SB 868

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 868 (Senator Feldman, *et al.*)

Finance Health and Government Operations

Health Insurance – Consumer Protections and Maryland Health Insurance Coverage Protection Commission

This bill expresses that the General Assembly finds and declares that it is in the public interest to ensure that the health care protections established by the federal Patient Protection and Affordable Care Act (ACA) continue to protect Maryland residents in light of continued threats to the ACA. The bill extends the Maryland Health Insurance Coverage Protection Commission for an additional three years through June 30, 2023. The commission must establish a specified workgroup to monitor actions relating to the ACA and determine the most effective manner of ensuring that Maryland consumers can obtain and retain quality health insurance, independent of any action or inaction on the part of the federal government or any changes to federal law or its interpretation. The commission must include the findings of the workgroup in its 2019 annual report. **The bill takes effect June 1, 2019.**

Fiscal Summary

State Effect: The bill's requirements can be handled with existing resources. Revenues are not affected.

Local Effect: None.

Small Business Effect: None.

Analysis

Current Law:

Federal Patient Protection and Affordable Care Act

Title I of the ACA provides numerous market reforms and consumer protections that have been adopted in Maryland law by reference, including:

- dependent coverage up to the age of 26;
- preexisting condition exclusions;
- prohibition on policy rescissions;
- provisions regarding wellness and prevention programs;
- prohibition on annual or lifetime limits on the dollar value of benefits;
- prohibition on excessive waiting periods in the large group market;
- requirements relating to choice of health care professional and patient access to obstetrical and gynecological care;
- emergency services coverage requirements;
- standards for summaries of benefits and coverage explanations;
- minimum loss ratio requirements and premium rebate guidelines;
- annual limitations on cost sharing;
- availability of child only plans;
- minimum benefit requirements for catastrophic plans;
- prohibition on discriminatory premium rates;
- coverage for individuals participating in clinical trials;
- contract requirements for stand-alone dental plans;
- guaranteed availability and renewability of coverage; and
- prescription drug benefit requirements.

Individual Market Consumer Protections

In the individual market, State law requires guaranteed issuance (§ 15-1316 of the Insurance Article) and renewability (§ 15-1309 of the Insurance Article). However, there is no blanket prohibition on preexisting condition exclusions. Thus, carriers may exclude preexisting conditions from coverage. Furthermore, while a carrier may not deny or refuse to renew coverage because of claims experience or a health-related status, a carrier can charge higher premiums based on health status.

Small Group Market Consumer Protections

In the small group market, State law requires guaranteed issuance (§§ 15-1208.1, 15-1208.2, 15-1209, and 15-1210 of the Insurance Article) and renewability (§ 15-1212 of the Insurance Article). State law also provides for community rating and limits adjustment of small group rates to certain factors such as age, geography, and family composition (§ 15-1205 of the Insurance Article). However, as in the individual market, there is no blanket prohibition on preexisting condition exclusions. Thus, carriers may exclude preexisting conditions from coverage. Furthermore, carriers may charge higher premiums based on health status for certain plans within certain parameters for a limited period of time.

Large Group Market Consumer Protections

In the large group market, State law requires guaranteed issuance (§§ 15-1406 and 15-1410 of the Insurance Article). State law also prohibits eligibility rules based on any health status-related factor (§ 15-1406 of the Insurance Article) and prohibits a carrier from charging an individual a premium that is greater than a similarly situated individual based on any health status-related factor (§ 15-1407 of the Insurance Article). However, as in the individual and small group markets, there is no blanket prohibition on preexisting condition exclusions. Thus, carriers may exclude preexisting conditions from coverage or impose waiting periods.

Maryland Health Insurance Coverage Protection Commission

Chapter 17 of 2017 established the commission to (1) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. Chapters 37 and 38 of 2018 altered the membership and charge of the commission to include studying and making recommendations for individual and group health insurance market stability, including specified options. By December 31 each year, the commission must submit a report on its findings and recommendations. The commission is jointly staffed by the Department of Legislative Services, Maryland Department of Health, and Maryland Insurance Administration. The commission was established for three years and will terminate on June 30, 2020.

Background:

Legal Challenge to the Patient Protection and Affordable Care Act

A principal feature of the ACA is an individual mandate that requires each individual to (1) have minimum essential health insurance coverage; (2) qualify for an exemption; or (3) make a "shared responsibility payment" with their federal income tax return for the months without coverage or an exemption. In December 2017, the federal Tax Cut and Jobs Act of 2017 (TCJA) eliminated the tax penalty for failure to comply with the mandate effective tax year 2019.

In response, in February 2018, 20 states filed suit in *Texas v. United States* that the ACA (as amended by TCJA) is unconstitutional as it is not supported by a tax penalty. The lawsuit asserts that the entire ACA is unlawful. Seventeen state attorneys general are defending the ACA and assert that the mandate remains constitutional and that, even without the individual mandate, the remainder of the ACA would stand.

On December 14, 2018**,** Judge Reed O'Connor issued a grant of summary judgment declaring that the entire ACA is invalid. On December 30, 2018**,** Judge O'Connor reaffirmed this decision and issued a stay and partial final judgment on the claim that the ACA's individual mandate is unconstitutional. This permitted immediate appeal and allows the ACA to remain in full effect pending appeals.

In early January 2019, the U.S. Department of Justice and the 17 state attorneys general appealed the case to the Fifth Circuit. On February 14, 2019, the Fifth Circuit Court of Appeals granted two requests to intervene in the ongoing litigation – one by the U.S. House of Representatives and the other by state attorneys general in four additional states (Colorado, Iowa, Michigan, and Nevada). The Fifth Circuit also denied a request from the intervenor states, led by California, for an expedited briefing schedule. The federal government's brief is due on March 25, 2019.

Additional Information

Prior Introductions: None.

Cross File: HB 697 (Delegate Pendergrass, *et al.*) - Health and Government Operations.

Information Source(s): The Commonwealth Fund; *Health Affairs;* Office of the Attorney General; Maryland Insurance Administration; Department of Legislative Services

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