Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

Senate Bill 510 (Senator Frosh)
Finance

Maryland Health Insurance Plan - Denials of Eligibility for Coverage - Hearings and Appeal Process

This bill requires the Board of Directors for the Maryland Health Insurance Plan (MHIP) to give an individual an opportunity for a hearing before the board may deny eligibility for MHIP coverage. An individual may be represented by counsel at the hearing. The board is authorized to issue subpoenas for the attendance of a witness or production of evidence in connection with the hearing. An individual who is aggrieved by a final decision of the board in a contested case may seek judicial review.

Fiscal Summary

State Effect: Special fund expenditures for MHIP increase by at least $72,300 beginning in FY 2013 for personnel expenses associated with implementing the bill. Future years reflect annualization and inflation.

(in dollars)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Revenues	$0	$0	$0	$0	$0
SF Expenditure	72,300	91,300	97,500	101,900	106,600
Net Effect	($72,300)	($91,300)	($97,500)	($101,900)	($106,600)

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The board must provide an individual with notice and hold the hearing in accordance with contested case hearing procedures under the Administrative Procedure Act. Notice must be provided at least five days prior to the hearing. Any subpoena issued by the board must be served via certified mail or by the sheriff in the county where the individual to be served resides.

Current Law/Background: MHIP is an independent unit of State government, the purpose of which is to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically uninsurable residents. MHIP is governed by a 10-member board of directors, which establishes both the standard benefit package offered by MHIP and the premium rates that may be charged.

MHIP has a State and a federal component. MHIP State is a high-risk health insurance pool funded with enrollee premiums and an annual uncompensated care assessment on hospital rates. Under the MHIP State Plus option, enrollees with incomes at or below 300% of federal poverty guidelines (FPG) receive additional premium subsidies. Medical eligibility for the program requires that applicants have been denied individual coverage, have been offered coverage that excludes or limits coverage for a medical condition, or have specific health conditions.

MHIP Federal is a high-risk health insurance pool established under the federal Patient Protection and Affordable Care Act (ACA) and is funded by premiums from enrollees and federal funds. MHIP Federal is intended to last only until the establishment of health care exchanges per ACA, beginning in January 2014. After that time, it is anticipated that enrollees in both high-risk pools will be able to obtain coverage through the exchange, and the future of MHIP is uncertain.

Under Code of Maryland Regulations 31.17.03.19, an individual must file any initial complaints regarding a denial of MHIP eligibility with the MHIP administrator. If the MHIP administrator upholds the initial denial, the individual may appeal this denial to the board or its designee. The MHIP administrator must comply with complaint processes for adverse decisions, grievance decisions, and the complaint process for coverage decisions under Title 15 of the Insurance Article. MHIP members and providers must have the same appeal rights granted to members and providers under other insurance plans.

In the case of *David Brooks v. Maryland Health Insurance Plan*, a former MHIP participant sought financial remedy for termination from MHIP under the premise of deprivation of due process. The Court of Special Appeals held, in an unreported decision, that the plaintiff was denied due process of law when MHIP revoked his health

insurance without an evidentiary hearing before a neutral arbiter on his Maryland residency.

Section 15-10D-02 of the Insurance Article requires health insurance carriers to establish an internal appeals process for disputes regarding coverage decisions, which include initial eligibility determinations. Within 30 days after a coverage decision has been made, a carrier must send written notice of the decision, which must state the specific factual bases for the carrier's decision and include, among other things, information about the individual's right to file an appeal with the carrier or directly with the Insurance Commissioner if the coverage decision involves an urgent medical condition. A final decision must be provided in writing within 60 days of the date of the appeal. Within 30 calendar days after the appeal decision has been made, each carrier must send a written notice of the appeal decision, which must state the specific factual bases for the carrier's decision and include, among other things, information about the right to file a complaint with the Insurance Commissioner within four months of receipt of a carrier's appeal decision. A carrier has the burden of persuasion that its coverage decision or appeal decision is correct. The Commissioner must issue in writing a final decision on all complaints within the Commissioner's jurisdiction and provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with the Administrative Procedure Act. If the Commissioner upholds a carrier's decision, an individual may seek judicial review.

Chapters 3 and 4 of 2011 expanded the definition of "coverage decision" to include a determination by a carrier that an individual is not eligible for coverage under a health benefit plan. According to MHIP, based on this change, MHIP and the Maryland Insurance Administration (MIA) determined that MHIP appeals regarding eligibility denials would be more appropriately reviewed directly by MIA. Effective January 2012, MHIP began referring all eligibility appeals to MIA for review and revising all certificates of coverage to notify members of the change in the procedure for appeals. MIA is conducting investigations, issuing written findings, and providing members opportunity for a hearing in accordance with current law.

State Expenditures: According to MHIP, the bill would negate the current process of referring eligibility appeals to MIA and instead require the MHIP board to hear appeals. MHIP anticipates receiving approximately 168 eligibility appeals in fiscal 2012. A majority of these appeals stem from termination for nonpayment of MHIP premiums, while others relate to residency or prior credible coverage issues. Special fund expenditures for MHIP increase by $72,339 in fiscal 2013, which reflects the bill's October 1, 2012 effective date. This estimate reflects the cost of hiring one paralegal to facilitate the appeals process required under the bill for an estimated 126 appeals. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	1
Salary and Fringe Benefits	$65,716
One-time Start-up Costs	4,485
Other Operating Expenses	2,138
Total FY 2013 MHIP Expenditures	**$72,339**

Future year expenditures reflect a full salary with annual increases and employee turnover as well as annual increases in operating expenditures. The estimate does not assume an increase in board meetings and related reimbursements as MHIP advises that the hearings would be delegated to staff.

Any corresponding reduction in workload at MIA is expected to be minimal as staff would be redirected to other appeals.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Maryland Health Insurance Plan, Judiciary (Administrative Office of the Courts), Office of Administrative Hearings, Department of Legislative Services

Fiscal Note History: First Reader - March 6, 2012
ncs/mwc

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