2021 Annual Report on the Impact of Changes to the Affordable Care Act in Maryland

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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 (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monitor federal statutes and regulations to determine whether provisions of the ACA or corresponding regulations are repealed or amended to the benefit or detriment of Maryland consumers and (2) by December 31 each year until 2024, submit a specified joint report to the Senate Finance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 2022 Notice of Benefit and Payment Parameters Final Rule, the 2020 Grandfathered Group Health Plans Final Rule, the 2019 Exchange Program Integrity final rule, the 2021 Notice of Benefit and Payment Parameters Final Rule, the Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority Final Rule, the Families First and CARES Acts as they relate to COVID-19 testing and vaccines, and the Consolidated Appropriations Act, 2021 (H.R. 133) as it relates to coverage of emergency services and choice of health care professional under the ACA.

Changes to ACA Regulations via 2022 Notice of Benefit and Payment Parameters Final Rule

The Notice of Benefit and Payment Parameters (NBPP) is published annually to make updates to rules and regulations governing the implementation and enforcement of the ACA. The 2022 NBPP Final Rule was published in three parts on January 19, 2021, May 5, 2021, and September 27, 2021. The MIA, HEAU, and MHBE focused on certain provisions of the NBPP outlined below.

Revisions to Special Enrollment Periods – 45 CFR §155.420

The U.S. Department of Health and Human Services (HHS) adopted several changes to the regulations governing special enrollment periods (SEPs) through the 2022 NBPP. HHS routinely uses the annual NBPP to clarify or add to the situations in which a qualified individual can access a SEP in response to changes in the market, a change in consumer circumstances, etc. All of the changes described below are effective for 2022.

A. New plan options for certain enrollees eligible for a SEP at 45 CFR §155.420(a)(4)(ii)(C) to allow On-Exchange enrollees who are determined newly ineligible for the advance payments of the premium tax credit (APTC) to change to another On-Exchange plan at any metal level:[1]

    - Previously, individuals who qualified for this SEP could only change to a Qualified Health Plan (QHP) one metal level higher or lower if there was no other QHP available at their current metal level
        - In 2021, there were multiple QHPs available for purchase through MHBE at every metal level except Platinum
        - This meant the only Maryland enrollees who could change metal levels were those enrolled in the Platinum plan, who would have been able to change to a Gold plan

[1] 86 FR 24126; 85 FR 24290

- Consumers enrolled in On-Exchange plans gain the ability, if desired, to change to any other On-Exchange plan if they lose eligibility for APTC
- Individuals who qualify for this SEP may also continue to purchase off-Exchange coverage without limitation on plan options pursuant to 45 CFR §147.104(b)(2)(iii)

B. New SEP for individuals who did not receive timely notice of an event that triggers eligibility for an SEP– 45 CFR §147.104(b)(2)(ii); 45 CFR §§155.420(b)(5) and (c)(5):[2]

- Applicable On-Exchange and Off-Exchange
- Individuals will have 60 days from the date they knew, or reasonably should have known, they experienced a triggering event to select a new plan
- Individuals who utilize this SEP have the option to elect the earliest effective date that would have been available had they received timely notice of the triggering event
- HHS believes this SEP will allow consumers to maintain continuity of coverage in situations when an individual should have received notice of a triggering event; for example, loss of employer-sponsored coverage due to the employer's failure to pay premiums resulting in retroactive termination of coverage

C. New SEP for cessation of employer COBRA contributions – 45 CFR §§155.420(d)(15) and (e)(1):[3]

- Applicable On-Exchange and Off-Exchange
- Individuals are eligible for this SEP if an employer ceases contributions to an employee's COBRA coverage or if government subsidies of COBRA coverage cease; the latter trigger was added following passage of the American Rescue Plan, which provided for COBRA coverage subsidies from the federal government through September 30, 2021
- This SEP is *not* subject to 45 CFR §155.420(e)(1), which states an individual is not eligible for a SEP if the individual fails to timely pay COBRA premiums
    - If an employer or the government is partially subsidizing an individual's COBRA coverage and those contributions cease prior to the end of the COBRA coverage period, the employee can voluntarily opt out of COBRA coverage and access this SEP
    - If an employee is paying the full costs of COBRA coverage and fails to make timely payment of premiums, the individual is ineligible for this SEP

D. New SEP for individuals with incomes no greater than 150% of the Federal Poverty Level – 45 CFR §155.420(d)(16):[4]

- Individuals eligible for APTC whose income is expected to be no greater than 150% of the Federal Poverty Level (FPL) can enroll in an On-Exchange plan or change from one On-Exchange plan to another one time per month:
    - Individuals not yet enrolled can enroll in any metal level of coverage, but the intent, as further explained below, is for individuals to enroll in a low-cost, 94% AV Silver cost-sharing reduction plan
    - Individuals currently enrolled in an Exchange plan, and their enrolled dependents, may change to any Silver QHP

[2] 86 FR 24220; 86 FR 24290
[3] 86 FR 24223; 86 FR 24290
[4] 86 FR 53433-34; 86 FR 53441; 86 FR 53503-04

    - Current Exchange plan enrollees interested in adding new individuals or dependents to coverage can add these individuals or dependents to their current QHP, enroll with them in a new Silver QHP, or enroll in a new Silver QHP for themselves and a separate QHP for the new enrollees
- This SEP is permanent but will remain effective only as long as expanded APTC subsidies, as enacted by the American Rescue Plan Act, remain in effect
    - These expanded APTC subsidies have resulted in many low income consumers with income no greater than 150% of FPL being eligible to enroll in a near-$0 premium 94% AV Silver cost-sharing reduction plan, and this SEP was designed to target this situation,
- SEP effectively provides continuous open enrollment for individuals with incomes of between 138% and 150% FPL, providing additional opportunities for the uninsured to enroll in On-Exchange coverage and, in 2022, for those who lose Medicare eligibility at the end of the Public Health Emergency to enroll in On-Exchange coverage
    - Note: Individuals who lose eligibility for Medicaid are already eligible for a 60-day SEP; if they fail to enroll before the end of that SEP, they can enroll through this new SEP
- This SEP is optional for State-Based Exchanges; MHBE has decided to implement and must do so through the regulatory process; updates to MHBE's SEP regulations at COMAR 14.35.07.12-.19 are in progress and are expected to be finalized no later than Summer 2022
    - An estimated 1.5%, or 3,500 individuals, of the MHC-eligible uninsured population would be eligible for the SEP.

At this time, the MIA, HEAU and MHBE agree no legislation is needed to address these amendments. Existing Maryland law already gives the MIA and MHBE the authority to enforce the SEPs, and their associated effective dates, detailed in Sections A, B, and C. With regard to the SEP detailed in Section D, as noted, MHBE is updating the appropriate regulations at COMAR 14.35.07.12-.19 to provide for implementation.

Changes to the Open Enrollment Period - 45 CFR § 155.410(e)

In the 2022 NBPP, HHS amended 45 CFR §155.410(e) to extend the open enrollment period (OEP) for federally-facilitated exchanges to November 1 through January 15 instead of November 1 through December 15. In general, HHS' goal for the expanded ten-week OEP is to increase health coverage access. The rule also gives state-based marketplaces the option to adopt expanded open enrollment periods, and on September 20, 2021, the MHBE Board of Trustees voted to adopt the expanded open enrollment period for the 2022 plan year. MHBE will evaluate whether to continue the policy in future years.

Further, MHBE has made operational changes to accelerate effective dates for enrollments made in December: previously, enrollments made December 15 - December 31 were effective February 1, but this year all December enrollments will have an effective date of January 1. Enrollments made January 1 - January 15 will continue to have an effective date of February 1.

The dates for the annual OEP and the corresponding effective dates of coverage are codified in Maryland law at § 15-1316 of the Insurance Article. Section 15-1316 currently provides that the dates "shall be the dates adopted by the federal Department of Health and Human Services." Since the amended federal regulation gives state-based marketplaces the option to adopt expanded open enrollment periods, but does not adopt specific dates for state-based marketplaces, the MIA, HEAU and MHBE recommend that the General Assembly consider whether to revise § 15-1316 to specifically authorize MHBE to adopt the expanded OEP dates if permitted by the federal Department of Health and Human Services.

2020 Grandfathered Group Health Plans Final Rule

On December 15, 2020, the U.S. Department of Treasury, the U.S. Department of Labor, and 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. The final rule applies only to group grandfathered plans. Due to the estimated low remaining enrollment in individual grandfathered plans, the tri-agencies expressed the view that amending the requirements for grandfathered individual health insurance coverage would be of limited utility.

The final rule permits grandfathered group health coverage that is a high deductible health plan (HDHP) to increase fixed-amount cost-sharing requirements, such as deductibles, to the extent necessary to maintain its status as an HDHP under the Internal Revenue Code without losing grandfather status. This change was intended to ensure that participants and beneficiaries enrolled in HDHP coverage remain eligible to contribute to a health savings account. The final rule also provides an alternative method of measuring permitted increases in fixed-amount cost sharing for grandfathered group plans. Grandfathered plans that increase cost-sharing above certain thresholds lose their grandfathered status, and for fixed-amount cost sharing, the threshold is based on the "maximum percentage increase." The final rule changed the method for calculating the maximum percentage increase to use a different measure that the tri-agencies argued would allow plans and carriers to better account for changes in the costs of health coverage over time. The new methodology allows grandfathered plans to increase fixed-amount cost sharing to a greater extent than the prior regulations without losing grandfathered status. The tri-agencies faced some criticism for the changes because of the likely increase in consumer costs and because grandfathered plans provide less comprehensive coverage than required under the ACA. The tri-agencies made clear that the final rule does not allow a non-grandfathered plan to become grandfathered. The final rule became effective on June 15, 2021.

The 2020 legislation added new § 15-1A-03 of the Insurance Article, which requires the Commissioner, to the extent necessary, to adopt regulations that establish criteria that a health benefit plan must meet to be considered a grandfathered plan. The law expressly requires the MIA's regulations to be consistent with the federal regulations for grandfathered plans under 45 CFR § 147.140 that were in effect on December 1, 2019. Section 15-1A-02 of the Insurance Article separately gives the Commissioner general authority to enforce the requirements of the ACA, and, therefore, as long as the ACA remains in effect, it will not be necessary for the Commissioner to adopt regulations establishing criteria for grandfathered plans. However, if it does become necessary for the Commissioner to adopt these regulations in the future, the current text of § 15-1A-03 of the Insurance Article would require the Commissioner to ignore the changes to the federal regulations that became effective on June 15, 2021 under the new final rule. The MIA, HEAU and MHBE recommend that the General Assembly consider whether the date referenced in § 15-1A-03 of the Insurance Article should remain December 1, 2019 or be updated to June 15, 2021.

2019 Exchange Program Integrity Final Rule

On December 27, 2019, HHS issued the final rule *Patient Protection and Affordable Care Act; Exchange Program Integrity* (84 Fed. Reg. 71674) on exchange program integrity that changed the way that insurers must bill, and consumers must pay, for certain abortion services in qualified health plans. Under the rule, insurers must send, and consumers must pay, two separate monthly bills for the amount of the premium attributable to non-Hyde abortion services and the amount of the premium for all other services (45 CFR 156.280(e)(2)(ii) and (iii)). Separate paper bills may be included in the same envelope or mailing. Separate electronic bills must be sent in separate emails or electronic communications. Insurers must instruct the enrollee to pay the bills in separate transactions and make reasonable efforts to collect the

payment separately. The rule made these requirements effective with the first billing cycle following June 27, 2020.

On May 8, 2020 CMS published the interim final rule *Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program* (85 FR 27550). In this rule, CMS announced a 60-day extension from the original deadline of June 27, 2020 for implementation of the billing and payment requirements previously described, citing a need for QHP issuers and exchanges to devote resources to respond to the COVID-19 emergency. CMS also announced a non-enforcement policy that would delay enforcement to: 1) one year after the regulation was published (Dec 2019), or 2) six months after the federal emergency ends, whichever is later.[5]

California, Maryland and other states, on January 30, 2020, challenged the HHS final rule relating to separate premium billing for abortion coverage. On July 20, 2020, Judge Laurel Beeler granted the states' motion for summary judgment and set the rule aside. The court found that the rule was arbitrary and capricious because the Administration did not advance a reasoned explanation for deviating from its prior rule and industry practice. Judge Beeler's decision followed a similar ruling issued by the District of Maryland's Judge Catherine Blake on July 10, 2020, in *Planned Parenthood of Maryland, Inc., et al. v. Azar et al.*, No. 1:20-cv-00361-CCB (D. Md. July 10, 2020). On September 17, 2020, the United States appealed to the U.S. Court of Appeals for the Ninth Circuit.

Following the change in Administration, the United States moved to suspend appellate proceedings to allow new HHS agency officials sufficient time to become familiar with the issues, and the proceedings were held in abeyance. Following the issuance of HHS final rulemaking repealing the portion of the regulation challenged in the appeal, the appeal was voluntarily dismissed on September 29, 2021.

No recommendations are being made for the General Assembly to enact legislation in relation to these billing requirements at this time.

Changes to ACA Regulations via 2021 Notice of Benefit and Payment Parameters Final Rule

On May 14, 2020, the HHS published the 2021 NBPP Final Rule. Last year, the MIA, HEAU and MHBE reported on revisions to several provisions of the NBPP that were to the benefit or detriment of Maryland consumers. A further update regarding one of the revised provisions is provided below.

Direct Support from Drug Manufacturers (Drug Coupons) – 45 CFR §156.130(h)

HHS revised the wording of 45 CFR §156.130(h)[6] to clarify a carrier may, to the extent permitted by state law, count towards an enrollee's out-of-pocket maximum any form of direct support, i.e. "discount cards," manufacturer coupons, etc. offered by prescription drug manufacturers. Further, carriers must be transparent regarding how they will treat direct support in their plan and marketing materials (85 FR 29230, 29232, 29234).

Until plan year 2020, ACA regulations were silent on the issue of the impact of direct support on enrollees' out-of-pocket maximums. However, the 2020 NBPP, published on April 25, 2019, temporarily adopted a regulation that specified a carrier may choose to count or exclude direct support from an

[5] https://www.federalregister.gov/d/2020-09608/p-551.
[6] 84 Federal Register 80 at 17567-8; https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08017.pdf

enrollee's out-of-pocket maximum when an enrollee selects a brand name drug for which a medically appropriate generic equivalent is available. In issuing the regulation, HHS recognized that copayment support may help beneficiaries by encouraging adherence to existing medication regimens, particularly when copayments may be unaffordable to many patients, but noted that the availability of a coupon may cause physicians and beneficiaries to choose an expensive brand-name drug when a less expensive and equally effective generic or other alternative is available. HHS posited that, "when consumers are relieved of copayment obligations, manufacturers are relieved of a market constraint on drug prices which can distort the market and the true costs of drugs. Such coupons can add significant long-term costs to the health care system that may outweigh the short-term benefits of allowing the coupons, and counter-balance issuers' efforts to point enrollees to more cost effective drugs." Balancing those concerns with those of patients needing access to medications, HHS also noted that that when there is no generic equivalent available or medically appropriate, it is less likely that the manufacturer's coupon would disincentivize a lower cost alternative and thereby distort the market. The regulation as published raised significant questions as to if carriers were *required* to count direct support towards an enrollee's out-of-pocket maximum in other circumstances, i.e. for a brand name drug for which a medically appropriate generic equivalent is not available.[7]

Due to substantial national confusion expressed by state regulators, and a potential conflict with IRS requirements for HSA-compatible high deductible health plans, HHS announced on August 26, 2019, that the federal government would not be enforcing the provision in the 2020 NBPP relating to direct support offered by drug manufacturers, and would revisit the issue in the 2021 NBPP.

In revising this regulation in the 2021 NBPP, HHS clarified stakeholder concerns and left decisions on how to treat direct support to carriers and state law.

Maryland law does not currently address this issue, meaning each carrier may determine how it will handle the issue of direct support, when such action is consistent with other applicable laws and rules (e.g., HIPAA and non-discrimination requirements). Consumers and consumer advocates have expressed serious concerns to the MIA and HEAU that carrier requirements excluding direct support from counting towards a member's out-of-pocket costs are harmful as direct support allows some enrollees to access high-cost, medically necessary prescription drugs through their plan's prescription drug benefit that they may not otherwise have accessed due to deductible, coinsurance, or copay amounts. There have also been complaints in recent years that carriers added contract terms which exclude drug manufacturer coupons from applying to an enrollee's annual limits on out-of-pocket costs that are non-transparent, vague, and sometimes incorporated into contracts without proper notice.

In response to the latter concern, MHBE mandated in its 2021 Letter to Issuers Seeking to Participate in Maryland Health Connection that carriers shall disclose in their "Important Information About This Plan" document if they use a copay accumulator program for prescription drugs covered in their formulary. Issuers must also provide information on how the program may impact enrollees' out-of-pocket costs. This has resulted in increased transparency in plans offered through the Exchange.

By the end of 2020, four states – Arizona, Illinois, Virginia, and West Virginia – had passed laws that limit or prohibit copay accumulator programs, according to Ben Chandhok, senior director of state legislative affairs at the Arthritis Foundation.[8] Seventeen states had considered similar bills in 2020.[9]

[7] 85 Federal Register 94 at 29261; 45 CFR § 156.130 (h)
[8] https://khn.org/news/2021-health-plans-granted-leeway-to-limit-consumers-benefit-from-drug-coupons/.
[9] *Id.*

Last year, the MIA, HEAU and MHBE recommended that the General Assembly consider legislation to best address the needs of Marylanders and directed the General Assembly to a 2020 Report to the Massachusetts Legislature titled "Prescription Drug Coupon Study." (https://www.mass.gov/doc/prescription-drug-coupon-study/download) The 2020 legislation failed but the Prescription Drug Affordability Board is supposed to provide a study to the General Assembly to assist with legislative decisions regarding possible limits or prohibitions on copay accumulator programs.

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)

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 six 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*, 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*, and the proposed roll back of the antidiscrimination protections, this body enacted 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 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 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*, on September 2, 2020, Judge Boasberg 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 Judge Boasberg'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 will 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.

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 anticipates a Notice of Proposed Rulemaking to be issued no later than April 2022. Though no Order has been issued on that Motion, the proceedings remain in abeyance.

The Families First and CARES Acts mandate coverage of costs related to testing for COVID-19 and vaccines

Through passage of the Families First Act[10] and the CARES Act,[11] Congress amended the ACA to mandate private[12] and public[13] insurance coverage, with few exceptions,[14] of COVID-19 testing and related items and services without cost sharing or medical management requirements.[15] Congress mandated the

[10] FAMILIES FIRST CORONAVIRUS RESPONSE ACT, PL 116-127, March 18, 2020, 134 Stat 178 ("Families First Act")

[11] CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY ACT, PL 116-136, March 27, 2020, 134 Stat 281 ("CARES Act")

[12] SEC. 6001. COVERAGE OF TESTING FOR COVID–19. (d) TERMS. —The terms ''group health plan''; ''health insurance issuer''; ''group health insurance coverage'', and ''individual health insurance coverage'' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code of 1986, as applicable. Families First Act, 134 Stat 201. Families First Act, 134 Stat 202.

[13]The Families First Act mandates coverage with no cost sharing for enrollees in Medicare, Medicare Advantage, Medicaid and CHIP plans in Sections 6002 through 6004. 134 Stat 203-207.

[14] Short-term, limited-duration insurance is expressly excluded from the definition of health insurance under the ACA, and is not covered by the Families First Act or the CARES Act; excepted benefits are likewise not covered, Section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91(b)(5) and (c)).

[15] SEC. 6001. COVERAGE OF TESTING FOR COVID–19. (a) IN GENERAL. [Health plans] shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period []:
(1) In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act, and the administration of such in vitro diagnostic products.
(2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product. Families First Act, 134 Stat 201.

SEC. 3201. COVERAGE OF DIAGNOSTIC TESTING FOR COVID-19. Paragraph (1) of section 6001(a) of division F of the Families First Coronavirus Response Act (Public Law 116-127) is amended to read as follows:
``(1) An in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19, and the administration of such a test, that—"
(A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb-3);``
(B) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb-3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;``
(C) is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or``

same coverage, and also provided funding, for the testing of uninsured individuals.[16] Vaccine coverage is mandated subject to the same exceptions.[17]

The Families First Act and the CARES Act are in effect through the period of the federal public health emergency, currently set to expire January 16, 2022, unless an earlier termination date is announced, or a further extension is granted.[18]

The General Assembly granted the Governor discretion to authorize similar coverage provisions for testing and vaccines in emergency legislation that went into effect March 19, 2020, and has since expired.[19]

The COVID-19 Testing, Contact Tracing, and Vaccination Act of 2021[20] mandated coverage of COVID-19 testing and related items and services without cost sharing or medical management requirements, but was vetoed by the Governor.

Topics that may warrant further consideration by the legislature during the 2022 Session are mandated coverage of COVID-19 vaccines and testing and related items and services without cost sharing or medical management requirements.

Consolidated Appropriations Act, 2021 (H.R. 133)

The provisions of Division BB, Title I – No Surprises Act (NSA) of the federal Consolidated Appropriations Act, 2021 included several amendments to the Public Health Service Act. In general, the NSA establishes comprehensive consumer protections related to balance billing by health care providers for emergency services and for certain services performed by out-of-network providers at in-network facilities. The revisions to the Public Health Service Act under the NSA are generally outside the scope of this report because the NSA is distinct from the ACA. However, Section 102 of the NSA established new insurance requirements for coverage, cost-sharing, and balance billing protections with respect to emergency services that are more comprehensive than the existing insurance requirements for emergency services under the ACA, which were expressly codified into Maryland law at § 15-1A-14 of the Insurance Article. The new NSA requirements for emergency services apply to plan years beginning on or after January 1, 2022, and will supersede the less consumer protective requirements under the ACA. For this reason, the NSA included an amendment to the ACA emergency services requirements currently codified at 42 U.S.C. 300gg–19a indicating that the current ACA requirements shall not apply to group or individual health insurance coverage with respect to plan years beginning on or on January 1, 2022.

(D) other test that the Secretary determines appropriate in guidance." CARES Act, 134 Stat.366-67.

[16] In the Families First Act, Congress appropriated $1 billion to cover costs related to testing of uninsured individuals, defined as an individual not enrolled in (1) a federal health care program or (2) an ACA-compliant private health insurance plan. 134 Stat. 182.

[17] SEC. 3203. RAPID COVERAGE OF PREVENTIVE SERVICES AND VACCINES FOR CORONAVIRUS. (a) [Health plans shall] cover (without cost-sharing) any qualifying coronavirus preventive service…. (b) Definitions.--For purposes of this section: (1) Qualifying coronavirus preventive service.--The term "qualifying coronavirus preventive service"' means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is--(A) an evidence-based item or service that has in effect a rating of ``A" or ``B" in the current recommendations of the United States Preventive Services Task Force; or (B) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. CARES Act, 134 Stat. 367-68.

[18] https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

[19] COVID-19 Public Health Emergency Protection Act of 2020, 2020 Maryland Laws Ch. 14 (effective March 19, 2020 through April 30, 2021)("Emergency Protection Act")

[20] https://mgaleg.maryland.gov/2021RS/veto_letters/hb0836.pdf

Similarly, the ACA'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, apply to grandfathered plans under the NSA, effective January 1, 2022.

While the General Assembly will separately need to consider whether to take broader action regarding overall implementation of the NSA in Maryland during the 2022 Session, the MIA, HEAU and MHBE recommend that §§ 15-1A-03, 13 and 14 of the Insurance Article be amended to conform to federal law, since certain provisions of the existing law will be preempted by the more consumer protective federal requirements of the NSA beginning on January 1, 2022.