Department of Legislative Services

Maryland General Assembly
2014 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 96 (Chair, Finance Committee)(By Request - Departmental - Insurance Administration, Maryland)

Finance Health and Government Operations

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

This departmental bill further alters State health insurance law to conform with and implement the federal Patient Protection and Affordable Care Act (ACA) and corresponding federal regulations.

The bill takes effect July 1, 2014.

Fiscal Summary

State Effect: Minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2015. Special fund revenues also increase beginning in FY 2015 from receipt of new permit fees. Issuance of permits can be handled with existing budgeted resources.

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 Enrollment Permits: The bill establishes initial, biennial renewal, and reinstatement fees for a Small Business Health Options Program (SHOP) Exchange enrollment permit.

Conversion Rights for Group Contracts: The bill repeals the requirement that a carrier send written notice of conversion rights for group or blanket health insurance products. This language is now obsolete as all nongrandfathered health benefit plans are guaranteed issue, effective January 1, 2014.

Bona Fide Wellness Programs: The bill repeals existing language governing bona fide wellness programs that may be offered under group policies and contracts and replaces it with updated language reflecting final federal guidelines. Specifically, the bill clarifies the requirements for a reasonable alternative standard requirement for an "activity-only wellness program" and establishes reasonable alternative standard requirements for an "outcome-based wellness program."

Special Enrollment Periods: The bill establishes a special enrollment period under both a small employer health benefit plan and an individual plan through the Exchange for the placement of a child for foster care.

Small Employer Coverage: The bill also repeals language requiring part-time employees to have been continuously employed for at least four months and allowing a small employer *to elect* to offer coverage to all of its employees who are covered under another plan. Both of these provisions conflict with guaranteed issue requirements under ACA and related federal regulations.

Open Enrollment Period for SHOP Exchange Health Benefit Plans: The bill expands the qualifying events that trigger an open enrollment period for a SHOP Exchange Health Benefit plan to include when (1) an eligible employee's or dependent's enrollment or nonenrollment in a qualified health plan (QHP) is unintentional, inadvertent, or erroneous and the result of the error, misrepresentation, or inaction of an agent of the Exchange or the U.S. Department of Health and Human Services (HHS) or (2) an eligible employee is an Indian as defined under the federal Indian Health Care Improvement Act. If an eligible employee or dependent meets the requirements of the triggering event, the Exchange may take action to correct or eliminate the effects of the error, misrepresentation, or inaction. An eligible employee who meets the requirements of the triggering event may enroll in a QHP or change from one QHP to another one time per month.

Carrier Requirements: The bill repeals the requirement that a carrier, within seven days after cancellation or nonrenewal of a health benefit plan, send each enrolled employee written notice of the cancellation or nonrenewal and the individual's available conversion rights. The requirement that carriers that offer individual health benefit plans submit quarterly reports to the Insurance Commissioner regarding the number of applications submitted to the carrier and the number declined is also repealed. Further, the bill repeals the requirement that, if a carrier denies coverage under a medically underwritten policy in the individual market, the carrier must provide the individual with information about the Maryland Health Insurance Plan (MHIP) and provide MHIP with information about the individual denied coverage.

Special Enrollment in the Individual Exchange: The bill establishes two additional triggering events for a special enrollment period in the Individual Exchange. First, when an individual or dependent enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of federal premium tax credits (based in part on a finding that the individual is ineligible for qualifying coverage in an employer-sponsored plan), a carrier must permit an individual or dependent who is enrolled in an employer-sponsored plan and who will lose eligibility or coverage in the next 60 days to access the special enrollment period prior to the end of the individual's existing coverage, although the individual is not eligible for advance payment of the federal premium tax credit until the end of the coverage. The second triggering event is when it has been determined by the Exchange that an individual was not enrolled in a QHP, not enrolled in the QHP selected by the individual, or is eligible for but not receiving advance federal premium tax credits or cost-sharing reductions as a result of misconduct on the part of a nonexchange entity.

Eligible Individuals in the Individual Market: The existing definition of "eligible individual" in the individual market is repealed. Instead, "eligible individual" is defined as an individual who applies for or is covered under an individual health benefit plan. The definition is altered, particularly to remove creditable coverage requirements, to comply with guaranteed issue requirements under ACA and related federal regulations.

Creditable Coverage: The bill expands the definition of "creditable coverage" to include coverage of an individual under the Maryland Children's Health Program (MCHP).

Guaranteed Availability of Coverage: The bill specifies that guaranteed availability of coverage provisions under ACA apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets in Maryland.

Suspended Review of a Claim During a Grace Period: The bill authorizes a carrier to suspend review of a claim for reimbursement of a preauthorized or approved health care service if the patient is in the second or third month of a grace period. A carrier must

maintain an automated eligibility verification system that was available to the health care provider by telephone or the Internet at the time the health care service was provided. The provider must be informed that the patient is in the second or third month of a grace period and review of a claim may be suspended. A carrier must send a specified written notice to the person filing the claim. Within 30 days after receipt of payment of premium, a carrier must mail or transmit payment for the claim or send a specified notice of receipt and status of the claim.

Individual Market Open Enrollment Period: The bill alters the dates for open enrollment periods and the associated effective dates of coverage to comply with federal changes. Beginning November 15, 2014, unless an alternative date is adopted by HHS, a carrier that sells health benefit plans to individuals in the State must establish an annual open enrollment period. The annual open enrollment period for 2014 must begin on November 15, 2014, and extend through January 15, 2015, unless alternative dates are adopted by HHS. The annual open enrollment period for years beginning on or after January 1, 2015, must begin on October 15 and extend through December 7 each year.

For an individual that enrolls in coverage during the 2014 open enrollment period, coverage must begin January 1, 2015 (if the application is received by December 15, 2014), and February 1, 2015 (if the application is received between December 16, 2014, and January 15, 2015). These dates may be changed if an alternative date is adopted by HHS. For years beginning on and after January 1, 2015, the effective date of coverage must be January 1 of the following calendar year.

Current Law:

SHOP Exchange Enrollment Permits: The Maryland Health Benefit Exchange is authorized to establish a Consolidated Services Center (CSC) or call center, which may employ individuals to assist the SHOP Exchange or the Individual Exchange. CSC employees are required to hold a SHOP Exchange enrollment permit or an Individual Exchange enrollment permit. To qualify for an enrollment permit, an applicant must be age 18 or older, trustworthy, and of good moral character. Applicants must be engaged by, and receive compensation only through, the CSC and complete and comply with any ongoing training program requirements. Applicants for a SHOP Exchange enrollment permit must also pass the written examination for a SHOP navigator license.

Conversion Rights for Group Contracts: Section 15-114 of the Health Insurance Article requires group or blanket health insurance contracts to provide the same conversion rights and conditions, without a physical examination or statement of health, to a covered dependent spouse if the dependent spouse ceases to be a qualified family member because of divorce or the death of the spouse. This provision is now obsolete as all nongrandfathered health benefit plans are guaranteed issue, effective January 1, 2014.

Bona Fide Wellness Programs: Chapters 682 and 683 of 2009 authorized health insurance carriers to provide reasonable incentives to an insured, subscriber, or member for participation in a bona fide wellness program. 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.

Incentives may be based on an individual satisfying a standard related to a health factor if (1) all incentives for participation do not exceed 30% of the cost of coverage under the plan (incentives may be increased an additional 20% for programs designed to prevent or reduce tobacco use); (2) the program is reasonably designed to promote health or prevent disease; (3) the program gives individuals the opportunity to qualify for the incentive at least annually; (4) the program is available to all similarly situated individuals; and (5) individuals are provided a reasonable alternative standard or a waiver of the standard.

Carriers must provide reasonable alternative standards or waivers of standards for obtaining incentives to individuals for whom it is unreasonably difficult due to a medical condition to satisfy the standard or medically inadvisable to attempt to satisfy the standard. Carriers must disclose the availability of reasonable alternative standards or waivers in all policy forms pertaining to the wellness program. To determine compliance, the Insurance Commissioner may request a review of a carrier's bona fide wellness program by an independent review organization at the expense of the carrier.

Special Enrollment Periods: A carrier must provide certain special enrollment periods in small employer health benefit plans when an employee or dependent was covered under another employer-sponsored plan and subsequently lost coverage or an eligible employee acquires a new dependent through marriage, birth, adoption, or placement for adoption. If an employee enrolls any eligible individual during the special enrollment period, coverage must become effective as specified based on the triggering event.

Open Enrollment Period for SHOP Exchange Health Benefit Plans: A carrier must provide an open enrollment period of at least 30 days for each eligible employee who (1) becomes eligible outside of the initial or annual open enrollment period or (2) experiences a triggering event. A triggering event occurs when (1) an eligible employee/dependent loses minimum essential coverage; (2) the QHP in the SHOP Exchange in which an individual is enrolled violates a material provision of the contract; (3) an eligible employee/dependent gains access to a new QHP as a result of a move; (4) an eligible employee/dependent demonstrates that he or she meets other exceptional circumstances; (5) an eligible employee/dependent is enrolled in an employer-sponsored plan that is not qualifying coverage and is allowed to terminate coverage; or (6) an

eligible employee/dependent loses eligibility for Medicaid or MCHP or becomes eligible with respect to coverage under the SHOP Exchange under Medicaid or MCHP.

Carrier Requirements: Within seven days after cancellation or nonrenewal of a health benefit plan, a carrier must send each enrolled employee written notice of its action and the conversion rights available. Carriers that offer individual health benefit plans must submit quarterly reports to the Insurance Commissioner regarding the number of applications submitted for coverage and the number of declinations issued. If a carrier denies coverage under a medically underwritten policy, the carrier must provide the individual with specific information about the availability of MHIP and provide MHIP with the name and address of the individual denied coverage and the relevant insurance producer, if available.

Special Enrollment in the Individual Exchange: Carriers must provide special enrollment periods for individuals with certain triggering events, including when an individual loses minimum essential coverage or gains or becomes a dependent through marriage, birth, adoption, or placement for adoption.

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.

Grace Periods in the Individual Exchange: QHPs 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 HHS 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: Beginning October 15, 2014, a carrier that sells health benefit plans to individuals in the State must establish an annual open enrollment period. The annual open enrollment period must begin on October 15 and

extend through December 7 each year. If an individual enrolls in a health benefit plan during the open enrollment period, the effective date of coverage must be January 1 of the following calendar year.

Background:

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 took 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.

Bona Fide Wellness Programs: Federal regulations implementing ACA divide wellness programs into two categories: "participatory" programs (those that generally are available without regard to health status) and "health-contingent" programs, which may be "activity-only" or "outcome-based." Activity-only programs require certain activities that relate to a health factor, such as diet or exercise, while "outcome-based" programs require participants to meet specific health outcomes such as weight loss or a reduction in blood pressure. Health-contingent programs must meet the following requirements: (1) employees must have an opportunity to qualify for the reward annually; (2) the reward cannot exceed 30% of the total cost of health care coverage, with an additional 20% available for programs that reduce tobacco use; (3) programs must be reasonably designed to promote health or prevent disease; (4) the full reward must be uniformly available, including reasonable alternatives; and (5) the employer must provide adequate notice of the plan, its alternatives, and the available benefits.

State Revenues: MIA special fund revenues increase by a minimal amount in fiscal 2015 only from the $125 rate and form filing fee. Revenues also increase beginning in fiscal 2015 from the new SHOP Exchange enrollment permit fee. Permits will be issued to some CSC employees. The number of permits issued will depend on the number of CSC employees requiring such permits and staff turnover. MIA estimates than no more than 100 permits will be issued annually. The initial fee is $54. Permits must be renewed biennially for a fee of $54 and may be reinstated for a fee of $100. Revenues continue in future years.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Human Resources, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

Fiscal Note History: First Reader - January 13, 2014
ncs/ljm Revised - Senate Third Reader - March 18, 2014

Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510

ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

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

BILL NUMBER: SB 96

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