HOUSE BILL 806

C3 9lr1643

By: **Delegates Morgan, Szeliga, Arikan, Buckel, Chisholm, Clark, Corderman, M. Fisher, Hornberger, Howard, Jacobs, Kipke, Krebs, Long, Malone, McComas, McKay, Metzgar, Otto, Rose, and Saab**

Introduced and read first time: February 8, 2019
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Maryland Health Benefit Exchange – Individual Exchange – Copper Plans to Lower Rates

FOR the purpose of requiring the Maryland Health Benefit Exchange, contingent on the approval of a waiver application under a certain provision of federal law, to make copper plans available in the Individual Exchange to certain individuals, notwithstanding certain provisions of law; requiring the Exchange, on or before a certain date, to apply to certain officials for a certain waiver in order to implement the provision of copper plans in the State; requiring the Exchange to certify a certain health benefit plan as a copper plan if the plan provides certain coverage, contingent on the approval of a waiver application under a certain provision of federal law; prohibiting the Exchange from requiring a certain health benefit plan to provide certain benefits mandated under certain provisions of law as a condition of certification as a copper plan, notwithstanding certain provisions of law; establishing certain requirements for a certain health benefit plan to be certified as a copper plan; prohibiting a certain health benefit plan from being denied a certification as a copper plan under certain circumstances; prohibiting a managed care organization from being required to offer a copper plan in the Exchange; authorizing the Exchange to deny, suspend, or revoke a certain certification based on a certain finding under certain circumstances; authorizing the Exchange to impose certain remedies and take certain actions under certain circumstances; requiring the Exchange to consider certain factors in determining the amount of a certain penalty; providing that certain penalties available to the Exchange shall be in addition to certain penalties imposed for certain violations; authorizing a carrier to appeal a certain order or decision and request a certain hearing under certain circumstances; providing that certain demand for a hearing stays a certain decision and certain orders under certain circumstances; providing that a certain court has jurisdiction over a certain case and is required to make a certain determination under certain circumstances; requiring that certain certification standards related to network adequacy or network directory

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

accuracy be consistent with certain provisions of law; prohibiting certain benefits from being required in certain copper plans; prohibiting certain carriers from offering certain individual health benefit plans unless the carrier also offers certain copper plans in the Individual Exchange, notwithstanding certain provisions of law; defining a certain term; making conforming changes; providing for the application of certain provisions of this Act; providing for a delayed effective date for certain provisions of this Act; making certain provisions of this Act subject to a certain contingency; and generally relating to the Maryland Health Benefit Exchange and copper plans.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 5–615(c)(2)(iv)
Annotated Code of Maryland
(2015 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1303, 31–101(c–1), (p), (u), and (w), 31–108, 31–113.1(a), 31–115(b)(3) and (5)(vi), and 31–116
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 31–101(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

BY adding to
Article – Insurance
Section 31–101(c–2) and 31–115.1
Annotated Code of Maryland
(2017 Replacement Volume and 2018 Supplement)

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

Article – Health – General

5–615.

(c) (2) The information sheet developed by the Department under this subsection shall be provided by:

(iv) The Maryland Health Benefit Exchange, in accordance with **[**§ 31–108(g)**]** **§ 31–108(H)** of the Insurance Article.

Article – Insurance

31–101.

(a) In this title the following words have the meanings indicated.

(c–1) "Consolidated Services Center" or "CSC" means the consumer assistance call center established in accordance with the requirement to operate a toll–free hotline under § 1311(d)(4) of the Affordable Care Act and **[**§ 31–108(b)(5)**] § 31–108(C)(5)** of this title.

(C–2) "COPPER PLAN" MEANS AN INDIVIDUAL HEALTH BENEFIT PLAN CERTIFIED BY THE EXCHANGE TO MEET THE CRITERIA FOR CERTIFICATION DESCRIBED IN § 31–115.1 OF THIS TITLE.

(p) "Qualified dental plan" means a dental plan certified by the Exchange that provides limited scope dental benefits, as described in **[**§ 31–108(b)(2)**] § 31–108(C)(2)** of this title.

(u) "Qualified vision plan" means a vision plan certified by the Exchange that provides limited scope vision benefits, as described in **[**§ 31–108(b)(3)**] § 31–108(C)(3)** of this title.

(w) "SHOP Exchange" means the Small Business Health Options Program authorized under **[**§ 31–108(b)(13)**] § 31–108(C)(13)** of this title.

31–108.

(a) On or before January 1, 2014, the functions and operations of the Exchange shall include at a minimum all functions required by § 1311(d)(4) of the Affordable Care Act.

(B) (1) CONTINGENT ON THE APPROVAL OF A WAIVER UNDER § 1132 OF THE AFFORDABLE CARE ACT, THE EXCHANGE SHALL MAKE COPPER PLANS AVAILABLE IN THE INDIVIDUAL EXCHANGE TO QUALIFIED INDIVIDUALS.

(2) ON OR BEFORE OCTOBER 1, 2019, THE EXCHANGE SHALL APPLY TO THE UNITED STATES SECRETARY OF HEALTH AND HUMAN SERVICES AND TO THE UNITED STATES SECRETARY OF THE TREASURY FOR A WAIVER UNDER § 1332 OF THE AFFORDABLE CARE ACT OF APPLICABLE PROVISIONS OF THE AFFORDABLE CARE ACT IN ORDER TO IMPLEMENT THE PROVISION OF COPPER PLANS IN THE STATE.

[(b)**] (C)** On or before January 1, 2014, in compliance with § 1311(d)(4) of the Affordable Care Act, the Exchange shall:

(1) make qualified plans available to qualified individuals and qualified employers;

(2) allow a carrier to offer a qualified dental plan through the Exchange that provides limited scope dental benefits that meet the requirements of § 9832(c)(2)(A) of the Internal Revenue Code, either separately, in conjunction with, or as an endorsement to a qualified health plan, provided that the qualified health plan provides pediatric dental benefits that meet the requirements of § 1302(b)(1)(J) of the Affordable Care Act;

(3) allow a carrier to offer a qualified vision plan through the Exchange that provides limited scope vision benefits that meet the requirements of § 9832(c)(2)(A) of the Internal Revenue Code, either separately, in conjunction with, or as an endorsement to a qualified health plan, provided that the qualified health plan provides pediatric vision benefits that meet the requirements of § 1302(b)(1)(J) of the Affordable Care Act;

(4) consistent with the guidelines developed by the Secretary under § 1311(c) of the Affordable Care Act, implement procedures for the certification, recertification, and decertification of:

(i) health benefit plans as qualified health plans;

(ii) dental plans as qualified dental plans; and

(iii) vision plans as qualified vision plans;

(5) provide for the operation of a toll–free telephone hotline to respond to requests for assistance;

(6) provide for initial, annual, and special enrollment periods, in accordance with guidelines adopted by the Secretary under § 1311(c)(6) of the Affordable Care Act;

(7) maintain a Web site through which enrollees and prospective enrollees of qualified plans may obtain standardized comparative information on qualified health plans, qualified dental plans, and qualified vision plans;

(8) with respect to each qualified plan offered through the Exchange:

(i) assign a rating to each qualified plan in accordance with the criteria developed by the Secretary under § 1311(c)(3) of the Affordable Care Act and any additional criteria that may be applicable under the laws of the State and regulations adopted by the Exchange under this title; and

(ii) determine each qualified health plan's coverage level in accordance with regulations adopted by the Secretary under § 1302(d)(2)(A) of the Affordable Care Act and any additional regulations adopted by the Exchange under this

title;

(9) (i) present qualified plan options offered by the Exchange in a standardized format, including the use of the uniform outline of coverage established under § 2715 of the federal Public Health Service Act; and

(ii) to the extent necessary, modify the standardized format to accommodate differences in qualified health plan, qualified dental plan, and qualified vision plan options;

(10) in accordance with § 1413 of the Affordable Care Act, provide information and make determinations regarding eligibility for the following programs:

(i) the Maryland Medical Assistance Program under Title XIX of the Social Security Act;

(ii) the Maryland Children's Health Program under Title XXI of the Social Security Act; and

(iii) any applicable State or local public health insurance program;

(11) facilitate the enrollment of any individual who the Exchange determines is eligible for a program described in item (10) of this subsection;

(12) establish and make available by electronic means a calculator to determine the actual cost of coverage of a qualified plan offered by the Exchange after application of any premium tax credit under § 36B of the Internal Revenue Code and any cost–sharing reduction under § 1402 of the Affordable Care Act;

(13) in accordance with this title, establish a SHOP Exchange through which qualified employers may access coverage for their employees at specified coverage levels and meet standards for the federal qualified employer tax credit;

(14) implement a certification process for individuals exempt from the individual responsibility requirement and penalty under § 5000A of the Internal Revenue Code on the grounds that:

(i) no affordable qualified health plan that covers the individual is available through the Exchange or the individual's employer; or

(ii) the individual meets other requirements under the Affordable Care Act that make the individual eligible for the exemption;

(15) implement a process for transfer to the United States Secretary of the Treasury the name and taxpayer identification number of each individual who:

(i) is certified as exempt from the individual responsibility

requirement;

(ii) is employed but determined eligible for the premium tax credit on the grounds that:

1. the individual's employer does not provide minimum essential coverage; or

2. the employer's coverage is determined to be unaffordable for the individual or does not provide the requisite minimum actuarial value;

(iii) notifies the Exchange under § 1411(b)(4) of the Affordable Care Act that the individual has changed employers; or

(iv) ceases coverage under a qualified health plan during the plan year, together with the date coverage ceased;

(16) provide notice to employers of employees who cease coverage under a qualified health plan during a plan year, together with the date coverage ceased;

(17) conduct processes required by the Secretary and the United States Secretary of the Treasury to determine eligibility for premium tax credits, reduced cost–sharing, and individual responsibility requirement exemptions;

(18) establish a Navigator Program in accordance with § 1311(i) of the Affordable Care Act and this title;

(19) carry out a plan to provide appropriate assistance for consumers seeking to purchase products through the Exchange, including the implementation of:

(i) a navigator program for the SHOP Exchange and a navigator program for the Individual Exchange; and

(ii) the toll–free hotline required under item (5) of this subsection; and

(20) carry out a public relations and advertising campaign to promote the Exchange.

[(c)**] (D)** (1) In carrying out the functions under subsections (a) and **[**(b)**] (C)** of this section, the Exchange shall comply with § 508 of the federal Rehabilitation Act of 1973 and any regulations adopted under § 508 of the Act.

(2) The obligation for the Exchange to comply with § 508 of the federal Rehabilitation Act of 1973 does not affect any other requirements relating to accessibility for persons with disabilities to which the Exchange may be subject under the federal Americans with Disabilities Act of 1990.

[(d)**] (E)** If an individual enrolls in another type of minimum essential coverage, neither the Exchange nor a carrier offering qualified health plans through the Exchange may charge the individual a fee or penalty for termination of coverage on the grounds that:

(1) the individual has become newly eligible for that coverage; or

(2) the individual's employer–sponsored coverage has become affordable under the standards of § 36B(c)(2)(C) of the Internal Revenue Code.

[(e)**] (F)** The Exchange, through the advisory committees established under § 31–106(g) of this title or through other means, shall consult with and consider the recommendations of the stakeholders represented on the advisory committees in the exercise of its duties under this title.

[(f)**] (G)** The Exchange may not make available:

(1) any health benefit plan that is not a qualified health plan;

(2) any dental plan that is not a qualified dental plan; or

(3) any vision plan that is not a qualified vision plan.

[(g)**] (H)** The Exchange shall provide the advance directive information sheet developed under § 5–615 of the Health – General Article:

(1) in the Exchange's consumer publications;

(2) on the Exchange's Web site; and

(3) at the request of an applicant.

31–113.1.

(a) In accordance with the requirement to operate a toll–free hotline under § 1311(d)(4) of the Affordable Care Act and **[**§ 31–108(b)(5)**] § 31–108(C)(5)** of this title, the Exchange may establish a Consolidated Services Center.

31–115.

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

(3) except as provided in subsection (e) 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)**] § 31–108(C)(8)(II)** of this title;

(5) be offered by a carrier that:

(vi) does not charge any cancellation fees or penalties in violation of **[**§ 31–108(d)**] § 31–108(E)** of this title; and

31–115.1.

(A) (1) CONTINGENT ON THE APPROVAL OF A WAVIER UNDER § 1332 OF THE AFFORDABLE CARE ACT, THE EXCHANGE SHALL CERTIFY AN INDIVIDUAL HEALTH BENEFIT PLAN AS A COPPER PLAN IF THE PLAN PROVIDES COVERAGE FOR:

(I) THE ESSENTIAL HEALTH BENEFITS DESCRIBED UNDER § 1302(B) OF THE AFFORDABLE CARE ACT; AND

(II) INDIVIDUALS OF ANY AGE.

(2) THE EXCHANGE MAY NOT REQUIRE, AS A CONDITION FOR CERTIFICATION AS A COPPER PLAN, AN INDIVIDUAL HEALTH BENEFIT PLAN TO PROVIDE COVERAGE FOR BENEFITS MANDATED UNDER THE HEALTH – GENERAL ARTICLE OR THIS ARTICLE THAT ARE NOT DESCRIBED UNDER § 1302(B) OF THE AFFORDABLE CARE ACT.

(B) TO BE CERTIFIED AS A COPPER PLAN, A HEALTH BENEFIT PLAN SHALL:

(1) BE OFFERED BY A CARRIER THAT:

(I) IS LICENSED AND IN GOOD STANDING TO OFFER HEALTH INSURANCE COVERAGE IN THE STATE; AND

(II) OFFERS QUALIFIED HEALTH BENEFIT PLANS IN THE INDIVIDUAL EXCHANGE;

(2) OBTAIN PRIOR APPROVAL OF PREMIUM RATES AND DEDUCTIBLES FROM THE COMMISSIONER;

(3) MEET ANY COST–SHARING REQUIREMENTS ESTABLISHED BY THE COMMISSIONER;

(4) (I) SUBMIT TO THE EXCHANGE NOTICE OF ANY PREMIUM INCREASE BEFORE IMPLEMENTATION OF THE INCREASE; AND

(II) POST THE INCREASE ON THE WEBSITE OF THE CARRIER OF THE PLAN;

(5) SUBMIT TO THE EXCHANGE AND THE COMMISSIONER, AND MAKE AVAILABLE TO THE PUBLIC, IN PLAIN LANGUAGE, 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; AND

(V) ANY OTHER INFORMATION AS DETERMINED APPROPRIATE BY THE EXCHANGE AND THE COMMISSIONER;

(6) 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, COPAYMENTS, AND COINSURANCE, IN A MANNER DETERMINED BY THE EXCHANGE;

(7) COMPLY WITH ANY REGULATIONS ESTABLISHED BY THE EXCHANGE THAT PROHIBIT:

(I) CHARGES FOR CANCELLATION FEES; OR

(II) OTHER PENALTIES; AND

(8) MEET THE REQUIREMENTS FOR CERTIFICATION AND COMPLY WITH ANY OTHER REQUIREMENT ESTABLISHED UNDER REGULATIONS ADOPTED BY THE EXCHANGE OR THE COMMISSIONER, INCLUDING:

(I) TRANSITION OF CARE LANGUAGE IN CONTRACTS AS DETERMINED APPROPRIATE TO ENSURE CARE CONTINUITY AND REDUCE DUPLICATION AND COSTS OF CARE;

(II) CRITERIA THAT ENCOURAGE AND SUPPORT HEALTH BENEFIT PLANS IN FACILITATING CROSS–BORDER ENROLLMENT; AND

(III) DEMONSTRATING COMPLIANCE WITH THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUALITY ACT OF 2008.

(C) A HEALTH BENEFIT PLAN MAY NOT BE DENIED CERTIFICATION AS A COPPER PLAN:

(1) SOLELY ON THE GROUNDS THAT THE HEALTH BENEFIT PLAN IS A FEE–FOR–SERVICE PLAN; OR

(2) THROUGH THE IMPOSITION OF PREMIUM PRICE CONTROLS BY THE EXCHANGE.

(D) A MANAGED CARE ORGANIZATION MAY NOT BE REQUIRED TO OFFER A COPPER PLAN IN THE EXCHANGE.

(E) (1) SUBJECT TO THE CONTESTED CASE HEARING PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE AND SUBSECTION (C) OF THIS SECTION, THE EXCHANGE MAY DENY CERTIFICATION OF A HEALTH BENEFIT PLAN AS A COPPER PLAN, OR SUSPEND OR REVOKE THE CERTIFICATION AS A COPPER PLAN, BASED ON A FINDING THAT THE HEALTH BENEFIT PLAN DOES NOT SATISFY REQUIREMENTS OR HAS OTHERWISE VIOLATED STANDARDS FOR CERTIFICATION THAT ARE:

(I) ESTABLISHED UNDER THE REGULATIONS ADOPTED BY THE EXCHANGE TO CARRY OUT THIS TITLE; 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 THE PLAN OR CARRIER 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 ANY OTHER VIOLATION UNDER ANY OTHER STATE OR FEDERAL LAW.

(6) (I) A CARRIER, UNDER TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE AND THE EXCHANGE'S APPEALS AND GRIEVANCE PROCESS, MAY:

1. APPEAL AN ORDER OR A DECISION ISSUED BY THE EXCHANGE UNDER THIS SECTION; AND

2. REQUEST A HEARING.

(II) A DEMAND FOR A HEARING STAYS A DECISION OR AN ORDER OF THE EXCHANGE PENDING THE HEARING, AND A FINAL ORDER OF THE EXCHANGE RESULTING FROM THE HEARING, 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.

(F) ANY CERTIFICATION STANDARDS ESTABLISHED UNDER SUBSECTION (B) OF THIS SECTION RELATED TO NETWORK ADEQUACY OR NETWORK DIRECTORY ACCURACY SHALL BE CONSISTENT WITH THE PROVISIONS OF § 15–112 OF THIS ARTICLE.

31–116.

(a) **[**The**]** **EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, THE** essential health benefits required under § 1302(a) of the Affordable Care Act:

(1) shall be the benefits in the State benchmark plan, selected in accordance with this section; and

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

(i) subject to subsection **[**(f)**]** **(G)** of this section, all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange; and

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

(B) BENEFITS MANDATED BY THE STATE BENCHMARK PLAN, OR OTHERWISE MANDATED BY STATE LAW, THAT ARE NOT ESSENTIAL HEALTH

BENEFITS AS DESCRIBED IN § 1302(B) OF THE AFFORDABLE CARE ACT MAY NOT BE REQUIRED IN COPPER PLANS OFFERED IN THE EXCHANGE.

[(b)**] (C)** In selecting the State benchmark plan, the State seeks to:

(1) balance comprehensiveness of benefits with plan affordability to promote optimal access to care for all residents of the State;

(2) accommodate to the extent practicable the diverse health needs across the diverse populations within the State; and

(3) ensure the benefit of input from the stakeholders and the public.

[(c)**] (D)** (1) The State benchmark plan, for 2017 and until the Secretary requires that a new benchmark plan be selected, shall be selected by the Commissioner, in consultation with the Exchange:

(i) based on enrollment for the first quarter of 2014, from the largest health plan by enrollment in any of the three largest small group insurance products by enrollment in the State's small group market; and

(ii) through an open, transparent, and inclusive process, which shall include at least one public hearing and an opportunity for public comment.

(2) In selecting the State benchmark plan, the Commissioner, in consultation with the Exchange, may exclude, consistent with applicable federal regulations:

(i) a health care service, benefit, coverage, or reimbursement for covered health care services that is required under this article or the Health – General Article to be provided or offered in a health benefit plan that is issued or delivered in the State by a carrier; or

(ii) reimbursement required by statute, by a health benefit plan for a service when that service is performed by a health care provider who is licensed under the Health Occupations Article and whose scope of practice includes that service.

[(d)**] (E)** In selecting the State benchmark plan, the Commissioner, in consultation with the Exchange, shall:

(1) select a plan that complies with all requirements of this title and the Affordable Care Act, the federal Mental Health Parity and Addiction Equity Act of 2008, and any other federal laws, regulations, policies, or guidance applicable to state benchmark plans and essential health benefits;

(2) for individual health benefit plans, require that the health benefit plans

include any mandated benefits that were required in individual health benefit plans before December 31, 2011, if the benefits are not included in the selected benchmark plan; and

(3) if the selected state benchmark plan does not comply with any federal benefit requirement, supplement the required benefits, to the extent permitted by federal law, with benefits similar to those chosen by the Maryland Health Care Reform Coordinating Council in 2012.

[(e)**] (F)** Within 10 days after selecting the State benchmark plan, the Commissioner shall submit a report, in accordance with § 2–1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee advising the Committees of the Commissioner's selection and the process used in making the selection.

[(f)**] (G)** (1) (i) In this subsection the following words have the meanings indicated.

(ii) "Exchange certified stand–alone dental plan" means a stand–alone dental plan that has been certified by the Exchange for sale outside the Exchange under § 31–115 of this title.

(iii) "Purchaser" means:

1. with respect to an individual health benefit plan, the individual applying for coverage; and

2. with respect to a small group health benefit plan, the employer applying for coverage.

(2) To the extent permitted under federal law, a health benefit plan offered outside the Exchange to individuals or small employers is not required to provide pediatric dental essential health benefits if:

(i) at the time the carrier offers the health benefit plan, the carrier discloses in a form approved by the Commissioner that the health benefit plan does not provide the full range of pediatric dental essential health benefits; and

(ii) the carrier is reasonably assured that the enrollee has obtained full coverage of pediatric dental essential health benefits through an Exchange certified stand–alone dental plan.

(3) A carrier shall:

(i) disclose to a potential purchaser, for those health benefit plans sold outside the Exchange that do not provide the pediatric dental essential health benefits, that the plan does not include the pediatric dental essential health benefits; and

(ii) for those health benefit plans sold outside the Exchange that do not provide the pediatric dental essential health benefits, include on its application completed by a purchaser the following:

"Have you obtained stand–alone dental coverage that provides pediatric dental essential health benefits through a Maryland Health Benefit Exchange certified stand–alone dental plan offered outside the Maryland Health Benefit Exchange?

Yes ____ No ____

If you answered "Yes", please provide the name of the company issuing the stand–alone dental coverage.

If you answered "No", you will be issued a health benefit plan that includes the pediatric dental essential health benefits."

(4) The Administration shall place on its Web site a list of the Exchange certified stand–alone dental plans in the State.

SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–1303.

(a) In addition to any other requirements under this article, a carrier that offers individual health benefit plans in this State shall:

(1) have demonstrated the capacity to administer the individual health benefit plans, including adequate numbers and types of administrative staff;

(2) have a satisfactory grievance procedure and ability to respond to calls, questions, and complaints from enrollees or insureds; and

(3) design policies to help ensure that enrollees or insureds have adequate access to providers of health care.

(b) (1) Except as provided in this subsection and § 31–110(f) of this article, a carrier may not offer individual health benefit plans in the State unless the carrier also offers**:**

(I) qualified health plans, as defined in § 31–101 of this article, in the Individual Exchange of the Maryland Health Benefit Exchange in compliance with the requirements of Title 31 of this article**; AND**

(II) NOTWITHSTANDING ANY OTHER STATE OR FEDERAL LAW, COPPER PLANS, AS DEFINED IN § 31–101 OF THIS ARTICLE, IN THE INDIVIDUAL EXCHANGE OF THE MARYLAND HEALTH BENEFIT EXCHANGE IN COMPLIANCE WITH THE REQUIREMENTS OF TITLE 31 OF THIS ARTICLE.

(2) A carrier is exempt from the requirement in paragraph (1) of this subsection if:

(i) 1. the reported total aggregate annual earned premium from all individual health benefit plans in the State for the carrier and any other carriers in the same insurance holding company system, as defined in § 7–101 of this article, is less than $10,000,000; or

2. the only individual health benefit plans that the carrier offers in the State are student health plans as defined in 45 C.F.R. § 147.145;

(ii) the Commissioner determines that the carrier complies with the procedures established under paragraph (3) of this subsection; and

(iii) when the carrier ceases to meet the requirements for the exemption, the carrier provides to the Commissioner immediate notice and its plan for complying with the requirement in paragraph (1) of this subsection.

(3) The Commissioner shall establish procedures for a carrier to submit evidence each year that the carrier meets the requirements necessary to qualify for an exemption under paragraph (2) of this subsection.

(4) Notwithstanding the exemption provided in paragraph (2) of this subsection, any carrier that offers a catastrophic plan, as defined by the Affordable Care Act, in the State also must offer at least one catastrophic plan in the Maryland Health Benefit Exchange.

(5) Notwithstanding the exemption provided in paragraph (2) of this subsection, the Commissioner, in consultation with the Maryland Health Benefit Exchange:

(i) may assess the impact of the exemption provided in paragraph (2) of this subsection and, based on that assessment, alter the limit on the amount of annual premiums that may not be exceeded to qualify for the exemption; and

(ii) shall make any change in the exemption requirement by regulation.

SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1 of the year immediately following the date notice is received by the Department of Legislative Services in accordance with Section 4 of this Act.

SECTION 4. AND BE IT FURTHER ENACTED, That Sections 2 and 3 of this Act shall take effect contingent on the State's receipt of a § 1332 waiver under the Affordable Care Act to implement the provision of copper plans in the State. If a waiver is received on or before July 1, 2020, Sections 2 and 3 of this Act shall take effect on January 1 of the year immediately following the date notice of the letter is received by the Department of Legislative Services in accordance with this section. If the State does not receive a waiver under § 1332 of the Affordable Care Act on or before July 1, 2020, Sections 3 and 4 of this Act, with no further action required by the General Assembly, shall be null and void. The Maryland Health Benefit Exchange, within 5 days after receiving approval of a § 1332 waiver under the Affordable Care Act, shall forward a copy of the letter to the Department of Legislative Services, 90 State Circle, Annapolis, Maryland 21401.

SECTION 5. AND BE IT FURTHER ENACTED, That, except as provided in Section 4 of this Act, this Act shall take effect June 1, 2019.