Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 556 (Chair, Finance Committee)(By Request - Departmental - Maryland Insurance Administration)

Finance | Health and Government Operations

Health Insurance - Selection of State Benchmark Plan and Required Conformity With Federal Law

This emergency departmental bill alters State insurance law to conform to the federal Patient Protection and Affordable Care Act (ACA) and corresponding federal regulations adopted by the U.S. Department of Health and Human Services in implementing ACA and federal regulations issued under the federal Mental Health Parity and Addiction Equity Act (MHPAEA). The bill also alters the selection of the State benchmark plan used to establish the essential health benefits (EHBs) required to be included in health plans offered in the individual and small group health insurance markets, including requiring the Maryland Insurance Commissioner, in consultation with the Maryland Health Benefit Exchange (MHBE), to select the State benchmark plan.

Fiscal Summary

State Effect: Implementation can be handled by the Maryland Insurance Administration (MIA) with existing budgeted resources. Revenues are not affected.

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:

Prescription Drug Benefit Requirements: The bill specifies that prescription drug benefit requirements under ACA apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets in Maryland.

Limitation on Deductibles for ACA Employer-sponsored Plans: The bill repeals language that specified that the annual limitation on deductibles for employer-sponsored plans provision of ACA applies to health insurance coverage offered in the small group market issued or delivered in the State.

Mandated Benefits for Mental Health and Substance Use Disorder: The bill amends Maryland's mental health parity law (§ 15-802 of the Insurance Article) by altering definitions; clarifying applicability; and modifying requirements for health benefit plans subject to § 15-802 to provide a minimum amount of benefits for the diagnosis and treatment of a mental illness, emotional disorder, or substance use disorder. The bill standardizes required coverage levels for individual, group, and blanket health insurance plans (previously referred to as policies or contracts).

Definition of Full-time Employee: The bill alters the definition of "full-time employee" to mean, *with respect to a calendar month,* an employee of a small employer who works, on average, at least 30 hours per week. "Full-time employee" *does not* include a seasonal employee as defined in federal law.

Definition of Health Benefit Plan: The bill conforms the definition of "health benefit plan" to the definition found in federal ACA regulations.

Special Enrollment Periods for Small Employers: The bill alters provisions relating to annual open enrollment periods to conform with the special enrollment periods that apply to employees of small employers under ACA regulations.

The individuals eligible to enroll during a special enrollment period are expanded to include (1) an eligible employee who acquires a new dependent through a child support order or other court order; (2) the spouse of an eligible employee through a child support order or other court order; and (3) at the option of the Small Business Health Options Program (SHOP) Exchange, an enrollee who is the eligible employee or the spouse of an eligible employee if the enrollee loses a dependent or is no longer considered to be a dependent due to divorce or legal separation, or the death of the employee or dependent.

The circumstances that qualify a triggering event are expanded to include an employee or dependent losing pregnancy-related coverage or medically needy coverage. The bill also clarifies that, for SHOP Exchange health benefit plans, a triggering event occurs if an eligible employee's or dependent's enrollment or nonenrollment in a qualified health plan (QHP) is the result of the error, misrepresentation, *misconduct*, or inaction of specified entities, including a *non-Exchange entity providing enrollment assistance or conducting enrollment activities*.

A triggering event due to loss of medically needy coverage is permitted only once per year per individual. Loss of minimum essential coverage does not include loss of coverage due to voluntary termination of coverage.

Renewal of Health Benefit Plans for Small Employers: "Plan" and "product" are defined in conformity with federal regulations. The bill specifies that renewal requirements apply at the product level. A carrier must mail a renewal notice to a small employer at least *60* days (rather than 45) before the expiration of a health benefit plan. A carrier may make a uniform modification of coverage (a change to a small employer's health benefit plan that is effective uniformly among small employers with the same product) for a product only at the time of renewal. For plans modified at the time of renewal, the bill specifies the circumstances under which the plan must be considered to be the same plan.

The bill also specifies that a carrier may cancel or refuse to renew a health benefit plan, in the case of a health maintenance organization (HMO) for which there is no longer any enrollee who lives, resides, or works in the HMO's approved service area, provided that notice of the termination is provided to each small employer and employee at least 90 days prior to termination of coverage.

Renewal of Individual Health Benefit Plans: "Plan" and "product" are defined in conformity with federal regulations. A carrier may make a uniform modification of coverage (a change to a health benefit plan that is effective uniformly for all individuals with the same product) for a product only at the time of renewal. A carrier must provide notice of renewal or uniform modification of coverage for (1) a grandfathered health plan, at least 60 days before the date of renewal and (2) a nongrandfathered health benefit plan before the date of the first day of the next annual open enrollment period. For plans modified at the time of renewal, the bill specifies the circumstances under which the plan must be considered to be the same plan.

The bill also specifies that a carrier may cancel or refuse to renew an individual health benefit plan if the individual no longer resides, lives, or works in the service area provided only if notice of the termination is provided to the individual at least 90 days prior to termination of coverage.

Creditable Coverage: The bill repeals obsolete provisions regarding certificates of creditable coverage used to reduce preexisting condition limitations, which are no longer applicable under ACA.

High Level and Low Level Policy Forms: The bill repeals obsolete definitions of "high level policy form" and "low level policy form" and repeals provisions describing ratings for high and low level policy forms, which are no longer permitted under ACA.

Annual Open Enrollment – Individual Market: The bill links the annual open enrollment period for the individual health benefit plan market to the dates adopted by the U.S. Department of Health and Human Services. A carrier participating in the individual exchange must provide the special enrollment periods specified in federal law for individuals who purchase coverage through the individual exchange (45 CFR § 155.420) and for individuals who purchase coverage outside the individual exchange (45 CFR § 147.104(b)(2)).

Student Health Plans: The bill establishes special requirements for student health plans to conform to federal regulations. A carrier that offers a student health plan is not required to accept individuals who are not students or dependents of covered students; establish open enrollment periods; establish effective dates based on a calendar year; offer health benefit plan contracts on a calendar year basis; or renew, or continue in force, coverage for individuals who are no longer students or dependents of students. A student administrative health fee is not considered a cost-sharing requirement with respect to specified recommended preventive services.

Nonrenewal of Group Health Benefit Plans – Exceptions: A carrier is not required to renew a group health benefit plan in the case of an HMO where there is no longer any enrollee who lives, resides, or works in the HMO's approved service area, provided that notice of the nonrenewal is provided to each employer and employee at least 90 days prior to termination of coverage.

Nonrenewal of Plans: "Product" is defined in conformity with federal regulations. The bill specifies that renewal requirements apply at the product level. A carrier may make a uniform modification of coverage for a product only at the time of renewal.

Wellness Programs: The bill alters the definition of a "bona fide wellness program," instead defining a "wellness program" consistent with § 15-509 of the Insurance Article and in conformity with federal regulations. The definition of "adverse decision" is altered to conform to this change. The bill clarifies that the wellness programs governed by § 27-210 of the Insurance Article are those provided as a benefit outside of the health insurance or HMO contract. Wellness benefits found in health benefit contracts remain subject to § 15-509 of the Insurance Article.

Selection of the State Benchmark Plan: The State benchmark plan for 2017 must be selected by the Insurance Commissioner, in consultation with MHBE, through an open and transparent process that includes at least one public hearing and an opportunity for public comment. Selection must be based on enrollment for the first quarter of 2014, from the largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the State's small group market. The Insurance Commissioner must, for individual health benefit plans, require that the plans include any mandated benefits that were required in individual health benefit plans prior to December 31, 2011, if the benefits are not included in the selected benchmark plan. If the selected benchmark plan does not comply with any federal benefit requirement, the Insurance Commissioner must supplement the required benefits, to the extent permitted by federal law, with benefits similar to those chosen by the Maryland Health Care Reform Coordinating Council (MHCRCC) in 2012. The Insurance Commissioner must submit a report to specified committees of the General Assembly within 10 days of selecting the benchmark plan.

Miscellaneous: The bill adds a definition of "grandfathered health plan coverage" to conform to federal regulations. The definition of "affiliation period" is repealed as it is obsolete under ACA. The definition of "small employer" for purposes of MHBE is clarified. "Small employer" means an employer that, during the preceding calendar year, employed an average of not more than (1) 50 employees for plan years that begin before January 1, 2016, and (2) 100 employees for plan years that begin on or after January 1, 2016, or another number of employees or date as provided under federal law.

Appendix 1 provides a summary of the bill's major provisions by statutory citation and includes the federal regulatory or statutory citation to which the bill's changes seek to conform.

Current Law/Background: 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.

MHPAEA requires group health plans of large employers, as well as QHPs sold in health insurance exchanges and in the small group and individual markets as of January 1, 2014, to equalize health benefits for addiction and mental health care and medical and surgical services in many fundamental ways.

MHPAEA prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits than those imposed on other general medical benefits. Patients can no longer be denied insurance reimbursement when they reach a lifetime or annual spending cap imposed on mental health or substance use disorder care. MHPAEA also imposes

nondiscrimination standards on medical management practices, medical necessity determinations, and provider network and compensation practices. While an employer is not required to offer any health insurance coverage for addiction or mental health care, the coverage of any service for these disorders – including a primary care practitioner's treatment of depression or the coverage of any medication for a mental or substance use disorder in a prescription drug formulary – renders the plan subject to MHPAEA.

Creditable coverage is health insurance coverage that an individual held previously that could be used to offset a preexisting condition exclusion in a new health plan. Preexisting condition limitations are no longer permitted under ACA; therefore, creditable coverage is no longer necessary.

Student health plans are treated separately under ACA based on unique pooling provisions that allow the cost of coverage for similar benefits to reflect the student population rather than outside populations. This results in coverage that should be more affordable than many of the individual plans available through state exchanges. Student health plans cannot be purchased through an exchange, nor can individuals covered by such policies receive a federal premium tax credit or cost-sharing assistance.

Federal ACA regulations define "product" as a discrete package of health insurance coverage benefits that a health insurance issuer offers using a particular product network type within a service area. "Plan" is defined as the pairing of the health insurance coverage benefits under the product with a metal tier level and service area.

Per 45 CFR § 155.420, for individuals who purchase coverage through the individual exchange, a state exchange must allow a qualified individual or enrollee (and dependents, when specified) to enroll in or change from one QHP to another when certain triggering events occur, including loss of certain coverage; the qualified individual or enrollee gains a new dependent; certain errors, misrepresentation, or inaction by the federal government, an exchange, or the agent of an exchange; a QHP substantially violates a material provision of its contract; new eligibility or ineligibility for cost-sharing reductions or the federal premium tax credit; certain moves; the qualified individual or a dependent gains lawful citizenship; the qualified individual is an Indian (and, thus, must be allowed to change QHPs up to once per month); and other exceptional circumstances.

Per 45 CFR § 147.104(b)(2), a health insurer in the individual market must provide a limited open enrollment period for these same triggering events, with the exception of when an individual or dependent (1) gains citizenship status; (2) is an Indian; and (3) meets other exceptional circumstances defined by the state exchange.

Federal regulations issued in February 2015 authorize states to select a benchmark plan for designation of EHBs required to be included in health plans in 2017. The federal Centers

for Medicare and Medicaid Services require states to make their selection by June 1, 2015. State law currently requires MHCRCC to make the selection and to follow a specified process in doing so. However, the council is not established in statute and has not met for more than a year. The bill requires the benchmark plan to be the largest health plan in one of the three largest products offered in the small group market and to include, in the individual market, all of the mandated benefits that are in the current benchmark plan.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Academic Health Plans, Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 11, 2015
md/ljm Revised - Senate Third Reader - March 31, 2015
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Analysis by: Jennifer B. Chasse

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

Appendix 1
Provisions of SB 556

Section of Bill	Summary	Federal Citation
§ 15-137.1 INS	Specifies that ACA prescription drug benefit requirements apply to individual health insurance coverage and health insurance coverage offered in the small group and large group markets; repeals the annual limitation on deductibles for the employer-sponsored plans provision of ACA that applies to health insurance coverage offered in the small group market	45 CFR § 156.122
§ 15-802 INS & § 19-703.1 HG	Conform with provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA); repeal the definition of "large employer"; add a definition of "grandfathered health plan coverage"	45 CFR § 146.136 and § 147.140
§ 15-1201 INS	Conforms the definitions of "health benefit plan" and "full-time employee"	45 CFR § 146.145(b); guidance by the Internal Revenue Service (IRS)
§§ 15-1208.1 & 15-1208.2 INS	Conform the special enrollment periods that apply to employees of small employers	45 CFR §§ 155.420 and 155.725
§ 15-1212 INS	Adds definitions of "plan" and "product"; specifies that renewal requirements apply at the product level; establishes a 60-day notice of renewal; establishes new rules regarding uniform modification of coverage; specifies notice requirements for termination of certain coverage	45 CFR § 144.103; § 147.106(c)(1); § 146.152(b) and § 147.106(f)(2); § 147.106(e) and § 146.152
§ 15-1301 INS	Repeals obsolete definitions of "creditable coverage," "high level policy form," and "low level policy form"; adds a definition of "grandfathered health plan coverage"; amends the definition of "health benefit plan"	45 CFR § 147.140; § 148.220

Section of Bill	Summary	Federal Citation
§ 15-1309 INS	Establishes a 60-day notice of renewal or uniform modification; adds requirements regarding uniform modification of coverage; specifies notice requirements for termination of certain coverage	45 CFR § 148.122(i) and § 147.106(f)(1); § 148.122(e)(1) and (g)
§ 15-1310 & § 15-1311 INS	Repeal provisions regarding how certificates of creditable coverage are used to reduce preexisting condition exclusions	45 CFR § 148.124
§ 15-1312 INS	Repeals provisions regarding rating limits for high level policy forms and low level policy forms, which are no longer permitted under ACA	No longer permitted
§ 15-1316 INS	Links the annual open enrollment period for the individual health benefit plan market to the open enrollment period adopted by the U.S. Department of Health and Human Services; requires carriers to provide the special enrollment periods specified in federal regulations	45 CFR § 155.420 and § 104(b)(2); § 147.104(b)(2)
§ 15-1318 INS	Defines and clarifies exceptions for student health plans	45 CFR § 147.145
§ 15-1401 INS	Repeals definitions of "affiliation period" and "certificates of creditable coverage," which are obsolete under ACA; amends the definition of "health benefit plan" to conform with federal regulations	45 CFR § 148.124; § 146.145(b)
§§ 15-1403 - 15-1405 INS	Repeal provisions regarding how certificates of creditable coverage are used to reduce preexisting condition exclusions	45 CFR § 148.124
§ 15-1408 INS	Specifies that a carrier is not required to renew a group health benefit plan in specified circumstances if notice of nonrenewal is provided at least 90 days prior to termination of coverage	45 CFR § 146.152(b)(5)

Section of Bill	Summary	Federal Citation
§ 15-1409 INS	Defines "product"; specifies that renewal is at the product level; adds uniform modification of coverage requirements	45 CFR § 144.103; § 147.106(c); § 147.106(e)
§§ 15-10A01 & 27-210 INS	Add a new definition of "wellness program" consistent with § 15-509 of the Insurance Article and in conformity with federal regulations; clarify that the wellness benefit applies only to benefits offered extra-contractually (wellness benefits found in health benefit contracts are subject to § 15-509 of the Insurance Article); conform the definition of "adverse decision" accordingly	45 CFR § 146.121
§ 31-101 INS	Conforms the definitions of "full-time employee" regarding seasonal workers and "plan year"; defines "minimum essential coverage" to comply with federal law; amends the definitions of "health benefit plan" and "small employer"	IRS guidance; 25 U.S. Code § 5000A; 45 CFR § 148.220
§ 31-116 INS	Alters the selection of the State benchmark plan used to establish the essential health benefits required to be included in health plans offered in the individual and small group health insurance markets	None applicable

ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Health Insurance – Conformity with Federal Law

BILL NUMBER: SB 556

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