HB 361

Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE
Revised

House Bill 361 (Chair, Health and Government Operations Committee)(By Request - Departmental - Insurance Administration, Maryland)

Health and Government Operations | Finance

Health Insurance - Conformity with and Implementation of Federal Patient Protection and Affordable Care Act

This departmental bill alters State insurance law to conform to the federal Patient Protection and Affordable Care Act (ACA) and corresponding federal regulations adopted by the federal Centers for Medicare and Medicaid Services.

The majority of the bill's provisions take effect January 1, 2014. Provisions establishing Small Business Health Options Program (SHOP) Exchange navigator fees, specifying open enrollment period requirements, and repealing the termination date on a provision of law relating to health insurance for self-employed individuals take effect June 1, 2013.

Fiscal Summary

State Effect: Special fund revenues for the Maryland Insurance Administration (MIA) increase by an estimated $5,400 in FY 2014 from SHOP Exchange navigator license fees. A minimal amount of such revenues may be received by MIA in FY 2013. Future years reflect biennial renewal. Issuance of licenses can be handled with existing budgeted resources. Expenditures are not affected.

(in dollars)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
SF Revenue	-	$5,400	-	$5,400	-
Expenditure	0	0	0	0	0
Net Effect	$0	$5,400	$0	$5,400	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: MIA has determined that this bill has minimal or no impact on small business (attached). The Department of Legislative Services concurs with this assessment. (The attached assessment does not reflect amendments to the bill.)

Analysis

Bill Summary:

SHOP Exchange Navigators: The bill establishes license, biennial renewal, and reinstatement fees for SHOP Exchange navigators. The Insurance Commissioner is authorized to deny a SHOP Exchange navigator license after notice and opportunity for a hearing.

ACA Provisions Applicable in Maryland: The bill specifies that annual limitations on cost sharing, child-only plan offerings in the individual market, minimum benefit requirements for catastrophic plans, health insurance premium rates, coverage for individuals participating in approved clinical trials, and contract requirements for stand-alone dental plans sold in the exchange apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets in Maryland. The annual limit on deductibles for the employer-sponsored plans provision of ACA applies in the small group market.

The bill alters the definition of "child dependent" for purposes of required insurance coverage up to age 25 to exclude children who, under ACA, are allowed to remain covered under a parent's policy until age 26.

Preexisting Condition Exclusions: The bill specifies that carriers may impose a preexisting condition provision, under specified circumstances, only for plan years that begin prior to January 1, 2014, and for individual health benefit policies that are issued or delivered prior to January 1, 2014.

Comprehensive Standard Health Benefit Plan: The requirement that the Insurance Commissioner annually transmit to the Maryland Health Care Commission information necessary to evaluate the Comprehensive Standard Health Benefit Plan (CSHBP) is repealed.

Out-of-state Association Contracts: Disclosure requirements on insurers and nonprofit health service plans that require evidence of individual insurability for coverage under an out-of-state association contract are repealed.

Small Employers: The existing definition of "eligible employee" in the small group market is repealed. Instead, "eligible employee" is defined as an employee who is offered coverage under a health benefit plan by a small employer. "Eligible employee," at the option of the small employer, may include only full-time employees or full-time and part-time employees. "Full-time employee" means an employee of a small employer who works, on average, at least 30 hours per week. "Part-time employee" means an employee of a small employer who has a normal work week of at least 17.5 hours and is not a full-time employee.

The definition of "small employer" in the small group market is replaced with the definition of "small employer" under the Maryland Health Benefit Exchange (50 or fewer employees on average if the preceding calendar year ended on or before January 1, 2016, and 100 or fewer employees on average if the preceding calendar year ended after January 1, 2016). The bill specifies how the number of employees of an employer must be determined – by adding (1) the number of full-time employees and (2) the number of full-time equivalent employees, which must be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

A carrier must set premium rates for the entire plan year for each small employer. The effective date of this provision is January 1, 2014, or the effective date of Section 2 of Chapter 152 of 2012 (HB 443), the Maryland Health Benefit Exchange Act of 2012, if the effective date of that section is amended.

SHOP Exchange: A carrier is prohibited from imposing a minimum participation requirement for a qualified employer if the qualified employer designates a coverage level within which its employees may choose any qualified health plan in the SHOP Exchange. Small employers are authorized to collect premiums and transmit them to the SHOP Exchange. A carrier is also prohibited from imposing a minimum participation requirement for small employers if the small employer group applies for coverage during the open enrollment period.

Grandfathered Health Plans: The bill specifies that the laws regarding increasing access to care choices or lowering the cost-sharing arrangement in CSHBP and guaranteed issuance, guaranteed renewal, and adjusted community rating apply only to grandfathered health plans beginning on January 1, 2014.

Small Employer Open Enrollment Period: A carrier must establish a standardized annual open enrollment period of at least 30 days for each small employer before the end of the small employer's plan year. During open enrollment, each eligible employee must be permitted to enroll, disenroll, or change enrollment. A carrier must provide an open enrollment period of at least 30 days for each eligible employee who becomes eligible

outside of the initial or annual open enrollment period. Likewise, an open enrollment period of at least 30 days must be provided for an individual who experiences a triggering event, as specified in the bill.

Grace Periods in the Individual Exchange: Qualified health plans issued on or after January 1, 2014, in the Individual Exchange must include a grace period provision for a qualified individual who is receiving advance payments of federal premium tax credits and has paid at least one full month's premium during the benefit year. The grace period must be three consecutive months and be in addition to any other grace period required under State law. During the grace period, a carrier (1) must pay all appropriate claims for services rendered to the qualified individual in the first month of the grace period; (2) may pend claims for services rendered to the qualified individual in the second and third months of the grace period; (3) must notify the U.S. Department of Health and Human Services that the qualified individual is in the grace period; and (4) must notify providers of the possibility that claims may be denied when a qualified individual is in the second and third months of the grace period. The bill also specifies that carriers are exempt from existing clean claims payment requirements with respect to qualified individuals who are in a grace period.

Individual Market Open Enrollment Period: Carriers that sell health benefit plans to individuals in the State must establish an initial open enrollment period from October 1, 2013, through March 31, 2014, and accept all applicants who apply for coverage during that period. The bill specifies the dates on which coverage must begin based on the date of receipt of the application. These provisions take effect June 1, 2013.

The bill requires a carrier to provide a limited open enrollment period for an individual enrolled in a noncalendar year individual health benefit plan to enroll in a health benefit plan issued by the carrier.

Beginning October 15, 2014, a carrier that sells health benefit plans to individuals in the State must establish an annual open enrollment period that begins on October 15 and extends through December 7. During the open enrollment period, an individual must be permitted to enroll, disenroll, or change enrollment in a health benefit plan offered by the carrier. If an individual enrolls in coverage, the effective date must be January 1 of the following calendar year. Carriers must provide special open enrollment periods for individuals with certain triggering events. If an individual is determined newly eligible or ineligible for advance payments of federal premium tax credits or has a change in eligibility for federal cost-sharing reductions, a carrier must permit an individual, whose existing coverage through an employer-sponsored plan will no longer be affordable or provide minimum value for the upcoming year, to access the special enrollment period before the end of the individual's coverage through the employer-sponsored plan.

Certain Native Americans are permitted to enroll in a health benefit plan or change from one benefit plan to another in the Individual Exchange one time per month.

Discontinuation of Individual Health Benefit Plans: Carriers are permitted to cancel or refuse to renew an individual health benefit plan in specified circumstances. For individual health benefit plans that are not grandfathered health plans, a carrier may discontinue to offer a particular plan if the carrier (1) provides notice at least 90 days prior to discontinuation of the coverage; (2) offers each individual the option to purchase any other individual health benefit plan offered by the carrier; and (3) acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage. Provisions of law that authorize carriers to cancel or refuse to renew coverage if the individual no longer resides, lives, or works in the service area or the membership of the individual in an association plan ceases are repealed as obsolete.

Exception to Requirement to Renew an Individual Health Benefit Plan: A health maintenance organization (HMO) may limit the individuals who may apply for coverage to those who live or reside in the HMO's service area and deny coverage to individuals if the HMO demonstrates to the Insurance Commissioner that (1) it will not have the capacity to adequately deliver services to additional individuals due to obligations to existing enrollees and (2) it is denying coverage uniformly without regard to claims experience or health-status related factors. HMOs that deny coverage under these provisions may not offer coverage in the individual market within the service area to any individual for a period of 180 days after the date that coverage is denied.

A carrier may deny a health benefit plan to an individual if the carrier demonstrates to the Commissioner that (1) it does not have the financial reserves to offer additional coverage and (2) it is denying coverage uniformly without regard to claims experience or health-status related factors. Carriers that deny coverage may not offer coverage in the individual market before the later of the 181st day after the carrier denies coverage and the date the carrier demonstrates to the Commissioner that the carrier has sufficient financial reserves to underwrite coverage.

Bona Fide Wellness Programs: The bill increases the maximum financial incentives for bona fide wellness programs to 30% of the cost of employee-only coverage (or family coverage when the plan provides coverage for family members). This amount may be increased by an additional 20 percentage points to the extent that the additional amount is in connection with a program to prevent or reduce tobacco use. This provision conforms with ACA and related regulations.

Self-employed Individuals in the Small Group Market: The bill repeals the termination date on a provision of law that excludes self-employed individuals and sole proprietors from the small group health insurance market.

Current Law/Background:

SHOP Exchange: Chapter 152 of 2012 (HB 443) established the SHOP Exchange Navigator Program to provide health insurance enrollment and eligibility services in the SHOP Exchange. A SHOP Exchange navigator must hold a SHOP Exchange navigator license, issued by the Insurance Commissioner. However, Chapter 152 did not specifically authorize the Commissioner to charge a fee.

ACA Insurance Provisions: Among other provisions, ACA includes a number of patient protection provisions that took effect on September 23, 2010, for new policies upon issuance and for existing policies upon renewal, including coverage for children up to age 26 on a parent's policy, a ban on lifetime limits and on preexisting condition limitations on children, a restriction on annual limits, and coverage of certain preventive services without cost sharing. Additional insurance reforms will take effect January 1, 2014, including policies that prohibit most insurance plans from excluding people for preexisting conditions, discriminating based on health status, and imposing annual monetary caps on coverage as well as reforms to require guaranteed issue and renewal of policies, premium rating rules, nondiscrimination in benefits, and mental health and substance abuse parity.

Grandfathered Health Plans: To allow individuals to keep the health insurance coverage they already had, ACA "grandfathered" health plans that were in effect on the date ACA was enacted (March 23, 2010) and exempted such plans from many required changes. Grandfathered health plans must adhere to certain consumer protections under ACA and may not significantly reduce benefits, increase cost sharing, or, for a health benefit plan sponsored by an employer, reduce the employer's share of premiums.

Small Employers: The definition of "small employer" is amended to be consistent with the definition found in ACA. Employers who were considered to be small employers under the prior law will still be able to renew the grandfathered plans under the protections provided by the federal Health Insurance Portability and Accountability Act (better known as HIPAA). However, employers purchasing new plans outside the exchange after January 1, 2014, will be subject to the new definition of "small employer," which is also consistent with the definition used inside the exchange. Though there is no requirement that small businesses offer health insurance, beginning in 2014 under ACA, businesses with more than 50 employees will have to pay a penalty if they do not offer affordable coverage. Businesses with 50 or fewer full-time employees are exempt from these penalties.

Self-employed Individuals in the Small Group Market: Chapter 347 of 2005 (SB 1014) made self-employed individuals and sole proprietors ineligible for health insurance coverage in the small group market. Self-employed individuals and sole proprietors enrolled in the small group market on September 30, 2005, were permitted to remain covered, provided they continue to work and reside in the State and are self-employed. Self-employed individuals not already insured in the small group market have the option of enrolling in the Maryland Health Insurance Plan (better known as MHIP) if they cannot get coverage in the individual market. The provisions related to eligibility for small group coverage were initially scheduled to terminate on September 30, 2008. Chapter 76 of 2008 (HB 462) extended the termination date to September 30, 2011, while Chapter 104 of 2011 (HB 156) further extended the termination date to December 31, 2013. Under ACA, sole proprietors and self-employed individuals will be limited to purchasing in the individual market. Those who have remained insured under self-employed contracts can continue to renew them.

Discontinuation of Individual Health Benefit Plans: HIPAA provides for guaranteed renewability by requiring carriers to renew coverage unless a specific exception applies. A carrier may discontinue offering a particular type of coverage in the individual market if the carrier provides notice, and individuals are allowed to purchase any other individual product currently offered by the carrier. Maryland law does not permit a carrier to withdraw a product or particular type of coverage unless it elects not to renew all of its individual health benefit plans in the State. Thus, unlike in other states, a carrier cannot cease to sell an individual product unless it withdraws from the individual market. Under ACA, effective January 1, 2014, individual insurance will be guaranteed issue. An individual who loses coverage at any time during the year will be entitled to purchase new individual coverage through the exchange.

Clean Claims: A "clean claim" is a properly submitted claim for reimbursement. A carrier must permit a provider 180 days from the date a covered service is rendered to submit a claim. Within 30 days of receipt, a carrier must pay the claim or send a notice of receipt with the status of the claim. If a carrier denies a claim, it must permit a provider at least 90 working days to appeal. If a carrier erroneously denies a claim and the provider notifies the carrier within one year, the carrier must reprocess the claim. If a carrier disputes a portion of a claim, it must provide payment for any undisputed portion within 30 days of receipt of the claim. A carrier that does not pay clean claims must pay interest on the amount of the claim that remains unpaid 30 days after the claim is received.

Bona Fide Wellness Programs: A bona fide wellness program is a program designed to promote health or prevent or detect disease or illness, reduce or avoid poor clinical outcomes, prevent complications from medical conditions, promote healthy behaviors, or prevent and control injury.

Chapters 682 and 683 of 2009 (HB 610/SB 638) authorized carriers to provide reasonable incentives to an insured, subscriber, or member for participation in a bona fide wellness program under specified circumstances and clarified that it is not discrimination or a rebate for a carrier to provide such incentives if the incentives are provided as specified.

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 for nonparticipation. A carrier may not market the bona fide wellness program solely as an incentive or inducement to purchase coverage from the carrier. Except in specified situations, a wellness program may not condition an incentive on an individual satisfying a standard related to a health factor.

State Revenues: Special fund revenues for MIA increase by $5,400 in fiscal 2014 from fees paid by an estimated 100 individuals seeking an initial SHOP Exchange navigator license at a fee of $54. In fiscal 2016 and 2018, special fund revenues will again increase by approximately $5,400 from biennial renewal fees ($54) paid by an estimated 100 SHOP Exchange navigators.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Budget and Management, Maryland Health Insurance Plan, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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ns/ljm Revised - House Third Reader - March 27, 2013
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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Health Insurance – Conformity with Federal Patient Protection and Affordable Care Act

BILL NUMBER: HB 361

PREPARED BY: Maryland Insurance Administration

PART A. ECONOMIC IMPACT RATING

This agency estimates that the proposed bill:

__X__ WILL HAVE MINIMAL OR NO ECONOMIC IMPACT ON MARYLAND SMALL BUSINESS

OR

___ WILL HAVE MEANINGFUL ECONOMIC IMPACT ON MARYLAND SMALL BUSINESSES

PART B. ECONOMIC IMPACT ANALYSIS

The proposed legislation will have no impact on small business in Maryland.