Title 14
INDEPENDENT AGENCIES
Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE
14.35.18 Small Business Health Options Program

Authority: Insurance Article, §§ 31-106(c)(1)(iv), 31-108(b)(13), 31-111 Annotated Code of Maryland

Notice of Proposed Action

The Maryland Health Benefit Exchange proposes to adopt new Regulations .01-.08 under chapter, COMAR 14.35.18 Small Business Health Options Program.

Statement of Purpose

The purpose of this action is to establish the regulatory framework for the small business health option program

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Taylor Kasky, Senior Health Policy Analyst, Maryland Health Benefit Exchange, 750 E. Pratt Street, Baltimore MD 21202, or call 410-547-7971, or email to taylor.kasky2@maryland.gov, or fax to 410-547-7373. Comments will be accepted through June 18, 2019. A public hearing has not been scheduled.

.01 Scope

This chapter sets forth the requirements for the Small Business Health Options Program. This chapter does not address the individual exchange or qualified dental plans or qualified vision plans.

.02 Definitions

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “Common law employee” has the meaning stated in 20 CFR § 404.1007.

(2) "Date of enrollment" means the date of enrollment of an individual covered under a group health plan or health insurance coverage in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) “Employer group health insurance coverage” means health coverage offered by an employer to an employee and the employee’s dependents, if eligible, under:

(a) Government health coverage, such as the Federal Employees Health Benefit program;

(b) Health coverage offered in the small or large group market by an employer within a state; or

(c) Grandfathered health coverage offered by an employer in a group market.

(4) “Full-time employee” is a common law employee working on average, at least 30 hours per week.

(5) “Independent contractor” means a 1099 employee working 30 or more hours per week.

(6) “Member” means any person enrolled in a health benefit plan.

(7) “Part-time employee” means a common law employee working fewer than 30 hours per week, or seasonal worker working more than 120 days per year.

(8) “Participation rate” means the percentage of eligible employees electing to participate in a health benefit plan out of all eligible employees.

(9) “Participation requirement” means a policy provision, or a carrier's underwriting guideline if there is no such provision, which requires that a group attain a certain participation rate in order for a carrier to accept the group for enrollment in the plan.

(10) "Qualified employee" means an employee who:

(a) Works on a full-time basis with a normal work week of thirty or more hours, but does not include an employee who works on a temporary or substitute basis, and

(b) Is hired to work for a period of not less than five months.

(11) “Qualified employer” means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, provided that the employer:

(a) Has its principal place of business in the State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(b) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the State.

(12) “Rescission” means a cancellation or discontinuance of coverage that has retroactive effect.

(13) “Waiting period” means the period of time that must pass before coverage for a qualified employee who is otherwise eligible to enroll under the terms of a small group health plan can become effective.

.03 Eligibility for SHOP Exchange

A. Non-discrimination. No policy shall exclude a qualified employee or dependent on the basis of age, sex, sexual orientation, gender identity, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition.

B. SHOP Exchange employer eligibility.

(1) An employer is eligible to purchase insurance on the SHOP Exchange if it meets the following requirements as established by the Insurance Article § 31-101(z)(1), Annotated Code of Maryland:

(a) Has 50 or fewer employees; and

(b) At least one full-time employee who is not the spouse or other dependent of the owner; and

(c) Has its principal place of business in Maryland; and

(d) Elects to offer, at a minimum, all full-time employees coverage in a qualified health plan through the SHOP Exchange; and

(e) Either:

(i) Elects to provide coverage through the SHOP to all eligible employees, wherever employed; or

(ii) Elects to provide coverage through the SHOP to all of its eligible employees who are principally employed in Maryland.

(2) For the purpose of determining the number of qualified employees, a business shall be considered to be one (1) qualified small business or group if:

(a) It is eligible to file a combined tax return for purpose of state taxation; or

(b) It comprises two or more companies that are part of the same parent-subsidiary controlled group, as defined by 26 CFR § 1.1563-1 (a)(2).

C. New employers. An employer that was not in existence for the entirety of the preceding calendar year shall have eligibility determined as established by the Insurance Article § 31-101, Annotated Code of Maryland.

D. Eligibility application. All qualified small businesses must submit an eligibility application in accordance with relevant provisions of 45 CFR § 155.716.

E. Duration of eligibility. A determination of an employer’s eligibility to participate in SHOP remains valid until the employer makes a change that could end its eligibility under 45 CFR § 155.710(b), or until the employer withdraws from participation in the SHOP.

F. Eligible employee.

(1) Full-time common law employees are eligible for SHOP participation.

(2) An employer who elects to cover part-time and seasonal employees working more than 120 days per year shall calculate full-time equivalency of the employee’s hours by:

(a) Calculating the total number of hours worked by all part-time and seasonal employees per month; and

(b) Dividing the total number of hours worked by 120.

G. Groups with non-common law employees.

(1) The following groups are eligible for SHOP participation if at least one common law full-time employee is also employed and elects to enroll in SHOP coverage:

(a) A corporate partner;

(b) A S corporation shareholder with more than 2% ownership;

(c) A business that employs contractual 1099 employees.

(d) A sole proprietor.

H. Household employers. A household employer is eligible for SHOP participation, under the following conditions:

(1) Relevant eligibility requirements pursuant to this regulation are met; and

(2) The Employer has filed, or will file for the subsequent tax year, an appropriate Schedule H (Form 1040) or Form 941 demonstrating that a household employee is employed, and all appropriate taxes have been paid or withheld.

I. Minimum participation. A qualified employer must meet the following minimum participation requirements:

(1) At least 75% minimum participation is required for qualified employers, if the qualified employer designates a coverage level within which its employees may choose any qualified health plan in the SHOP Exchange; and

(2) Where the qualified employer selects one carrier from which eligible employees may choose a plan from that carrier, the carrier may not impose a minimum participation requirement that exceeds 75% of eligible employees; and

(3) Minimum participation must be attained prior to initial plan enrollment, and annually prior to plan renewal for employee choice groups.

J. Participation determination. In applying a minimum participation requirement to determine whether the applicable percentage of participation is met, a carrier may not consider as eligible employees:

(1) those who have group spousal coverage under a public or private plan of health insurance or another employer's health benefit arrangement, including Medicare, Medicaid, and CHAMPUS, that provides benefits similar to or exceeding the benefits provided under a bronze level health plan as described in 45 CFR § 156.140; or

(2) employees who are under the age of 26 years who are covered under their parent's health benefit plan.

K. Waiver of minimum participation period. Small employers that cannot comply with minimum participation requirements may apply for coverage during the period that begins on November 15 and extends through December 15 of any year.

L. Determination outcomes.

(1) A group shall be enrolled once it has been determined that the group satisfied the minimum participation requirement.

(2) Should a group become enrolled as the result of an error in computing participation level, enrollment shall continue until the end of the month following the month in which a termination notice is sent.

(3) The determination of an employer's eligibility to participate in the SHOP remains valid until the employer makes a change that ends or alters its eligibility, or the employer withdraws from participation in the SHOP.

M. Eligibility redetermination.

(1) The SHOP Exchange may request new eligibility applications from employers in order to conduct eligibility re-determination.

(2) Requests shall be made by the SHOP Exchange no later than 60 prior to the employer's renewal date.

N. Eligibility adjustment period.

(1) When information submitted on the SHOP single employer application is inconsistent with information collected from third-party data sources through the verification process or otherwise received by the SHOP Exchange, the SHOP Exchange shall:

(a) Make a reasonable effort to identify and address any causes of typographical errors or clerical errors;

(b) Notify the employer of the inconsistency;

(c) Provide the employer with a period of 30 days from the date the notice is sent, to present satisfactory documentary evidence to support the employer's application, or resolved the inconsistency;

(d) If after this 30 day period, the SHOP Exchange has not received satisfactory documentary evidence, the SHOP Exchange shall:

(i) Notify the employer of its denial or termination of eligibility and of the employer's right to appeal such determination; and

(ii) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the SHOP at the end of the month following the month in which the ineligibility notice is sent.

O. Employer eligibility appeal.

(1) An employers has the right to appeal:

(a) A notice of denial or termination of eligibility; and

(b) A failure by the SHOP Exchange to provide a timely eligibility determination or a timely notice of an eligibility determination.

(2) All appeals must be requested within 90 days from the date of the notice of denial or termination of eligibility.

(3) The SHOP Exchange shall provide a written notice of the right to appeal a denial of eligibility which includes:

(a) The reason for the denial or termination of eligibility, including a citation to the applicable regulations; and

(b) The procedure by which the employer may request an appeal of the denial or termination of eligibility.

(4) The SHOP Exchange shall issue written notice of the appeal decision to the employer within 90 days of the date the appeal request is received.

(5) If an employer is found eligible following the appeal decision, then at the employer's option, the effective date of coverage or enrollment through the SHOP Exchange under the decision is:

(a) Retroactive to the effective date of coverage or enrollment through the SHOP Exchange that the employer would have had if the employer had been correctly determined eligible; or

(b) Prospective to the first day of the month following the date of the notice of the appeal decision.

(6) If the employer is found ineligible under the appeal decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

P. Safe harbor. The SHOP Exchange and participating carriers shall treat a qualified small business which ceases to be eligible solely by reason of an increase in the number of employees, as an eligible small business until it otherwise fails to meet the eligibility criteria of this section, or it elects to terminate coverage for qualified employees through the SHOP Exchange.

Q. Reporting. Employers shall submit a new application within 30 days of any change made to the business structure that could alter its SHOP Exchange eligibility.

.04 Enrollment

A. Rolling enrollment period. A qualified employer may purchase coverage for its small group at any point during the year.

B. Length of plan year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage.

C. Effective coverage dates. The effective date of coverage is:

(1) No later than the first day of the following month for a group enrollment received on the first through the fifteenth day of any month.

(2) No later than the first day of the second following month for a group enrollment received on the sixteenth though the last day of any month.

(3) A qualified employer may opt for a later effective date within a quarter for which small group market rates are available.

D. Newly hired employees.

(1) The effective date of coverage for a qualified health plan selection received by the SHOP from a newly qualified employee is the first day of the month following the end of the waiting period.

(2) If the newly qualified employee makes a plan selection on the first day of the month and any applicable waiting period has ended by that date, coverage must be effective on that date.

E. Annual open enrollment period standards. A carrier must establish an open enrollment period that meets the requirements established under Insurance Article § 15-1208.1 - .2, Annotated Code of Maryland.

F. Eligibility requirement waiver period. If a small group health plan cannot comply with group participation rules for the offering of health insurance coverage, a carrier may restrict the availability of such coverage to an annual enrollment period that begins November 15 and extends through December 15 of each calendar year.

G. Special enrollment periods. Special enrollment periods shall be established in accordance with the requirements of Insurance Article § 15-1208.1 - .2, Annotated Code of Maryland.

(1) Notwithstanding section G. of this regulation, a special enrollment period of 90-days shall be established for individuals who become pregnant, beginning on the date a pregnancy in confirmed by a health care practitioner.

H. Waiting period. A small employer may implement a waiting period of no more than 90 days for any qualified employee.

I. Payment of first month’s premium.

(1) A small employer shall pay the first month’s premium to the carrier of the qualified health plan to effectuate enrollment when the small employer has:

(a) Enrolled in a qualified health plan after coverage from a previous enrollment in a qualified health plan the individual had was terminated; or

(b) Enrolled for the first time in a qualified health plan in the SHOP Exchange; or

(c) Enrolled in a qualified health plan offered by a different carrier of the same holding company in the SHOP Exchange.

(2) The first month’s premium payment to effectuate prospective coverage for qualified health plan selections made during an annual open enrollment period or during a special enrollment period shall be due from the employer on a uniformly applied date specified by the authorized carrier of the qualified health plan that is no earlier than the coverage effective date but no later than 30 calendar days from the coverage effective date.

(3) The first month’s premium payment to effectuate prospective coverage for qualified health plan selections made during a special enrollment period under Regulations F(1) of this chapter shall be due from the employer on a date specified by the authorized carrier of the qualified health plan and uniformly applied that is no earlier than the coverage effective date or no later than 30 calendar days from the date the carrier receives the enrollment transaction from the SHOP Exchange or the coverage effective date, whichever is later.

(4) Payment to effectuate retroactive coverage shall include the premium due from the employer for all months of retroactive coverage and shall also include the full premium amount of the first prospective month of coverage.

(5) Payment to effectuate retroactive coverage for qualified health plan selections made during a special enrollment period shall be due on a uniformly applied date specified by the authorized carrier that is no earlier than the coverage effective date and no later than 30 calendar days from the date the carrier receives the enrollment transaction from the SHOP Exchange or the coverage effective date, whichever is later.

(6) An authorized carrier may choose to extend the premium due date if the carrier does so in a uniform and consistent manner for all similarly situated applicants.

J. Group installation.

(1) A carrier shall install groups upon enrollment.

(2) Employee choice groups shall be effective on the date the group first effectuated coverage.

K. Renewal. A health insurance issuer offering SHOP coverage shall renew or continue in force the coverage in the manner prescribed under Insurance Article § 15-1212 of the Code.

.05 Termination, cancellation, and renewal of qualified health plan.

A. Termination.

(1) A qualified employer who participates in the SHOP who terminates SHOP coverage terminates the enrollment of the employees enrolled in plans under the SHOP.

(2) An employee who is the certificate holder of a qualified health plan purchased through the SHOP, who terminates enrollment in a qualified health plan also terminates the enrollment of the other enrollees in the employee's household.

(3) Each enrollee, who is not the certificate holder, may terminate enrollment in a qualified health plan without affecting the enrollment status of the employee's household or each individual member of the employee's household other than the enrollee.

(4) A carrier shall process the SHOP Exchange's termination determination promptly and without undue delay.

(5) A carrier shall maintain records of termination of enrollment in a qualified health plan in the format specified by the SHOP Exchange in an electronic data interchange format for a period of 10 years.

(6) A carrier shall make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act), including head-of-household and non-head-of-household enrollees, before terminating the individual's enrollment.

(7) A carrier shall send an electronic transaction to the SHOP Exchange documenting, or acknowledging, each termination of coverage carried out under this chapter, promptly and without undue delay.

B. Termination by the SHOP Exchange.

(1) Termination due to failure to pay.

(a) If payment for a group is not received by the end of the grace period stated in the group contract, the SHOP Exchange may terminate the group's coverage.

(b) The last day of coverage shall be the last day of the grace period stated in the group contract or 1st day of the coverage month.

(2) Termination due to error, misconduct, fraud, or misrepresentation of a group.

(a) Coverage may be retroactively terminated when:

(i) The enrollment in a qualified health plan through the SHOP Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the SHOP Exchange, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; or

(ii) The employee or group was enrolled in a qualified health plan without the employee or group's knowledge or consent by any third party, including third parties who have no connection with the SHOP Exchange; or

(iii) The eligibility determination was made based on information regarding the group that is false or misrepresentative as to the actual composition of the group.

(3) Notification of termination.

(a) If any employee's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or due to a loss of the employee's eligibility to participate in the SHOP, including where an employee losses eligibility because a qualified employer has lost its eligibility, the SHOP must notify the employee of the termination.

(b) Such notice of termination must include the termination effective date and reason for termination, and must be sent within 3 business days if an electronic notice is sent, and within 5 days if a mailed hard copy notice is sent.

C. Renewal, nonrenewal, and cancellation. Renewal, nonrenewal, and cancellation shall be conducted in accordance with the requirements of Insurance Article § 15-1212, Annotated Code of Maryland

.06 Coverage models

A. Employer Choice model requirements.

(1) A qualified employer may elect to make available to qualified employees a choice of qualified health plans offered through the SHOP Exchange by:

(a) A single issuer across all available coverage levels; or

(b) A single qualified health plan.

B. Employee Choice model requirements.

(1) A qualified employer may select two consecutive metal levels of coverage, and employees may choose any SHOP plan across all the insurance companies that offer plans at those metal levels.

.07 Employer contribution

A. An employer is not required to contribute to the qualified health plan premiums of its employees.

B. If an employer chooses to contribute to the qualified health plan premiums of its employees, the employer shall:

(1) Select a reference plan on which the contributions will be based; and

(2) Make a contribution that is:

(a) A fixed percentage of the premium of the reference plan, based on the coverage level selected by the qualified employee and the qualified employee's job classification; or

(b) A dollar amount that ensures that all of the qualified employer's employees with the same coverage level and job classification would pay the same amount if they purchased the reference plan.

(3) A reference plan selected under this paragraph:

(a) Under the employer choice model established at Section .05 of these Regulations, shall be a qualified plan that is:

(i) Offered by the carrier or insurance holding company system selected by the qualified employer; and

(ii) Among the qualified plans of the carrier or insurance holding company system selected by the qualified employer; or

(b) Under the employee choice model established at Section .05 of these Regulations, shall be a qualified plan offered by any carrier at the metal level selected by the qualified employer.

.08 Premium Rating

A. Premium rating.

(1) The total premium charged to a small group must be developed using a per-member rating method.

(2) For each covered employee and their covered dependents, the premium shall be determined as follows:

(a) For each adult age 21 and over, multiply the base rate by the applicable age and geographic area factors:

(b) For each covered child age 0-20, multiply the base rate of the oldest three children by the applicable age and geographic area factors.

B. Composite billing.

(1) Composite billing is only available under the employer choice model set forth in .06(A)(1) of this this regulation.

(2) The SHOP Exchange will determine premiums under composite billing based on the instructions issued by the Commissioner.