral programs the State Board of Examiners of Psychology may recognize as qualifying an applicant for a license to practice psychology in the State. A qualifying degree may be accredited by the Canadian Psychological Association or meet the qualifying criteria determined by the Council for the National Register of Health Service Providers in Psychology if the degree was received from a doctoral program in psychology that meets specified requirements. The bills also repeal the requirement that at least one year of required supervised professional experience occur after a doctoral degree has been awarded.

Social Workers

Senate Bill 628*/*House Bill 510* *(Chs. 86 and 87) require the Board of Social Work Examiners, when reviewing an application for licensure to practice social work, to notify each applicant of whether the applicant has been approved to take the licensure examination within 60 days after the application was submitted. The board is also required to establish a workgroup of interested stakeholders to examine and make recommendations to the General Assembly regarding the substance of licensure and the process by which licenses are issued.

Miscellaneous

Billing for Anatomic Pathology Services

House Bill 1150* *(Ch. 163) authorizes a clinical laboratory, a physician, or a group practice that provides anatomic pathology services for a patient in Maryland to bill the health care practitioner who orders but does not supervise or perform an anatomic pathology service on a Pap test specimen provided that the health care practitioner complies with specific disclosure and ethics requirements. The bill also authorizes a health care practitioner who collects a Pap specimen to bill a patient or payor for the service as long as the same disclosure and ethics requirements are met.

Loan Assistance Repayment Program

To address the workforce shortage of physicians in the State, ***Senate Bill 627*/*House Bill 714* *(both passed)*** alter the eligibility for the Janet L. Hoffman Loan Assistance Repayment Program by removing primary care physicians from the program and establishing a separate Maryland Loan Assistance Repayment Program for these health care practitioners. A more detailed discussion of these bills may be found under Part L – Education of this *90 Day Report*.

Health Care Facilities and Regulation

Hospitals

Financial Assistance and Debt Collection Policies

In February 2009, the Health Services Cost Review Commission (HSCRC) released a report on financial assistance and credit and collection practices of Maryland hospitals. HSCRC found that Maryland hospitals generally adhere to voluntary standards for financial assistance. However, HSCRC also determined that the State lacks standards for hospital credit and collection activities, hospitals' policies are ambiguous and varied, and oversight of third-party collection agencies may be insufficient.

***Senate Bill 776*/*House Bill 1069* (both passed)** alter requirements for hospital financial assistance and debt collection policies. At a minimum, hospitals must provide free care to patients with family incomes up to 150% of federal poverty guidelines and reduced-cost care to low-income patients with higher family incomes in accordance with the mission and service area of the hospital. Each hospital has to develop a financial assistance information sheet for patients and submit to HSCRC a debt collection policy that adheres to specified standards. A hospital that knowingly violates any financial assistance policy or regulation is subject to a fine of up to $50,000 per violation. HSCRC is required to establish a workgroup on patient financial assistance and debt collection, to review the need for uniform policies among hospitals, and to study and make recommendations on incentives for hospitals to provide free and reduced-cost care to patients without the means to pay their hospital bills.

Electronic Health Records

***House Bill 706* (passed)** requires the State Employee and Retiree Health and Welfare Benefits Program and health insurance carriers issuing or delivering health benefit plans in the State to provide incentives to providers, including facilities where health care is provided to patients or recipients, to promote the adoption and meaningful use of electronic health records. A more detailed discussion of this bill may be found under Part J – Public Health of this *90 Day Report.*

Trauma Centers

***Senate Bill 464*/*House Bill 521* (both passed)** expand eligibility for reimbursement for Level III trauma centers from the Maryland Trauma Physician Services Fund by doubling the maximum number of reimbursable trauma on-call hours annually and authorizing reimbursement for costs incurred to maintain trauma physicians on-call in plastic surgery, major vascular surgery, oral or maxillofacial surgery, and thoracic surgery. Reimbursement is contingent upon availability of funds. Each year by May 1, the Maryland Health Care Commission (MHCC) must determine appropriate levels of payment that can be sustained from the trauma fund given expected revenue. If revenue is insufficient to meet expected payments, MHCC is prohibited from reimbursing Level III trauma centers for more than 35,040 trauma on-call hours or for those

practice areas specified under the bills until the remaining costs eligible for reimbursement are fully funded.

Prince George's Hospital Authority

The Prince George's County Health System, which includes Prince George's Hospital Center, has been faced with financial difficulties for the past several years, experiencing lost market share, revenue losses, low liquidity, significant deferred capital needs, poor bond ratings, and a disadvantageous payor mix. Both the State and Prince George's County have provided significant financial support to help the hospital meet its financial needs.

Chapter 680 of 2008 established the Prince George's County Hospital Authority to implement a competitive bidding process for transferring the system to new ownership. Under Chapter 680, an agreement to transfer the system was to be reached prior to the beginning of the 2009 session. This did not occur. To support ongoing efforts to transfer the system, ***Senate Bill 1039/House Bill 1486 (Chs. 116 and 117)*** alter the scope of the authority, including authorizing an extension of the bidding process, clarifying the duration of State and county funding commitments, and authorizing MHCC to issue an exemption from the certificate of need process and waive requirements of the State Health Plan. The authority must complete its obligations prior to the expiration of the authority on May 22, 2010, and certain State agencies have to designate consultants to advise the authority.

The fiscal 2010 budget includes $12.0 million in operating support for the authority. The State has also committed to provide long-term financial support of $75.0 million in operating funds ($15.0 million in fiscal 2011 through 2015) and $24.0 million in capital funds ($4.0 million in fiscal 2012 and $10.0 million in fiscal 2013 and 2014). Under ***Senate Bill 1039/House Bill 1486 (Chs. 116 and 117)***, the State and Prince George's County must be relieved of some or all of their long-term funding obligations to support the system only to the extent that any fund balance remains after the transfer of all of the system's components to a new owner(s), or after the authority has expired without agreement on the transfer of all of the system's components to a new owner(s).

Bon Secours Hospital

Bon Secours Hospital is a 125-bed community hospital located in West Baltimore. Over the past three years, the financial challenges facing the hospital escalated significantly due to volume declines and the need for $14.0 million in annual physician subsidies due to a disadvantageous payor mix. To assist the hospital in the short-term, the fiscal 2010 budget includes authorization for a one-time $5.0 million operating grant. To receive the grant, the Board of Directors of Bon Secours Hospital, Baltimore, Inc. must report on a long-term, comprehensive, and sustainable solution to the hospital's financial issues, including a plan for implementing by fiscal 2011, a sustainable primary care centric approach that in addition to urgent care services will include expanded primary care access; improved mental health services; additional substance abuse assessment and treatment services; and other critical community services.

Nursing Homes

Chapter 200 of 2008 required the Department of Health and Mental Hygiene (DHMH) to develop a plan for accountability measures to use in a pay-for-performance (P4P) program. Funding for the P4P program will be derived from a reallocation of a portion of the rate increase funded by the quality assessment imposed on nursing facilities in the State. In December 2008, DHMH submitted a plan under which eligible providers will receive a composite score based on five specific scoring criteria.

***Senate Bill 664*/*House Bill 782* (both passed)** require DHMH to phase in the distribution of revenues to nursing facilities under the P4P program beginning July 1, 2010. By July 1, 2009, DHMH must send each nursing facility the scoring criteria, the performance of the facility relative to the scoring criteria, and the monies that would be received by the facility using the scoring criteria. Beginning July 1, 2010, DHMH must distribute 50% of the revenues from the quality assessment being used in the P4P program based on the scoring criteria. Beginning July 1, 2011, DHMH must fully implement the P4P program. By December 1, 2009, and annually thereafter, DHMH has to make necessary changes to the P4P program to determine the effect on providers and whether the measures are objective, measurable, and, when considered in combination, have a correlation to residents' quality of life and care. The bill also requires DHMH to consult with stakeholders to assess the State's long-term care reimbursement methodology and report its findings by October 1, 2010.

Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs) offer a full range of housing, residential services, and health care in order to serve older residents as their medical needs change over time. CCRCs are required to establish internal grievance procedures. ***House Bill 843* (passed)** expands the required components for internal grievance procedures and allows subscribers and providers to seek nonbinding mediation within 30 days after the conclusion of an internal grievance procedure. Internal grievance procedures must at least allow a subscriber or group of subscribers to submit a written complaint, require the provider to assign personnel to investigate the grievance, and give a subscriber the right to meet with management within 30 days after submission of a written grievance.

The Maryland Department of Aging regulates CCRCs, including providing approval of continuing care agreements – an agreement between a provider and a subscriber to provide continuing care. ***House Bill 952* (passed)** requires the department to review continuing care agreements or any other related agreements within 120 days of receipt, instead of the current 180 days. However, if the department submits comments or requests additional information from the provider, the 120-day review period is frozen until the requested information is received. If a provider seeks to modify an approved agreement, the department must limit its review to that modification.

Health Insurance

Relationship between Health Insurance Carriers and Health Care Providers

In the 2009 session, legislation addressed the contractual relationship between health insurance carriers and health care providers. Several bills, discussed below, were a result of recommendations of the Task Force on Health Care Access and Reimbursement, which issued its final report in December 2008. Other bills resulting from recommendations of the task force, ***Senate Bill 627/House Bill 714*** ***(both passed)*** are discussed under Part L – Education of this *90 Day Report*.

Payments to Nonparticipating Providers by Health Maintenance Organizations

In its final report, the Task Force on Health Care Access and Reimbursement recommended changes to the formula used to determine what a health maintenance organization must pay to a nonparticipating provider for covered services provided to an enrollee of a health maintenance organization. ***Senate Bill 380/House Bill 255*** ***(both passed)*** alter these rates. The bills take effect January 1, 2010, and terminate on December 31, 2014. For a nonevaluation and management service, the bills require a health maintenance organization (HMO) to pay noncontracting health care providers no less than 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, to a similarly licensed contracting provider for the same covered service.

For covered evaluation and management services, an HMO must pay a noncontracting health care provider at the greater of:

- 125% of the average rate the HMO paid as of January 1 of the previous calendar year in the same geographic area, for the same covered service, to similarly licensed contracting providers; or

- 140% of the Medicare rate for the same covered service, to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the Medicare Economic Index.

The bills require an HMO to calculate the average rate paid to similarly licensed providers under written contract with the HMO for the same covered service using a specified calculation (the sum of the contracted rate for all occurrences of the Current Procedural Terminology (CPT) code for that service divided by the total number of occurrences of the CPT code).

The bills also authorize the Maryland Insurance Administration to investigate and enforce a violation of the bills and require the Maryland Health Care Commission to annually review payment to health care providers to determine compliance with the bill and report its findings to the Maryland Insurance Administration.

Use of Physician Rating Systems by Health Insurance Carriers

In its final report the Task Force on Health Care Access and Reimbursement also recommended that the General Assembly pass legislation requiring that health plans licensed by the Maryland Insurance Administration fully disclose to consumers and physicians important aspects of their physician rating systems. In developing legislation, the task force recommended looking at the consent agreement developed by the Office of the Attorney General of the State of New York for health plans in that state.

Senate Bill 661*/*House Bill 585 ***(both passed)*** establish requirements for the Maryland Health Care Commission to approve ratings examiners to review physician rating systems. The bill prohibits health insurance carriers from using a physician rating system unless the system is approved by a ratings examiner. The bills require health insurance carriers to establish an appeals process for physicians to contest a rating in the system and to disclose any changes in evaluations to physicians at least 45 days before making the information available to enrollees. The bills also require the Maryland Insurance Administration to report annually to the Governor and the General Assembly on the number and types of appeals that have been filed by physicians with carriers regarding an evaluation in a physician rating system and the number of entities that the Maryland Health Care Commission has approved as ratings examiners. The bills take effect January 1, 2010.

Credentialing by Insurance Carriers

Finding that credentialing of health care providers is time consuming and expensive for hospitals and health plans, the Task Force on Health Care Access and Reimbursement recommended that the Maryland Insurance Administration and the Office of Health Care Quality should align their standards using the Council for Affordable Quality Healthcare provider data source. ***Senate Bill 646*/*House Bill 526*** ***(Chs. 90 and 91)*** authorize the Insurance Commissioner to designate as the uniform credentialing form a credentialing application developed by a nonprofit alliance of health plans and trade associations for an online credentialing system if the application is available to providers at no charge and use of the application is not conditioned on submitting the application to a carrier online.

Required Incentives for Electronic Health Records

House Bill 706 ***(passed)*** requires the Maryland Health Care Commission to adopt regulations, on or before September 1, 2011, that require State-regulated payors to provide incentives to health care providers to promote the adoption and meaningful use of electronic health records. Prior to the adoption of these regulations, the Maryland Health Care Commission must submit reports to the Senate Finance Committee and the House Health and Government Operations Committee in January 2010 and January 2011 on plans for the required regulations. A more detailed discussion of this bill may be found under the subpart "Public Health – Generally" within Part J – Health and Human Services of this *90 Day Report*.

Clarification of Prompt Pay Requirements

Errors may occur during the electronic processing of claims submitted by health care providers that result in the initial denial of a claim that was properly submitted (a "clean claim"). The health care provider must then resubmit the claim. ***Senate Bill 439*/*House Bill 440* (Chs. 66 and 67)** clarify that if a health insurance carrier fails to pay a clean claim for reimbursement or otherwise violates clean claims requirements, the carrier must pay interest on the amount of the claim that remains unpaid 30 days after the receipt of the initial clean claim for reimbursement.

Requirements for Insurer Provider Panels

***House Bill 141* (Ch. 131)** prohibits an insurer from using an insurance provider panel if the provider contract for the insurer provider panel requires a provider to participate on the insurer provider panel as a condition of participating on an HMO or non-HMO provider panel. An entity arranging an insurer provider panel must provide a health care provider with a schedule of applicable fees for up to the 50 most common services billed by a provider in that specialty at the time of contract, 30 days prior to a change, or upon request.

Provider Contracts for Dental Provider Panels

***Senate Bill 481*/*House Bill 145* (both passed)** prohibit a provider contract from requiring a provider, as a condition of participating in a fee-for-service dental provider panel, to participate in a capitated dental provider panel. The bills also require the Maryland Insurance Administration to review dental provider contracts, the terms and conditions of the contracts, and the impact that the contracts have on the dental profession and report its findings and recommendations by December 31, 2009, to the House Health and Government Operations Committee and the Senate Finance Committee.

Individual Market Regulation

***Senate Bill 79* (passed)** alters various aspects of the regulation of health insurance offered in the individual market.

Preexisting Conditions

In the individual market, carriers may medically underwrite policies. The carrier may inquire about conditions for which the applicant has received medical care or advice during the seven years immediately preceding the date of application. This is known as the "look back" period. An insurer or nonprofit health service plan must cover any condition revealed in the application or add an exclusionary rider for that particular condition. However, the insurer or nonprofit health service plan may exclude coverage for a preexisting condition identified in the look back period that is not revealed in the initial application for up to two years.

All states allow preexisting condition limitations in the individual market. Sixteen states have a look back period of 6 months or less, and 28 states have a maximum exclusion period of

12 months or less (including Pennsylvania, Virginia, and West Virginia). Twelve states and the District of Columbia have no limit on the look back period, and 8 states and the District of Columbia have no limit on the maximum exclusion period.

Senate Bill 79 alters preexisting condition provisions for individual health benefit plans by providing that a health insurance application form or nonprofit health service plan application form for specified individual health benefit plans may not contain inquiries about (1) a preexisting condition, illness, or disease for which the applicant has not received medical care or advice during the five years immediately before the date of application; or (2) medical screening, testing, monitoring, or any other similar medical procedure that the applicant received during the five years immediately before the date of application.

Under the bill, a carrier may not attach an exclusionary rider to an individual health benefit plan unless the carrier obtains the prior written consent of the policyholder. A carrier may impose a preexisting condition exclusion or limitation on an individual for a condition that was not discovered during the underwriting process only if the exclusion or limitation (1) relates to a condition for which medical care was received during the 12-month period immediately preceding the effective date of the individual's coverage; (2) extends for a period of not more than 12 months after the effective date of the coverage; and (3) is reduced by the aggregate of any applicable periods of creditable coverage.

Finally, a preexisting condition exclusion or limitation may not be imposed on an individual who is covered under any creditable coverage as specified but may be imposed on or after the end of the first 63-day period during which the individual was not covered for the entire period under any creditable coverage.

House Bill 32 ***(passed)*** contains provisions that are identical to the preexisting condition provisions of ***Senate Bill 79***.

Out-of-state Association Contracts

Individuals may purchase health insurance through an association that has been issued a group contract for its members. Association health plans provide an alternative to individual policies for those who do not have access to employer-based group coverage; however, they are not group insurance plans and, therefore, are not subject to the same regulation. Generally, Maryland law does not apply to contracts sold through associations in other states, even when coverage is provided to residents of Maryland.

Twelve carriers offer nonemployment based health insurance coverage to individuals in Maryland on a medically underwritten basis. Of these, three require the individual to join an out-of-state association (GoldenRule/FACT, Mega Life Insurance Company/NASE, and Time Insurance/Health Advocate Alliance). Other carriers offer coverage directly to an individual or through an association plan (such as AARP).

Senate Bill 79 requires carriers that require evidence of individual insurability and offer coverage under an out-of-state association contract to Maryland residents to disclose certain

information to applicants for coverage under the contract. A carrier must disclose (1) that coverage is conditioned on association membership; (2) all costs related to joining and maintaining membership in the association; (3) that membership fees or dues are in addition to the premium for coverage; (4) that the terms and conditions of coverage are determined by the association and carrier; (5) the health insurance benefits otherwise mandated in Maryland that are not included in the contract; (6) that the Maryland resident may purchase an individual health benefit plan that includes the mandated benefits that are not included in the contract; (7) that the contract is not regulated by the Maryland Insurance Commissioner; and (8) that the terms and conditions of coverage may be changed without the consent of a member. Carriers that collect membership fees or dues on behalf of an association must disclose this information on the enrollment application. The bill also authorizes the Insurance Commissioner to require a carrier that provides coverage under an out-of-state association contract to report annually to the Commissioner on the number of State residents covered under the out-of-state association contract.

House Bill 39 ***(passed)*** contains identical provisions on the regulation of out-of-state association contracts.

Restrictions on Rescission of Contracts and Certificates

After two years from the date of issue of a policy, no misstatements, except fraudulent misstatements, made by the applicant in the initial application for coverage may be used to void the policy or deny a claim for loss incurred or disability.

In 2008, the U.S. House of Representatives Committee on Oversight and Government Reform investigated rescission practices in the individual health insurance market after regulators in California and Connecticut uncovered evidence of improper rescissions.

Senate Bill 79 prohibits an insurer, nonprofit health service plan, or a health maintenance organization that conditions coverage on evidence of individual insurability from rescinding coverage on the basis of written information submitted on or with or omitted from an application unless the carrier completed medical underwriting and resolved all reasonable medical questions related to the written information before issuing the health benefit plan. A carrier must prove that any rescission of a health benefit plan complies with these provisions.

House Bill 235 ***(passed)*** contains identical provisions to the rescission provisions of ***Senate Bill 79***.

Loss Ratios

Loss ratios are the ratios of incurred claims to premiums earned (the share of premium revenues spent on medical care). Carriers must include loss ratios for all health benefit plans specific to the State in their required annual reports to the Insurance Commissioner. ***Senate Bill 79*** requires the Maryland Insurance Administration to study options to raise or define medical loss ratios in the individual, small group, and large group health insurance markets that incentivize reduction of health care costs and improvement of health care quality and report its

findings by December 1, 2009. Specifically, the administration is required to (1) study medical loss ratio requirements in other states to determine innovative ways to encourage health insurance carriers to incentivize adoption of electronic health records, implement wellness programs, and implement chronic care management programs; and (2) examine tiered medical loss ratio requirements in the small group market.

Small Group Market Regulation

Changes to the Comprehensive Standard Health Benefit Plan

Chapter 243 of 2007 required the Maryland Health Care Commission to conduct a study of the Comprehensive Standard Health Benefit Plan, the plan required to be offered in the small group health insurance market, and report by December 1, 2007, on options available to encourage more employers to enter the small group market. The commission asked its actuary, Mercer, to examine the plan and make recommendations to encourage participation, retention, prudent use of benefits, maintenance of a healthy lifestyle, and the use of care management. Options examined by Mercer included minimizing or eliminating the benefit "floor" and "ceiling"; altering rating principles by broadening the rating band to better reflect age-related risk, incorporating gender, allowing a 5% to 10% rate variation based on health factors, allowing premiums for new groups to be adjusted for health factors and blended to modified community rate over three to five years; increasing the small group size from 2-50 employees to 2-75 employees; and allowing the Health Insurance Portability and Accountability Act compliant preexisting condition exclusions.

***Senate Bill 637*/*House Bill 674* (both passed)** make several changes to small group market regulation as a result of the recommendations by Mercer. Specifically, the bills:

- permit preexisting condition limitations to the extent that they are allowed in the large group;

- repeal the floor on the Comprehensive Standard Health Benefit Plan;

- change the rating of health benefit plans issued in the small group market, effective July 1, 2010. The bills permit the use of health status in rating upon entry of a small employer into the small group, phased out over a period of three years. A carrier may charge based on this adjustment for health status an additional 10% above or below the community rate in the first year of enrollment, 5% above or below the community rate in the second year of enrollment, and 2% above or below the community rate in the third year of enrollment. The bills also authorize health insurance carriers to vary a rate charged for a health benefit plan in the small group up to 50% above or below the community rate based on age and geography;

- require the Maryland Health Care Commission to maintain on its web site an application that small businesses may use to compare premiums for health benefit plans offered through the small group market; and

- require the commission to report to the Governor and the General Assembly by December 1, 2009, on potential options for allowing plans with fewer benefits than the Comprehensive Standard Health Benefit Plan to be sold in the small group market and whether any additional authority is needed to effectively implement the premium comparison application.

Required Extended Election Period for Federal Subsidy

The American Recovery and Reinvestment Act of 2009 (ARRA) provides certain individuals involuntarily terminated by their employer a premium subsidy (65% of the premium for up to nine months) to help cover the costs of continuation of their group health benefits available under the Consolidated Omnibus Budget Reconciliation Act (COBRA). ARRA provides this subsidy both to those individuals who qualify for COBRA under federal law (employers with 20 or more employees) and to those who qualify for continuation coverage under State law (employers with less than 20 employees).

ARRA makes this subsidy available to individuals who were involuntarily terminated after September 1, 2008, and before December 31, 2009. For those individuals who became eligible for COBRA before February 16, 2009, the date of enactment of ARRA, but who declined coverage, ARRA provides a second election period. However, while this second election period is automatic for those who qualify for COBRA under federal law, states must act to provide this second election period to those who qualify for continuation coverage under state law.

***Senate Bill 84* (Ch. 22)** makes necessary changes to State law to enable individuals in small firms that were involuntarily terminated from their jobs between September and February to have a second opportunity to elect continuation coverage and obtain a federal premium subsidy. The bill requires health insurance carriers to allow an extended election period for continuation coverage for individuals who are eligible for continuation coverage under State law and are eligible for a federal subsidy or would be if an election of continuation coverage was in effect on the date of enactment of ARRA.

Regulation of Nonprofit Health Service Plans

Bills were passed during the 2009 session that specifically impact nonprofit health service plans that operate in the State.

Hearings and Orders on the Impact of Out-of-state Laws

In December 2008, the Council of the District of Columbia approved the Medical Insurance Empowerment Amendment Act of 2008. This Act requires the Commissioner for the Department of Insurance, Securities, and Banking of the District of Columbia to determine whether the portion of CareFirst's surplus attributable to the District of Columbia is excessive and order CareFirst to divest itself of excessive surplus through community health reinvestment. The Act also requires CareFirst to offer, set specified affordability and adequacy standards for,

and advertise the availability of an open enrollment program. More specifically, CareFirst must make an open enrollment program available to a minimum of 2,500 subscribers from the District of Columbia and may not charge a premium that exceeds 125% of standard market rates.

***Senate Bill 1070*/*House Bill 1534* (both passed)** authorize the Maryland Insurance Commissioner to hold a hearing if another state enacts a law that requires a nonprofit health service plan operating in Maryland to provide a program or benefits for the residents of another state. The hearing must review and evaluate the impact of the law on the nonprofit health service plan, including the impact on surplus, premium rates for policies issued or delivered in Maryland, and solvency. The Commissioner must determine whether the impact on the nonprofit health service plan is harmful to the interests of subscribers covered by policies issued or delivered in Maryland and issue an appropriate order to protect the subscribers, where necessary. The order may prohibit the nonprofit health service plan from subsidizing the program or benefits for the residents of another state through premiums charged to subscribers under policies issued or delivered in Maryland or use of any surplus earned through policies issued or delivered in Maryland.

Senior Prescription Drug Assistance Program

***House Bill 1472* (passed)** makes clarifying changes to the Senior Prescription Drug Assistance Program (SPDAP) and specifies how CareFirst must provide a subsidy for assistance with the Medicare Part D coverage gap for individuals enrolled in SPDAP.

The bill clarifies that there are two subsidies provided to SPDAP: (1) a subsidy under § 14-106 of the Insurance Article, which funds the SPDAP premium subsidy and is capped at $14.0 million in fiscal 2010; and (2) a subsidy under § 14-106.2 of the Insurance Article, which provides assistance with the Medicare Part D coverage gap and is provided in an amount of $4.0 million in years in which CareFirst incurs a specified surplus.

The bill also alters the timing of the second subsidy to simplify administration of SPDAP. Beginning with calendar 2009, CareFirst must transfer $4.0 million to SPDAP if it has a surplus that exceeds 800% of specified consolidated risk-based capital (RBC) requirements. CareFirst is not required to make the transfer if its surplus does not exceed the specified level. The RBC threshold for determining the transfer is based on the corporation's annual March 1 filing with the Maryland Insurance Administration. By September 1 of each year, CareFirst must notify SPDAP whether it will transfer the $4.0 million subsidy during the next calendar year. CareFirst must pay the $4.0 million subsidy to SPDAP in quarterly installments of $1.0 million beginning October 1 for the next calendar year.

Mandated Benefits Coverage

There are 43 mandated health insurance benefits that certain carriers must provide to their enrollees. Several bills that passed during the 2009 session added to or modified these mandates.

Breast Cancer Screening

House Bill 405 ***(passed)*** alters the health insurance mandate regarding coverage of mammograms by requiring insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. As of March 2008, these guidelines include:

- Yearly mammograms recommended starting at age 40 and continuing for as long as a woman is in good health.
- Clinical breast exam as part of a periodic health exam every three years for women in their twenties and thirties and annually for women age 40 and older.
- Women at high risk (greater than 20% lifetime risk of breast cancer) should get an MRI and a mammogram annually.

Hospitalization and Home Visits Following a Mastectomy

The estimated incidence of mastectomies nationally for women younger than age 65 is 0.018%, with 65% of patients sent home within 24 hours. Anecdotal evidence suggests that, in the absence of a mandate, 48-hour inpatient stays are often covered or approved by carriers when medically necessary or requested by the physician or patient. In 2008, 20 states required coverage for an inpatient stay following a mastectomy, with 8 requiring a minimum 48-hour stay, and the remainder generally requiring that length of stay be determined by the physician.

Senate Bill 173/House Bill 41 ***(both passed)*** require insurers, nonprofit health service plans, and HMOs to provide coverage for a minimum 48-hour inpatient hospital stay following a mastectomy. A patient may request a shorter length of stay. For a patient who receives less than a 48-hour inpatient stay or who undergoes a mastectomy on an outpatient basis, a carrier must provide coverage for one home visit scheduled to occur within 24 hours after discharge and an additional home visit if prescribed. Carriers may not deny, limit, or impair the participation of physicians under contract with the carrier for advocating the interest of mastectomy patients, including lengthier inpatient stays or additional home visits. Carriers must provide notice annually about the coverage provided under the bills.

Coverage for Off-label Use of Drugs

Off-label use of a drug is the prescription of a medication in a manner different from that approved by the federal Food and Drug Administration. As many as one of every five drugs prescribed in the United States may be for off-label use. Off-label use is particularly prevalent in cancer therapy, where as many as 50% to 75% of all drug uses are off-label.

Under Maryland law, if a policy or contract of health insurance provides coverage for drugs, coverage must be provided for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature. Coverage of

an off-label use of a drug must include medically necessary services associated with the administration of the drug. The mandate does not require coverage of a drug if has determined use of the drug to be contraindicated or if the drug is experimental and not approved for any indication. ***Senate Bill 985*/*House Bill 456* *(Chs. 112 and 113)*** alter the definition of "standard reference compendia" for purposes of mandated coverage of off-label use of drugs to mean any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Maryland Insurance Commissioner.

Prosthetic Parity Act

Prosthetic devices enable amputees to perform everyday activities, return to work, exercise, and contribute to society. An estimated 14,000 nonelderly individuals live with limb loss in Maryland. The cost of prosthetic devices generally ranges from $2,000 to $40,000, with some advanced prostheses costing as much as $100,000.

Eleven states require coverage of prosthetic devices. Most of these states cap reimbursement at Medicare levels and either limit deductibles or copayments to Medicare levels ($100, 20%) or require them to be comparable to other benefits under the plan.

Senate Bill 341*/*House Bill 579* *(both passed) require insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for prosthetic devices, components of prosthetic devices, and repair of prosthetic devices. "Prosthetic device" means an artificial device to replace, in whole or in part, a leg, arm, or eye. Prosthetic devices may not be subject to a higher copayment or coinsurance requirement than those required for any primary care benefits. A carrier may not impose an annual or lifetime dollar maximum on coverage for prosthetic devices, separate from any maximum that applies in the aggregate to all covered benefits. A carrier may not establish requirements for medical necessity or appropriateness for prosthetic devices that are more restrictive than those under the Medicare Coverage Database.

Health Insurance Regulation – Miscellaneous

Antifraud Plans

Under current law, if an insured has a compensable injury or disability at the time of a claim, insurers have no way to determine if the insured later ceases to be entitled to the benefit. In some cases, an insured no longer entitled to benefits may continue to collect payments, which is insurance fraud subject to existing penalties. In the absence of affirmative statements of continued eligibility, prosecuting these cases of insurance fraud has been difficult for the Maryland Insurance Administration.

Authorized insurers, nonprofit health service plans, and fraternal benefit societies are required to create and file with the Insurance Commissioner an insurance antifraud plan that includes specific procedures to prevent and report insurance fraud and facilitate prosecution of insurance fraud cases. ***House Bill 142* *(passed)*** extends this requirement to third-party administrators.

In addition, the bill provides that as part of an antifraud plan, authorized insurers may require in writing that individuals receiving disability benefits periodically affirm that they remain entitled to the benefits and have had no change in the condition entitling them to the benefits. An insurer that requires affirmation must disclose to the individual receiving benefits that knowingly and willfully providing false information or knowingly and willfully failing to provide information is a crime subject to a fine and imprisonment.

Annuity Contracts and Qualified State Long-Term Care Insurance Partnership

The federal Qualified State Long-Term Care Insurance Partnership began in the early 1990s. The program allows individuals to retain a greater portion of their assets under Medicaid if the individual purchases a long-term care insurance policy and exhausts the benefits of the policy. States benefit because Medicaid becomes the last payor of long-term care services rather than the first.

Maryland's Qualified State Long-Term Care Insurance Partnership program is not fully operational, but carriers should begin selling qualified long-term care insurance policies under the program in 2009. Final regulations were effective in December 2008, and carriers may file for certification from the Maryland Insurance Administration. The Department of Health and Mental Hygiene filed the required State Plan Amendment with the federal Centers for Medicare and Medicaid Services in December 2008 but as of March 2009 is awaiting a response.

Senate Bill 716*/*House Bill 590* *(both passed) repeal the requirement that the outline of coverage, which carriers must provide to long-term care insurance applicants, include a statement as to whether the policy or contract is approved under the Qualified State Long-Term Care Insurance Partnership. The bills also require that a certificate issued under group long-term care insurance include a statement as to whether the policy or contract is intended to qualify as a partnership policy under the Qualified State Long-Term Care Insurance Partnership.

Senate Bill 716*/*House Bill 590 also authorize an annuity contract to include a rider or supplemental contract provision that offers a contract holder reimbursement or payment for long-term care. Beginning January 1, 2010, the federal government will begin to treat long-term care coverage included with an annuity contract as tax qualified. Thus, the bills' provision regarding annuities will allow State residents to take advantage of the option of purchasing long-term care insurance coverage through an annuity policy on a tax-qualified basis.

Definition of Coverage Decisions – Pharmacy Inquiries

When filling a prescription for a patient, a pharmacist or pharmacy staff member may call a carrier or pharmacy benefits manager (PBM) to inquire as to whether a particular medication is covered, whether prior authorization is required, or what the appropriate copayment amount is. ***Senate Bill 854*/*House Bill 1071* *(Chs. 103 and 104)*** exclude a "pharmacy inquiry" from the definition of coverage decision for purposes of the internal appeals process for carrier coverage decisions and subsequent complaints to the Maryland Insurance Commissioner. A "pharmacy inquiry" is defined as an inquiry submitted by a pharmacist or pharmacy on behalf of a member

to a carrier or a PBM at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under a health benefit plan.

Medicare Coverage and Continuation Coverage – Provisions that Relate to Federal Laws and Programs

Senate Bill 84 ***(Ch. 22)*** reenacts provisions of law established under Chapter 289 of 2005, which terminated on June 30, 2008. Carriers that sell Medicare supplement plan policies must make available a Medicare supplement policy plan A to disabled individuals younger than age 65 during the six-month period after the individual enrolls in Medicare Part B. A carrier may not charge such individuals a rate higher than the average of the premiums paid by all policy holders age 65 and older in the State who are covered under that plan A policy.

The Act also addresses an issue emerging from new federal requirements relating to Medicare supplement plans by altering minimum requirements for Medicare supplement policies.

Required Reports by the Maryland Insurance Administration

Senate Bill 636 ***(Ch. 89)*** repeals a provision of law that would apply the rules of the small group health insurance market to the entire commercial market if and when a certain trigger is reached. Instead, the Maryland Insurance Commissioner, by December 1 of each year, must report to the General Assembly on the estimated number of insured and self-insured contracts for health benefit plans in the State and the number of insured and self-insured lives younger than age 65 enrolled in health benefit plans in the State. An obsolete reporting requirement is also repealed.

Regulation of Wellness Programs

Senate Bill 638**/*****House Bill 610*** ***(both passed)*** authorize a carrier to provide reasonable incentives to an insured, subscriber, or member for participation in a bona fide wellness program under specified circumstances and clarify that it is not discrimination or a rebate for a carrier to provide such incentives if the incentives are provided as specified. The definition of "bona fide wellness program" is expanded to include programs designed to promote health or prevent and control injury, but no longer includes promoting healthy lifestyle choices. "Health factor" means health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, or disability. "Incentive" means a discount of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, the absence of a surcharge, the value of a benefit that would otherwise not be provided, or a specified rebate. The definition of "wellness benefit" in the small group health insurance market is also altered to conform to the provisions of the bills.

A carrier may not make participation in a bona fide wellness program a condition of coverage. Participation must be voluntary, and a penalty may not be imposed on an insured, subscriber, or member for nonparticipation. A carrier may not market the bona fide wellness program solely as an incentive or inducement to purchase coverage from the carrier. A bona fide

wellness program may not condition an incentive on an individual satisfying a standard related to a health factor except as specified.

Incentives may be based on an individual satisfying a standard related to a health factor if (1) all incentives for participation do not exceed 20% of the cost of specified coverage under the plan; (2) the program is reasonably designed to promote health or prevent disease; (3) the program gives individuals the opportunity to qualify for the incentive at least annually; (4) the program is available to all similarly situated individuals; and (5) individuals are provided a reasonable alternative standard or a waiver of the standard.

A bona fide wellness program must be construed to be reasonably designed to promote health or prevent disease if the program (1) has a reasonable chance of improving the health of or preventing disease in participating individuals; (2) is not overly burdensome; (3) is not a subterfuge for discriminating based on a health factor; and (4) is not highly suspect in the method chosen to promote health or prevent disease.

A carrier must provide a reasonable alternative standard or a waiver of the standard for any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to attempt to satisfy the otherwise applicable standard. A carrier may seek verification that a health factor makes it unreasonably difficult or medically inadvisable to satisfy or attempt to satisfy the otherwise applicable standard. A carrier must disclose the availability of a reasonable alternative standard or wavier. A denial by a carrier of a request for an alternative standard or waiver of a standard constitutes an adverse decision.

The Insurance Commissioner may request a review of a carrier's bona fide wellness program by an independent review organization to determine if the program meets the bills' requirements. The expense of the review must be paid by the carrier.

Drug Therapy Management in Group Model Health Maintenance Organizations

***Senate Bill 791*/*House Bill 725* (both passed)** allow licensed physicians and licensed pharmacists participating in a group model health maintenance organization (HMO) to provide drug therapy management to patients under specified circumstances. The bills also exempt group model HMOs that wish to provide drug therapy management to a patient from having to enter into a therapy management contract with the patient.

The drug therapy management authorized under the bills must be provided under a physician-pharmacist agreement that is approved by the State Board of Pharmacy and State Board of Physicians and must also be provided through the internal pharmacy operations of the HMO.

The bills require that a patient be informed of drug therapy management procedures; that he or she may decline to participate or withdraw from drug therapy management participation at any time; and, that neither the physician nor pharmacist has been coerced or given economic incentives, except for normal reimbursement, or involuntarily required to participate. The

patient's documented informed consent to participate in drug therapy management must be obtained after making the required disclosure.

These bills are also discussed under the subpart "Health Occupations" within Part J – Health and Human Services of this *90 Day Report*.

Human Services

Social Services

The Family Investment Program (FIP) is the State's program for serving welfare recipients and assisting recipients in becoming self-sufficient through job training and employment assistance. ***House Bill 268*** ***(passed)*** requires the Secretary of the Department of Budget and Management, with the assistance of the Secretary of the Department of Human Resources (DHR), to develop and implement a plan to hire FIP recipients, children of current or former recipients, foster youth, and child support obligors in various State agencies. In addition, similar FIP hiring programs for local governments and entities that contract with the State are also amended to add children of current or former recipients, foster youth, and child support obligors. The bill also establishes that current job skills enhancement programs within the FIP must target job training for the above mentioned individuals for employment in energy and environmental industries and construction.

Temporary Cash Assistance (TCA) provides financial assistance to dependent children and other family members deprived of support due to the death, incapacitation, underemployment, or unemployment of one or both parents. TCA is the cash assistance component of the FIP. As a condition of receiving TCA, the recipient must assign child support rights to the State. ***House Bill 1466*** ***(passed)*** brings the State in compliance with the Federal Deficit Reduction Act of 2005 by repealing a provision that requires TCA applicants and recipients to assign to the State the right to receive child support accrued prior to receiving TCA. Under the bill, the applicant or recipient must assign to the State all right, title, and interest in support only for the period that the family receives TCA.

The Office of Home Energy Programs (OHEP) within DHR provides home energy assistance to Maryland residents through local agencies in each jurisdiction. The Electric Universal Service Program (EUSP), which is administered by DHR and overseen by the Public Service Commission, helps make electric bills more affordable to low-income customers through bill assistance and arrearage retirement. ***Senate Bill 703***/***House Bill 736*** ***(both passed)*** makes changes to the EUSP by eliminating the $1.5 million limit on the total amount of assistance that DHR may provide annually for the retirement of arrearages. This bill also allows a household to benefit from arrearage retirement once every seven years, rather than once in a lifetime.

A more detailed discussion of energy assistance issues may be found under subpart "Public Service Companies" within Part H – Business and Economic Issues of this *90 Day Report*.

The Elderly

Continuing Care Retirement Communities (CCRCs) offer a full range of housing, residential services, and health care in order to serve older residents as their medical needs change over time. ***House Bill 843*** ***(passed)*** expands the components that a CCRC must include in its internal grievance procedures and allows subscribers and providers to seek mediation within 30 days after the conclusion of an internal grievance procedure. For a further discussion of this bill, see the subpart "Health Care Facilities and Regulation" within Part J – Health and Human Services of this *90 Day Report*.

Senate Bill 761/***House Bill 113*** ***(both passed)*** require the Secretary of the Department of Health and Mental Hygiene (DHMH) to report to the General Assembly on the feasibility of creating a coordinated care program to reform the provision of long-term care services under the Medical Assistance program. The goal is to improve and integrate the care of individuals, including health care services, and to meet the various needs of seniors and adults with disabilities in the State. A more detailed discussion of this bill may be found under subpart "Public Health – Generally" under Part J – Health and Human Services of this *90 Day Report*.

In order to better coordinate services and provide additional consumer input, ***House Bill 1480*** ***(passed)*** adds the Secretary of the Department of Veterans Affairs, the Director of the Governor's Office of the Deaf and Hard of Hearing, and the Chair of the Commission on Aging to the membership of the Interagency Committee on Aging Services.

The duties of the State Advisory Council on Quality Care at the End of Life include monitoring trends in care to Marylanders with life-threatening illnesses and studying the impact of State statutes, regulations, and policies on the provision of care at the end of life. ***Senate Bill 1054*** ***(Ch. 118)*** adds a representative of the nursing home industry to the membership of the State Advisory Council on Quality of Care at the End of Life.

The Disabled

Employers are prohibited from discrimination in various aspects of employment because of an individual's disability. For purposes of employment discrimination, a disability is defined as a physical disability, infirmity, malformation, or disfigurement that is caused by bodily injury, birth defect, or illness, including epilepsy, or a mental impairment or deficiency.

Senate Bill 670/***House Bill 393*** ***(both passed)*** expand the definition of a disability to include a record of having a physical or mental impairment or being regarded as having a physical or mental impairment. The bill prohibits an employer from failing or refusing to make a reasonable accommodation for the known disability of an otherwise qualified employee. However, an employer is not required to accommodate an employee's disability if doing so would cause undue hardship on the employer's business. In addition, the bill prohibits an employer from retaliation against an employee, applicant, or member who has opposed any prohibited employment practice or participated in an investigation, proceeding, or hearing relating to a discrimination charge.

Children

Child Abuse and Neglect

Under current law, newly employed child welfare casework staff are hired provisionally and must complete a training program and pass a competency test before being granted permanent employment status. In order to streamline the hiring process for experienced caseworkers, fill vacancies with experienced workers, and assign cases sooner, ***Senate Bill 83 (passed)*** requires the Secretary of DHR to develop and implement mandatory standards that exempt newly hired individuals who have documented and verified casework experience or hold appropriate State licensure from the training program. However, the Secretary must require a caseworker who is exempted from the training program and who fails the competency test to participate in the program and take and pass the competency test before being granted permanent employment status.

As part of efforts to protect the future children of abusive parents, ***Senate Bill 421*/*House Bill 144* *(both passed)*** require the Secretary of DHMH to notify the executive director of the Social Services Administration in DHR when an individual whose parental rights have been terminated and who has been identified in a central registry as responsible for child abuse or neglect has a subsequent child. If the executive director receives birth record information for an individual whose parental rights have been terminated, the executive director must (1) verify the identity of the birth parent; and (2) notify the local department of social services so that the department may review its records and, when appropriate, provide an assessment of the family and offer any needed services.

Child Support

In order to ensure that State law conforms with regulations adopted by the federal Office of Child Support Enforcement and to avoid a substantial loss of federal funds, ***Senate Bill 70 (passed)*** requires a court to include in any support order that is established or modified a provision requiring one or both parents to include the child in the parent's health insurance coverage if (1) the parent can obtain health insurance coverage through an employer or any form of group health insurance coverage; (2) the child can be included at a "reasonable cost" to the parent; and (3) the health insurance coverage is "accessible" to the child. If health insurance coverage at a reasonable cost is not available at the time a support order is established or modified, the court (1) may require one or both parents to include the child in the parent's health insurance coverage if health insurance coverage at a reasonable cost becomes available in the future; and (2) shall require one or both parents to provide cash medical support in an amount not to exceed 5% of the actual income of the parent ordered to provide cash medical support. The grant for Child Support Enforcement Services to the State, which totaled $81.8 million in fiscal 2009 and the grant for Temporary Assistance for Needy Families, which totaled approximately $229.1 million in fiscal 2009, are at risk of being suspended in Maryland if State law does not conform to federal requirements.

Adoption

"Post adoption services" means medical treatment, mental health services, parenting classes, or other direct services provided by DHR after a child is adopted and to assist in preventing the child from being returned to the care and supervision of DHR. ***House Bill 683 (passed)*** expands the eligibility for post adoption support services provided under the Post Adoption Support Services Pilot Program to all adoptions in the State. In order to ensure the equitable distribution of funds, DHR (1) must allow the delivery of post adoption services to at least 125 families and may award up to $2,000 to each family; (2) must dedicate 80% of the funds to families of children adopted through local departments and 20% of the funds to remaining adoptive families; and (3) after October 31, 2009, but before November 30, 2009, must evaluate the distribution of funds as set forth above, and may reallocate funds if necessary to achieve an equitable distribution. The bill extends the termination date of the program until December 31, 2010.

Foster Care

Chapter 536 of 2004 required the Governor's Office for Children, in cooperation with DHR and the Department of Juvenile Services (DJS), to plan for and determine the cost of an objective and standardized system of outcomes evaluation for out-of-home placements used by State agencies. Chapter 133 of 2007 required DHR, DJS, and the Governor's Office for Children to develop, coordinate, and implement a system for outcomes evaluation by July 1, 2008, to measure the effectiveness of residential child care programs. The Governor's Office for Children manages the ongoing work of the group and developed a data collection system known as the Children Services Outcome Measurement System. ***Senate Bill 690*/*House Bill 713* (both passed)** require the Governor's Office for Children to measure the effectiveness of "treatment foster care homes" based on the existing "systems for outcomes evaluation" process currently used for residential child care programs. Beginning July 2011, this requirement will expand to include residential programs operated by or under contract with DJS and foster care homes approved by a local department of social services.

Chapter 506 of 2000 established the tuition waiver program for children in foster care homes. Chapter 644 of 2007 extended the program to foster care children in out-of-home placements. In order to provide an incentive for foster parents to adopt an entire family of children, and accordingly, keep families together, ***Senate Bill 372*/*House Bill 538* (both passed)** expand eligibility for tuition and mandatory fee waivers for public institutions of higher education in Maryland to younger siblings of foster care recipients who have been adopted by the same family. To be eligible, the foster care children must share one or both parents before the adoption and be adopted from an out-of-home placement, at the same time, by the same family. The bill also expands eligibility to foster care recipients who were adopted from an out-of-home placement after their thirteenth, rather than fourteenth, birthday.

Family Day Care Homes and Child Care Centers

According to Save the Children, over 11 million children in the United States under the age of five are in some type of child care arrangement while their parents work, yet most states

have not taken necessary steps to ensure that child care facilities are prepared to respond to the needs of children in the event of emergencies. ***Senate Bill 356*/*House Bill 712* *(both passed)*** require the Maryland State Department of Education (MSDE) to adopt regulations requiring family day care homes and child care centers to have written emergency preparedness plans for emergency situations that require the evacuation, sheltering in place, or other protection of children. Before adopting the regulations, MSDE and the State Superintendent of Schools must consult with the Maryland Emergency Management Agency, the Maryland Emergency Management Association, the Maryland Institute for Emergency Medical Services Systems, and the Maryland Department of Disabilities.

Joint Committee on Children, Youth, and Families

The Joint Committee on Children, Youth, and Families is charged with identifying State policies and actions that promote conditions of well-being for Maryland's children, youth, and families. The joint committee must report on its work and any recommendations to the General Assembly by December 1 of each year. The joint committee is scheduled to terminate on June 30, 2009. ***Senate Bill 413*/*House Bill 244*** (***Chs. 63 and 64)*** repeal the termination date of the joint committee.