HB 123

Department of Legislative Services

Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 123 (Chair, Health and Government Operations Committee)(By Request - Departmental - Maryland Insurance Administration)

Health and Government Operations | Finance

Health Insurance - Required Conformity With Federal Law

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, as well as to reflect a recent court decision. The bill also alters the definition of "small employer" relating to entities that lease employees.

The bill takes effect June 1, 2017.

Fiscal Summary

State Effect: Special fund revenues for the Maryland Insurance Administration (MIA) increase minimally from the $125 rate and form filing fee in FY 2018 only (although some may be filed in the last month of FY 2017 instead). MIA can handle any additional workload 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/Current Law/Background:

Short-term Medical Insurance: Short-term medical insurance may be purchased from a nonadmitted insurer provided that, among other things, the policy term does not exceed 11 months, the term may not be extended or renewed, and specified notice is provided to the applicant. The bill establishes that a policy term must be *less than three months*, and it requires the contract and any application materials to prominently specify that (1) the coverage is not minimum essential coverage that satisfies the health coverage requirements of the ACA and (2) if an individual does not have such coverage, he or she may owe an additional payment with taxes.

The bill also codifies the federal definition of short-term limited duration insurance. Under 45 C.F.R. § 144.103, short-term limited duration insurance must have an expiration date of less than three months. It must also prominently display in the contract and any application materials that it is not minimum essential coverage under the ACA and that, without such coverage, an individual may owe an additional payment with taxes.

Preventive and Wellness Services and Chronic Disease Management: The ACA requires nongrandfathered health plans to cover 10 essential health benefits (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.

Under the Maryland Insurance Article, these EHBs must be included in the State benchmark plan and required in all qualified health plans (QHPs) offered in the Maryland Health Benefit Exchange (MHBE) and all individual health benefit plans and health benefit plans offered to small employers outside of MHBE (with the exception of grandfathered health plans). The bill adds preventive and wellness services and chronic disease management to the list of the ACA provisions applicable in Maryland to ensure MIA can enforce the federal requirement.

Similar Supplemental Coverage: A health benefit plan does not include specified supplemental benefits if the benefits are provided under a separate policy, certificate, or contract. This includes "similar supplemental coverage" if (1) the coverage is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, and (2) the coverage is not supplemental solely because it becomes secondary or supplemental under a coordination of benefits clause.

Federal regulations recently clarified the scope of the ACA exception for similar supplemental coverage. Thus, the bill replaces the description of similar supplemental coverage and instead specifies that such coverage qualifies for the exception described in federal regulations.

Under 45 CFR 146.145(b)(5)(i)(C), to be similar supplemental coverage, coverage must be designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, and/or provide benefits for items and services not covered by the primary coverage and that are not EHBs under the ACA in the state where the coverage is issued. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination of benefits provision.

Triggering Event Resulting from Permanent Move in the Small Business Health Options Program: An eligible employee or dependent enrolled in a QHP in the Small Business Health Options Program (SHOP) exchange is eligible for a special open enrollment period when the eligible enrollee or dependent gains access to a new QHP as a result of a permanent move.

Federal regulations under 45 CFR 155.420(d) published in May 2016 specify that, in order for a triggering event to occur as a result of a permanent move, an individual must have either (1) had minimum essential coverage for 1 or more days during the 60 days preceding the date of the permanent move *or* (2) been living outside the United States or in a United States territory at the time of the permanent move. The bill adds these conditions to the triggering event.

Additional Triggering Events in the Small Business Health Options Program Exchange: The bill repeals a triggering event if an eligible employee or a dependent has a loss of coverage under a noncalendar year health benefit plan, even if the individual has the option to renew the coverage under the plan. Federal regulations were recently revised to indicate that this special enrollment period is not applicable to the small group market.

The bill also establishes the following new triggering events in the SHOP exchange to reflect new special enrollment periods available under federal regulations:

- an eligible employee or dependent adequately demonstrates that a material error related to plan benefits, service area, or premium influenced the individual's decision to purchase a QHP;
- an eligible employee or dependent is a victim of domestic abuse or spousal abandonment, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- an eligible employee or dependent applies for coverage through the individual exchange, is assessed as potentially eligible for Medicaid or the Maryland

Children's Health Program (MCHP), and is determined ineligible for such programs either after open enrollment has ended or more than 60 days after the qualifying event; and

- an eligible employee or dependent applies for coverage through Medicaid or MCHP during the annual open enrollment period and is determined ineligible for such programs after open enrollment has ended.

The bill specifies that, if a victim of domestic abuse or spousal abandonment meets the requirements for the triggering event, the victim's dependents may enroll in a QHP at the same time as the victim. Further, the bill applies an existing triggering event in the SHOP exchange to any dependent of an Indian.

Guaranteed Renewability Requirements: The bill specifies that a carrier will not be considered to have elected not to renew all health benefit plans in the State if the carrier complies with specified federal regulations. Federal regulations recently clarified guaranteed renewability requirements, specifying that a carrier that does not renew all current products while offering at least one new product in the same market is not subject to the existing five-year ban imposed for failure to renew.

Under 45 CFR 147.106(d)(3), a carrier is not considered to have discontinued all health insurance coverage in a market if the carrier makes available at least one product that is the same as the discontinued product or at least one new product in the same market.

Definition of Health Benefit Plans and Fixed Indemnity Insurance: Fixed indemnity insurance is an "excepted benefit" and, thus, not subject to any of the ACA's requirements or prohibitions. Prior to the ACA, federal regulations required group fixed indemnity coverage to pay benefits on a per period basis (*i.e.,* $100 per day of hospitalization). Regulations promulgated post-ACA in 2014 permitted the continued marketing of per service indemnity policies in the individual market, but only if certain requirements were met; specifically, (1) fixed indemnity insurance could only be sold to individuals who otherwise had minimum essential coverage; (2) benefits under the indemnity policy could not be coordinated with benefits under other health coverage or cover exclusions under other coverage; (3) benefits had to be paid on a fixed dollar basis regardless of actual expenses incurred or covered by other coverage; and (4) the consumer had to be provided with a prominent notice that the coverage was not a substitute for major medical coverage and could result in imposition of the individual responsibility tax.

In July 2016, in *Central United Life Insurance, Co. v. Burwell,* the D.C. Circuit Court of Appeals affirmed a lower court injunction against these 2014 regulations, in particular the prohibition on the sale of fixed indemnity insurance unless the purchaser attests that he or she already has minimum essential coverage. The bill alters the definition of "health benefit plan" in the individual market to reflect this ruling.

Uniform Modification of Coverage: "Uniform modification of coverage" is a change to a small employer's health benefit plan that is made in accordance with State or federal requirements and is effective uniformly among all small employers with the same product. Alternatively, it is a change that meets all of the following requirements: (1) the product is offered by the same carrier; (2) the product is offered as the same network type; (3) the product continues to cover at least a majority of the same service area; (4) within the product, each plan has the same cost-sharing structure as prior to modification with specified exceptions; (5) the product provides the same covered benefits with specified exceptions; and (6) the modification is effective uniformly among small employers with the same product. The bill repeals both definitions and instead specifies that "uniform modification of coverage" is a change to a small employer's health benefit plan that meets the criteria stated in federal regulations.

Under 45 CFR § 147.106(e), an insurer may only modify coverage at the time of renewal. The modification must be consistent with state law and effective uniformly among group health plans with that product. A modification is considered a uniform modification of coverage if made within a reasonable time period after and directly related to the imposition or modification of a federal or state requirement. A modification is also considered a uniform modification of coverage if the product (1) is offered by the same issuer; (2) is offered as the same product network type; (3) continues to cover at least a majority of the same service area; (4) has the same cost-sharing structure for each plan within the product as before the modification, except for any variation solely related to changes in cost and utilization or to maintain the same metal tier level; and (5) provides the same covered benefits, except for specified cumulative changes.

Federal Medicare Anti-duplication Provision: The bill prohibits a carrier from cancelling or refusing to renew an individual health benefit plan because an eligible individual is entitled to or enrolled in Medicare if the individual is renewing coverage under the same policy or contract of insurance.

Section 1882(d)(3)(A) of the federal Social Security Act prohibits the sale of health insurance that duplicates a beneficiary's Medicare benefits in order to protect Medicare beneficiaries from excessive or unnecessary coverage. Federal regulations specify that Medicare entitlement or enrollment is not a basis to not renew coverage in the individual market under the same policy or contract of insurance.

Definition of Small Employer Relating to Leased Employees: The bill alters the definition of small employer to specify that, to the extent permitted by federal law, an entity that leases employees from a professional employer organization (PEO), coemployer, or other organization engaged in employee leasing and that otherwise meets a specified description must be treated as a small employer (and in turn subject to small group regulations relating to health insurance). A PEO, coemployer, or other organization engaged in employee

leasing is exempt from the small group market for health insurance coverage under specified circumstances and may obtain health insurance coverage as a large employer.

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

Exhibit 1
Provisions of House Bill 123 of 2017

Section of Bill	Summary	Federal Citation
§ 3-306.2 INS	Reduces the maximum term of a short-term medical insurance policy purchased from a nonadmitted insurer and specifies certain disclosure requirements	45 CFR 144.103
§ 15-137.1 INS	Adds preventive and wellness services and chronic disease management to the list of the ACA requirements that the Maryland Insurance Administration can enforce	§ 1302(b)(I) of the ACA
§§ 15-1201, 15-1301, 15-1401, and 31-101 INS	Amend the definition of "health benefit plan" to strike an unnecessary example and clarify similar supplemental coverage	45 CFR 146.145(b)(5)(i)(C)
§ 15-1208.2 INS	Clarifies when an eligible employee or dependent in the Small Business Health Options Program (SHOP) exchange qualifies for a triggering event related to a permanent move	45 CFR 155.420(d)(7), published on May 11, 2016, as interim final regulations
	Adds new triggering events in the SHOP exchange relating to material errors, victims of domestic abuse or spousal abandonment, and determination of ineligibility for Medicaid or the Maryland Children's Health Program and makes clarifying changes regarding certain dependents	45 CFR 155.420(d)(8)(ii),(10),(11), and (12); 45 CFR 155.725(j)(2)(i)

Section of Bill	Summary	Federal Citation
§§ 15-1212, 15-1308, and 15-1409 INS	Clarify guaranteed renewability requirements for carriers that do not renew all current products	45 CFR 147.106(d)(3)
§§ 15-1301 and 31-101 INS	Amend the definition of "health benefit plan" in the individual market to repeal certain provisions relating to hospital indemnity or fixed indemnity coverage	Court ruling (*Central United Life Insurance, Co. v. Burwell*) that the federal government went beyond its authority in requiring individuals to attest that they have minimum essential coverage to qualify for fixed indemnity coverage
§ 15-1309 INS	Repeals the definition of uniform modification of coverage and instead specifies that a change to a small employer's health benefit plan must meet the criteria stated in federal regulations	45 CFR 147.106(e)
	Prohibits a carrier from canceling or refusing to renew an individual health benefit plan because an eligible individual is entitled to or enrolled in Medicare if the individual is renewing coverage under the same policy or contract of insurance	45 CFR 147.106(h)(2)
§ 31-101 INS	Requires an entity that leases employees from specified organizations to be treated as a small employer	N/A

ACA: federal Patient Protection and Affordable Care Act

Source: Maryland Insurance Administration; Department of Legislative Services

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Health Affairs Blog; Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 9, 2017
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ANALYSIS OF ECONOMIC IMPACT ON SMALL BUSINESSES

TITLE OF BILL: Health Insurance – Required Conformity with Federal Law

BILL NUMBER: HB 123

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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