SB 872

Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 872 (Senator Feldman, *et al.*)
Finance Health and Government Operations

Health Insurance - Consumer Protections

This emergency bill establishes, in a new subtitle, the consumer protection provisions of the federal Patient Protection and Affordable Care Act (ACA) that are currently specified through cross-references in Maryland law; it also establishes nondiscrimination provisions. The bill generally applies to any health benefit plan offered in the small group, individual, or large group markets and specifies exceptions for grandfathered plans. The Insurance Commissioner is authorized to enforce these provisions and must adopt specified regulations. The bill expresses legislative intent and includes a reporting requirement.

Fiscal Summary

State Effect: The bill primarily codifies existing federal law. The bill's additional requirements (new responsibilities for the Insurance Commissioner, enforcement of nondiscrimination provisions by the Maryland Commission on Civil Rights (MCCR), and a reporting requirement) can be handled with existing resources. Revenues are not affected.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Prohibition Against Discrimination

A carrier is prohibited from refusing, withholding, or denying coverage under a health benefit plan to, or otherwise discriminating against, any individual on the grounds of race, sex, color, creed, national origin, marital status, sexual orientation, age, gender identity, or disability. MCCR must enforce these provisions.

These prohibitions do not apply to limitations or restrictions related to age or marital status that are specifically authorized or required under the Insurance Article to limit or restrict eligibility for insurance coverage or benefits.

Preexisting Conditions and Prohibition on Health Factors as a Condition of Eligibility

A carrier is prohibited from (1) excluding or limiting benefits because a health condition was present before the effective date of coverage or (2) denying coverage because a health condition was present before or on the date of denial. This prohibition applies whether or not (1) any medical advice, diagnosis, care, or treatment was recommended or received for the condition or (2) the health condition was identified as a result of either a pre-enrollment questionnaire or physical examination given to an individual or a review of records relating to the pre-enrollment period. This prohibition applies to all plans, except for individual grandfathered plans.

A carrier may not establish rules for eligibility for enrollment into a health benefit plan based on specified health status-related factors such as health condition, claims experience, or receipt of health care. A carrier may not require an individual, as a condition of enrollment or continued enrollment, to pay a premium or contribution greater than that of a similarly situated individual on the basis of any health status-related factor.

Rating Factors and Ratios

The bill codifies permissible rating factors, authorizing a carrier to determine a premium rate based on (1) age; (2) geography; (3) whether the plan covers an individual or family; and (4) tobacco use. A premium rate based on age may not vary by a ratio of more than 3 to 1 for individuals aged 21 and older and must include one-year age bands for individuals aged 21 through 63 and a single age band for individuals aged 64 and older. For individuals younger than age 21, a premium rate based on age must be actuarially justified, consistent with the uniform age rating curve, and include one-year age bands for individuals younger than age 15 and one-year age bands for individuals aged 15 through 19. A premium rate

based on tobacco use may not vary by a ratio of more than 1.5 to 1. These provisions apply only to a carrier offering an individual or small group plan.

Coverage of Children Up to Age 26

A carrier that offers a health benefit plan (including a grandfathered plan) that provides for dependent coverage of a child must continue to make that coverage available until the child is 26 years of age.

Access to Preventive Services without Cost-sharing Requirements

A carrier may not impose any cost-sharing requirements for specified (1) evidence-based items or services; (2) immunizations; (3) evidence-informed preventive care and screenings for infants, children, and adolescents; (4) preventive care and screenings for women; and (5) contraceptive coverage for women.

Prohibition on Lifetime or Annual Limits

A carrier that offers a health benefit plan, including a grandfathered plan, may not establish lifetime limits or annual limits on the dollar value of benefits for any insured individual.

Waiting Periods for Group Plans

A carrier that offers a group plan, including a grandfathered plan, may not apply a waiting period of more than 90 days before coverage takes effect for an individual who is eligible to be covered under the plan.

Designation of Primary Care Providers

If a carrier requires or provides for the designation of a primary care provider, the carrier must allow each insured to designate any participating primary care provider (or pediatrician for a child) if the provider is available to accept the insured individual.

Access to Obstetrical and Gynecological Care

A carrier must treat the provision of obstetrical and gynecological care and the ordering of related items and services as care authorized by the insured individual's primary care provider. A carrier may not require authorization or a referral for obstetrical and gynecological care by a participating obstetrician/gynecologist.

Emergency Services

If a carrier provides coverage for emergency services in an emergency department of a hospital or freestanding medical facility, the carrier may not require an insured to obtain prior authorization and must provide coverage regardless of whether the provider furnishing the emergency services contracts with the carrier. If the provider does not contract with the carrier, the carrier (1) may not impose any limitation on coverage that is more restrictive than services furnished by a contracted provider; (2) may only impose the same cost-sharing requirement that would apply for a contracted provider; and (3) must reimburse the provider at a specified rate.

Summary of Benefits and Coverage

A carrier must compile and provide to *consumers* a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable health benefit plan and complies with specified standards or regulations. The summary must be presented in a specified manner and include specified information. These provisions apply to all health benefit plans, including grandfathered and nongrandfathered plans.

Each carrier must also provide a summary of benefits and coverage explanation (which may be in paper or electronic form) that complies with specified standards to *applicants and insureds*, as specified. A carrier must provide notice of any material modification in the terms of the plan or coverage at least 60 days before the effective date of the modification.

The Maryland Insurance Administration (MIA) must levy a fine of up to $1,000 against a carrier that willfully fails to provide information under these requirements.

Medical Loss Ratio and Premium Rebates

The minimum acceptable medical loss ratio (MLR) is 85% for the large group market and 80% for the small group and individual markets. The Commissioner may set higher MLRs in regulation. Each carrier must comply with specified requirements for calculating MLRs and related reporting and rebate requirements.

Catastrophic Plans

A carrier may offer a catastrophic plan in the individual market only to individuals who are younger than age 30 before the beginning of the plan year or who hold a specified hardship exemption. A catastrophic plan must require a specified deductible.

Limitations on Cost Sharing for Essential Health Benefits

Each carrier must comply with annual limitations on cost sharing for essential health benefits (EHBs) covered under health benefit plans, including any regulations adopted by the Commissioner.

Prescription Drug Essential Health Benefits

Individual and small group plans must be considered to provide prescription drug EHB coverage only if the plan complies with specified federal regulations or regulations adopted by the Commissioner.

Prohibition on Policy Rescissions

The bill prohibits a carrier from rescinding the coverage under a health benefit plan, with specified exceptions such as fraud. A carrier that rescinds coverage must comply with regulations adopted by the Commissioner. These provisions apply to all health benefit plans, including grandfathered and nongrandfathered plans.

Responsibilities of the Insurance Commissioner

The Commissioner must, to the extent necessary, adopt regulations that (1) establish criteria that a health benefit plan must meet to be considered a grandfathered plan; (2) establish criteria that a health benefit plan must meet to be considered a plan that covers EHBs; (3) establish standards for the summary of benefits and coverage; (4) define "medical loss ratio" and establish requirements for calculating MLRs and related reporting and rebate requirements; (5) establish annual limitations on cost sharing; (6) establish criteria to determine if an individual or small group plan provides prescription drug EHB coverage; and (7) establish requirements that a carrier must comply with to rescind coverage. Generally, regulations must be consistent with specified federal regulations and rules as of December 1, 2019.

Responsibilities of the Maryland Health Benefit Exchange

To the extent necessary, the Maryland Health Benefit Exchange (MHBE) must adopt regulations that establish a process for issuing hardship and affordability exemptions, consistent with specified federal regulations and rules as of December 1, 2019.

Reporting Requirement

MIA, the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General, and MHBE must (1) monitor federal statutes and regulations to determine whether

provisions of the ACA or corresponding regulations are repealed or amended to the benefit or detriment of Maryland consumers and (2) by December 31 each year until 2024, submit a specified joint report to the Senate Finance Committee and the House Health and Government Operations Committee.

Intent of the General Assembly

The bill expresses legislative intent that the bill's changes, including moving specified insurance provisions within the Insurance Article and supplementing cross-references to the ACA with the codification of specific statutory language, further implement the continuing intent of the General Assembly to ensure that Maryland residents benefit from the consumer protections.

Current Law:

Federal Patient Protection and Affordable Care Act

The ACA requires nongrandfathered health plans to cover 10 EHBs, which include items and services in the following categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services; including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including dental and vision care.

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.

Nondiscrimination Provisions

The ACA provides two sets of nondiscrimination provisions: (1) health status-related factors; and (2) civil rights (race, color, national origin, sex, disability, and age). Maryland law covers health status but is silent on civil rights.

Background:

Consumer Protection Workgroup

Chapters 417 and 418 of 2019 required the Maryland Health Insurance Coverage Protection Commission to establish a workgroup to (1) monitor the appeal of the decision of the U.S. District Court for the Northern District of Texas in *Texas v. United States* regarding the ACA and the implications of the decision for the State; (2) monitor federal enforcement of the ACA; and (3) 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 workgroup included representatives from MIA, HEAU, carriers, the Maryland Hospital Association, and consumer advocates. The workgroup met four times during the 2019 interim. The workgroup reviewed Senate Bill 868/House Bill 697 of 2019 (as those bills were introduced) and, after considering several drafts and comments, made recommendations for legislation for the 2020 session. This bill generally implements those recommendations.

Legal Challenge to the Patient Protection and Affordable Care Act

On December 18, 2019, the Fifth Circuit Court of Appeals affirmed the U.S. District Court for the Northern District of Texas' determination that the ACA's individual mandate is no longer considered a tax because the penalty for the mandate was reduced to $0 in the Tax Cuts and Jobs Act of 2017 (and, therefore, that the U.S. Congress does not have constitutional authority to enforce the mandate). However, the circuit court did not affirm the district court's determination that the individual mandate is not severable from the other provisions in the ACA. Instead, the circuit court remanded the severability issue to the district court and advised the district court to "employ a finer toothed comb" in determining which portions of the ACA are inseverable. California Attorney General Xavier Becerra, who has led the defense of the ACA after the U.S. Department of Justice declined to do so, has appealed the circuit court's decision to the U.S. Supreme Court. The Supreme Court denied the request to expedite its decision about whether to take the case and will instead decide whether to review the case according to its regular timeframe. If the court does take the case, it may not be argued or decided until 2021.

Additional Information

Prior Introductions: SB 868 and HB 697 of 2019, *as introduced*, contained similar provisions. Those bills were significantly amended and enacted as Chapters 417 and 418 of 2019, which required the review that resulted in recommendations for this legislation.

Designated Cross File: HB 959 (Delegate Pendergrass, *et al.*) - Health and Government Operations.

Information Source(s): Office of the Attorney General; Department of Budget and Management; Maryland Health Benefit Exchange; Maryland Commission on Civil Rights; Maryland Insurance Administration; Kaiser Family Foundation; Department of Legislative Services

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