

HOUSE BILL 23

J5

(PRE-FILED)

4lr0324
CF SB 228

By: **Chair, Health and Government Operations Committee (By Request – Departmental – Maryland Insurance Administration)**

Requested: September 15, 2023

Introduced and read first time: January 10, 2024

Assigned to: Health and Government Operations

Committee Report: Favorable

House action: Adopted

Read second time: February 6, 2024

CHAPTER _____

1 AN ACT concerning

2 **Maryland Health Benefit Exchange – Qualified Health Plans – Dental Coverage**

3 FOR the purpose of repealing a certain provision of law providing that a qualified health
4 plan is not required under certain circumstances to provide essential benefits that
5 duplicate the minimum benefits of qualified dental plans; repealing the authority of
6 the Maryland Health Benefit Exchange to require children enrolling in a qualified
7 health plan to have essential pediatric dental benefits required by the federal
8 Secretary of Health and Human Services; and generally relating to qualified health
9 plans certified by the Maryland Health Benefit Exchange.

10 BY repealing and reenacting, with amendments,

11 Article – Insurance

12 Section 31–113(p)(7)(ii), 31–115, and 31–116(a)(2)(ii)

13 Annotated Code of Maryland

14 (2017 Replacement Volume and 2023 Supplement)

15 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

16 That the Laws of Maryland read as follows:

17 **Article – Insurance**

18 31–113.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.



1 (p) (7) If a carrier or a captive producer fails to comply with the requirements
2 of this subsection, the Exchange may:

3 (ii) impose sanctions against the carrier under [~~§ 31–115(k)~~] §
4 **31–115(J)** of this subtitle.

5 31–115.

6 (a) The Exchange shall certify:

7 (1) health benefit plans as qualified health plans;

8 (2) dental plans as qualified dental plans, which may be offered by carriers
9 as:

10 (i) stand–alone dental plans; or

11 (ii) dental plans sold in conjunction with or as an endorsement to
12 qualified health plans;

13 (3) vision plans as qualified vision plans, which may be offered by carriers
14 as:

15 (i) stand–alone vision plans; or

16 (ii) vision plans sold in conjunction with or as an endorsement to
17 qualified health plans; and

18 (4) stand–alone dental plans for sale outside the Exchange.

19 (b) To be certified as a qualified health plan, a health benefit plan shall:

20 (1) [~~except as provided in subsection (c) of this section,~~] provide the
21 essential health benefits required under § 1302(a) of the Affordable Care Act and § 31–116
22 of this subtitle;

23 (2) obtain prior approval of premium rates and contract language from the
24 Commissioner;

25 (3) except as provided in subsection [(e)] **(D)** of this section, provide at least
26 a bronze level of coverage, as defined in the Affordable Care Act and determined by the
27 Exchange under § 31–108(b)(8)(ii) of this subtitle;

28 (4) (i) ensure that its cost–sharing requirements do not exceed the
29 limits established under § 1302(c)(1) of the Affordable Care Act; and

1 (ii) if the health benefit plan is offered through the SHOP Exchange,
2 ensure that the health benefit plan's deductible does not exceed the limits established
3 under § 1302(c)(2) of the Affordable Care Act;

4 (5) be offered by a carrier that:

5 (i) is licensed and in good standing to offer health insurance
6 coverage in the State;

7 (ii) offers in each Exchange, the Individual and the SHOP, in which
8 the carrier participates, at least one qualified health plan:

9 1. at a bronze level of coverage;

10 2. at a silver level of coverage; and

11 3. at a gold level of coverage;

12 (iii) if the carrier participates in the Individual Exchange and offers
13 any health benefit plan in the individual market outside the Exchange, offers at least one
14 qualified health plan at the silver level and one at the gold level in the individual market
15 outside the Exchange;

16 (iv) if the carrier participates in the SHOP Exchange and offers any
17 health benefit plan in the small group market outside the SHOP Exchange, offers at least
18 one qualified health plan at the silver level and one at the gold level in the small group
19 market outside the SHOP Exchange;

20 (v) charges the same premium rate for each qualified health plan
21 regardless of whether the qualified health plan is offered through the Exchange, through
22 an insurance producer outside the Exchange, or directly from a carrier;

23 (vi) does not charge any cancellation fees or penalties in violation of
24 § 31-108(d) of this subtitle; and

25 (vii) complies with the regulations adopted by the Secretary under §
26 1311(d) of the Affordable Care Act and by the Exchange under § 31-106(c)(1)(iv) of this
27 subtitle;

28 (6) meet the requirements for certification established under the
29 regulations adopted by:

30 (i) the Secretary under § 1311(c)(1) of the Affordable Care Act,
31 including minimum standards for marketing practices, network adequacy, essential
32 community providers in underserved areas, accreditation, quality improvement, uniform
33 enrollment forms and descriptions of coverage, and information on quality measures for
34 health plan performance; and

1 (ii) the Exchange under § 31–106(c)(1)(iv) of this subtitle;

2 (7) be in the interest of qualified individuals and qualified employers, as
3 determined by the Exchange;

4 (8) provide any other benefits as may be required by the Commissioner
5 under any applicable State law or regulation; and

6 (9) meet any other requirements established by the Exchange under this
7 subtitle, including:

8 (i) transition of care language in contracts as determined
9 appropriate by the Exchange to ensure care continuity and reduce duplication and costs of
10 care;

11 (ii) criteria that encourage and support qualified plans in facilitating
12 cross-border enrollment; and

13 (iii) demonstrating compliance with the federal Mental Health Parity
14 and Addiction Equity Act of 2008.

15 [(c) (1) A qualified health plan is not required to provide essential benefits that
16 duplicate the minimum benefits of qualified dental plans, as provided in subsection (h) of
17 this section, if:

18 (i) the Exchange has determined that at least one qualified dental
19 plan is available to supplement the qualified health plan's coverage; and

20 (ii) at the time the carrier offers the qualified health plan, the carrier
21 discloses in a form approved by the Exchange that:

22 1. the plan does not provide the full range of essential
23 pediatric dental benefits; and

24 2. qualified dental plans providing these and other dental
25 benefits also not provided by the qualified health plan are offered through the Exchange.

26 (2) The Exchange may determine whether a carrier may elect to include
27 nonessential oral and dental benefits in a qualified health plan.]

28 [(d) (C) The Exchange may determine whether a carrier may elect to offer
29 coverage for nonessential vision benefits in either the SHOP Exchange or Individual
30 Exchange.

31 [(e) (D) A qualified health plan is not required to provide at least a bronze level
32 of coverage under subsection (b)(3) of this section if the qualified health plan:

1 (1) meets the requirements and is certified as a qualified catastrophic plan
2 as provided under the Affordable Care Act; and

3 (2) will be offered only to individuals eligible for catastrophic coverage.

4 **[(f)] (E)** A health benefit plan may not be denied certification:

5 (1) solely on the grounds that the health benefit plan is a fee-for-service
6 plan;

7 (2) through the imposition of premium price controls by the Exchange; or

8 (3) solely on the grounds that the health benefit plan provides treatments
9 necessary to prevent patients' deaths in circumstances the Exchange determines are
10 inappropriate or too costly.

11 **[(g)] (F)** In addition to other rate filing requirements that may be applicable
12 under this article, each carrier seeking certification of a health benefit plan shall:

13 (1) (i) submit to the Exchange notice of any premium increase before
14 implementation of the increase; and

15 (ii) post the increase on the carrier's website;

16 (2) submit to the Exchange, the Secretary, and the Commissioner, and
17 make available to the public, in plain language as required under § 1311(e)(3)(b) of the
18 Affordable Care Act, accurate and timely disclosure of:

19 (i) claims payment policies and practices;

20 (ii) financial disclosures;

21 (iii) data on enrollment, disenrollment, number of claims denied, and
22 rating practices;

23 (iv) information on cost-sharing and payments with respect to
24 out-of-network coverage;

25 (v) information on enrollee and participant rights under Title I of
26 the Affordable Care Act; and

27 (vi) any other information as determined appropriate by the
28 Secretary and the Exchange; and

29 (3) make available information about costs an individual would incur
30 under the individual's health benefit plan for services provided by a participating health

1 care provider, including cost-sharing requirements such as deductibles, co-payments, and
2 coinsurance, in a manner determined by the Exchange.

3 **[(h)] (G)** (1) Except as provided in paragraphs (2) through (5) of this
4 subsection, the requirements applicable to qualified health plans under this subtitle also
5 shall apply to qualified dental plans to the extent relevant, whether offered in conjunction
6 with or as an endorsement to qualified health plans or as stand-alone dental plans.

7 (2) A carrier offering a qualified dental plan shall be licensed to offer dental
8 coverage but need not be licensed to offer other health benefits.

9 (3) A qualified dental plan shall:

10 (i) be limited to dental and oral health benefits, without substantial
11 duplication of other benefits typically offered by health benefit plans without dental
12 coverage; and

13 (ii) include at a minimum:

14 1. the essential pediatric dental benefits required by the
15 Secretary under § 1302(b)(1)(j) of the Affordable Care Act; and

16 2. other dental benefits required by the Secretary or the
17 Exchange.

18 (4) (i) The Exchange may determine:

19 1. the manner in which carriers must disclose the price of
20 oral and dental benefits and, to the extent relevant, medical benefits, when offered:

21 A. to the extent permitted by the Exchange, in a qualified
22 health plan;

23 B. in conjunction with or as an endorsement to a qualified
24 health plan; or

25 C. as a stand-alone plan; and

26 2. when a carrier offers a qualified dental plan in conjunction
27 with a qualified health plan, whether the carrier also must make the qualified health plan,
28 the qualified dental plan, or both qualified plans available on a stand-alone basis.

29 (ii) In determining the manner in which carriers must offer and
30 disclose the price of medical, oral, and dental benefits under this paragraph, the Exchange
31 shall balance the objectives of transparency and affordability for consumers.

32 (5) The Exchange may:

1 (i) exempt qualified dental plans from a requirement applicable to
2 qualified health plans under this subtitle to the extent the Exchange determines the
3 requirement is not relevant to qualified dental plans; and

4 (ii) establish additional requirements for qualified dental plans in
5 conjunction with its establishment of additional requirements for qualified health plans
6 under subsection (b)(9) of this section.

7 [(6) The Exchange may require children enrolling in a qualified health plan
8 to have the essential pediatric dental benefits required by the Secretary under §
9 1302(b)(1)(j) of the Affordable Care Act, whether offered:

10 (i) in the qualified health plan;

11 (ii) in conjunction with or as an endorsement to the qualified health
12 plan; or

13 (iii) as a stand-alone dental plan.]

14 [(i) (H) (1) Except as provided in paragraphs (2) through (5) of this
15 subsection, the requirements applicable to qualified health plans under this subtitle also
16 shall apply to qualified vision plans to the extent relevant, whether offered in conjunction
17 with or as an endorsement to qualified health plans or as stand-alone vision plans.

18 (2) A carrier offering a qualified vision plan shall be licensed to offer vision
19 coverage but need not be licensed to offer other health benefits.

20 (3) A qualified vision plan shall:

21 (i) be limited to vision and eye health benefits, without substantial
22 duplication of other benefits typically offered by health benefit plans without vision
23 coverage; and

24 (ii) include at a minimum:

25 1. the essential pediatric vision benefits required by the
26 Secretary under § 1302(b)(1)(j) of the Affordable Care Act; or

27 2. other vision benefits required by the Secretary or the
28 Exchange.

29 (4) (i) The Exchange may determine:

30 1. the manner in which carriers must disclose the price of
31 vision benefits and, to the extent relevant, medical benefits, when offered:

- 1 A. to the extent permitted by the Exchange, in a qualified
2 health plan;
- 3 B. in conjunction with or as an endorsement to a qualified
4 health plan; or
- 5 C. as a stand-alone plan; and

6 2. when a carrier offers a qualified vision plan in conjunction
7 with a qualified health plan, whether the carrier also must make the qualified health plan,
8 the qualified vision plan, or both qualified plans available on a stand-alone basis.

9 (ii) In determining the manner in which carriers must offer and
10 disclose the price of medical and vision benefits under this paragraph, the Exchange shall
11 balance the objectives of transparency and affordability for consumers.

12 (5) The Exchange may:

13 (i) exempt qualified vision plans from a requirement applicable to
14 qualified health plans under this subtitle to the extent the Exchange determines the
15 requirement is not relevant to qualified vision plans; and

16 (ii) establish additional requirements for qualified vision plans in
17 conjunction with its establishment of additional requirements for qualified health plans
18 under subsection (b)(9) of this section.

19 **[(j)] (I)** A managed care organization may not be required to offer a qualified
20 plan in the Exchange.

21 **[(k)] (J)** (1) Subject to the contested case hearing provisions of Title 10,
22 Subtitle 2 of the State Government Article, and subsection **[(f)] (E)** of this section, and
23 except as provided in subsection **[(l)(2)] (K)(2)** of this section, the Exchange may deny
24 certification to a health benefit plan, a dental plan, or a vision plan, or suspend or revoke
25 the certification of a qualified plan, based on a finding that the health benefit plan, dental
26 plan, vision plan, or qualified plan does not satisfy requirements or has otherwise violated
27 standards for certification that are:

28 (i) established under the regulations and interim policies adopted
29 by the Exchange to carry out this subtitle; and

30 (ii) not otherwise under the regulatory and enforcement authority of
31 the Commissioner.

32 (2) Certification requirements shall include providing data and meeting
33 standards related to:

34 (i) enrollment;

- 1 (ii) essential community providers;
- 2 (iii) complaints and grievances involving the Exchange;
- 3 (iv) network adequacy;
- 4 (v) quality;
- 5 (vi) transparency;
- 6 (vii) race, ethnicity, language, interpreter need, and cultural
7 competency (RELICC);
- 8 (viii) plan service area, including demographics;
- 9 (ix) accreditation; and
- 10 (x) complying with fair marketing standards developed jointly by
11 the Exchange and the Commissioner.

12 (3) Instead of or in addition to denying, suspending, or revoking
13 certification, the Exchange may impose other remedies or take other actions, including:

- 14 (i) taking corrective action to remedy a violation of or failure to
15 comply with standards for certification; and
- 16 (ii) imposing a penalty not exceeding \$5,000 for each violation of or
17 failure to comply with standards for certification.

18 (4) In determining the amount of a penalty under paragraph (3)(ii) of this
19 subsection, the Exchange shall consider:

- 20 (i) the type, severity, and duration of the violation;
- 21 (ii) whether the plan or carrier knew or should have known of the
22 violation;
- 23 (iii) the extent to which the plan or carrier has a history of violations;
24 and
- 25 (iv) whether the plan or carrier corrected the violation as soon as they
26 knew or should have known of the violation.

27 (5) The penalties available to the Exchange under this subsection shall be
28 in addition to any criminal or civil penalties imposed for fraud or other violation under any
29 other State or federal law.

1 (6) (i) A carrier or plan, under Title 10, Subtitle 2 of the State
2 Government Article and the Exchange's appeals and grievance process may:

3 1. appeal an order or decision issued by the Exchange under
4 this section; and

5 2. request a hearing.

6 (ii) A demand for a hearing stays a decision or order of the Exchange
7 pending the hearing, and a final order of the Exchange resulting from it, if the Exchange
8 receives the demand:

9 1. before the effective date of the order; or

10 2. within 10 days after the order is served.

11 (iii) If a petition for judicial review is filed with the appropriate court
12 under Title 10, Subtitle 2 of the State Government Article, the court has jurisdiction over
13 the case and shall determine whether the filing operates as a stay of the order from which
14 the appeal is taken.

15 **[(l)] (K)** (1) To be certified for sale outside the Exchange, a stand-alone
16 dental plan shall be reviewed and approved by the Administration as meeting appropriate
17 requirements, including:

18 (i) covering the State benchmark pediatric dental essential health
19 benefits;

20 (ii) complying with annual limits and lifetime limits applicable to
21 essential health benefits;

22 (iii) complying with annual limits on cost sharing applicable to
23 stand-alone dental plans under 45 C.F.R. § 156.150; and

24 (iv) meeting the same actuarial value requirement for the pediatric
25 dental essential health benefits that is required for a qualified dental plan.

26 (2) Subject to the contested case hearing provisions of Title 10, Subtitle 2
27 of the State Government Article, the Exchange may deny, suspend, or revoke the
28 certification of a stand-alone dental plan for sale outside the Exchange if the stand-alone
29 dental plan does not satisfy the requirements of paragraph (1) of this subsection.

30 **[(m)] (L)** Any certification standards established under subsection **[(k)] (J)** of
31 this section related to network adequacy or network directory accuracy:

32 (1) shall be consistent with the provisions of § 15-112 of this article; and

1 (2) may not be implemented until January 1, 2019.

2 31–116.

3 (a) The essential health benefits required under § 1302(a) of the Affordable Care
4 Act:

5 (2) notwithstanding any other benefits mandated by State law, shall be the
6 benefits required in:

7 (ii) [subject to § 31–115(c) of this subtitle,] all qualified health plans
8 offered in the Exchange.

9 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all
10 policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or
11 after January 1, 2025.

12 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
13 January 1, 2025.

Approved:

Governor.

Speaker of the House of Delegates.

President of the Senate.