Department of Legislative Services

Maryland General Assembly
2011 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 183 (The President, *et al.*) (By Request - Administration)
Finance Health and Government Operations

Health Insurance - Conformity with Federal Law

This Administration bill alters State insurance law to conform to federal requirements under the "Affordable Care Act" and allows the Maryland Insurance Commissioner to enforce such requirements. The bill also corrects a portion of Maryland's Mental Health Parity Law to meet the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.

The bill takes effect July 1, 2011, and applies to all group and individual health benefit plans for plan or policy years that begin on or after July 1, 2011.

Fiscal Summary

State Effect: Potential minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee to the extent that carriers do not meet medical loss ratios and are required to file new rates under the bill. Otherwise, MIA is currently enforcing the provisions of the Affordable Care Act. No impact on the State Employee and Retiree Health and Welfare Benefits Program (State plan) as it is already compliant with the federal law.

Local Effect: Any additional expense incurred by local governments for the cost of health insurance premiums can be attributed to the federal law.

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

Analysis

Bill Summary:

Provisions Regarding Compliance with the Affordable Care Act

The bill clarifies that specific provisions of the federal Patient Protection and Affordable Care Act (ACA) apply to health insurance coverage offered in the individual, small group, and large group markets by an authorized insurer, nonprofit health service plan, or health maintenance organization (carrier). These provisions include coverage of children up to age 26, preexisting condition exclusions, policy rescissions, wellness programs, lifetime limits, annual limits for essential benefits, waiting periods, designation of primary care providers, access to obstetrical and gynecological services, emergency services, summary of benefits and coverage explanation, minimum loss ratio requirements and premium rebates, and disclosure of information. The provisions do not apply to coverage for "excepted benefits" as defined under federal regulations.

Medical Loss Ratios: The bill requires health insurance coverage offered in the individual, small group, and large group markets by a carrier to comply with the medical loss ratio requirements of ACA. If the carrier does not meet these ratios, the Commissioner may require a carrier to file new rates.

Appeals and Grievances: The bill makes several changes to meet ACA requirements regarding appeals and grievance processes. The bill authorizes a "member's representative" (an individual who has been authorized by the member to file a grievance or a complaint on the member's behalf) to file a grievance with a carrier and an appeal with the Commissioner. Written notice provided by a carrier after the carrier has made a decision regarding a grievance decision or an appeal decision unrelated to medical necessity must include information that the Health Advocacy Unit is available to assist the member (or member's representative) in filing a complaint with the Commissioner.

A carrier must file revisions to its internal grievance process with the Commissioner and the Health Advocacy Unit at least 30 days before use. A carrier must notify individuals that, when filing a complaint with the Commissioner, the individual will have to release any medical records required to be reviewed in order to make a determination on an appeal. Carriers must provide all notices regarding appeals and grievances in a culturally and linguistically appropriate manner.

The bill authorizes direct filing of a complaint with the Commissioner if the carrier waives the requirement that the carrier's internal grievance process be exhausted first or the carrier has failed to comply with the internal grievance process. A complaint may be

filed with the Commissioner *within four months* after receipt of a carrier's decision regarding nonemergency adverse, grievance, or coverage decisions.

The Commissioner must allow a member, the member's representative, or a health care provider filing a complaint at least five working days to provide any additional information requested by the Commissioner to make a final decision on a complaint regarding an adverse decision or grievance decision.

The Commissioner is *required* to seek advice from an independent review organization (IRO) or medical expert for medical necessity complaints filed with the Commissioner. An IRO must be nationally accredited.

The bill clarifies that an individual may appeal a final decision of the Commissioner and requires the Commissioner to file certain documents in the court in which the appeal is pending according to a specified timeframe.

The Commissioner must provide written notice to all parties to a complaint of the available remedy to the party after the Commissioner makes a decision on a complaint. A member may request a hearing or petition for judicial review but a carrier is limited to judicial review only.

Coverage of Children Up to Age 26: The bill makes two changes to reflect the provision of ACA that allows children to remain on their parent's policy until age 26. First, an existing reporting requirement is altered to require carriers to notify parents of coverage options for children 60 days before the child *reaches the limiting age under the policy or contract.* Second, the methodology for how a carrier calculates the mandatory 75% participation rate requirement in the small group market is modified to require carriers to exclude employees younger than age 26 who are covered under their parent's health benefit plan.

Rescission: The section of law that allows individuals to file an appeal with a carrier and a complaint with the Commissioner about a coverage decision is altered to include a determination by a carrier that an individual is not eligible for coverage under the carrier's health benefit plan and any determination by a carrier that results in the rescission of an individual's coverage. A member's representative may file a complaint regarding an administrative denial of coverage.

Provisions Regarding the Federal Mental Health Parity and Addiction Equity Act of 2008

The bill clarifies the definition of small employer to mean an employer with 2 to 50 employees. The Maryland Health Care Commission (MHCC) is also required to

include federal mental health parity benefits for small employers who meet the definition of a large employer.

Current Law/Background:

Provisions Regarding Compliance with the Affordable Care Act

As the State's insurance regulator, MIA is responsible for overseeing and enforcing many of the insurance requirements under ACA. While the individual and employer mandates will be enforced primarily by the federal government, MIA will ensure that insurers adhere to the new consumer protections in the federal law.

Chapter 17 of 2010 gave the Commissioner broad authority to enforce the provisions of the federal reform law; however, the authority was only extended until July 1, 2011. The provisions of ACA apply under federal law, regardless of whether this bill is enacted. However, the bill allows the Commissioner, rather than the federal government, to permanently enforce the provisions.

Federal Health Care Reform – the Affordable Care Act: In March 2010, major federal health care reform legislation, the Patient Protection and Affordable Care Act, was enacted to expand health care coverage, control health care costs, and improve the health care delivery system. 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.

Excepted Benefits: Federal regulations (45 C.F.R. § 146.145(c)) state that the requirements of ACA do not apply to any group health plan or group health insurance coverage with respect to specific "excepted benefits" including accident-only coverage, disability-income coverage, liability insurance, workers' compensation insurance, automobile medical payment insurance, credit-only insurance, and coverage for on-site medical clinics. Limited-scope dental, vision, or long-term care benefits, and certain supplemental health insurance are excepted if they are provided separately. Benefits provided under a health flexible spending arrangement, coverage for a specified disease or illness, and fixed indemnity insurance are excepted under certain circumstances.

Medical Loss Ratios: Loss ratios are the ratios of incurred claims to premiums earned (the share of premium revenues spent on medical care). Under Maryland law, carriers must include loss ratios in their required annual reports to the Commissioner. Regulators consider the medical loss ratio when evaluating rates to make sure a reasonable amount

of the premium dollar is allocated to the cost of benefits. Medical loss ratio requirements are 60% in the individual market and 75% in the small group market. There is no medical loss ratio in the large group market.

Under ACA, effective January 1, 2011, carriers must provide an annual rebate to each enrollee on a pro rata basis if a health plan's medical loss ratio for the plan year is less than 85% in the large group market or less than 80% in the small group or individual market. States may establish higher medical loss ratios in regulation. According to MIA, the actual medical loss ratios imposed by ACA are subject to change and federal regulations are forthcoming. Unlike the bill, ACA does not require carriers that do not meet medical loss ratios to file new rates.

Coverage of Children Up to Age 26: Under Maryland law, carriers must allow a child dependent to remain on an insured's plan until age 25. ACA extended dependent coverage until age 26.

Minimum Participation Requirements in the Small Group Market: Carriers in the small group market can impose minimum participation requirements on small employers wishing to purchase the Comprehensive Standard Health Benefit Plan (CSHBP). Minimum participation requirements cannot exceed 75% of eligible employees. In applying a minimum participation requirement, a carrier must exclude employees who have spousal coverage that provides benefits similar to or exceeding the benefits provided under CSHBP.

Appeals and Grievances: Under current law, carriers must establish an internal appeals process for members and health care providers to dispute coverage decisions. Within 30 calendar days after a coverage decision is made, a carrier must send written notice of the coverage decision, including the basis for the carrier's decision and the right to appeal. A carrier must render a final coverage decision in writing within 60 working days after the appeal is filed. Within 30 calendar days of the appeal decision, a carrier must send written notice of the appeal decision, including the basis for the carrier's decision and the right to file a complaint with the Commissioner within 60 working days of receipt of the appeal decision. A carrier must annually file its internal grievance process with the Commissioner even if no changes are made.

A carrier's internal appeals process must be exhausted before filing a complaint with the Commissioner, except when the coverage decision involves an urgent medical condition for which care has not been rendered. The Commissioner must issue in writing a final decision on all complaints and provide written notice to all parties of the opportunity and time period for requesting a hearing to contest a final decision.

Under ACA, carriers must implement certain appeals and external review processes. Among other things, these processes must provide notice to enrollees in a culturally and linguistically appropriate manner. Federal regulations regarding ACA require that the decision of an independent review organization be binding.

Independent Review Organizations: In cases considered appropriate by the Commissioner, the Commissioner may seek advice from an IRO or medical expert regarding medical necessity complaints. The Commissioner may select and base the final decision on a medical necessity complaint on the professional judgment of an IRO or medical expert. An IRO must meet certain criteria and submit specified information to the Commissioner.

Health Advocacy Unit: The Health Education and Advocacy Unit (part of the Consumer Protection Division of the Office of the Attorney General) assists consumers whose health plan has refused to cover a medical procedure or pay for a medical service that has already been provided.

Rescission: A carrier must establish an internal appeals process for use by its members and health care providers to dispute coverage decisions made by the carrier. The process must cover a determination by the carrier that results in noncoverage of a health care service. The internal appeals process does not have to address a determination that an individual is not eligible for coverage under the carrier's plan or a determination that results in rescission of an individual's coverage.

ACA prohibits a carrier from rescinding health insurance once an enrollee is covered except in cases of fraud or intentional misrepresentation. Coverage can only be canceled with prior notice under specified circumstances.

Provisions Regarding the Federal Mental Health Parity and Addiction Equity Act of 2008

Maryland generally requires large group health insurers to provide mental health coverage that is comparable to the coverage they provide for physical illnesses; however, the federal Mental Health Parity and Addiction Equity Act of 2008 requires further equity between the coverage levels for mental and physical health services.

Under Maryland law, calculation of employer size for a small business (2 to 50 employees) does not include part-time employees. However, part-time employees are counted in the federal calculation of employer size. Thus, some Maryland employers who meet the State definition of small employer are large employers under federal law. Furthermore, a small business may purchase CSHBP in the small group market if it has fewer than 50 employees but continues to renew the policy even if

employee size grows beyond 50 in future years. To comply with federal law, the bill clarifies the definition of small employer and requires MHCC to include mental health and substance abuse benefits required under the mental health parity law in the small group market for those employers that, through inclusion of part-time employees or growth in the total number of employees over time, meet the large employer definition.

Additional Comments: The State plan is currently in compliance with ACA. Though no fiscal impact is assumed under this bill, the Department of Budget and Management estimates that compliance will cost approximately $16 million in fiscal 2011, largely due to coverage of children up to age 26.

Additional Information

Prior Introductions: None.

Cross File: HB 170 (The Speaker, *et al.*) (By Request - Administration) - Health and Government Operations.

Information Source(s): Worcester County, Baltimore City, Department of Budget and Management, Governor's Office, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

Fiscal Note History: First Reader - February 14, 2011
ncs/mwc Revised - Senate Third Reader - April 1, 2011

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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Health Insurance – Conformity with Federal Law

BILL NUMBER: SB 183/HB 170

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

While some of the technical changes included in this bill impacts small businesses, the federal law, PPACA, would already require these changes. The only amendment included in this bill that is not required by PPACA or regulations issued by the Secretary of Health and Mental Hygiene under PPACA, is the provision found in § 15-1206 of the Insurance Article, which is being amended to protect small employers from losing their small group contracts due to failure to meet participation requirements if employees under age 26 chose to be their parent's plans. This amendment is a protection for small businesses.