SENATE BILL 756

C3 9lr2704
SB 617/07 – FIN & B&T

By: **Senator Pipkin**
Introduced and read first time: February 6, 2009
Assigned to: Finance and Budget and Taxation

A BILL ENTITLED

AN ACT concerning

Consumer Health Open Insurance Coverage Act of 2009

FOR the purpose of prohibiting the Department of Health and Mental Hygiene, on or after a certain date, from applying for certain waivers or expanding a certain program except under certain circumstances; requiring the Secretary of Health and Mental Hygiene to provide health benefits for certain program recipients through the Maryland Health Insurance Exchange on or after a certain date; requiring the Department, in consultation with the Maryland Health Care Commission, to develop a certain system; requiring the Secretary to apply for a certain federal waiver; establishing the Maryland Health Insurance Exchange in the Maryland Health Care Commission; requiring the Commission to oversee the administration of the Exchange; requiring the Commission to administer a Maryland Health Insurance Coverage Verifications System; requiring the Commission to appoint a director of the Exchange, with the advice and consent of the Governor; providing that the director of the Exchange is an employee of the Commission; providing for the duties of the director of the Exchange; authorizing the Exchange to enter into certain contracts subject to approval by the Commission; requiring that certain expenses of the Exchange be paid only from certain funds; providing that certain accounts of the Exchange are special fund accounts and not part of the General Fund of the State; exempting the Exchange from certain requirements; providing for the certification of participating plans in the Exchange for a certain period of time; requiring participating plans to give certain notice to the Exchange under certain circumstances; providing that an individual must meet certain eligibility requirements to participate in the Exchange; requiring participating plans in the Exchange to make certain data available; requiring certain employers to file a certain annual form with the Commission; requiring the Commission to transmit copies of certain forms to certain departments or agencies; renaming the Maryland Small Employer Health Reinsurance Pool to be the Maryland Health Insurance Risk Transfer Pool; requiring the Pool to be operational on or after a certain date; authorizing the Pool to enter into a certain agreement with

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

a self–funded health benefit plan; requiring that a carrier that issues a health benefit plan in the State participate in the Pool; requiring the Board of the Pool to establish a certain methodology to determine certain premium rates; providing that the Pool is exempt from certain provisions of law; providing for the establishment of a certain formula to make certain assessments on reinsuring carriers; requiring the Board of the Pool to make a certain evaluation; requiring the Commission to adopt certain regulations and procedures; requiring the Commission to make certain recommendations; requiring the Commission to comply with certain provisions of law in carrying out certain duties; providing for application and enrollment in the Exchange; providing that certain insurance producers may apply to the Exchange on behalf of certain individuals; requiring certain insurance producers to be paid a certain commission under certain circumstances; providing that certain membership organizations may apply to the Exchange on behalf of certain individuals; requiring certain membership organizations to be paid certain consideration under certain circumstances; requiring the Exchange to verify the eligibility of applicants; requiring that the Exchange give eligible applicants the opportunity to elect coverage under certain plans under certain circumstances; providing for the termination of coverage of individuals in the Exchange under certain circumstances; authorizing participating plans to charge a certain premium under certain circumstances; authorizing participating plans to impose a preexisting condition provision under certain circumstances; providing that an individual may be deemed to have a certain amount of creditable coverage under certain circumstances; requiring the Exchange to provide for the election of coverage outside of regular open seasons under certain circumstances; providing that coverage of a participating individual may not be canceled or not renewed under certain circumstances; providing that a participating individual who is not a resident of the State shall remain an eligible individual for a certain period of time under certain circumstances; authorizing certain employers to apply to the Exchange to sponsor a participating employer–subsidized plan; requiring certain employers to enter into a certain agreement with the Exchange; requiring the Secretary of Budget and Management to enter into a certain contract with the Exchange; prohibiting the Maryland Health Insurance Plan from accepting any new enrollees after a certain date; providing that individuals enrolled in the Maryland Health Insurance Plan after a certain date may continue coverage under the Plan only under certain circumstances; requiring that coverage of all enrollees in the Maryland Health Insurance Plan terminate after a certain date except under certain circumstances; prohibiting certain carriers from issuing or renewing a group health benefit plan to certain employers except under certain circumstances after a certain date; requiring certain carriers to establish certain community rates for health benefit plans offered through the Exchange; repealing a certain reporting requirement; prohibiting a carrier from issuing or renewing certain individual health benefit plans other than through the Exchange except under certain circumstances; prohibiting a carrier from offering a health benefit plan through the Exchange unless the Maryland Insurance Commissioner has made a certain certification of the plan; requiring that the certification of certain plans be exempt from certain provisions of law;

providing for the duration of a certain certification; requiring certain carriers to offer a certain benefit; prohibiting a carrier from conditioning the sale of a certain benefit on participation of certain employees in certain programs or activities; establishing a certain tax credit for certain individuals; repealing certain provisions of law relating to the purpose and operation of the Maryland Health Insurance Plan; repealing certain provisions of law relating to the regulation of small group market health insurance; requiring the Maryland Insurance Administration to submit a certain notice to the federal government by a certain date; providing for the effective dates of this Act; making the provisions of this Act severable; defining certain terms; repealing and altering certain definitions; and generally relating to health insurance coverage and regulation.

BY adding to
Article – Health – General
Section 15–146, 19–103(c)(14), and 19–108; 19–142 through 19–151 to be under the new part "Part IV. Maryland Health Insurance Exchange"; and 19–154 to be under the new part "Part V. Maryland Health Insurance Coverage Verifications System"
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–103(c)(6), (12), and (13)
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing
Article – Health – General
Section 19–108
Annotated Code of Maryland
(2005 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 14–502, 14–508, 15–1201, 15–1202, 15–1204, 15–1205, 15–1208.1, 15–1216 through 15–1221, 15–1309, and 15–1408
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1222 through 15–1224
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY repealing

Article – Insurance
Section 15–1207, 15–1303(c), and 15–1313
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY adding to
Article – Insurance
Section 15–1207
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

BY repealing and reenacting, with amendments,
Article – State Personnel and Pensions
Section 2–502(a)
Annotated Code of Maryland
(2004 Replacement Volume and 2008 Supplement)

BY adding to
Article – Tax – General
Section 10–728
Annotated Code of Maryland
(2004 Replacement Volume and 2008 Supplement)

BY repealing
Article – Insurance
Section 15–1206, 15–1208, 15–1209 through 15–1211, 15–1213, and 15–1215
Annotated Code of Maryland
(2006 Replacement Volume and 2008 Supplement)

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

Article – Health – General

15–146.

(A) IN THIS SECTION, "EXCHANGE" MEANS THE MARYLAND HEALTH INSURANCE EXCHANGE ESTABLISHED UNDER TITLE 19, SUBTITLE 1, PART IV OF THIS ARTICLE.

(B) ON OR AFTER JULY 1, 2010, THE DEPARTMENT MAY NOT APPLY FOR A FEDERAL WAIVER FOR THE PROGRAM OR EXPAND POPULATIONS COVERED UNDER THE PROGRAM UNLESS THE WAIVER OR EXPANSION IS PROVIDED THROUGH THE EXCHANGE.

(C) (1) ON OR AFTER THE FIRST DAY OF THE PLAN YEAR FOLLOWING THE FIRST OPEN SEASON CONDUCTED BY THE EXCHANGE AS PERMITTED BY

FEDERAL LAW OR WAIVER, THE SECRETARY SHALL PROVIDE HEALTH BENEFITS UNDER THE PROGRAM THROUGH THE EXCHANGE FOR PROGRAM RECIPIENTS THAT ARE UNDER 65 YEARS OF AGE AND THAT DO NOT HAVE A PHYSICAL DISABILITY.

(2) (I) THE DEPARTMENT, IN CONSULTATION WITH THE MARYLAND HEALTH CARE COMMISSION, SHALL DEVELOP A SYSTEM TO CHARGE APPROPRIATE PREMIUMS FOR PROGRAM RECIPIENTS RECEIVING HEALTH BENEFITS IN ACCORDANCE WITH THIS SUBSECTION.

(II) THE SYSTEM REQUIRED UNDER THIS PARAGRAPH SHALL CHARGE PREMIUMS ON A SLIDING SCALE BASED ON THE INCOME OF THE PROGRAM RECIPIENT.

(3) THE SECRETARY SHALL APPLY FOR ANY FEDERAL WAIVER NECESSARY TO IMPLEMENT THIS SUBSECTION.

19–103.

(c) The purpose of the Commission is to:

(6) In accordance with **[**Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan**]** **PART IV OF THIS SUBTITLE, OVERSEE THE ADMINISTRATION OF THE MARYLAND HEALTH INSURANCE EXCHANGE**;

(12) Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; **[**and**]**

(13) Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Health Services Cost Review Commission**; AND**

(14) IN ACCORDANCE WITH PART V OF THIS SUBTITLE, ADMINISTER A MARYLAND HEALTH INSURANCE COVERAGE VERIFICATIONS SYSTEM.

[19–108.

(a) In addition to the duties set forth elsewhere in this subtitle, the Commission:

(1) Shall adopt regulations specifying the Comprehensive Standard Health Benefit Plan to apply under Title 15, Subtitle 12 of the Insurance Article; and

(2) On or before March 1, 2008, in consultation with the Department, shall propose regulations to:

(i) Specify the components of wellness benefits, offered under Title 15, Subtitle 12 of the Insurance Article, that include incentives or differential cost–sharing for employees based on their participation in wellness activities; and

(ii) Require small employers receiving a subsidy of small employer health benefit plan premium contributions under Title 15, Subtitle 12A of the Insurance Article to agree to purchase a wellness benefit.

(b) In carrying out its duties under this section, the Commission shall comply with the provisions of § 15–1207 and Title 15, Subtitle 12A of the Insurance Article.**]**

19–108.

(A) IN ADDITION TO THE DUTIES SET FORTH ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL:

(1) ADOPT, IN ACCORDANCE WITH TITLE 10 OF THE STATE GOVERNMENT ARTICLE, PROCEDURES FOR RESOLVING DISPUTES RELATING TO THE OPERATION OF THE MARYLAND HEALTH INSURANCE EXCHANGE ESTABLISHED UNDER PART IV OF THIS SUBTITLE, INCLUDING DISPUTES WITH RESPECT TO:

(I) THE ELIGIBILITY OF AN INDIVIDUAL TO PARTICIPATE IN THE EXCHANGE;

(II) THE IMPOSITION OF A COVERAGE SURCHARGE ON A PARTICIPATING INDIVIDUAL BY A PARTICIPATING PLAN;

(III) THE IMPOSITION OF A PREEXISTING CONDITION PROVISION ON A PARTICIPATING INDIVIDUAL BY A PARTICIPATING PLAN; AND

(IV) ANY OTHER MATTERS RELATING TO THE EXCHANGE;

(2) MAKE RECOMMENDATIONS TO THE GENERAL ASSEMBLY ON THE ALLOWABLE RATE VARIATIONS AUTHORIZED UNDER § 15–1205 OF THE INSURANCE ARTICLE;

(3) PROVIDE FOR OTHER MATTERS NECESSARY TO CARRY OUT THE COMMISSION'S DUTIES UNDER PART IV OF THIS SUBTITLE; AND

(4) ADOPT REGULATIONS TO ADMINISTER PARTS IV AND V OF THIS SUBTITLE.

(B) IN CARRYING OUT ITS DUTIES UNDER THIS SECTION, THE COMMISSION SHALL COMPLY WITH THE PROVISIONS OF PARTS IV AND V OF THIS SUBTITLE.

PART IV. MARYLAND HEALTH INSURANCE EXCHANGE.

19–142.

(A) IN THIS PART THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "ADMINISTRATOR" HAS THE MEANING STATED IN THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1002.

(C) "APPLICANT" MEANS AN INDIVIDUAL SEEKING TO PARTICIPATE IN THE MARYLAND HEALTH INSURANCE EXCHANGE.

(D) "CARRIER" MEANS:

(1) AN AUTHORIZED INSURER THAT PROVIDES HEALTH INSURANCE IN THE STATE;

(2) A NONPROFIT HEALTH SERVICE PLAN THAT IS LICENSED TO OPERATE IN THE STATE; OR

(3) A HEALTH MAINTENANCE ORGANIZATION THAT IS LICENSED TO OPERATE IN THE STATE.

(E) "COMMISSIONER" MEANS THE MARYLAND INSURANCE COMMISSIONER.

(F) "CREDITABLE COVERAGE" HAS THE MEANING STATED IN § 15–1301 OF THE INSURANCE ARTICLE.

(G) "ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL WHO MEETS THE REQUIREMENTS OF § 19–147 OF THIS SUBTITLE.

(H) "EMPLOYER" MEANS ANY PERSON THAT:

(1) EMPLOYS ONE OR MORE PERSONS IN THE STATE; AND

(2) FILES PAYROLL TAX INFORMATION ON THOSE PERSONS.

(I) "EXCHANGE" MEANS THE MARYLAND HEALTH INSURANCE EXCHANGE ESTABLISHED BY § 19–143 OF THIS SUBTITLE.

(J) "EXCHANGE DIRECTOR" MEANS THE DIRECTOR OF THE EXCHANGE.

(K) "FEDERAL HEALTH COVERAGE TAX CREDIT ELIGIBLE INDIVIDUAL" MEANS AN INDIVIDUAL WHO IS ELIGIBLE FOR BENEFITS UNDER 26 U.S.C. § 35(C).

(L) "INSURANCE PRODUCER" MEANS A PERSON LICENSED TO SELL, SOLICIT, OR NEGOTIATE INSURANCE IN THE STATE.

(M) "PARTICIPATING EMPLOYER–SUBSIDIZED PLAN" MEANS A GROUP HEALTH PLAN:

(1) THAT MEETS THE DEFINITION OF "GROUP HEALTH PLAN" IN THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1191B;

(2) THAT IS SPONSORED BY AN EMPLOYER; AND

(3) IN WHICH THE PLAN SPONSOR HAS ENTERED INTO AN AGREEMENT WITH THE EXCHANGE TO OFFER AND ADMINISTER HEALTH INSURANCE BENEFITS FOR ENROLLEES IN THE PLAN.

(N) "PARTICIPATING INDIVIDUAL" MEANS A PERSON THAT:

(1) SEEKS TO OBTAIN COVERAGE UNDER BENEFIT PLANS OFFERED THROUGH THE EXCHANGE; AND

(2) THE EXCHANGE HAS DETERMINED TO BE AN ELIGIBLE INDIVIDUAL.

(O) "PARTICIPATING PLAN" MEANS A HEALTH BENEFIT PLAN OFFERED THROUGH THE EXCHANGE.

(P) "PLAN YEAR" MEANS THE PERIOD OF TIME DURING WHICH THE INSURED IS COVERED UNDER A HEALTH BENEFIT PLAN, AS STIPULATED IN THE CONTRACT GOVERNING THE PLAN.

(Q) (1) "PREEXISTING CONDITION" MEANS A MEDICAL CONDITION THAT WAS PRESENT BEFORE THE EFFECTIVE DATE OF COVERAGE, WHETHER OR NOT ANY MEDICAL ADVICE OR TREATMENT WAS RECOMMENDED OR RECEIVED REGARDING THE CONDITION.

(2) "PREEXISTING CONDITION" DOES NOT INCLUDE:

(I) PREGNANCY; OR

(II) GENETIC INFORMATION, IN THE ABSENCE OF A DIAGNOSIS OF A CONDITION RELATED TO THE INFORMATION.

(R) "PREEXISTING CONDITION PROVISION" MEANS A PROVISION IN A HEALTH BENEFIT PLAN THAT DENIES, EXCLUDES, OR LIMITS BENEFITS FOR AN ENROLLEE FOR EXPENSES OR SERVICES RELATING TO A PREEXISTING CONDITION.

(S) "QUALIFIED DEPENDENT" MEANS AN INDIVIDUAL WHO QUALIFIES AS A DEPENDENT AS DEFINED IN 26 U.S.C. § 152.

(T) "RATE" MEANS THE PREMIUMS OR FEES CHARGED BY A HEALTH BENEFIT PLAN FOR COVERAGE UNDER THE PLAN.

(U) (1) "RESIDENT" MEANS AN INDIVIDUAL WHO IS LEGALLY DOMICILED AND PHYSICALLY RESIDES ON A PERMANENT AND FULL–TIME BASIS IN A PLACE OF PERMANENT HABITATION IN THE STATE.

(2) "RESIDENT" INCLUDES AN INDIVIDUAL WHO IS A FULL–TIME STUDENT ATTENDING AN INSTITUTION OUTSIDE THE STATE.

19–143.

(A) THERE IS A MARYLAND HEALTH INSURANCE EXCHANGE IN THE COMMISSION.

(B) THE PURPOSE OF THE EXCHANGE IS TO PROVIDE CHOICE OF HEALTH INSURANCE PLANS TO PARTICIPATING INDIVIDUALS.

19–144.

(A) THE COMMISSION SHALL APPOINT AN EXCHANGE DIRECTOR, WITH THE ADVICE AND CONSENT OF THE GOVERNOR.

(B) (1) THE EXCHANGE DIRECTOR SHALL BE A FULL–TIME EMPLOYEE OF THE COMMISSION.

(2) THE EXCHANGE DIRECTOR SHALL:

(I) ADMINISTER ALL OF THE EXCHANGE'S ACTIVITIES AND CONTRACTS; AND

(II) SUPERVISE THE STAFF OF THE EXCHANGE.

(C) THE EXCHANGE DIRECTOR SHALL SERVE AT THE PLEASURE OF THE COMMISSION.

(D) THE EXCHANGE DIRECTOR SHALL BE IN THE EXECUTIVE SERVICE OR MANAGEMENT SERVICE OF THE STATE PERSONNEL MANAGEMENT SYSTEM.

(E) THE COMMISSION, IN CONSULTATION WITH THE SECRETARY, SHALL DETERMINE THE APPROPRIATE JOB CLASSIFICATION AND, SUBJECT TO THE STATE BUDGET, THE COMPENSATION FOR THE EXCHANGE DIRECTOR.

19–145.

(A) THE EXCHANGE DIRECTOR SHALL DEVELOP AND ADMINISTER A PROGRAM THAT WILL OFFER ALL ELIGIBLE INDIVIDUALS THE OPPORTUNITY TO PURCHASE A HEALTH BENEFIT PLAN THROUGH THE EXCHANGE.

(B) SUBJECT TO APPROVAL BY THE COMMISSION, THE EXCHANGE DIRECTOR SHALL ESTABLISH AND ADMINISTER PROCEDURES FOR THE EFFECTIVE OPERATION OF THE EXCHANGE, INCLUDING PROCEDURES FOR:

(1) PROVIDING INFORMATION ON THE EXCHANGE TO APPLICANTS;

(2) ENROLLING ELIGIBLE INDIVIDUALS IN THE EXCHANGE AND MANAGING ENROLLMENT, INCLUDING:

(I) CREATING A STANDARD APPLICATION FORM TO COLLECT INFORMATION NECESSARY TO DETERMINE THE ELIGIBILITY AND PREVIOUS COVERAGE HISTORY OF AN APPLICANT; AND

(II) PROCESSING ANY PAYMENTS FOR COVERAGE RECEIVED BY THE EXCHANGE;

(3) PREPARING AND DISTRIBUTING CERTIFICATE OF ELIGIBILITY FORMS AND ENROLLMENT INSTRUCTION FORMS TO INSURANCE PRODUCERS AND THE PUBLIC;

(4) THE ELECTION OF COVERAGE BY PARTICIPATING INDIVIDUALS FROM AMONG PARTICIPATING PLANS, INCLUDING ESTABLISHING

AND ADMINISTERING AN ANNUAL OPEN ENROLLMENT PERIOD AND PROVIDING FOR COVERAGE ELECTIONS OUTSIDE OF THE ANNUAL OPEN ENROLLMENT ON THE OCCURRENCE OF ANY QUALIFYING EVENT SPECIFIED IN THIS PART;

(5) PREPARING AND DISTRIBUTING TO PARTICIPATING INDIVIDUALS THE FOLLOWING INFORMATION:

(I) DESCRIPTIONS OF THE COVERAGE, BENEFITS, LIMITATIONS, COPAYMENTS, AND PREMIUMS FOR ALL PARTICIPATING PLANS;

(II) FORMS AND INSTRUCTIONS FOR ELECTING COVERAGE AND ARRANGING PAYMENT FOR COVERAGE; AND

(III) ANY OTHER INFORMATION THE EXCHANGE DEEMS NECESSARY IN ORDER FOR PARTICIPATING INDIVIDUALS TO MAKE INFORMED COVERAGE ELECTIONS;

(6) THE HANDLING OF AND ACCOUNTING FOR FUNDS RECEIVED AND DISBURSED BY THE EXCHANGE; AND

(7) COLLECTING AND TRANSMITTING TO THE APPLICABLE PARTICIPATING PLANS ALL PREMIUM PAYMENTS OR CONTRIBUTIONS MADE BY OR ON BEHALF OF PARTICIPATING INDIVIDUALS, INCLUDING DEVELOPING MECHANISMS TO:

(I) RECEIVE AND PROCESS EMPLOYER CONTRIBUTIONS AND PAYROLL DEDUCTIONS MADE BY PARTICIPATING INDIVIDUALS, REGARDLESS OF WHETHER SUCH INDIVIDUALS ARE ENROLLED IN A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN;

(II) ENABLE A PARTICIPATING INDIVIDUAL TO PAY ANY PORTION OF COVERAGE OFFERED THROUGH THE EXCHANGE BY ELECTING TO ASSIGN TO THE EXCHANGE ANY FEDERAL EARNED INCOME TAX CREDIT PAYMENTS DUE TO THE PARTICIPATING INDIVIDUAL; AND

(III) RECEIVE AND PROCESS ANY APPLICABLE FEDERAL OR STATE TAX CREDITS OR OTHER PREMIUM SUPPORT PAYMENTS FOR THE HEALTH INSURANCE COVERAGE OF PARTICIPATING INDIVIDUALS.

(C) THE EXCHANGE DIRECTOR SHALL PUBLICIZE THE EXISTENCE OF THE EXCHANGE AND DISSEMINATE INFORMATION ON ELIGIBILITY REQUIREMENTS AND ENROLLMENT PROCEDURES FOR THE EXCHANGE.

(D) THE EXCHANGE DIRECTOR SHALL ESTABLISH AND MAINTAIN ACCOUNTS FOR THE RECEIPT AND DISBURSEMENT OF FUNDS USED TO MANAGE AND OPERATE THE EXCHANGE, INCLUDING:

(1) A SEGREGATED MANAGEMENT ACCOUNT FOR THE RECEIPT AND DISBURSEMENT OF MONEY ALLOCATED TO FUND THE EXPENSES INCURRED IN ADMINISTERING THE EXCHANGE; AND

(2) A SEGREGATED OPERATIONS ACCOUNT FOR:

(I) THE RECEIPT OF ALL PREMIUM PAYMENTS OR CONTRIBUTIONS MADE BY OR ON BEHALF OF PARTICIPATING INDIVIDUALS; AND

(II) THE DISBURSEMENT OF:

1. PREMIUM PAYMENTS TO PARTICIPATING PLANS; AND

2. COMMISSIONS OR PAYMENTS TO INSURANCE PRODUCERS AND OTHER ENTITIES ENTITLED TO PAYMENT.

(E) (1) THE EXCHANGE SHALL ESTABLISH AND ADMINISTER AT LEAST ONE SERVICE CENTER.

(2) A SERVICE CENTER ESTABLISHED UNDER THIS SUBSECTION SHALL:

(I) PROVIDE INFORMATION ON THE EXCHANGE AND THE PLANS OFFERED THROUGH THE EXCHANGE TO APPLICANTS; AND

(II) ENROLL ELIGIBLE INDIVIDUALS SEEKING TO PARTICIPATE IN THE EXCHANGE.

(F) SUBJECT TO APPROVAL BY THE COMMISSION, THE EXCHANGE DIRECTOR MAY:

(1) ENTER INTO CONTRACTS WITH PUBLIC OR PRIVATE ENTITIES TO CARRY OUT THE DUTIES OF THE EXCHANGE UNDER THIS PART, INCLUDING CONTRACTS TO ADMINISTER APPLICATIONS, ELIGIBILITY VERIFICATION, ENROLLMENT, AND PREMIUM PAYMENTS FOR SPECIFIC GROUPS OR POPULATIONS;

(2) TAKE ANY LEGAL ACTION NECESSARY OR PROPER ON BEHALF OF THE EXCHANGE;

(3) HIRE OR CONTRACT WITH APPROPRIATE LEGAL, ACTUARIAL, AND OTHER ADVISORS TO PROVIDE TECHNICAL ASSISTANCE IN THE MANAGEMENT AND OPERATION OF THE EXCHANGE;

(4) ESTABLISH AND EXECUTE A LINE OF CREDIT, AND ESTABLISH ONE OR MORE CASH AND INVESTMENT ACCOUNTS TO CARRY OUT THE DUTIES OF THE EXCHANGE;

(5) ESTABLISH AND COLLECT FEES FROM PARTICIPATING INDIVIDUALS, PARTICIPATING PLANS, AND PARTICIPATING EMPLOYER–SUBSIDIZED PLANS SUFFICIENT TO FUND THE COSTS OF ADMINISTERING THE EXCHANGE;

(6) APPLY FOR GRANTS FROM PUBLIC AND PRIVATE ENTITIES; AND

(7) CONTRACT WITH SPONSORING EMPLOYERS OF PARTICIPATING EMPLOYER–SUBSIDIZED PLANS TO ACT AS THE PLAN'S ADMINISTRATOR AND UNDERTAKE THE OBLIGATIONS REQUIRED OF THE ADMINISTRATOR FOR THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN.

(G) ALL OPERATING EXPENSES OF THE EXCHANGE SHALL BE PAID FROM FUNDS COLLECTED BY OR ON BEHALF OF THE EXCHANGE.

(H) THE ACCOUNTS OF THE EXCHANGE ARE SPECIAL FUND ACCOUNTS AND THE MONEY IN THE ACCOUNTS IS NOT PART OF THE GENERAL FUND OF THE STATE.

(I) THE STATE MAY NOT PROVIDE GENERAL FUND APPROPRIATIONS TO THE EXCHANGE.

(J) ALL DEBTS, CLAIMS, OBLIGATIONS, AND LIABILITIES OF THE EXCHANGE SHALL BE THE DEBTS, CLAIMS, OBLIGATIONS, AND LIABILITIES OF THE EXCHANGE ONLY AND NOT OF THE STATE OR THE STATE'S AGENCIES, INSTRUMENTALITIES, OFFICERS, OR EMPLOYEES.

(K) THE EXCHANGE IS EXEMPT FROM:

(1) TAXATION BY THE STATE AND LOCAL GOVERNMENT;

(2) THE REQUIREMENTS OF § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE; AND

(3) THE REQUIREMENTS OF DIVISION II OF THE STATE FINANCE AND PROCUREMENT ARTICLE, EXCEPT AS PROVIDED IN TITLE 14, SUBTITLE 3 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

19–146.

(A) THE EXCHANGE SHALL OFFER TO PARTICIPATING INDIVIDUALS ONLY PLANS THAT HAVE BEEN CERTIFIED BY THE COMMISSIONER AS ELIGIBLE TO BE OFFERED THROUGH THE EXCHANGE.

(B) FOR EACH PLAN YEAR, THE EXCHANGE SHALL OFFER ALL PLANS THAT:

(1) AGREE TO ABIDE BY THE RULES GOVERNING PLAN PARTICIPATION IN THE EXCHANGE; AND

(2) HAVE BEEN CERTIFIED BY THE COMMISSIONER AS ELIGIBLE TO BE OFFERED THROUGH THE EXCHANGE AS OF THE DATE ESTABLISHED BY THE EXCHANGE FOR PLANS TO APPLY TO BE A PARTICIPATING PLAN FOR THE SPECIFIED PLAN YEAR.

(C) AN OFFERING OF A PARTICIPATING PLAN SHALL BE FOR A TERM OF AT LEAST 1 YEAR, AND MAY BE AUTOMATICALLY RENEWED IN THE ABSENCE OF A NOTICE OF TERMINATION BY THE PLAN OR NOTICE BY THE COMMISSIONER THAT THE PLAN IS NO LONGER CERTIFIED AS ELIGIBLE TO BE OFFERED THROUGH THE EXCHANGE.

(D) BEFORE A CARRIER NOTIFIES MEMBERS OF A PARTICIPATING PLAN OF THE CARRIER'S INTENT TO DISCONTINUE THE OFFERING OF THE PARTICIPATING PLAN, THE CARRIER SHALL GIVE WRITTEN NOTICE OF ITS INTENT TO DISCONTINUE THE PARTICIPATING PLAN TO THE EXCHANGE DIRECTOR AND THE COMMISSIONER.

(E) EACH PARTICIPATING PLAN SHALL MAKE AVAILABLE TO THE EXCHANGE ANY REPORTS, DATA, OR OTHER INFORMATION THAT THE EXCHANGE FINDS REASONABLY NECESSARY TO PERFORM ADEQUATELY AND EFFECTIVELY THE FUNCTIONS ASSIGNED TO IT UNDER THIS PART.

19–147.

AN INDIVIDUAL SHALL BE CONSIDERED AN "ELIGIBLE INDIVIDUAL" TO RECEIVE COVERAGE THROUGH THE EXCHANGE IF THE PERSON MEETS ONE OR MORE OF THE FOLLOWING QUALIFICATIONS:

(1) THE INDIVIDUAL IS A RESIDENT OF THE STATE;

(2) THE INDIVIDUAL IS NOT A RESIDENT OF THE STATE, BUT IS EMPLOYED AT LEAST 20 HOURS A WEEK AT A LOCATION IN THE STATE AND THE INDIVIDUAL'S EMPLOYER DOES NOT OFFER A GROUP HEALTH INSURANCE PLAN IN WHICH THE INDIVIDUAL IS ELIGIBLE TO PARTICIPATE;

(3) THE INDIVIDUAL IS ENROLLED IN, OR IS ELIGIBLE TO ENROLL IN, A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN;

(4) THE INDIVIDUAL IS SELF–EMPLOYED AND THE PRINCIPAL PLACE OF BUSINESS OF THE INDIVIDUAL IS IN THE STATE;

(5) THE INDIVIDUAL IS A FULL–TIME STUDENT ATTENDING AN INSTITUTION OF HIGHER EDUCATION LOCATED IN THE STATE; OR

(6) THE INDIVIDUAL IS A QUALIFIED DEPENDENT OF AN INDIVIDUAL WHO IS ELIGIBLE TO PARTICIPATE IN THE EXCHANGE BY MEETING ONE OR MORE OF THE QUALIFICATIONS OF THIS SECTION.

PART V. MARYLAND HEALTH INSURANCE COVERAGE VERIFICATIONS SYSTEM.

19–154.

(A) EVERY EMPLOYER IN THE STATE SHALL FILE ANNUALLY WITH THE COMMISSION A FORM FOR EACH EMPLOYEE EMPLOYED IN THE STATE INDICATING:

(1) THE HEALTH INSURANCE COVERAGE STATUS OF THE EMPLOYEE AND THE EMPLOYEE'S DEPENDENTS, INCLUDING:

(I) THE NAME OF THE INSURER OR PLAN SPONSOR; AND

(II) WHETHER THE EMPLOYEE AND THE EMPLOYEE'S DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH PLAN SPONSORED BY THE EMPLOYER;

(2) IF THE EMPLOYEE OR A DEPENDENT OF THE EMPLOYEE IS NOT COVERED BY A HEALTH INSURANCE PLAN, WHETHER THE EMPLOYEE HAS ELECTED TO BECOME A PARTICIPATING INDIVIDUAL IN THE EXCHANGE; AND

(3) WHETHER THE EMPLOYEE HAS ELECTED TO BE CONSIDERED FOR ELIGIBILITY UNDER ANY PUBLICLY FINANCED HEALTH INSURANCE PROGRAM OR PREMIUM SUBSIDY PROGRAM ADMINISTERED BY THE STATE.

(B) EACH FORM REQUIRED UNDER SUBSECTION (A) OF THIS SECTION SHALL BE SIGNED BY THE EMPLOYEE TO WHOM IT PERTAINS.

(C) THE COMMISSION SHALL TRANSMIT COPIES OF ALL FORMS ON WHICH THE EMPLOYEE HAS ELECTED TO BE CONSIDERED FOR ELIGIBILITY UNDER A PUBLICLY FINANCED HEALTH INSURANCE PROGRAM OR PREMIUM SUBSIDY PROGRAM TO THE APPROPRIATE DEPARTMENT OR AGENCY.

Article – Insurance

15–1216.

(a) The Commissioner shall establish the Maryland **[**Small Employer Health Reinsurance Pool**]** **HEALTH INSURANCE RISK TRANSFER POOL**.

(b) The Pool shall be operational and may reinsure claims in accordance with this subtitle on or after July 1, **[**1994**]** **2010**.

(C) THE COMMISSIONER SHALL REQUIRE PARTICIPATION IN THE POOL BY ALL CARRIERS ISSUING HEALTH BENEFIT PLANS IN THE STATE.

(D) WITH THE APPROVAL OF THE COMMISSIONER, THE POOL MAY ENTER INTO AN AGREEMENT WITH A SELF–FUNDED HEALTH BENEFIT PLAN TO PERMIT THE PLAN TO BE A REINSURING CARRIER FOR ALL PRIMARY INSUREDS COVERED BY THE PLAN WHO ARE STATE RESIDENTS OR EMPLOYED IN THE STATE, AND THEIR COVERED DEPENDENTS.

[(c)**]** **(E)** (1) The reinsuring carriers shall elect a Board of Directors to be composed of seven members.

(2) The Board shall include representation from carriers whose principal business in health insurance is comprised of small employers and, to the extent possible, at least one nonprofit health service plan, at least one commercial carrier, and at least one health maintenance organization.

(3) A carrier, including its affiliates, may not be represented by more than one member on the Board.

(4) The term of a member is 3 years except that the terms of initial members shall be staggered for periods of 1 to 3 years.

(5) At the end of a term, a member continues to serve until a successor is elected.

(6) Vacancies shall be filled by an election of the remaining Board members.

(7) A member who is elected after a term has begun serves only for the rest of the term and until a successor is elected.

(8) A member who serves two consecutive full 3–year terms may not be reelected for 3 years after the completion of those terms.

[(d)**] (F)** The Board shall choose a Chairman.

[(e)**] (G)** (1) The Board shall appoint an Executive Director, who shall be the chief administrative officer of the Pool.

(2) The Executive Director serves at the pleasure of the Board.

(3) Under the direction of the Board, the Executive Director shall perform any duty or function that the Board requires.

[(f)**] (H)** The Pool may employ a staff in accordance with the budget of the Pool.

[(g)**] (I)** (1) The Board shall submit to the Commissioner a plan of operation to ensure the fair, reasonable, and financially sound administration of the Pool.

(2) The Commissioner may amend or rescind a plan of operation if the Commissioner finds that the Pool is not operating in a fair, reasonable, and financially sound manner.

15–1217.

(a) At a minimum, the plan of operation shall:

(1) establish procedures for the handling and accounting of Pool assets and moneys and for an annual fiscal report to the Commissioner;

(2) establish procedures for reinsuring claims submitted to the Pool in accordance with this subtitle;

(3) establish procedures for collecting assessments from members to reinsure claims submitted to the Pool and to pay for administrative expenses incurred or estimated to be incurred during the period;

(4) establish procedures for recouping any net losses to the Pool for the calendar year by assessing reinsuring carriers under § 15–1221 of this subtitle; and

(5) provide for any additional matters at the discretion of the Board.

(b) The Board has the general powers and authority granted under the laws of the State to health insurers and health maintenance organizations authorized to transact business, except for the power to issue health benefit plans directly to groups or individuals.

(c) The Board may:

(1) enter into contracts as necessary or proper to carry out this subtitle and, with approval of the Commissioner, enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued;

(3) take any legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the Pool or reinsuring carriers or necessary to avoid the payment of improper claims against the Board;

(4) define the health benefit plans and medical conditions for which claims may be reinsured with the Pool in accordance with this subtitle**, PROVIDED THAT:**

(I) ANY PLAN OFFERED THROUGH THE EXCHANGE SHALL BE ALLOWED TO REINSURE CLAIMS WITH THE POOL; AND

(II) ANY PLAN THAT IS NOT A HEALTH BENEFIT PLAN MAY NOT BE ALLOWED TO REINSURE CLAIMS WITH THE POOL;

(5) establish rules, conditions, and procedures that relate to reinsurance of claims by the Pool;

(6) establish actuarial functions as appropriate for the operation of the Pool;

(7) assess reinsuring carriers in accordance with the provisions of § 15–1221 of this subtitle;

(8) make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses, to be credited against any assessments due after the close of the fiscal year;

(9) appoint appropriate committees as necessary to provide technical assistance in the operation of the Pool, policy and other contract design, and any other function within the authority of the Pool; and

(10) borrow money to carry out the purposes of the Pool.

15–1218.

(a) A reinsuring carrier may reinsure with the Pool as provided in this section.

(b) **[**At a minimum, the Pool shall reinsure up to the level of coverage specified under the Standard Plan.

(c)**]** A reinsuring carrier may reinsure an entire employer group within 60 days after commencement of the group's coverage under a health benefit plan.

[(d)**] (C) [**(1)**]** A reinsuring carrier may reinsure an eligible **[**employee or dependent**]** **INDIVIDUAL** within 60 days after commencement of coverage **[**with the small employer.

(2) A reinsuring carrier may reinsure a newly eligible employee or dependent within 60 days after commencement of coverage of the eligible employee or dependent**]** **UNDER A HEALTH BENEFIT PLAN ISSUED BY THE CARRIER**.

[(e)**] (D)** (1) The Pool may not reimburse a reinsuring carrier with respect to the claims of an individual until the reinsuring carrier has incurred claims for the individual of $5,000 in a calendar year for benefits covered by the Pool.

(2) After the initial $5,000 of incurred claims, the reinsuring carrier is responsible for 10% of the next $50,000 of incurred claims during the calendar year, and the Pool shall reinsure the remainder.

(3) The liability of a reinsuring carrier under this subsection may not exceed $10,000 in any 1 calendar year with respect to any individual.

[(f)**] (E)** (1) The Board annually shall adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in costs and utilization within the standard market for health benefit plans in the State.

(2) Unless the Board proposes and the Commissioner approves a lower adjustment factor, the adjustment in paragraph (1) of this subsection may not be less than the annual change in the medical component of the "Consumer Price Index for all Urban Consumers" of the Department of Labor, Bureau of Labor Statistics.

[(g)**] (F)** A reinsuring carrier may terminate reinsurance on a plan anniversary for one or more of the individuals in a small employer group.

15–1219.

(a) (1) (i) As part of the plan of operation, the Board shall establish a methodology to determine premium rates to be charged by the Pool to reinsure **[**small employers and**]** individuals **AND EMPLOYER GROUPS** under this section and § 15–1218 of this subtitle.

(ii) The methodology shall provide for the development of base reinsurance premium rates that shall be multiplied by the factors set forth in paragraph (2) of this subsection to determine the premium rates for the Pool.

(iii) The Board shall establish the base reinsurance premium rates at levels that reasonably approximate gross premiums charged to **[**small employers**]** **INDIVIDUALS AND EMPLOYER GROUPS** by carriers for health benefit plans up to the level of coverage that the Board determines.

(2) Premiums for the Pool shall be as follows:

(i) an entire group may be reinsured for a rate that is 1.5 times the base reinsurance premium rate for the group established under this subsection; and

(ii) an individual may be reinsured for a rate that is 5 times the base reinsurance premium rate for the individual established under this subsection.

(3) (i) The Board periodically shall review the methodology established under paragraph (1) of this subsection, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the Pool.

(ii) The Board may propose changes to the methodology, subject to the approval of the Commissioner.

(b) If a health benefit plan for a small employer is entirely or partially reinsured with the Pool, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements that relate to premium rates set forth in § 15–1205 of this subtitle.

15–1220.

(a) The Pool shall manage and invest all moneys collected by or on behalf of the Pool through premium charges, assessments, earnings from investments, or otherwise, through a financial management committee composed of the Executive Director and two members of the Board.

(b) All operating expenses of the Pool shall be paid from funds collected by or on behalf of the Pool.

(c) The account of the Pool is a special fund account and the moneys in the account are not part of the General Fund of the State.

(d) The State may not provide General Fund appropriations to the Pool and the obligations of the Pool are not a debt of the State or a pledge of the credit of the State.

(e) All debts, claims, obligations, and liabilities of the Pool, whenever incurred, shall be the debts, claims, obligations, and liabilities of the Pool only and not of the State or the State's agencies, instrumentalities, officers, or employees.

(f) The Pool is exempt from:

(1) taxation by the State and local government;

(2) § 7–302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE;

[(2)**] (3)** the general procurement law provisions of Division II of the State Finance and Procurement Article; and

[(3)**] (4)** Division I of the State Personnel and Pensions Article.

15–1221.

(a) On or before the last day of February of each year, the Board shall determine and report to the Commissioner the net loss of the Pool for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) Any net loss for the year shall be recouped by assessments imposed on reinsuring carriers.

(c) (1) As part of the plan of operation, the Board shall establish a formula to make assessments against reinsuring carriers.

(2) The assessment formula shall be based on:

(i) each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans that are delivered or issued for delivery to **[**small**]** **INDIVIDUALS AND** employers in the State by reinsuring carriers; and

(ii) each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans that are delivered or issued for delivery during that calendar year to **[**small**]** **INDIVIDUALS AND** employers in the State by reinsuring carriers.

(3) **[**The assessment formula may not result in an assessment share for a reinsuring carrier that is less than 50% nor more than 150% of an amount that is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans that are delivered or issued for delivery to small employers in the State to total premiums earned by all reinsuring carriers in the preceding calendar year from health benefit plans that are delivered or issued for delivery to small employers in the State.

(4)**]** As appropriate and with the approval of the Commissioner, the Board may change the assessment formula established in accordance with this subsection.

[(5)**] (4)** The Board may provide for assessment shares attributable to premiums from all health benefit plans and to premiums from newly issued health benefit plans to vary during a transition period.

[(6)**] (5)** Subject to approval by the Commissioner, the Board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations and that are federally qualified under the Health Maintenance Organization Act of 1973 to the extent that restrictions are imposed on the health maintenance organizations that are not imposed on other carriers.

[(7)**] (6)** Premiums and benefits paid by a reinsuring carrier that are less than an amount determined by the Board to justify the cost of collection may not be considered in determining assessments.

(d) (1) On or before the last day of February of each year, the Board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the Pool in the previous calendar year.

(2) If the Board determines that the assessments needed to fund the losses incurred by the Pool in the previous calendar year will exceed 5% of the total premiums earned that year from health benefit plans that are delivered or issued for delivery in the State, the Board shall evaluate the operation of the Pool and report its findings to the Commissioner within 90 days after the end of the calendar year in which the losses were incurred.

(3) The evaluation required under paragraph (2) of this subsection shall include:

(i) any recommendations for changes to the plan of operation;

(ii) an estimate of future assessments;

(iii) the administrative costs of the Pool;

(iv) the appropriateness of the premiums charged;

(v) the level of insurer retention under the Pool; and

(vi) the costs of coverage for **[**small employers**]** **INDIVIDUALS AND EMPLOYER GROUPS**.

(4) If the Board fails to file the report with the Commissioner within 90 days after the end of the applicable calendar year, the Commissioner may evaluate the operations of the Pool and implement amendments to the plan of operation that the Commissioner considers necessary to reduce future losses and assessments.

(e) If assessments exceed net losses of the Pool, the excess shall be held in an interest–bearing account and used by the Board to offset future losses, including reserves for incurred but not reported claims, or to reduce Pool premiums.

(f) The Board annually shall determine the assessment share of each reinsuring carrier based on annual statements and other reports that the Board considers necessary and that reinsuring carriers file with the Board.

(g) The plan of operation shall provide for imposition of an interest penalty for late payment of assessments.

(h) (1) (i) A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the Board.

(ii) The request for deferment shall be made in writing to the Commissioner within 15 days after receipt of the assessment notice.

(2) The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that payment of the assessment would place the reinsuring carrier in a financially impaired condition.

(3) (i) Any amount deferred shall be assessed against the other reinsuring carriers in a manner consistent with the basis for assessment set forth in this section.

(ii) The reinsuring carrier receiving the deferment remains liable to the Pool for the amount deferred and may not reinsure any individuals or groups in the Pool until it pays that amount.

15–1222.

(a) (1) The Board shall report to the Commissioner on or before June 1 of each year.

(2) At a minimum, the report shall include:

(i) a description of the operations of the Pool for the preceding calendar year;

(ii) an audited statement of the financial condition of the Pool as of the preceding December 31; and

(iii) an audited detailed statement of the revenues received and expenditures of the Pool made during the preceding calendar year.

(b) The operations of the Board are subject to an annual audit by an independent auditor, and the audit report and working papers are subject to review by the Legislative Auditor.

15–1223.

Participation in the Pool as reinsuring carriers, establishment of rates, forms, or procedures, or any other joint or collective action required by §§ 15–1218, 15–1219, and 15–1221 of this subtitle may not be the basis of any legal action, criminal or civil liability, or penalty against the Pool or any of its reinsuring carriers either jointly or separately.

15–1224.

The Commissioner may order the dissolution of the Pool if the Commissioner determines that the Pool is not financially viable, and provision is made to ensure the protection of those insured by the members of the Pool.

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

Article – Health – General

19–148.

(A) (1) AN INDIVIDUAL MAY APPLY DIRECTLY TO THE EXCHANGE TO ENROLL IN THE EXCHANGE AS A PARTICIPATING INDIVIDUAL.

(2) IF THE EXCHANGE DETERMINES THAT AN INDIVIDUAL APPLYING TO THE EXCHANGE FOR ENROLLMENT IS AN ELIGIBLE INDIVIDUAL, THE EXCHANGE SHALL ENROLL THAT INDIVIDUAL.

(B) AN INDIVIDUAL ENROLLED IN A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN SHALL BE ENROLLED AUTOMATICALLY IN THE EXCHANGE AS A PARTICIPATING INDIVIDUAL.

(C) AN INDIVIDUAL WHO IS A QUALIFIED DEPENDENT OF A PARTICIPATING INDIVIDUAL ALSO SHALL BE A PARTICIPATING INDIVIDUAL.

(D) (1) AN INSURANCE PRODUCER LICENSED IN THE STATE MAY APPLY TO THE EXCHANGE ON BEHALF OF AN INDIVIDUAL SEEKING ENROLLMENT IN THE EXCHANGE AS A PARTICIPATING INDIVIDUAL.

(2) IF THE EXCHANGE ENROLLS THAT INDIVIDUAL, THE PARTICIPATING PLAN CHOSEN BY THE INDIVIDUAL SHALL PAY THE INSURANCE PRODUCER THAT APPLIED TO THE EXCHANGE ON BEHALF OF THAT INDIVIDUAL THE CONSIDERATION PROVIDED FOR IN SUBSECTION (G) OF THIS SECTION.

(E) (1) AN INSURANCE PRODUCER LICENSED IN THE STATE MAY APPLY TO THE EXCHANGE ON BEHALF OF AN EMPLOYER SEEKING TO SPONSOR A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN THROUGH THE EXCHANGE.

(2) IF THE EXCHANGE ENROLLS INDIVIDUALS ELIGIBLE FOR BENEFITS UNDER THE TERMS OF THAT PARTICIPATING EMPLOYER–SUBSIDIZED PLAN, THEN THE PARTICIPATING PLAN CHOSEN BY THE INDIVIDUAL SHALL PAY THE INSURANCE PRODUCER THAT APPLIED TO THE EXCHANGE ON BEHALF OF THAT EMPLOYER THE CONSIDERATION PROVIDED FOR IN SUBSECTION (G) OF THIS SECTION.

(F) (1) A MEMBERSHIP ORGANIZATION, INCLUDING A LABOR UNION, A PROFESSIONAL ORGANIZATION, A TRADE ASSOCIATION, OR A CIVIC ASSOCIATION, MAY APPLY TO THE EXCHANGE ON BEHALF OF ITS MEMBERS SEEKING ENROLLMENT IN THE EXCHANGE AS PARTICIPATING INDIVIDUALS.

(2) IF THE EXCHANGE ENROLLS ANY OF THOSE INDIVIDUALS, THEN THE PARTICIPATING PLAN CHOSEN BY THE INDIVIDUAL SHALL PAY THE MEMBERSHIP ORGANIZATION THE CONSIDERATION PROVIDED FOR IN SUBSECTION (G) OF THIS SECTION.

(3) NOTHING IN THIS SUBSECTION SHALL BE INTERPRETED TO MEAN THAT:

(I) A MEMBERSHIP ORGANIZATION THAT ENROLLS MEMBERS IN THE EXCHANGE IS LICENSED AS AN INSURANCE PRODUCER; OR

(II) A MEMBERSHIP ORGANIZATION MAY PROVIDE ANY OTHER SERVICES REQUIRING LICENSURE AS AN INSURANCE PRODUCER WITHOUT FIRST OBTAINING ANY REQUIRED LICENSE.

(G) (1) THE COMMISSION SHALL DETERMINE THE AMOUNT OF THE STANDARD CONSIDERATION PAID TO LICENSED INSURANCE PRODUCERS AND OTHER QUALIFIED ENTITIES FOR ENROLLING ELIGIBLE INDIVIDUALS IN THE EXCHANGE.

(2) THE AMOUNT OF THE STANDARD CONSIDERATION PAID UNDER THIS SUBSECTION:

(I) MAY NOT BE LESS THAN 5% OF THE PREMIUM FOR THE COVERAGE SELECTED BY THE APPLICABLE PARTICIPATING INDIVIDUAL; AND

(II) SHALL APPLY UNIFORMLY TO ALL INDIVIDUALS AND ENTITIES ELIGIBLE TO RECEIVE THE PAYMENTS.

(H) (1) THE EXCHANGE SHALL VERIFY THE ELIGIBILITY OF ALL APPLICANTS.

(2) THE EXCHANGE MAY REQUIRE THAT APPLICANTS SUBMIT DOCUMENTATION, STATEMENTS UNDER OATH, OR ANY OTHER INFORMATION THE EXCHANGE CONSIDERS NECESSARY TO DETERMINE THE ELIGIBILITY OF AN APPLICANT.

(I) WHEN THE EXCHANGE DETERMINES THAT AN APPLICANT IS AN ELIGIBLE INDIVIDUAL, THE EXCHANGE SHALL GIVE THE PARTICIPATING INDIVIDUAL THE OPPORTUNITY TO ELECT COVERAGE UNDER A PARTICIPATING PLAN DURING THE NEXT ANNUAL OPEN SEASON OR AT APPLICABLE OTHER TIMES AS SPECIFIED IN SUBSECTION (L) OF THIS SECTION.

(J) EXCEPT AS PROVIDED IN §§ 15–1208.1, 15–1212, AND 15–1309 OF THE INSURANCE ARTICLE, COVERAGE OF A PARTICIPATING INDIVIDUAL UNDER A PARTICIPATING PLAN SHALL CEASE:

(1) ON THE DEATH OF THE PARTICIPATING INDIVIDUAL;

(2) ON THE DATE THE PARTICIPATING INDIVIDUAL REQUESTS THAT COVERAGE TERMINATE;

(3) ON THE DATE THAT ANY LAWS OF THE STATE REQUIRE CANCELLATION OF A POLICY;

(4) AT THE EXCHANGE'S OPTION, 30 DAYS AFTER THE EXCHANGE OR THE CARRIER UNDER THE PARTICIPATING PLAN MAKES ANY INQUIRY CONCERNING A PARTICIPATING INDIVIDUAL'S ELIGIBILITY TO WHICH THE PARTICIPATING INDIVIDUAL DOES NOT REPLY, OR WHOSE REPLY FAILS TO SATISFY THE EXCHANGE THAT THE INDIVIDUAL CONTINUES TO BE AN ELIGIBLE INDIVIDUAL; OR

(5) IF THE PARTICIPATING INDIVIDUAL CEASES TO BE AN ELIGIBLE INDIVIDUAL, ON THE LAST DAY OF THE CURRENT POLICY PERIOD FOR WHICH THE REQUIRED PREMIUMS HAVE BEEN PAID.

(K) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE EXCHANGE SHALL ESTABLISH AND ADMINISTER A REGULAR OPEN SEASON, IN ADVANCE OF EACH PLAN YEAR, DURING WHICH PARTICIPATING INDIVIDUALS:

(I) MAY ELECT COVERAGE UNDER ANY PARTICIPATING PLAN AT THE PLAN'S SPECIFIED RATES AND WITHOUT THE PLAN IMPOSING ANY WAITING PERIODS OR COVERAGE EXCLUSIONS; AND

(II) MAY NOT BE DECLINED COVERAGE.

(2) IF A PARTICIPATING INDIVIDUAL HAS LESS THAN 18 MONTHS OF CREDITABLE COVERAGE, THE PLAN MAY ELECT TO:

(I) CHARGE A PREMIUM NOT TO EXCEED 150% OF THE OTHERWISE APPLICABLE STANDARD RATE, FOR A PERIOD NOT TO EXCEED 18 MONTHS, REDUCED BY THE NUMBER OF MONTHS OF CREDITABLE COVERAGE THAT THE INDIVIDUAL HAS;

(II) IMPOSE ONE OR MORE PREEXISTING CONDITION PROVISIONS, FOR A PERIOD NOT TO EXCEED 12 MONTHS, REDUCED BY THE NUMBER OF MONTHS OF CREDITABLE COVERAGE THAT THE INDIVIDUAL HAS; OR

(III) WAIVE THE IMPOSITION OF ANY PREEXISTING CONDITION PROVISIONS PERMITTED UNDER ITEM (II) OF THIS PARAGRAPH AND INSTEAD EXTEND THE APPLICABLE RATE SURCHARGE PERMITTED UNDER ITEM (I) OF THIS PARAGRAPH BY THE NUMBER OF MONTHS THE PLAN WOULD OTHERWISE BE PERMITTED UNDER ITEM (II) OF THIS PARAGRAPH TO IMPOSE A PREEXISTING CONDITION PROVISION.

(3) AN INDIVIDUAL SHALL BE DEEMED TO HAVE 18 MONTHS OF CREDITABLE COVERAGE IF THE INDIVIDUAL BECOMES A PARTICIPATING INDIVIDUAL DUE TO:

(I) ENROLLMENT IN A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN;

(II) QUALIFICATION AS A FEDERAL HEALTH COVERAGE TAX CREDIT ELIGIBLE INDIVIDUAL;

(III) BECOMING A NEWLY QUALIFIED DEPENDENT OF ANOTHER PARTICIPATING INDIVIDUAL THROUGH BIRTH, ADOPTION, OR COURT–ORDERED CUSTODY OR LEGAL GUARDIANSHIP; OR

(IV) LOSS OF COVERAGE UNDER THE MARYLAND HEALTH INSURANCE PLAN UNDER § 14–502(C) OF THE INSURANCE ARTICLE.

(4) PERIODS OF CREDITABLE COVERAGE WITH RESPECT TO ANY PARTICIPATING INDIVIDUAL SHALL BE ESTABLISHED THROUGH PRESENTATION OF CERTIFICATIONS OR IN ANY OTHER MANNER AS SPECIFIED IN FEDERAL OR STATE LAW.

(5) A PARTICIPATING PLAN MAY NOT IMPOSE A PREEXISTING CONDITION PROVISION FOR MEDICAL CONDITIONS THAT ARE PRESENT BEFORE THE DATE THAT IS 6 MONTHS PRIOR TO THE DATE THE INDIVIDUAL FIRST BECOMES A PARTICIPATING INDIVIDUAL.

(L) THE EXCHANGE SHALL PROVIDE FOR THE ELECTION OF COVERAGE OUTSIDE OF REGULAR OPEN SEASONS UNDER THE FOLLOWING CIRCUMSTANCES:

(1) DURING THE FIRST 90 DAYS AFTER THE EXCHANGE BEGINS TO ACCEPT APPLICATIONS FOR PARTICIPATION IN THE EXCHANGE;

(2) IN THE CASE OF A PARTICIPATING INDIVIDUAL, WHEN:

(I) THE PARTICIPATING PLAN UNDER WHICH THE PARTICIPATING INDIVIDUAL IS COVERED:

1. VOLUNTARILY TERMINATES PARTICIPATION IN THE EXCHANGE;

2. HAS ITS PARTICIPATION IN THE EXCHANGE SUSPENDED OR TERMINATED FOR CAUSE BY THE EXCHANGE; OR

3. IS DECERTIFIED BY THE COMMISSIONER PRIOR TO THE END OF THE PLAN YEAR; OR

(II) THE PARTICIPATING INDIVIDUAL IS ENROLLED IN A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN AND, UNDER THE TERMS OF THE PLAN, CEASES TO BE ELIGIBLE FOR COVERAGE THROUGH THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN; AND

(3) IN THE CASE OF AN ELIGIBLE INDIVIDUAL WHO LOSES ELIGIBILITY FOR COVERAGE AS A RESULT OF A QUALIFYING EVENT AND APPLIES TO BECOME A PARTICIPATING INDIVIDUAL IN THE EXCHANGE WITHIN 63 DAYS OF THE QUALIFYING EVENT AND THE QUALIFYING EVENT CONSTITUTES A LOSS OF COVERAGE DUE TO:

(I) THE DEATH OF A SPOUSE, PARENT, OR LEGAL GUARDIAN;

(II) DIVORCE, LEGAL SEPARATION, OR A CHANGE IN LEGAL GUARDIANSHIP OR CUSTODY;

(III) A CHANGE IN THE EMPLOYMENT STATUS OF THE INDIVIDUAL OR, IF A QUALIFIED DEPENDENT, THE EMPLOYMENT STATUS OF A SPOUSE, PARENT, OR LEGAL GUARDIAN, INCLUDING:

1. TERMINATION OF EMPLOYMENT;

2. REDUCTION IN THE NUMBER OF HOURS OF EMPLOYMENT;

3. REDUCTION IN EMPLOYER CONTRIBUTIONS TOWARD COVERAGE; OR

4. EXHAUSTION OF CONTINUATION OF COVERAGE;

(IV) ATTAINING AN AGE AT WHICH COVERAGE LAPSES UNDER THE PLAN;

(V) BECOMING AN ELIGIBLE INDIVIDUAL BY BECOMING A RESIDENT OF THE STATE OR BECOMING EMPLOYED BY A PERSON IN THE STATE;

(VI) BECOMING AN ELIGIBLE INDIVIDUAL BY BECOMING A QUALIFIED DEPENDENT OF AN INDIVIDUAL; OR

(VII) BECOMING SUBJECT TO A COURT ORDER REQUIRING THE INDIVIDUAL TO PROVIDE HEALTH INSURANCE COVERAGE TO CERTAIN DEPENDENTS OR ENTERING INTO A NEW ARRANGEMENT FOR THE CUSTODY OF DEPENDENTS THAT REQUIRES THE PROVISION OF HEALTH INSURANCE FOR THOSE DEPENDENTS.

19–149.

(A) (1) ANY PARTICIPATING INDIVIDUAL MAY CONTINUE TO ELECT COVERAGE UNDER A PARTICIPATING PLAN IN ACCORDANCE WITH THE RULES AND PROCEDURES OF THE EXCHANGE IF:

(I) THE INDIVIDUAL REMAINS AN ELIGIBLE INDIVIDUAL; AND

(II) THE INDIVIDUAL FOLLOWS THE PARTICIPATING PLAN'S RULES REGARDING CANCELLATION FOR NONPAYMENT OF PREMIUMS OR FRAUD.

(2) A PARTICIPATING INDIVIDUAL'S COVERAGE UNDER A PARTICIPATING PLAN MAY NOT BE CANCELED OR NOT RENEWED BECAUSE OF ANY CHANGE IN EMPLOYER OR EMPLOYMENT STATUS, MARITAL STATUS, HEALTH STATUS, AGE, MEMBERSHIP IN ANY ORGANIZATION, OR OTHER CHANGE THAT DOES NOT AFFECT THE INDIVIDUAL'S ELIGIBILITY TO PARTICIPATE IN THE EXCHANGE.

(B) A PARTICIPATING INDIVIDUAL WHO IS NOT A RESIDENT OF THE STATE AND WHO CEASES TO BE AN ELIGIBLE INDIVIDUAL DUE TO A QUALIFYING EVENT SHALL REMAIN AN ELIGIBLE INDIVIDUAL AND SHALL BE CONSIDERED A PARTICIPATING INDIVIDUAL FOR A PERIOD NOT TO EXCEED 36 MONTHS FROM THE DATE OF THE QUALIFYING EVENT, IF:

(1) THE QUALIFYING EVENT CONSISTS OF A LOSS OF ELIGIBLE INDIVIDUAL STATUS DUE TO:

(I) VOLUNTARY OR INVOLUNTARY TERMINATION OF EMPLOYMENT FOR REASONS OTHER THAN GROSS MISCONDUCT; OR

(II) LOSS OF QUALIFIED DEPENDENT STATUS FOR ANY REASON; AND

(2) THE PARTICIPATING INDIVIDUAL ELECTS TO REMAIN A PARTICIPATING INDIVIDUAL AND NOTIFIES THE EXCHANGE OF THIS ELECTION WITHIN 63 DAYS OF THE QUALIFYING EVENT.

19–150.

(A) ANY EMPLOYER MAY APPLY TO THE EXCHANGE TO BE THE SPONSOR OF A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN.

(B) ANY EMPLOYER SEEKING TO BE THE SPONSOR OF A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN, AS A CONDITION OF PARTICIPATION IN THE EXCHANGE, SHALL ENTER INTO A BINDING AGREEMENT WITH THE EXCHANGE, THAT SHALL INCLUDE THE FOLLOWING CONDITIONS:

(1) THE SPONSORING EMPLOYER DESIGNATES THE EXCHANGE DIRECTOR TO BE THE PLAN'S ADMINISTRATOR FOR THE EMPLOYER'S GROUP HEALTH PLAN AND THE EXCHANGE DIRECTOR AGREES TO UNDERTAKE THE OBLIGATIONS REQUIRED OF A PLAN ADMINISTRATOR UNDER FEDERAL LAW;

(2) ONLY THE COVERAGE AND BENEFITS OFFERED BY PARTICIPATING PLANS SHALL CONSTITUTE THE COVERAGE AND BENEFITS OF THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN;

(3) THE EMPLOYER RESERVES THE RIGHT TO OFFER BENEFITS SUPPLEMENTAL TO THE BENEFITS OFFERED THROUGH THE EXCHANGE, BUT ANY SUPPLEMENTAL BENEFITS OFFERED BY THE EMPLOYER SHALL CONSTITUTE A SEPARATE PLAN UNDER FEDERAL LAW, FOR WHICH THE EXCHANGE DIRECTOR MAY NOT BE THE PLAN ADMINISTRATOR AND FOR WHICH NEITHER THE EXCHANGE DIRECTOR NOR THE EXCHANGE SHALL BE RESPONSIBLE IN ANY MANNER;

(4) THE EMPLOYER AGREES THAT, FOR THE TERM OF THE AGREEMENT, THE EMPLOYER WILL NOT OFFER TO INDIVIDUALS ELIGIBLE TO PARTICIPATE IN THE EXCHANGE DUE TO THEIR ELIGIBILITY FOR COVERAGE UNDER THE EMPLOYER'S PARTICIPATING EMPLOYER–SUBSIDIZED PLAN ANY SEPARATE OR COMPETING GROUP HEALTH PLAN OFFERING THE SAME OR SUBSTANTIALLY SIMILAR BENEFITS AS THOSE PROVIDED BY PARTICIPATING PLANS THROUGH THE EXCHANGE, WHETHER OR NOT ANY OF THOSE INDIVIDUALS WOULD OTHERWISE QUALIFY AS ELIGIBLE INDIVIDUALS ABSENT THEIR ENROLLMENT IN THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN;

(5) THE EMPLOYER RESERVES THE RIGHT TO DETERMINE THE CRITERIA FOR ELIGIBILITY, ENROLLMENT, AND PARTICIPATION IN THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN AND THE TERMS AND AMOUNTS OF THE EMPLOYER'S CONTRIBUTIONS TO THAT PLAN, SO LONG AS FOR THE TERM OF THE AGREEMENT WITH THE EXCHANGE, THE EMPLOYER AGREES NOT TO ALTER OR AMEND ANY CRITERIA OR CONTRIBUTION AMOUNTS AT ANY TIME

OTHER THAN DURING AN ANNUAL PERIOD DESIGNATED BY THE EXCHANGE FOR PARTICIPATING EMPLOYER–SUBSIDIZED PLANS TO MAKE THOSE CHANGES IN CONJUNCTION WITH THE EXCHANGE'S ANNUAL OPEN SEASON; AND

(6) THE EMPLOYER AGREES TO MAKE AVAILABLE TO THE EXCHANGE DIRECTOR ANY OF THE EMPLOYER'S DOCUMENTS, RECORDS, OR INFORMATION, INCLUDING COPIES OF THE EMPLOYER'S FEDERAL AND STATE TAX AND WAGE REPORTS, THAT THE COMMISSION REASONABLY DETERMINES ARE NECESSARY FOR THE EXCHANGE DIRECTOR TO VERIFY:

(I) THAT THE EMPLOYER IS IN COMPLIANCE WITH THE TERMS OF ITS AGREEMENT WITH THE EXCHANGE GOVERNING THE EMPLOYER'S SPONSORSHIP OF A PARTICIPATING EMPLOYER–SUBSIDIZED PLAN;

(II) THAT THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN IS IN COMPLIANCE WITH THE APPLICABLE FEDERAL AND STATE LAWS RELATING TO GROUP HEALTH PLANS, PARTICULARLY THOSE RELATING TO NONDISCRIMINATION IN COVERAGE; AND

(III) THE ELIGIBILITY, UNDER THE TERMS OF THE EMPLOYER'S PLAN, OF THOSE INDIVIDUALS ENROLLED IN THE PARTICIPATING EMPLOYER–SUBSIDIZED PLAN.

19–151.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION, THE SECRETARY OF BUDGET AND MANAGEMENT SHALL ENTER INTO A CONTRACT WITH THE EXCHANGE FOR THE EXCHANGE TO PROVIDE HEALTH INSURANCE BENEFITS TO ALL INDIVIDUALS ELIGIBLE FOR THE STATE EMPLOYEE AND RETIREE HEALTH AND WELFARE BENEFITS PROGRAM ESTABLISHED UNDER TITLE 2, SUBTITLE 5 OF THE STATE PERSONNEL AND PENSIONS ARTICLE.

(B) COVERAGE FOR INDIVIDUALS WHO ARE ENTITLED TO RECEIVE BENEFITS UNDER PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT IS NOT REQUIRED TO BE PART OF THE CONTRACT REQUIRED BY SUBSECTION (A) OF THIS SECTION.

19–152. RESERVED.

19–153. RESERVED.

Article – Insurance

14–502.

(a) There is a Maryland Health Insurance Plan.

(b) The Plan is an independent unit of the State government.

[(c) The purpose of the Plan is to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically uninsurable residents of the State by July 1, 2003.**]**

(C) (1) THE PLAN MAY NOT ACCEPT ANY NEW ENROLLEES ON OR AFTER THE FIRST DAY OF THE PLAN YEAR FOLLOWING THE FIRST OPEN SEASON CONDUCTED BY THE MARYLAND HEALTH INSURANCE EXCHANGE, IN ACCORDANCE WITH § 19–148(L) OF THE HEALTH – GENERAL ARTICLE.

(2) INDIVIDUALS WHO REMAIN ENROLLED IN THE PLAN AFTER THE DATE SPECIFIED IN PARAGRAPH (1) OF THIS SUBSECTION MAY CONTINUE COVERAGE ONLY IN ACCORDANCE WITH ANY RIGHT THE INDIVIDUAL MAY HAVE TO CONTINUE COVERAGE UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

[(d) It is the intent of the General Assembly that the Plan operate as a nonprofit entity and that Fund revenue, to the extent consistent with good business practices, be used to subsidize health insurance coverage for medically uninsurable individuals.**]**

[(e)**] (D)** (1) The operations of the Plan are subject to the provisions of this subtitle whether the operations are performed directly by the Plan itself or through an entity contracted with the Plan.

(2) The Plan shall ensure that any entity contracted with the Plan complies with the provisions of this subtitle when performing services that are subject to this subtitle on behalf of the Plan.

14–508.

(a) **[**The Plan shall be the alternative mechanism for eligible individuals under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. 148.128.

(b)**]** The Plan may not apply a preexisting condition exclusion to an eligible individual who applies for coverage under the Plan within 63 days of terminating prior creditable coverage.

[(c)**] (B)** If the Board imposes a limit on the number of individuals who can participate in the Plan, the limit may not be applied to HIPAA eligible individuals.

15–1201.

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

(b) "Board" means the Board of Directors of the Pool established under § 15–1216 of this subtitle.

(c) "Carrier" means a person that:

(1) offers health benefit plans in the State covering **[**eligible employees of small employers**]** **INDIVIDUALS OR EMPLOYER GROUPS**; and

(2) is:

(i) an authorized insurer that provides health insurance in the State;

(ii) a nonprofit health service plan that is licensed to operate in the State;

(iii) a health maintenance organization that is licensed to operate in the State; or

(iv) any other person or organization that provides health benefit plans subject to State insurance regulation.

[(d) "Commission" means the Maryland Health Care Commission established under Title 19, Subtitle 1 of the Health – General Article.

(e) (1) "Eligible employee" means:

(i) an individual who:

1. is an employee, partner of a partnership, or independent contractor who is included as an employee under a health benefit plan; and

2. works on a full–time basis and has a normal workweek of at least 30 hours; or

(ii) a sole employee of a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under § 501(c)(3), (4), or (6) of the Internal Revenue Code who:

1. has a normal workweek of at least 20 hours; and

2. is not covered under a public or private plan for health insurance or other health benefit arrangement.

(2) "Eligible employee" does not include an individual who works:

(i) on a temporary or substitute basis; or

(ii) except for an individual described in paragraph (1)(ii) of this subsection, for less than 30 hours in a normal workweek.**]**

(D) "EMPLOYER" MEANS ANY PERSON THAT:

(1) EMPLOYS ONE OR MORE INDIVIDUALS IN THE STATE; AND

(2) FILES PAYROLL TAX INFORMATION ON THOSE INDIVIDUALS.

(E) "EXCHANGE" MEANS THE MARYLAND HEALTH INSURANCE EXCHANGE ESTABLISHED UNDER TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE.

(f) (1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits;

(ii) a nonprofit health service plan; or

(iii) a health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" includes a policy or certificate for hospital or medical benefits that covers residents of this State who are eligible employees and that is issued through:

(i) a multiple employer trust or association located in this State or another state; or

(ii) a professional employer organization, coemployer, or other organization located in this State or another state that engages in employee leasing.

(3) "Health benefit plan" does not include:

[(i) accident–only insurance;

(ii) fixed indemnity insurance;

(iii) credit health insurance;

(iv) Medicare supplement policies;

(v) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policies;

(vi) long–term care insurance;

(vii) disability income insurance;

(viii) coverage issued as a supplement to liability insurance;

(ix) workers' compensation or similar insurance;

(x) disease–specific insurance;

(xi) automobile medical payment insurance;

(xii) dental insurance; or

(xiii) vision insurance.**]**

(I) ONE OR MORE, OR ANY COMBINATION OF, THE FOLLOWING:

1. COVERAGE ONLY FOR ACCIDENT INSURANCE OR DISABILITY INCOME INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

3. LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT–ONLY INSURANCE;

7. COVERAGE FOR ON–SITE MEDICAL CLINICS; OR

8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FEDERAL REGULATIONS ISSUED IN ACCORDANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT,

UNDER WHICH BENEFITS FOR MEDICAL CARE ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS;

(II) THE FOLLOWING BENEFITS, IF THEY ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE, OR ARE OTHERWISE NOT AN INTEGRAL PART OF A PLAN:

1. LIMITED–SCOPE DENTAL OR VISION BENEFITS;

2. BENEFITS FOR LONG–TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY–BASED CARE, OR ANY COMBINATION OF THESE BENEFITS; AND

3. SUCH OTHER SIMILAR, LIMITED BENEFITS AS ARE SPECIFIED IN FEDERAL REGULATIONS ISSUED IN ACCORDANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT;

(III) THE FOLLOWING BENEFITS, IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS:

1. COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS; OR

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE; OR

(IV) THE FOLLOWING BENEFITS, IF OFFERED AS A SEPARATE INSURANCE POLICY:

1. MEDICARE SUPPLEMENTAL HEALTH INSURANCE, AS DEFINED UNDER § 1882(G)(1) OF THE SOCIAL SECURITY ACT;

2. COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER TITLE 10, CHAPTER 55 OF THE UNITED STATES CODE; OR

3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER AN EMPLOYER–SPONSORED PLAN.

(g) "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability including conditions arising out of acts of domestic violence; or

(8) disability.

[(h) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period provided under the health benefit plan.**]**

(H) "PLAN YEAR" MEANS THE PERIOD OF TIME DURING WHICH THE INSURED IS COVERED UNDER A HEALTH BENEFIT PLAN, AS STIPULATED IN THE CONTRACT GOVERNING THE PLAN.

(i) "Pool" means the Maryland **[**Small Employer Health Reinsurance Pool**]** **HEALTH INSURANCE RISK TRANSFER POOL** established under this subtitle.

[(j) "Preexisting condition" means:

(1) a condition existing during a specified period immediately preceding the effective date of coverage, that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(k) "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

(l)**] (J)** "Reinsuring carrier" means a carrier that participates in the Pool.

[(m)**] (K)** "Risk–assuming carrier" means a carrier that does not participate in the Pool.

[(n)**] (L)** "Small employer" means:

(1) an employer described in § 15–1203 of this subtitle; or

(2) an entity that leases employees from a professional employer organization, coemployer, or other organization engaged in employee leasing and that otherwise meets the description of § 15–1203 of this subtitle.

[(o) "Special enrollment period" means a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

(p) "Standard Plan" means the Comprehensive Standard Health Benefit Plan adopted by the Commission in accordance with § 15–1207 of this subtitle and Title 19, Subtitle 1 of the Health – General Article.**]**

[(q)**] (M)** (1) "Wellness program" means a program or activity that:

(i) is designed to improve health status and reduce health care costs; and

(ii) complies with guidelines developed by the Commission.

(2) "Wellness program" includes programs and activities for:

(i) smoking cessation;

(ii) reduction of alcohol misuse;

(iii) weight reduction;

(iv) nutrition education; and

(v) automobile and motorcycle safety.

[(r)**] (N)** "Wellness benefit" means a benefit offered as a rider to a health benefit plan that provides coverage for a program or activity that:

(1) is designed to:

(i) prevent or detect disease or illness;

(ii) reduce or avoid poor clinical outcomes;

(iii) prevent complications from medical conditions; or

(iv) promote healthy behaviors and lifestyle choices; and

(2) complies with regulations adopted by the Commission.

15–1202.

(a) **[**This subtitle applies only to a health benefit plan that:

(1) covers eligible employees of small employers in the State; and

(2) is issued or renewed on or after July 1, 1994, if:

(i) any part of the premium or benefits is paid by or on behalf of the small employer;

(ii) any eligible employee or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of the small employer for any part of the premium;

(iii) the health benefit plan is treated by the employer or any eligible employee or dependent as part of a plan or program under the United States Internal Revenue Code, 26 U.S.C. § 106, § 125, or § 162; or

(iv) the small employer allows eligible employees to pay for the health benefit plan through payroll deductions.**] EXCEPT AS PROVIDED IN §§ 15–1208.1 AND 15–1212 OF THIS SUBTITLE, A CARRIER MAY NOT ISSUE OR RENEW A GROUP HEALTH BENEFIT PLAN TO A SMALL EMPLOYER, OTHER THAN THROUGH THE EXCHANGE, AFTER THE FIRST DAY OF THE PLAN YEAR FOLLOWING THE FIRST REGULAR OPEN SEASON CONDUCTED BY THE EXCHANGE IN ACCORDANCE WITH § 19–148(L) OF THE HEALTH – GENERAL ARTICLE.**

(b) A carrier is subject to the requirements of § 15–1403 of this title in connection with health benefit plans issued under this subtitle.

15–1204.

(a) In addition to any other requirement under this article, a carrier shall:

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

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

(3) provide, in the case of individuals covered under more than one health benefit plan, for coordination of coverage under all of those health benefit plans in an equitable manner; and

(4) design policies to help ensure adequate access to providers of health care.

(b) **[**A person may not offer a health benefit plan in the State unless the person offers at least the Standard Plan.**]** **A CARRIER MAY NOT OFFER A HEALTH BENEFIT PLAN THROUGH THE EXCHANGE UNLESS THE COMMISSIONER FIRST HAS CERTIFIED TO THE EXCHANGE THAT:**

(1) THE CARRIER SEEKING TO OFFER THE PLAN IS AUTHORIZED TO ISSUE HEALTH INSURANCE IN THE STATE AND IS IN GOOD STANDING WITH THE ADMINISTRATION;

(2) THE PLAN MEETS THE REQUIREMENTS OF §§ 15–1205 AND 15–1207 OF THIS SUBTITLE; AND

(3) THE PLAN AND THE CARRIER ARE IN COMPLIANCE WITH ALL OTHER APPLICABLE LAWS REGULATING INSURANCE IN THE STATE.

(c) **[**A carrier may not offer a health benefit plan that has fewer benefits than those in the Standard Plan**]** **THE COMMISSIONER MAY NOT MAKE THE CERTIFICATION REQUIRED UNDER SUBSECTION (B) OF THIS SECTION UNLESS THE CARRIER AGREES TO PARTICIPATE IN THE POOL**.

(d) **[**A carrier may offer benefits in addition to those in the Standard Plan if:

(1) the additional benefits:

(i) are offered and priced separately from benefits specified in accordance with § 15–1207 of this subtitle; and

(ii) do not have the effect of duplicating any of those benefits; and

(2) the carrier:

(i) clearly distinguishes the Standard Plan from other offerings of the carrier;

(ii) indicates the Standard Plan is the only plan required by State law; and

(iii) specifies that all enhancements to the Standard Plan are not required by State law**]** **THE COMMISSIONER MAY NOT CERTIFY ANY PLAN THAT EXCLUDES INDIVIDUALS FROM COVERAGE WHO OTHERWISE ARE DETERMINED BY THE EXCHANGE TO MEET THE ELIGIBILITY REQUIREMENTS FOR PARTICIPATING INDIVIDUALS, AS DEFINED IN § 19–142 OF THE HEALTH – GENERAL ARTICLE**.

(e) **[**Notwithstanding subsection (b) of this section, a health maintenance organization may provide a point of service delivery system as an additional benefit through another carrier regardless of whether the other carrier also offers the Standard Plan**] EXCEPT AS PROVIDED IN TITLE 14, SUBTITLE 3 OF THE STATE FINANCE AND PROCUREMENT ARTICLE, THE CERTIFICATION OF PLANS TO BE OFFERED THROUGH THE EXCHANGE IS EXEMPT FROM THE PROVISIONS OF DIVISION II OF THE STATE FINANCE AND PROCUREMENT ARTICLE**.

(f) **[**A carrier may offer coverage for dental care and services as an additional benefit**] EACH CERTIFICATION SHALL BE VALID FOR A UNIFORM TERM OF AT LEAST 1 YEAR, BUT MAY BE MADE AUTOMATICALLY RENEWABLE IN THE ABSENCE OF NOTICE OF:**

(1) WITHDRAWAL OF CERTIFICATION BY THE COMMISSIONER; OR

(2) DISCONTINUATION OF PARTICIPATION IN THE EXCHANGE BY THE PLAN.

(g) (1) In this subsection, "prominent carrier" means a carrier that insures at least 10% of the total lives insured **[**in the small group market**] THROUGH THE EXCHANGE**.

(2) (i) A prominent carrier shall offer a wellness benefit for a health benefit plan offered under this subtitle.

(ii) A carrier that is not a prominent carrier may offer a wellness benefit for a health benefit plan offered under this subtitle.

(3) A carrier may not condition the sale of a wellness benefit to **[**a small**] AN** employer on participation of the eligible employees of the **[**small**]** employer in wellness programs or activities.

(H) (1) CERTIFICATION OF A PLAN DURING A TERM OF CERTIFICATION MAY BE WITHDRAWN ONLY AFTER NOTICE TO THE CARRIER AND OPPORTUNITY FOR A HEARING IN ACCORDANCE WITH TITLE 10 OF THE STATE GOVERNMENT ARTICLE.

(2) (I) THE COMMISSIONER MAY ELECT NOT TO RENEW THE CERTIFICATION OF ANY CARRIER AT THE END OF A CERTIFICATION TERM.

(II) ANY CARRIER MAY CONTEST A DECISION OF THE COMMISSIONER UNDER THIS PARAGRAPH IN ACCORDANCE WITH TITLE 10 OF THE STATE GOVERNMENT ARTICLE.

15–1205.

(a) (1) In establishing a community rate for a health benefit plan **OFFERED THROUGH THE EXCHANGE**, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to health status or occupation or any other factor not specifically authorized under this subsection.

(2) **[**A**] IN DETERMINING THE SCHEDULE OF RATES FOR A PLAN OFFERED THROUGH THE EXCHANGE, A** carrier may adjust the community rate only for:

(i) age**, BASED ON AGE BANDS OF AT LEAST 5 YEARS IN WIDTH**; and

(ii) geography based on the following contiguous areas of the State:

1. the Baltimore metropolitan area;

2. the District of Columbia metropolitan area;

3. Western Maryland; and

4. Eastern and Southern Maryland.

(3) Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

(4) (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph (2) of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.

(ii) A discount offered under subparagraph (i) of this paragraph shall be:

1. applied to reduce the rate otherwise payable by the small employer;

2. actuarially justified;

3. offered uniformly to all small employers; and

4. approved by the Commissioner.

(b) A carrier shall apply all risk adjustment factors under subsection (a) of this section consistently with respect to all health benefit plans that are issued, delivered, or renewed in the State.

(c) (1) Based on the adjustments allowed under subsection (a)(2) of this section, a carrier may charge a rate that **[**is 40% above or 50% below the community rate**]:**

(I) IF THE PLAN VARIES ITS RATES ON THE BASIS OF AGE, IS NOT MORE THAN 55% ABOVE OR BELOW THE COMMUNITY RATE; AND

(II) IF THE PLAN VARIES ITS RATES ON THE BASIS OF GEOGRAPHY, IS NOT MORE THAN 20% ABOVE THE RATE FOR THE SAME AGE BAND IN THE AREA WITH THE LOWEST RATE.

(2) **[**(i)**]** On or before October 1, 2007, the Commission shall adopt regulations that require carriers to collect and report to the Commission data on participation, by rate band, in health benefit plans issued, delivered, or renewed under this subtitle.

[(ii) On or before January 1, 2011, the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee regarding the effect of the 50% rate adjustment authorized under paragraph (1) of this subsection on participation in health benefit plans issued, delivered, or renewed under this subtitle.**]**

(d) (1) A carrier shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles.

(2) A carrier that is a health maintenance organization and that includes a subrogation provision in its contract as authorized under § 19–713.1(d) of the Health – General Article shall:

(i) use in its rating methodology an adjustment that reflects the subrogation; and

(ii) identify in its rate filing with the Administration, and annually in a form approved by the Commissioner, all amounts recovered through subrogation.

(e) (1) A carrier may offer an administrative discount to a small employer if the small employer elects to purchase, for its employees, an annuity, dental insurance, disability insurance, life insurance, long term care insurance, vision insurance, or, with the approval of the Commissioner, any other insurance sold by the carrier.

(2) The administrative discount shall be offered under the same terms and conditions for all qualifying small employers.

[15–1207.

(a) In accordance with Title 19, Subtitle 1 of the Health – General Article, the Commission shall adopt regulations that specify:

(1) the Comprehensive Standard Health Benefit Plan to apply under this subtitle; and

(2) the requirements for a wellness benefit offered by a carrier to apply under this subtitle.

(b) The Commission shall require that the minimum benefits allowed to be offered in the Standard Plan:

(1) by a health maintenance organization, shall include at least the actuarial equivalent of the minimum benefits required to be offered by a federally qualified health maintenance organization; and

(2) by an insurer or nonprofit health service plan on an expense–incurred basis, shall be actuarially equivalent to at least the minimum benefits required to be offered under item (1) of this subsection.

(c) (1) Subject to paragraph (2) of this subsection, the Commission shall exclude or limit benefits or adjust cost–sharing arrangements in the Standard Plan if the average rate for the Standard Plan exceeds 10% of the average annual wage in the State.

(2) The Commission annually shall determine the average rate for the Standard Plan by using the average rate submitted by each carrier that offers the Standard Plan.

(d) In establishing benefits the Commission shall judge preventive services, medical treatments, procedures, and related health services based on:

(1) their effectiveness in improving the health status of individuals;

(2) their impact on maintaining and improving health and on reducing the unnecessary consumption of health care services; and

(3) their impact on the affordability of health care coverage.

(e) The Commission may exclude:

(1) 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

(2) 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.

(f) The Standard Plan shall include uniform deductibles and cost–sharing associated with its benefits, as determined by the Commission.

(g) In establishing cost–sharing as part of the Standard Plan the Commission shall:

(1) include cost–sharing and other incentives to help prevent consumers from seeking unnecessary services;

(2) balance the effect of cost–sharing in reducing premiums and in affecting utilization of appropriate services; and

(3) limit the total cost–sharing that may be incurred by an individual in a year.**]**

15–1207.

FOR A PLAN TO BE OFFERED THROUGH THE EXCHANGE, A PLAN MUST:

(1) OFFER, SUBJECT TO THE PLAN'S DEDUCTIBLES AND COPAYMENT SCHEDULE, MAJOR MEDICAL COVERAGE THAT INCLUDES THE FOLLOWING CLASSES OF BENEFITS:

(I) HOSPITAL BENEFITS;

(II) SURGICAL BENEFITS;

(III) IN–HOSPITAL MEDICAL BENEFITS;

(IV) AMBULATORY PATIENT BENEFITS;

(V) PRESCRIPTION DRUG BENEFITS; AND

(VI) MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT BENEFITS;

(2) OFFER COVERAGE THAT MEETS THE REQUIREMENTS OF THE FEDERAL MENTAL HEALTH PARITY ACT, THE FEDERAL NEWBORNS' AND

MOTHERS' HEALTH PROTECTION ACT, AND THE FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT; AND

(3) PROVIDE A DETAILED DESCRIPTION TO POTENTIAL ENROLLEES OF THE SPECIFIC BENEFITS OFFERED BY THE PLAN, INCLUDING ANY MAXIMUMS, EXCLUSIONS, COPAYMENT REQUIREMENTS, OR OTHER BENEFIT LIMITATIONS.

15–1208.1.

(a) A carrier shall provide the special enrollment periods described in this section in each small employer health benefit plan.

(b) If the small employer elects **[**under § 15–1210(a)(3) of this subtitle**]** to offer coverage to all of its employees who are covered under another public or private plan of health insurance or another health benefit arrangement, a carrier shall allow an employee or dependent who is eligible, but not enrolled, for coverage under the terms of the employer's health benefit plan to enroll for coverage under the terms of the plan if:

(1) the employee or dependent was covered under an employer–sponsored plan or group health benefit plan at the time coverage was previously offered to the employee or dependent;

(2) the employee states in writing, at the time coverage was previously offered, that coverage under an employer–sponsored plan or group health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier requires the statement and provides the employee with notice of the requirement;

(3) the employee's or dependent's coverage described in item (1) of this subsection:

(i) was under a COBRA continuation provision, and the coverage under that provision was exhausted; or

(ii) was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and

(4) under the terms of the plan, the employee requests enrollment not later than 30 days after:

(i) the date of exhaustion of coverage described in item (3)(i) of this subsection; or

(ii) termination of coverage or termination of employer contributions described in item (3)(ii) of this subsection.

(c) All small employer health benefit plans shall provide a special enrollment period during which the following individuals may be enrolled under the health benefit plan:

(1) an individual who becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption;

(2) an eligible employee who acquires a new dependent through marriage, birth, adoption, or placement for adoption; and

(3) the spouse of an eligible employee at the birth or adoption of a child, provided the spouse is otherwise eligible for coverage.

(d) An eligible employee may not enroll a dependent during a special enrollment period unless the eligible employee:

(1) is enrolled under the health benefit plan; or

(2) applies for coverage for the eligible employee during the same special enrollment period.

(e) The special enrollment period under subsection (c) of this section shall be a period of not less than 31 days and shall begin on the later of:

(1) the date dependent coverage is made available; or

(2) the date of the marriage, birth, adoption, or placement for adoption, whichever is applicable.

(f) If an eligible employee enrolls any of the individuals described in subsection (c) of this section during the first 31 days of the special enrollment period, the coverage shall become effective as follows:

(1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) in the case of a dependent's birth, as of the date of the dependent's birth; and

(3) in the case of a dependent's adoption or placement for adoption, the date of adoption or placement for adoption, whichever occurs first.

15–1303.

[(c) (1) If a carrier denies coverage under a medically underwritten health benefit plan to an individual in the nongroup market, the carrier shall provide:

(i) the individual with specific information regarding the availability of coverage under the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of this article; and

(ii) the Maryland Health Insurance Plan with:

1. the name and address of the individual who was denied coverage; and

2. if the individual applied for coverage through an insurance producer, the name and, if available, the address of the insurance producer.

(2) The information provided by a carrier under this subsection shall be provided in a manner and form required by the Commissioner.**]**

15–1309.

(a) **[**Except as provided in subsection (b) of this section, a carrier shall renew an individual health benefit plan at the option of the eligible individual**]** **SUBJECT TO SUBSECTION (B) OF THIS SECTION, A CARRIER MAY NOT ISSUE OR RENEW AN INDIVIDUAL HEALTH BENEFIT PLAN OTHER THAN THROUGH THE MARYLAND HEALTH INSURANCE EXCHANGE ESTABLISHED UNDER TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE**.

(b) A carrier may not cancel or refuse to renew an individual health benefit plan except:

(1) for nonpayment of the required premiums;

(2) where the individual has performed an act or practice that constitutes fraud;

(3) where the individual has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the carrier elects not to renew all of its individual health benefit plans in the State in accordance with this article;

(5) where the individual no longer resides, lives, or works in the service area, provided that the coverage is terminated under this provision uniformly without regard to any health status–related factor of covered individuals; or

(6) where, in the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the

membership of the individual in the association ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status–related factor of covered individuals.

[15–1313.

The Administration shall provide on its website and in printed form on request a list of carriers, including contact information for each carrier, that offer individual health benefit plans in the State.**]**

15–1408.

(A) A carrier shall renew group health benefit plans **THAT ARE NOT PARTICIPATING PLANS, AS DEFINED IN § 19–142 OF THE HEALTH – GENERAL ARTICLE,** at the option of the policyholder or plan sponsor, except in any of the following cases:

(1) for nonpayment of the required premium;

(2) where the policyholder or plan sponsor has performed an act or practice that constitutes fraud;

(3) where the policyholder or plan sponsor has made an intentional misrepresentation of material fact under the terms of the coverage;

(4) where the policyholder or plan sponsor has failed to comply with a material plan provision relating the employer contributions or group participation rules;

(5) where the carrier elects not to renew all group health benefit plans in the State;

(6) in the case of a health maintenance organization, where there is no longer any enrollee who lives, resides, or works in the health maintenance organization's approved service area;

(7) in the case of a carrier that offers coverage only through one or more bona fide associations, when the membership of an employer in the association ceases and nonrenewal under this item is applied uniformly without regard to any health status–related factor relating to any covered individual; or

(8) the carrier makes an election under § 15–1409 of this subtitle.

(B) A CARRIER SHALL RENEW GROUP HEALTH PLANS THAT ARE PARTICIPATING PLANS, AS DEFINED IN § 19–142 OF THE HEALTH – GENERAL ARTICLE, IN ACCORDANCE WITH THE PROVISIONS OF TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE.

Article – State Personnel and Pensions

2–502.

(a) There is a State Employee and Retiree Health and Welfare Benefits Program, to be developed and administered by the Secretary **IN ACCORDANCE WITH TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE**.

Article – Tax – General

10–728.

(A) IN THIS SECTION, "EXCHANGE" MEANS THE MARYLAND HEALTH INSURANCE EXCHANGE ESTABLISHED UNDER TITLE 19, SUBTITLE 1, PART IV OF THE HEALTH – GENERAL ARTICLE.

(B) EXCEPT AS PROVIDED IN SUBSECTIONS (C) THROUGH (H) OF THIS SECTION, AN INDIVIDUAL MAY CLAIM A CREDIT AGAINST THE STATE INCOME TAX IN AN AMOUNT EQUAL TO 100% OF THE ELIGIBLE HEALTH INSURANCE PREMIUMS PAID BY THE INDIVIDUAL, IF THE INDIVIDUAL, AND WHEN APPLICABLE, THE SPOUSE OF THE INDIVIDUAL AND DEPENDENT CHILDREN OF THE INDIVIDUAL, ARE COVERED BY HEALTH INSURANCE PURCHASED THROUGH THE EXCHANGE:

(1) FOR AT LEAST 6 MONTHS OF THE TAXABLE YEAR; AND

(2) ON DECEMBER 31 OF THE TAXABLE YEAR.

(C) ELIGIBLE HEALTH INSURANCE PREMIUMS FOR WHICH THE CREDIT MAY BE CLAIMED SHALL CONSIST EXCLUSIVELY OF PAYMENTS BY THE INDIVIDUAL FOR HEALTH INSURANCE COVERAGE PURCHASED THROUGH THE EXCHANGE.

(D) FOR PURPOSES OF SUBSECTIONS (B) AND (C) OF THIS SECTION, THE COST OF COVERAGE SHALL BE TREATED AS PAID OR INCURRED BY AN EMPLOYER TO THE EXTENT THAT PAYMENT IS MADE BY THE INDIVIDUAL THROUGH A VOLUNTARY, PRE–TAX SALARY REDUCTION UNDER 26 U.S.C. § 125(D).

(E) THE CREDIT ALLOWED UNDER THIS SECTION:

(1) MAY NOT EXCEED $500 IF THE COVERAGE IS FOR ONE INSURED INDIVIDUAL;

(2) MAY NOT EXCEED $1,000 IF THE COVERAGE IS FOR TWO OR MORE INSURED INDIVIDUALS;

(3) MAY NOT BE CLAIMED BY MORE THAN ONE TAXPAYER WITH RESPECT TO THE SAME INSURED INDIVIDUAL;

(4) MAY NOT BE CLAIMED WITH RESPECT TO ANY INDIVIDUAL NOT COVERED BY THE COVERAGE SPECIFIED IN SUBSECTION (C) OF THIS SECTION FOR AT LEAST 6 MONTHS OF THE TAXABLE YEAR AND ON DECEMBER 31 OF THE TAXABLE YEAR;

(5) MAY NOT BE CLAIMED WITH RESPECT TO ANY INDIVIDUAL OTHER THAN:

(I) THE TAXPAYER;

(II) AN INDIVIDUAL WHO IS THE SPOUSE OF THE TAXPAYER FOR AT LEAST 6 MONTHS OF THE TAXABLE YEAR AND ON DECEMBER 31 OF THE TAXABLE YEAR; OR

(III) AN INDIVIDUAL WHO IS A DEPENDENT CHILD OF THE TAXPAYER FOR AT LEAST 6 MONTHS OF THE TAXABLE YEAR AND ON DECEMBER 31 OF THE TAXABLE YEAR; AND

(6) MAY NOT BE CLAIMED WITH RESPECT TO ANY INSURED INDIVIDUAL UNLESS ALL OF THE DEPENDENTS OF THE INSURED INDIVIDUAL ARE ALSO COVERED BY HEALTH INSURANCE, EITHER UNDER A PLAN OFFERED THROUGH THE EXCHANGE OR UNDER ANY CREDITABLE COVERAGE AS DEFINED IN § 15–1301 OF THE INSURANCE ARTICLE.

(F) THE TOTAL AMOUNT OF THE CREDIT ALLOWED UNDER THIS SECTION FOR ANY TAXABLE YEAR MAY NOT EXCEED THE STATE INCOME TAX FOR THAT TAXABLE YEAR, CALCULATED BEFORE APPLICATION OF THE CREDITS UNDER THIS SECTION AND §§ 10–701 AND 10–701.1 OF THIS SUBTITLE, BUT AFTER APPLICATION OF THE OTHER CREDITS ALLOWABLE UNDER THIS SUBTITLE.

(G) THE UNUSED AMOUNT OF THE CREDIT FOR ANY TAXABLE YEAR MAY NOT BE CARRIED OVER TO ANY OTHER TAXABLE YEAR.

(H) IN DETERMINING THE APPLICABILITY OF ANY PROVISION OF THIS SECTION, ANY CHILD WHO BECOMES A DEPENDENT OF A TAXPAYER BY REASON OF BIRTH OR A COURT ORDER RELATING TO ADOPTION OR CUSTODY AT ANY TIME WITHIN THE 6–MONTH PERIOD ENDING ON DECEMBER 31 OF THE

TAXABLE YEAR SHALL BE DEEMED TO HAVE BEEN A DEPENDENT CHILD OF THE TAXPAYER FOR THE ENTIRE 6–MONTH PERIOD ENDING ON DECEMBER 31 OF THE TAXABLE YEAR.

SECTION 3. AND BE IT FURTHER ENACTED, That Section(s) 15–1206, 15–1208, 15–1209 through 15–1211, 15–1213, and 15–1215 of Article – Insurance of the Annotated Code of Maryland be repealed.

SECTION 4. AND BE IT FURTHER ENACTED, That, no later than October 1, 2010, the Maryland Insurance Administration shall notify the Centers for Medicare and Medicaid Services that the State has established the Maryland Health Insurance Exchange and request that it be approved as an acceptable "alternative mechanism" under the federal Health Insurance Portability and Accountability Act in accordance with 45 C.F.R. 148.128(e).

SECTION 5. AND BE IT FURTHER ENACTED, That if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of this Act which can be given effect without the invalid provision or application, and for this purpose the provisions of this Act are declared severable.

SECTION 6. AND BE IT FURTHER ENACTED, That Sections 2 and 3 of this Act shall take effect July 1, 2010.

SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Section 6 of this Act, this Act shall take effect July 1, 2009.