Maryland Health Progress Act of 2013 as Amended

Senate Bill 274/House Bill 228

This bill constitutes the last step in the O'Malley-Brown Administration's three-year effort to use the tools of the Affordable Care Act to enhance Marylanders' access to quality and affordable health care. The bill puts in place the remaining policies necessary for the State's health benefit exchange to begin operations and expands Medicaid eligibility to ensure coverage for the State's most financially vulnerable. Together with HB 361, which conforms State law to the federal consumer protections and insurance market reforms going into effect next year, the Maryland Health Progress Act of 2013 ensures that Marylanders will reap the full benefits of health care reform and effective implementation of the Affordable Care Act.

In brief, the bill: 1) expands Medicaid to 133% of federal poverty; 2) establishes a dedicated funding stream for the Maryland Health Benefit Exchange (MHBE or Exchange) from the existing premium tax on health insurers; 3) provides for the migration of Maryland Health Insurance Plan (MHIP) members in a manner that eases their transition and mitigates the potential impact on rates; 4) allows for the development of a State reinsurance program to counteract potential short-term pressures on rates; 5) establishes policies to promote continuity of care when individuals move in and out of Medicaid and commercial insurance; and 6) makes other changes necessary for the MHBE to achieve final certification as a state-based exchange.

Components of Senate Bill 274/House Bill 228

Medicaid expansion

- Adults eligible up to 133% of FPL;
- Former foster care adolescents eligible up to age 26.

Dedicated funding stream to finance MHBE

- Annual distribution to MHBE from existing premium tax on health insurers sufficient to fund MHBE;
- Minimum $35 million annual appropriation;
- Any unspent appropriation reverts to general fund;
- Any non-State funds charged first; and
- CO-OP exemption from premium tax for 5 years.

Gradual transition of MHIP enrollees into MHBE

- Closed to new enrollees Jan 1, 2014;
- Transition of existing enrollees between January 1, 2014 and January 1, 2020;
- Required notice of options to members; and
- Annual report on MHIP transition, State reinsurance program, and use of funds.

Flexibility for State reinsurance wrap-around program

- MHIP funds may be used beginning CY'14 for State reinsurance program to mitigate rate impact of high-risk enrollees in individual market inside and outside Exchange;
- MHIP and MHBE Boards to determine timing and amount of funds to be used for reinsurance program from amount left after MHIP operations are funded and claims paid for enrollees remaining in Plan.

Wrongful insurance act

- Fraudulent act to function or hold oneself out as a SHOP or Individual Exchange navigator, or an application counselor, without appropriate license or certification.

Carrier delegation of functions to Exchange

- Exchange not within scope of third-party administrator statute;
- Where Exchange has assumed responsibility for premium collections and other activities normally performed by carriers, carrier not liable or subject to regulatory sanction for Exchange mistake;
- MIA has regulatory oversight over these delegated Exchange functions, and it may order restitution to consumer for actual damages, or to carrier for loss of premium or subsidies; and
- MHBE and carrier shall hold consumer harmless.

MHBE Standing Committee

- In March, 2014, the Exchange shall establish an ongoing, broad-based, standing stakeholder advisory committee on which a member of the Board will serve as liaison; and
- Committee shall be charged with providing input on policy issues either proposed by the Board liaison or on which the Board seeks feedback.

Accessibility for persons with disabilities

- MHBE shall comply with Section 508 of the Rehabilitation Act, and such compliance may not affect any obligation governing accessibility for individuals with disabilities to which it may be subject under the American with Disabilities Act.

Shop Exchange rules for employer premium contributions

- No employer is required to make premium contributions;
- Employers choosing to do so may pay a certain percentage or fixed dollar amount of a reference plan premium in a manner which does not discriminate against any employee.

Consolidated Services Center, SHOP Navigator and Individual Exchange Connector programs

- Call center, in collaboration with the Health Education and Advocacy Unit of the Attorney General, will support eligibility, enrollment, and other services of the Exchange;
- Employees assisting in QHP enrollment shall be required to have SHOP and Individual Exchange Enrollment permits;
- Employees shall be subject to same training, regulatory oversight, and limitations with respect to the markets outside the Exchange as SHOP and Individual Exchange navigators;
- Purpose of Connector program shall include providing assistance to individuals uninsured because of prior incarceration; and
- "Connector entity" substituted for "Navigator entity" to reflect new federal framework.

Captive producers

- Captive producers:
    - may transition carrier's existing enrollees into Exchange qualified plan, and may provide enrollment assistance to individuals who contact the carrier;
    - must act in best interests of consumer;
    - must disclose their employment with carrier, limitations on the assistance they may provide, and availability of other options in Exchange;
    - are subject to same restrictions as navigators with respect to providing information about other products and referring consumers back to any producer of record;
    - are subject to same licensing and Exchange authorization requirements as are independent producers;
- Carriers must:
    - document and retain records of such disclosures for three years;
    - provide disclosure records and updated lists of captive producers to Exchange;
- Non-compliance with requirements is grounds for sanctions for both captive producer and carrier;

- Program must be administered in non-discriminatory manner without adverse selection impact; and
- Program to be sunset after three years, with study and report in 2015 on its effect and whether or not it should be continued.

Application counselors

- Exchange may, depending on its needs and resources, certify application counselors and designate sponsoring entities to provide enrollment assistance to consumers;
- Counselors and entities may be providers, community-based organizations, or local government agencies;
- Counselors may not be paid by the Exchange, or by a carrier, producer, or TPA for their enrollment services; and
- Counselors shall be subject to navigator certification, training, and regulatory requirements.

Qualified plan certification and enforcement

- General categories of ACA plan certification requirements shall be applicable to MHBE certification standards, and Board policies incorporated into standards must be "interim policies" or regulations;
- MHBE may enforce plan certification requirements through corrective action, penalties, or denial, suspension, or revocation of certification;
- Penalties up to $5,000 per violation, with consideration of nature of violation, any corrective action, and carrier's knowledge and pattern of violations; and
- Carrier may appeal enforcement action, hearing request stays MHBE action pending final agency decision, and Administrative Procedure Act governs thereafter.

MCO/Carrier Exchange participation requirements

- Requirement that carriers offer silver and gold plans outside Exchange applicable only to carriers otherwise offering at least one plan outside the Exchange;
- Carriers must offer at least one QHP at each of the bronze, silver, and gold levels in each Exchange in which they participate (SHOP/Individual Exchange);
- A qualified health plan must be at least a bronze level of coverage unless it is a catastrophic plan; and
- Student health plans exempted from requirement that all carriers doing business in Maryland above certain premium threshold must offer plans on Exchange.

Qualified dental and vision plans

- In accordance with federal guidance, pediatric vision benefits must be embedded in the medical plan and may not be carved out as a stand-alone plan;
- MHBE and MIA must study and submit report in 2014 on impact of recent federal regulations permitting medical plans to carve out pediatric dental benefits if a stand-alone option is available; and
- MHBE authorized to require children to have essential pediatric dental benefits.

Administration of Exchange

- The bases on which MHBE may not discriminate specifically enumerated, including gender identity and sexual orientation;
- MHBE shall identify in its annual report disparities based on enumerated factors, to the extent data collection is feasible and permitted by law;
- MHBE may adopt "interim policies" only when necessary for timely compliance with federal guidance; policies must be submitted to AELR within 6 months, and shall sunset 12 months thereafter.

Continuity of care for Marylanders transitioning between commercial plans and Medicaid

- Purpose is to promote policies for Marylanders which minimize harmful disruptions in health care;
- Guidelines for circumstances under which carriers and MCOs shall, beginning in 2015:

    - Honor prior authorizations for treatment when requested by the member or provider, subject to confidentiality protections and certain time periods; and
    - Allow nonparticipating providers to continue course of treatment for certain medical and dental conditions without balance billing for certain time periods;
        - In-network rate shall be default payment, but carrier and provider may reach agreement on alternative payment;
        - Where no agreement reached, assignment of benefits law applicable;
    - Medicaid fee-for-service:
        - Provisions not applicable when members transition from commercial carriers into Medicaid fee-for-service programs;
        - Nonparticipating provider provisions applicable where individual transitioning from Medicaid FFS provider to commercial carrier; and
        - Prior authorization provisions applicable where individuals transitioning from Medicaid FFS behavioral health and dental services administered by TPA to commercial carrier;
    - Commercial carriers may address continuity of dental services by agreeing that the relinquishing carrier will pay for completion of a dental treatment in progress.
- Exchange, MIA, DHMH, and MHCC shall collect data and submit report in 2017 on efficacy of policies, and recommendations for any further legislation, with report to include assessment of impact on different populations, including individuals with mental health and substance use diagnoses, and on discrimination based on sexual orientation and gender identity.

Health Information Exchange

- Department of Health & Mental Hygiene authorized to make grants to CRISP, the State-designated Health Information Exchange.

Tobacco Rating

- MHBE and MIA shall conduct study and submit report by September, 2014 on the impact of tobacco rating on access, affordability, uptake, and health outcomes, and whether the State should institute more stringent requirements than the current permissible 1:1.5 rating.