SB 868

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 868 (Senator Feldman, *et al.*)
Finance

Health Insurance - Consumer Protections

This bill codifies various consumer protection provisions of the federal Patient Protection and Affordable Care Act (ACA) in Maryland law and repeals related references to the ACA. The Insurance Commissioner must adopt regulations and take other specified actions. The bill also extends the Maryland Health Insurance Coverage Protection Commission for an additional three years through June 30, 2023. **The bill takes effect July 1, 2019.**

Fiscal Summary

State Effect: The bill primarily codifies existing federal law. The bill's additional requirements (new responsibilities for the Insurance Commissioner and continued staffing of the commission) can be handled with existing resources. Revenues are not affected.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill expresses that it is the intent of the General Assembly to ensure that the health care protections established by the ACA continue to protect Maryland residents in light of continued threats to the ACA. The bill codifies a series of consumer protections that are in effect under the ACA but not consistently codified in Maryland law.

Preexisting Conditions and Prohibition on Health Factors as a Condition of Eligibility

The bill prohibits a carrier from excluding or limiting benefits or denying coverage because of a preexisting condition. A carrier may not establish rules for eligibility for enrollment into a health benefit plan based on specified health status factors such as health condition, claims experience, or disability.

Rating Factors and Ratios

The bill codifies permissible rating factors, authorizing a carrier in the individual market to determine a premium rate based on (1) age; (2) geography; (3) whether the plan covers an individual or family; and (4) tobacco use. A premium rate based on age may not vary by a ratio of more than 3 to 1 for adults. A premium rate based on tobacco use may not vary by a ratio of more than 1.5 to 1.

Coverage of Children up to Age 26

A carrier that offers a health benefit plan that provides coverage to a dependent child must continue to make coverage available for the child until the child is 26 years of age.

Prohibition on Policy Rescissions

The bill prohibits a carrier from rescinding a health benefit plan once the insured is covered under the plan, with specified exceptions such as fraud.

Prohibition on Lifetime or Annual Limits

The bill prohibits a carrier from establishing lifetime limits or annual limits on the dollar value of benefits for any insured individual.

Waiting Periods for Group Plans

The bill prohibits a carrier offering a group plan from applying a waiting period of more than 90 days before an individual is eligible to be covered under the group plan.

Designation of Primary Care Providers and Access to Obstetrical and Gynecological Care

If a carrier requires or provides for the designation of a primary care provider, the carrier must allow each insured to designate any participating primary care provider (or pediatrician for a child) if the provider is available to accept the insured individual.

A carrier must treat the provision of obstetrical and gynecological care as the authorization of the primary care provider. A carrier may not require authorization or a referral for obstetrical and gynecological care by a participating provider who specializes in obstetrics and gynecology.

Emergency Services

If a carrier provides coverage for emergency services in an emergency department, the carrier may not require an insured to obtain prior authorization and must provide coverage regardless of whether the provider furnishing the emergency services contracts with the carrier. If the provider does not contract with the carrier, the carrier may not impose any limitation on coverage that is more restrictive than services furnished by a contracted provider and must require the same cost sharing that would apply for a contracted provider.

Medical Loss Ratio and Premium Rebates

Carriers must submit to the Insurance Commissioner a specified report on their medical loss ratio, except in years in which the federal government collects a comparable report or determines annual rebate amounts. Carriers must provide specified premium rebates to each insured if the average medical loss ratios for the immediately preceding three years are less than a specified amount.

Carrier Disclosures

A carrier must disclose to an insured individual or employer the right to change premium rates and the factors that may affect changes in premium rates and the benefits and premiums available under all health benefit plans for which the employer or insured individual is qualified.

Child Only and Catastrophic Plans

Each carrier that offers a health benefit plan must offer an identical plan in which the only insured individuals are younger than age 21 as of the beginning of the plan year. A carrier may offer a catastrophic plan in the individual market if the plan (1) is only offered to individuals who are younger than age 30 at the beginning of the plan year or hold a specified hardship exemption and (2) covers specified benefits.

Responsibilities of the Insurance Commissioner

The Commissioner must adopt regulations to (1) develop standards for summary of benefits and coverage explanations for health benefit plans; (2) specify the minimum permissible loss ratios for health benefit plans that trigger premium rebates; (3) define

"hardship exemption" and "affordability exemption" to determine an individual's eligibility for enrollment in a catastrophic plan; (4) establish an annual limitation on cost sharing for health benefit plans; and (5) establish prescription drug requirements for health benefit plans. The Commissioner must also, in years in which the federal government does not collect a comparable report or determine annual rebate amounts, receive specified reports from carriers regarding loss ratios for health benefit plans and publish the reports on the Maryland Insurance Administration (MIA) website.

Current Law:

Federal Patient Protection and Affordable Care Act

Title I of the ACA provides numerous market reforms and consumer protections that have been adopted in Maryland law by reference, including:

- dependent coverage up to the age of 26;
- preexisting condition exclusions;
- prohibition on policy rescissions;
- provisions regarding wellness and prevention programs;
- prohibition on annual or lifetime limits on the dollar value of benefits;
- prohibition on excessive waiting periods in the large group market;
- requirements relating to choice of health care professional and patient access to obstetrical and gynecological care;
- emergency services coverage requirements;
- standards for summaries of benefits and coverage explanations;
- minimum loss ratio requirements and premium rebate guidelines;
- annual limitations on cost sharing;
- availability of child only plans;
- minimum benefit requirements for catastrophic plans;
- prohibition on discriminatory premium rates;
- coverage for individuals participating in clinical trials;
- contract requirements for stand-alone dental plans;
- guaranteed availability and renewability of coverage; and
- prescription drug benefit requirements.

Federal Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA) prohibits insurers from imposing preexisting condition exclusions on certain individuals. To qualify as HIPAA eligible, a person must (1) have had at least 18 months of prior coverage not interrupted by a gap of more than 63 consecutive days; (2) have exhausted any available

continuation coverage; (3) not be eligible for new group coverage or Medicare; and (4) have had their most recent coverage in a group health plan.

HIPAA prohibits discrimination within group health plans in coverage or premiums on the basis of health status and limits preexisting condition exclusions to 12 months (18 months for late enrollees), reduced by the number of months in which an enrollee had creditable coverage without a gap of more than 63 days. Preexisting conditions can only be based on a 6-month look back period (conditions for which care was sought within the previous 6 months).

Individual Market Consumer Protections

In the individual market, State law requires guaranteed issuance (§ 15-1316 of the Insurance Article) and renewability (§ 15-1309 of the Insurance Article). However, there is no blanket prohibition on preexisting condition exclusions. Thus, carriers may exclude preexisting conditions from coverage. Furthermore, while a carrier may not deny or refuse to renew coverage because of claims experience or a health-related status, a carrier can charge higher premiums based on health status.

Small Group Market Consumer Protections

In the small group market, State law requires guaranteed issuance (§§ 15-1208.1, 15-1208.2, 15-1209, and 15-1210 of the Insurance Article) and renewability (§ 15-1212 of the Insurance Article). State law also provides for community rating and limits adjustment of small group rates to certain factors such as age, geography, and family composition (§ 15-1205 of the Insurance Article). However, as in the individual market, there is no blanket prohibition on preexisting condition exclusions. Thus, carriers may exclude preexisting conditions from coverage. Furthermore, carriers may charge higher premiums based on health status for certain plans within certain parameters for a limited period of time.

Large Group Market Consumer Protections

In the large group market, State law requires guaranteed issuance (§§ 15-1406 and 15-1410 of the Insurance Article). State law also prohibits eligibility rules based on any health status-related factor (§ 15-1406 of the Insurance Article) and prohibits a carrier from charging an individual a premium that is greater than a similarly situated individual based on any health status-related factor (§ 15-1407 of the Insurance Article). However, as in the individual and small group markets, there is no blanket prohibition on preexisting condition exclusions. Thus, carriers may exclude preexisting conditions from coverage or impose waiting periods.

Responsibilities of the Insurance Commissioner

The regulations required to be adopted by and the reports required to be collected by the Commissioner under the bill are currently handled by the federal government (principally the U.S. Department of Health and Human Services).

Maryland Health Insurance Coverage Protection Commission

Chapter 17 of 2017 established the commission to (1) monitor potential and actual federal changes to the ACA, Medicaid, the Maryland Children's Health Program, Medicare, and the Maryland All-Payer Model; (2) assess the impact of such changes; and (3) provide recommendations for State and local action to protect access to affordable health coverage. Chapters 37 and 38 of 2018 altered the membership and charge of the commission to include studying and making recommendations for individual and group health insurance market stability, including specified options. By December 31 each year, the commission must submit a report on its findings and recommendations. The commission is jointly staffed by the Department of Legislative Services, Maryland Department of Health, and MIA. The commission was established for three years and will terminate on June 30, 2020.

Background:

Legal Challenge to the Patient Protection and Affordable Care Act

A principal feature of the ACA is an individual mandate that requires each individual to (1) have minimum essential health insurance coverage; (2) qualify for an exemption; or (3) make a "shared responsibility payment" with their federal income tax return for the months without coverage or an exemption. In December 2017, the federal Tax Cut and Jobs Act of 2017 (TCJA) eliminated the tax penalty for failure to comply with the mandate effective tax year 2019.

In response, in February 2018, 20 states filed suit in *Texas v. United States* that the ACA (as amended by TCJA) is unconstitutional as it is not supported by a tax penalty. The lawsuit asserts that the entire ACA is unlawful. Seventeen state attorneys general are defending the ACA and assert that the mandate remains constitutional and that, even without the individual mandate, the remainder of the ACA would stand.

On December 14, 2018**,** Judge Reed O'Connor issued a grant of summary judgment declaring that the entire ACA is invalid. On December 30, 2018**,** Judge O'Connor reaffirmed this decision and issued a stay and partial final judgment on the claim that the ACA's individual mandate is unconstitutional. This permitted immediate appeal and allows the ACA to remain in full effect pending appeals.

In early January 2019, the U.S. Department of Justice and the 17 state attorneys general appealed the case to the Fifth Circuit. On February 14, 2019, the Fifth Circuit Court of Appeals granted two requests to intervene in the ongoing litigation – one by the U.S. House of Representatives and the other by state attorneys general in four additional states (Colorado, Iowa, Michigan, and Nevada). The Fifth Circuit also denied a request from the intervenor states, led by California, for an expedited briefing schedule. The federal government's brief is due on March 25, 2019.

Actions in Other States

As of August 2018, four states (Colorado, Massachusetts, New York, and Virginia) have adopted all three of the following ACA or equivalent provisions into state law: guaranteed issue, preexisting condition exclusion, and community rating standards.

Additional Information

Prior Introductions: None.

Cross File: HB 697 (Delegate Pendergrass, *et al.*) - Health and Government Operations.

Information Source(s): The Commonwealth Fund; *Health Affairs;* Office of the Attorney General; Maryland Insurance Administration; Department of Legislative Services

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