HOUSE BILL 23

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(PRE–FILED) 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

A BILL ENTITLED

AN ACT concerning

Maryland Health Benefit Exchange – Qualified Health Plans – Dental Coverage

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

BY repealing and reenacting, with amendments,
Article – Insurance
Section 31–113(p)(7)(ii), 31–115, and 31–116(a)(2)(ii)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

31–113.

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

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

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

31–115.

(a) The Exchange shall certify:

(1) health benefit plans as qualified health plans;

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

(i) stand–alone dental plans; or

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

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

(i) stand–alone vision plans; or

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

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

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

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

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

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

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

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

(5) be offered by a carrier that:

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

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

1. at a bronze level of coverage;

2. at a silver level of coverage; and

3. at a gold level of coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) claims payment policies and practices;

(ii) financial disclosures;

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

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

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

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

(3) make available information about costs an individual would incur under the individual's health benefit plan for services provided by a participating health care provider, including cost–sharing requirements such as deductibles, co–payments, and coinsurance, in a manner determined by the Exchange.

[(h)**] (G)** (1) Except as provided in paragraphs (2) through (5) of this subsection, the requirements applicable to qualified health plans under this subtitle also

shall apply to qualified dental plans to the extent relevant, whether offered in conjunction with or as an endorsement to qualified health plans or as stand–alone dental plans.

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

(3) A qualified dental plan shall:

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

(ii) include at a minimum:

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

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

(4) (i) The Exchange may determine:

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

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

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

C. as a stand–alone plan; and

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

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

(5) The Exchange may:

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

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

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

(i) in the qualified health plan;

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

(iii) as a stand–alone dental plan.**]**

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

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

(3) A qualified vision plan shall:

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

(ii) include at a minimum:

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

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

(4) (i) The Exchange may determine:

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

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

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

C. as a stand–alone plan; and

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

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

(5) The Exchange may:

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

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

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

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

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

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

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

(i) enrollment;

(ii) essential community providers;

(iii) complaints and grievances involving the Exchange;

(iv) network adequacy;

(v) quality;

(vi) transparency;

(vii) race, ethnicity, language, interpreter need, and cultural competency (RELICC);

(viii) plan service area, including demographics;

(ix) accreditation; and

(x) complying with fair marketing standards developed jointly by the Exchange and the Commissioner.

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

(i) taking corrective action to remedy a violation of or failure to comply with standards for certification; and

(ii) imposing a penalty not exceeding $5,000 for each violation of or failure to comply with standards for certification.

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

(i) the type, severity, and duration of the violation;

(ii) whether the plan or carrier knew or should have known of the violation;

(iii) the extent to which the plan or carrier has a history of violations; and

(iv) whether the plan or carrier corrected the violation as soon as they knew or should have known of the violation.

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

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

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

2. request a hearing.

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

1. before the effective date of the order; or

2. within 10 days after the order is served.

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

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

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

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

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

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

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

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

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

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

31–116.

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

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

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

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

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