2022 Annual Report on the Impact of Changes to the Affordable Care Act in Maryland

MSAR #12765

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Maryland Insurance Administration
Maryland Health Benefit Exchange
Health Education and Advocacy Unit – Office of the Attorney General

Introduction

During the 2020 legislative session, Senate Bill 872 (Ch. 621) / House Bill 959 (Ch. 620) - Health Insurance - Consumer Protections passed the General Assembly ("the 2020 legislation"). The 2020 legislation established a new subtitle in the Insurance Article, and incorporated consumer protection provisions of the federal Patient Protection and Affordable Care Act (ACA) that were specified through cross-references in Maryland law, and also established nondiscrimination provisions. The bill requires the Maryland Insurance Administration (Administration or MIA), the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General, and the Maryland Health Benefit Exchange (MHBE) to (1) monitor federal statutes and regulations to determine whether provisions of the ACA or corresponding regulations are repealed or amended to the benefit or detriment of Maryland consumers and (2) by December 31 each year until 2024, submit a specified joint report to the Senate Finance Committee and the House Health and Government Operations Committee.

For this year's report, the MIA, HEAU, and MHBE specifically focused on the 2023 Notice of Benefit and Payment Parameters Final Rule, the 2020 Grandfathered Group Health Plans Final Rule, the No Surprises Act (NSA) of the federal Consolidated Appropriations Act of 2021, Coverage of Preventive Health Services Litigation, Section 1557 of the ACA, and the Extension of Enhanced Federal Premium Tax Credits under the Inflation Reduction Act (IRA) of 2022.

Carryover Recommendations from the 2021 Joint ACA Report

2020 Grandfathered Group Health Plans Final Rule

On December 15, 2020, the U.S. Department of Treasury, the U.S. Department of Labor, and the U.S. Department of Health and Human Services (HHS) (the tri-agencies) issued the final rule *Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage* (85 FR 81097) that amended the requirements for grandfathered group health plans and grandfathered group health insurance coverage to preserve their grandfather status.

Following the enactment of this Final Rule, which went into effect on June 15, 2021, the MIA, HEAU, and MHBE recommended in the 2021 Annual Report on the Impact of Changes to the Affordable Care Act in Maryland ("2021 Joint Report") that the General Assembly consider whether the date referenced in §15-1A-03 of Insurance Article should be updated from December 1, 2019 to June 15, 2021. The agencies repeat this recommendation in this report and further recommend that such a change should also be considered at §15-1A-01(e)(1) of the Insurance Article.

For a full discussion of this issue, refer to the "2020 Grandfathered Group Health Plan Final Rule" section on page five of the 2021 Joint Report.

No Surprises Act (NSA) of the federal Consolidated Appropriations Act of 2021

In the 2021 Joint Report, the MIA, HEAU, and MHBE recommended §§15-1A-03, 13, and 14 of the Insurance Article be amended to conform to federal law, since certain provisions of the existing law were preempted by the more consumer protective federal requirements of the NSA beginning on January 1, 2022. While the General Assembly did take up and pass legislation to implement the provisions of the NSA in Maryland during the 2022 session (Senate Bill 180, Chapter 221, Acts of 2022), the MIA, HEAU, and MHBE recommend the General Assembly revise the definition of "Emergency Medical Condition" at §15-1A-14(a)(2) to bring it into alignment with the NSA. We also recommend the General Assembly update 15-1A-13 and 15-1A-03 to align with the NSA's requirements related to the choice of a healthcare professional as the consumer's primary care provider, codified in § 15-1A-13 of the Insurance Article, applicable to grandfathered health plans under the NSA, effective January 1, 2022.

For additional details on this issue, refer to the "Consolidated Appropriations Act, 2021 (H.R. 133)" section on pages 10 and 11 of the 2021 Joint Report.

Changes to ACA Regulations via 2023 Notice of Benefit and Payment Parameters Final Rule

Presumptively Discriminatory Benefit Designs

The 2023 HHS Notice of Benefit and Payment Parameters (NBPP) Final Rule revised 45 CFR §156.125(a) to the benefit of Maryland consumers in an effort to "refine HHS' [Essential Health Benefit (EHB)] nondiscrimination policy." This regulation applies to non-grandfathered individual and small group plans, which includes those plans offered on Maryland's Individual and Small Business Health Options Program (SHOP) Exchanges. The effective date of this regulatory change is January 1, 2023, or upon renewal of any plan subject to EHB requirements.[1]

The revision added the following sentence to this regulation: "Beginning on January 1, 2023…a non-discriminatory benefit design that provides EHB is one that is clinically based."[2] Within the preamble to the Final Rule, HHS provided several examples of presumptively discriminatory benefit designs.[3]

One such example is coverage limitations based on age for benefits for autism spectrum disorder (ASD).[4] Habilitative services are a fundamental component of the treatment program for ASD. Maryland's Benchmark Plan includes separate benefits for habilitative services for children and habilitative services for adults. As required by COMAR 31.11.06.03A(23), COMAR 31.11.06.06B, and MIA Bulletins 13-01 and 15-33, habilitative services for children, which must be provided until at least the end of the month in which the member turns 19, are covered with no visit limitations. However, the Benchmark Plan provides that habilitative services for adults are available to the same extent as benefits for outpatient rehabilitative services, which are capped at 30 visits per therapy type (physical therapy, occupational therapy, speech therapy) per benefit year.

Upon finalization of the revised regulation, the MIA reviewed this benefit construction internally and discussed the matter with the Centers for Medicare & Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO). Following the MIA's internal review and discussion with CCIIO, the MIA determined the application of a visit limitation to habilitative services for adults is a presumptively discriminatory benefit design under 45 CFR §156.125(a) as revised. Accordingly, during the form review process for plan year 2023 non-grandfathered individual and small group filings, the MIA included an objection advising carriers of the regulatory change and instructed the carriers to either remove the visit limitation applied to adult habilitative services or to provide appropriate clinical justification for the inclusion of this limitation.

All carriers responded to the MIA's objection by removing the visit limitation from their adult habilitative services benefit. This process resulted in a better benefit for Maryland consumers as non-grandfathered individual and small group plans now cover habilitative services with no visit limitation regardless of a member's age. While the MIA believes the existing §15-1A-22(d) of the Insurance Article gives it sufficient authority to enforce the prohibition on plan designs that discriminate based on age absent clinical justification, the MIA, HEAU and MHBE also recommend the date within §15-1A-04(2) be updated to December 1, 2022, to incorporate the amendment to 45 CFR §156.125(a).

[1] 87 FR 27296

[2] 87 FR 27296; 87 FR 27390

[3] 87 FR 27301-27305

[4] 87 FR 27302

Guaranteed Availability of Coverage – 45 CFR 147.104(i)

The 2023 HHS NBPP Final Rule revised 45 CFR 147.104(i) to clarify a carrier must accept individuals and employers for new coverage even when the individual or employer owes past-due premiums for prior coverage from the same carrier or another carrier in the same controlled group. The carrier further cannot apply premium payments for new coverage to past-due premiums owed for prior coverage.[5]

Specifically, the revised regulation reads as follows: "Coverage denials for failure to pay premiums for prior coverage. A health insurance issuer that denies coverage to an individual or employer due to the individual's or employer's failure to pay premium owed under a prior policy, certificate, or contract of insurance, including by attributing payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance, violates paragraph (a) of this section."[6]

While this is a consumer-friendly regulatory change, there is no impact to Maryland consumers because Maryland-specific statutes and regulations related to the requirements for grace period provisions within insurance contracts currently prohibit such practice. Furthermore, the MIA has authority to directly enforce all of the ACA guaranteed availability of coverage requirements under §15-1A-02(a)(2)(xx) of the Insurance Article, which would automatically incorporate the revisions to 45 CFR 147.104(i). Accordingly, the MIA, HEAU, and MHBE agree that no legislative changes are needed to address this federal regulatory revision.

Medical Loss Ratio (MLR) Updates

The 2023 HHS NBPP Final Rule revised 45 CFR § 158 to the benefit of Maryland consumers. This regulation applies to all grandfathered and non-grandfathered plans in the individual, small group and large group marketplaces, and outlines the requirements for reporting and calculation of the annual Medical Loss Ratio (MLR) report that is required under § 158.110. The changes are to address loopholes that certain carriers may have been using to inappropriately overinflate their MLR to reduce or avoid MLR rebates due to consumers.

The first change was to 45 CFR § 158.140, which defines what carriers may consider as "incurred claims" costs when reporting MLR data. The previous version of the regulation, allowing an upward adjustment to claims for "[t]he amount of incentive and bonus payments made to providers" as part of the incurred claims costs, was being viewed over broadly and inappropriately utilized by certain carriers. HHS reported that, "[i]n the course of conducting MLR examinations pursuant to §§ 158.401 and 158.402, we observed some issuers reporting incentive or bonus payments to providers that are not based on quality or performance metrics, but rather, involve transferring excess premium revenue to providers to circumvent MLR rebate requirements and avoid paying MLR rebates when issuers do not meet the applicable MLR standard. The incentive for such arrangements is particularly high for integrated medical systems where the issuer is the subsidiary, owner, or affiliate of a provider group or a hospital system. Further, in some cases, these "incentives" or "bonuses" are not even paid to the clinical providers, but rather to the non-clinical parent holding company of the hospital or provider group and the issuer."

To close this loophole, the language in 45 CFR § 158.140 has been revised to clarify that only "[t]he amount of incentive and bonus payments made to providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers" may be included in incurred claims for MLR reporting and rebate calculation purposes. This change will result in lower MLRs for carriers that were exploiting the loophole and making inappropriate adjustments, increasing the magnitude of their average MLR rebate.

[5] 87 FR 27218

[6] 87 FR 27386

The second change was to 45 CFR § 158.150, which previously read, "[t]he report required in §158.110 of this subpart must include expenditures for activities that improve health care quality, as described in this section." Per the NBPP:

"Section 158.150 describes the types of activities that qualify as QIA (Quality Improvement Activities), but does not specify the types of expenses that may be included as QIA expenses, or the extent to which such expenses must relate to the activity. The lack of clarity in existing regulations has caused wide discrepancies in the types of expenses that issuers include in QIA expenses and creates an unequal playing field among issuers.

"Some issuers appropriately include only direct expenses, such as the salaries of the staff performing actual QIA functions in QIA expenses. However, other issuers additionally allocate indirect expenses such as overhead, marketing, lobbying, corporate or holding group overhead, and vendor profits in QIA expenses. For example, some issuers allocate to QIA fixed costs – such as office space or IT infrastructure – that would, for the most part, exist even if the issuer did not engage in any QIA. Some issuers include in QIA expenses amounts exceeding the cost of providing the actual QIA service. In addition, some issuers include the promotion or marketing of their QIA services to group policyholders or enrollees as QIA expenses. Some issuers also include the cost of developing the prices of QIA services sold to group policyholders, or costs associated with calculating and reporting QIA expenses. Further, some issuers are not able to precisely determine what portion of indirect costs is tied to QIA, as many issuers do not have an accurate method to quantify the actual cost of each expense category as it relates to each QIA, and thus issuers are often arbitrarily reporting or apportioning indirect expenses without adequate documentation or support.

In order to provide clarity that only direct QIA expenses should be included in the MLR calculation, 45 CFR § 158.150 has been revised to read "The report required in § 158.110 must include expenditures directly related to activities that improve health care quality, as such activities are described in this section."

Both of the above changes provide clarity on MLR reporting, and create a more level playing field between carriers and prevent carriers from exploiting loopholes to inappropriately inflate their MLR. The changes will make it more likely that Maryland consumers receive the full amount of any MLR rebates that they are owed. As such, for the same clarifying reasons, to provide transparency, and to forestall any arguments that carriers may assert to the contrary, it is recommended that Md. Code, Ins. § 15-1A-16 be revised to state that the Insurance Commissioner would adopt MLR regulations that "are consistent with 45 C.F.R. § 158.221, and any corresponding federal rules and guidance as those provisions were in effect December 1, 2022."

Actuarial Value Calculator Updates

The 2023 HHS NBPP Final Rule revised 45 CFR § 156.140(c) to the benefit of Maryland consumers. This regulation applies to non-grandfathered individual and small group plans, which includes those plans offered on Maryland's Individual and SHOP Exchanges. The effective date of this regulatory change is January 1, 2023, or upon renewal of any plan subject to EHB requirements.[7]

The regulation that has been altered defines the "metal levels" of coverage, which are defined by "actuarial value" (AV). Each metal level has an AV target (e.g., 60% for bronze) and a "de minimis variation" around that target. Carriers are only permitted to offer plans that fall within the de minimis variation range. From 2014 through 2017, the de minimis range for all metal levels was from -2% to +2% (e.g., a bronze plan could range from 58% to 62%). From 2018 through 2022, the de minimis range expanded to -4% to + 2% for all metal levels, with bronze having an "expanded bronze" de minimis range of -4% to +5%. The decrease in de minimis range for all metal levels meant that carriers could offer plans with higher cost-sharing on any particular metal level. For bronze, in order for a carrier to offer an "expanded bronze" plan with an AV between 62% and 65% it was required that the plan either a) be a Qualified High Deductible

[7] 87 FR 27296

Health Plan as defined by the IRS or b) exclude one or more non-preventive service categories from being subject to the deductible.

For 2023, the de minimis ranges have been reverted back to -2% to +2% for all metal levels except bronze, which continues to have the +5% expanded range. This has been done to help consumers better distinguish between metal levels. The expanded ranges had blurred the lines between metal levels, with the most generous bronze plan and the least generous silver plan having very similar AVs (65% vs 66%). On bronze, plans in the expanded range had grown significantly in popularity over the years from under 10% in 2018 to almost 2/3 of bronze enrollment as of 2021. On silver, plans in the low end of the range (66% to 68%) did represent a meaningful portion of enrollment (between 25% and 30%), but that portion of enrollment had been steady between 2018 and 2011. Given this dynamic and the continued difficulty for carriers to design a plan that fell within the standard bronze range, CMS decided to leave the expanded bronze unchanged at +5% and to raise the de minimis threshold for all metal levels back to -2%.

The changed AV de minimis ranges meant that certain plans were forced to lower their cost-sharing for 2023 (primarily deductible and out-of-pocket max) to stay in metal level range. Some plans were eliminated and had their membership mapped into other plans with lower cost-sharing.

An additional change was made to 45 CFR § 156.200 which sets the de minimis ranges for Individual marketplace qualified health plans (QHPs) to 0% to +2%. The purpose of this change was to make the on-Exchange silver plans have lower cost-sharing and modestly increase the on-exchange silver premium. Since advanced premium tax credits (APTCs) are linked to the premium for a benchmark plan (which is the second lowest cost silver QHP in a member's zip code), the increased generosity and increased premium of silver QHPs will result in higher APTC amounts, all other things being equal.

Finally, a change was made to 45 CFR § 156.400, which sets the de minimis ranges for the cost-sharing reduction (CSR) version of silver QHPs. The de minimis range for these plans had been -1% to +1% since 2014, but the range has now been changed to 0% to +1%. This was to be in line with the base silver QHP range which changed under § 156.200. This change will slightly lower cost-sharing for those who are below 250% FPL and are eligible for a CSR silver variation.

Coverage of Preventive Health Services Litigation

ACA Section 1302 requires individual and small-group market insurers to cover preventive and wellness services as "essential health benefits." ACA Section 2713 requires non-grandfathered individual, small-group, large-group, and self-funded group health plans to cover, without cost-sharing, the following preventive health services:

- Services given an "A" or "B" rating by the U.S. Preventive Services Task Force, a group of experts appointed by the head of the Agency for Healthcare Research and Quality (USPSTF), an agency within the U.S. Department of Health & Human Services (HHS);
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP), a group of experts appointed by the head of the Centers for Disease Control and Prevention (CDC);
- Services for women identified in guidelines published by the Health Resources and Services Administration (HRSA), an agency within HHS; and
- Services for infants, children, and adolescents published under HRSA guidelines.

These advisory bodies recommend key preventive services, such as:

- Immunizations;
- Screenings for breast cancer, cervical cancer, colorectal cancer, lung cancer, heart disease, hepatitis, and hypertension;
- Tobacco-cessation services; and
- U.S. Food and Drug Administration (FDA)-approved contraception.

Since the passage of the ACA, preventive services have become significantly more available and accessible to those individuals who need them most. Most basically, 71 million people now have access to free vaccines, cancer screenings, and primary care, among other services. Nadia Chait & Sherry Glied, Promoting Prevention Under the Affordable Care Act, 39 ANN. REV. PUB. HEALTH 507(2018), at 514. A range of academic studies suggests that individuals who have access to no-cost preventive services use them: One study of over 60,000 insured adults, for instance, found a significant increase in the uptake of blood pressure checks, cholesterol checks, and flu vaccinations in the wake of the ACA 's implementation. Xuesong Han, et al., Has Recommended Preventive Service Use Increased After Elimination of Cost-Sharing as Part of the Affordable Care Act in the United States?, 78 PREVENTIVE MED 85 (2015). The preventive services provisions, in other words, have had their intended effect - they have improved access to health services.

The preventive service mandate is facing a legal challenge in *Braidwood Management v. Bacerra* where, on September 7, 2022, a federal district court judge in Texas, held that the requirement that plans and insurers cover evidence-based services recommended by the United States Preventive Services Task Force (USPSTF) violated the Appointments clause and was thus unconstitutional.[8] He also ruled that the requirement that Braidwood Management cover an HIV prevention medication (PrEP) violated the Religious Freedom Restoration Act. The judge has requested additional briefing on the appropriate remedy, which remains outstanding.

During Maryland's 2020 legislative session, in the face of legal challenges to the ACA in *Texas v. United States*, and the proposed roll back of ACA consumer protections, including the preventive services protections, this body incorporated Section 2713 into state law. Md. Code Ann., Ins. § 15-1A-10. Since the preventive services protections have already been codified into Maryland law for insured health benefit plans, the MIA, HEAU and MHBE are not recommending additional legislation at this time, but direct the General Assembly to an issue brief by State Health and Value Strategies, in cooperation with Princeton University, which examines the market-wide implications if the ruling stands and outlines potential state strategies to mitigate the impact.

Section 1557 of the Patient Protection and Affordable Care Act (ACA); Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37160 (June 19, 2020) (the Final Rule); Litigation; 87 CFR 84824 (Aug. 4, 2022)(Proposed Rule)

ACA Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, disability, and age in a broad range of health programs and activities. In 2016, HHS promulgated a final rule, developed over the course of 6 years, to implement the nondiscrimination requirements of Section 1557. The 2016 rule specifically defined sex to include discrimination on the basis of gender identity and sex stereotyping, among other criteria. On June 19, 2020, HHS published a new rule, 85 Fed. Reg. 37,160 (June 19, 2020) (2020 Rule or Rule), rescinding most of the 2016 Rule's core provisions and amended other HHS regulations unrelated to Section 1557, reversing anti-discrimination protections that prohibit discrimination on the basis of race, color, national origin, disability, sex, and age. The 2020 Rule was published days after the June 15, 2020, Supreme Court decision, *Bostock v. Clayton County, Georgia*, 140 S. Ct. 1731 (2020), which held that discrimination based on transgender status or sexual orientation "necessarily entails discrimination based on sex." The Final Rule rolled back the 2016 rule and limited the protections for LGBTQ people, among others. The Final Rule would permit discrimination in our healthcare system by narrowing the scope of the statute's protections, exempting entities that are subject to Section 1557. It also eliminated important definitions of discrimination, opening the door to discriminatory treatment based on gender identity, sex stereotyping, and pregnancy termination.

During Maryland's 2020 legislative session, in the face of legal challenges to the ACA in *Texas v. United States*, 141 S. Ct. 2104 (2021), and the proposed roll back of the antidiscrimination protections, the General Assembly passed legislation to expand Maryland's antidiscrimination protections to specifically prohibit 1) hospitals, related institutions and licensed healthcare providers from refusing, withholding from, or denying any individual with respect to their

[8] On January 28, 2022, the Attorney General joined a multistate amicus brief in support of HHS's Motion for Summary Judgment.

medical care because of the person's race, color, religion, sex, age, national origin, marital status, sexual orientation, gender identity, or disability, 2020 Md. Laws Ch. 428 (H.B.1120); and 2) carriers from excluding consumers from participation in, denying benefits to, or otherwise subjecting consumers to discrimination because of the person's race, sex, creed, color, national origin, marital status, sexual orientation, age, gender, gender identity, or disability, 2020 Md. Laws Ch. 621 (S.B.872).

On July 20, 2020, the Attorney General joined a multistate suit filed in the Southern District of New York, *New York v HHS*, No. 20-cv-5583 (S.D.N.Y), that challenged the legality of the federal June 2020 Final Rule. That litigation was in the motions stage when in a similar case in the District Court for the District of Columbia, *Whitman-Walker Health v. HHS*, No. 20-cv-1630 (D. DC), on September 2, 2020, a judge issued an order preliminarily enjoining parts of the 2020 Rule. HHS was preliminarily enjoined from enforcing the repeal of the 2016 Rule's definition of discrimination "[o]n the basis of sex" insofar as it includes "discrimination on the basis of . . . sex stereotyping." (81 FR 31467) In addition, the agency was preliminarily enjoined from enforcing its incorporation of the religious exemption contained in Title IX. See 45 C.F.R. § 92.6(b). On October 31, 2020, the Defendants appealed the judge's September 2 Order to the United States Court of Appeals for the District of Columbia Circuit.

Following the change in Administration, on February 10, 2021, the United States moved to suspend the multistate suit filed in the Southern District of New York to allow new HHS agency officials sufficient time to become familiar with the issues, and the proceedings were held in abeyance.

In a required Joint Status Report, HHS reported that it intended to initiate a rulemaking proceeding on Section 1557, which would provide for the reconsideration of many or all of the provisions of the Section 1557 regulations that were challenged in the multistate litigation. HHS also reported that, on May 10, 2021, it issued a Notification of Interpretation and Enforcement of Section 1557 providing that the agency will interpret and enforce Section 1557's prohibition on discrimination on the basis of sex to include (1) discrimination on the basis of sexual orientation and (2) discrimination on the basis of gender identity. Three lawsuits challenged that guidance.[9]

On July 23, 2021, the parties filed a Joint Motion to Stay Proceedings and Hold Motions in Abeyance, noting as reflected in the 2021 Spring Unified Agenda of Federal Regulatory and Deregulatory Actions, that HHS anticipated a Notice of Proposed Rulemaking to be issued no later than April 2022. On February 3, 2022, the proceedings were stayed until 30 days after the conclusion of the agency's rulemaking.

On August 4, 2022, HHS issued a new proposed rule, which significantly mirrors the earlier rule, reverses major portions of the 2020 Final Rule, and includes new policies that would go beyond the 2016 rule, including, extending the rule to Medicare Part B providers, preventing discrimination based on marital, family or parental status, extending the rule to include telehealth services and clinical algorithms, inclusion of compliance training requirements and creating a process for entities to voice federal conscience or religious freedom objections. The comment period closed on October 3, 2022. The Attorney General's Office joined 21 other states in a comment letter largely supporting HHS for returning to the protections against discrimination in healthcare clearly envisioned by the ACA.

Inflation Reduction Act of 2022

In August 2022, the IRA extended the enhanced federal premium tax credits originally established by the American Rescue Plan Act. The enhanced premium tax credits are now set to expire by 2026 if the U.S. Congress does not extend them again. With the enhanced premium tax credits, in combination with the State Reinsurance Program, individual market premiums in Maryland are significantly discounted compared to small group premiums. Consequently, it is not cost-effective for the state to create a small business and nonprofit health insurance subsidy program; doing so

[9] On November 11, 2022, a federal district court judge in Texas, Judge Matthew Kacsmaryk, ruled in a class action lawsuit brought by two doctors that the *Bostock* decision did not apply to Title IX or Section 1557.

would risk creating adverse incentives that could result in low-income employees paying more for coverage in a small group plan than they would pay for individual market coverage. The Small Business & Nonprofit Health Insurance Subsidies Program Workgroup established by Maryland Senate Bill 632 of 2022 therefore recommended that the state postpone any implementation of a small business and nonprofit subsidy until after the expiration of enhanced premium tax credits in the individual market.