

HOUSE BILL 166

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CF SB 182

By: **The Speaker (By Request – Administration) and Delegates Hammen, Hubbard, Anderson, Arora, Barnes, Cullison, Dumais, Gutierrez, Guzzone, Hucker, A. Kelly, Lee, Morhaim, Nathan–Pulliam, Pena–Melnik, Pendergrass, Reznik, Rosenberg, V. Turner, and Zucker**

Introduced and read first time: January 26, 2011

Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Maryland Health Benefit Exchange Act of 2011

FOR the purpose of establishing the Maryland Health Benefit Exchange as an independent unit of State government; providing that the exercise by the Exchange of its authority under this Act is an essential governmental function; establishing the purposes of the Exchange; providing for the construction of certain provisions of this Act and certain regulations and actions; providing that the Exchange is subject to certain provisions of law; establishing the Board of Trustees of the Exchange; providing for the qualifications, appointment, terms, and removal of members of the Board; prohibiting a member of the Board or a member of the staff of the Exchange from having a certain affiliation with certain persons and entities; establishing certain rules governing action by the Board; establishing certain powers and duties of the Board; requiring a member of the Board to perform the member's duties in accordance with certain standards; requiring the Board to appoint an Executive Director of the Exchange, with the approval of the Governor, and to determine the Executive Director's compensation; establishing the duties of the Executive Director; authorizing the Executive Director to employ and retain a certain staff; requiring the Secretary of Budget and Management to review and make certain recommendations about certain changes to the Exchange's salary plans proposed by the Executive Director; providing that an employee or independent contractor of the Exchange is not subject to certain laws, regulations, or executive orders; establishing the Maryland Health Benefit Exchange Fund as a special, nonlapsing fund; specifying the contents and purpose of the Fund; requiring the State Treasurer to hold the Fund separately and invest the money of the Fund; requiring the Comptroller to account for the Fund; establishing certain functions and duties of the Exchange; prohibiting the Exchange and certain insurance carriers from charging certain fees or penalties; requiring the

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



Exchange, in carrying out certain duties, to consult with certain stakeholders; requiring the Exchange to certify certain health benefit plans as qualified health plans; establishing certain requirements for certification as a qualified health plan; prohibiting the Exchange from making available any health benefit plans that are not qualified health plans; requiring each carrier that seeks certification of a health benefit plan to take certain actions; providing that certain requirements applicable to qualified health plans also apply to qualified dental plans; authorizing the Exchange to impose certain fees or assessments or otherwise generate funding necessary to support its operations; requiring certain funds to be deposited in the Maryland Health Benefit Exchange Fund; requiring the Exchange to maintain a certain Web site and publish certain information on the Web site; requiring the Exchange to be administered in a certain manner; requiring the Exchange to keep an accurate accounting of all its activities, expenditures, and receipts; requiring the Board to report certain information to certain individuals on an annual basis; requiring the Board to cooperate with any investigation into the affairs of the Exchange conducted by certain individuals; defining certain terms; prohibiting the Exchange from implementing certain functions or imposing certain requirements before certain guidance is received; prohibiting the Exchange from implementing certain functions or imposing certain requirements before certain studies are conducted, reports are made, and actions are taken by the Governor and the General Assembly; expressing the intent of the General Assembly regarding the appointment of certain members of the Board; requiring the Exchange to conduct certain studies and make certain recommendations to the Governor and the General Assembly; requiring the Exchange to report its findings and recommendations on or before certain dates; and generally relating to the Maryland Health Benefit Exchange.

BY adding to

Article – Insurance

Section 31–101 through 31–111 to be under the new title “Maryland Health Benefit Exchange”

Annotated Code of Maryland

(2006 Replacement Volume and 2010 Supplement)

Preamble

WHEREAS, The federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended by the federal Health Care and Education Reconciliation Act of 2010, requires each state, by January 1, 2014, to establish a health benefit Exchange that makes available qualified health plans to qualified individuals and employers, and meets certain other requirements; and

WHEREAS, The Affordable Care Act requires each state to establish the governance and structure of its health benefit Exchange by March 2012; and

WHEREAS, The State seeks to establish a highly effective, efficient, and accountable Exchange to reduce the number of Marylanders without health insurance

and to provide Marylanders with high-quality, affordable private health plans at competitive cost; and

WHEREAS, The Maryland Health Benefit Exchange (Exchange) will pursue these goals by facilitating the purchase and sale of qualified health plans in the individual insurance market, assisting qualified employers in the enrollment of their employees in qualified health plans in the small group market, and administering the distribution of premium tax credits for individuals and small employers; and

WHEREAS, The State intends for the individual and small group markets in Maryland to continue to exist outside the Exchange and for the Exchange to supplement rather than replace these existing markets; and

WHEREAS, The State seeks to ensure that the Exchange will be financially self-sustaining by 2016 in compliance with the Affordable Care Act; and

WHEREAS, The State seeks to ensure that the Exchange's governing structure is broadly-based, reflecting the racial, ethnic, and geographic diversity of the State and the expertise and competence necessary to oversee the effective development and operation of the Exchange; and

WHEREAS, The State seeks to ensure that all populations can access the products offered by the Exchange by requiring cultural competence in all of its operations and outreach; and

WHEREAS, The State intends that determination of eligibility for public sector health insurance programs and federal subsidies for commercial insurance, as well as enrollment in such programs, shall be simplified through or in conjunction with the development of the Exchange; and

WHEREAS, The Exchange must be transparent, accountable, and able to perform inherently governmental functions such as determining income eligibility and citizenship status, coordinating with other State agencies and programs, and adopting rules and regulations governing health insurance plan participation; and

WHEREAS, The Exchange must at the same time be nimble and flexible, able to respond quickly to changing insurance market conditions, be sensitive and responsive to consumer demands, and remain insulated from changes in the political environment; and

WHEREAS, The State seeks to balance these multifaceted characteristics by creating a public entity, independent of other units of State government, which shall be subject to certain State laws and regulations to ensure transparency, accountability, and coordination with State agencies and programs, but which shall be exempt from other State administrative laws and regulations affecting government operations to ensure sufficient flexibility to operate effectively, efficiently, and in coordination with the private sector; and

WHEREAS, The State recognizes that after it establishes a fully operational Exchange, delineates the full scope of its functions, and has an opportunity to evaluate its operations and performance metrics, it should assess whether the Exchange would function more effectively as a nongovernmental, nonprofit entity or should remain an independent public entity; now, therefore,

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

Article – Insurance

TITLE 31. MARYLAND HEALTH BENEFIT EXCHANGE.

31–101.

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

(B) “AFFORDABLE CARE ACT” MEANS THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, AND ANY REGULATIONS ADOPTED OR GUIDANCE ISSUED UNDER THE ACTS.

(C) “BOARD” MEANS THE BOARD OF TRUSTEES OF THE EXCHANGE.

(D) “CARRIER” MEANS:

(1) AN INSURER AUTHORIZED TO SELL HEALTH INSURANCE;

(2) A NONPROFIT HEALTH SERVICE PLAN;

(3) A HEALTH MAINTENANCE ORGANIZATION; OR

(4) ANY OTHER ENTITY PROVIDING A PLAN OF HEALTH INSURANCE, HEALTH BENEFITS, OR HEALTH SERVICES AUTHORIZED UNDER THIS ARTICLE OR THE AFFORDABLE CARE ACT.

(E) “EXCHANGE” MEANS THE MARYLAND HEALTH BENEFIT EXCHANGE ESTABLISHED UNDER § 31–102 OF THIS TITLE.

(F) (1) “HEALTH BENEFIT PLAN” MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT OFFERED, ISSUED, OR DELIVERED BY A CARRIER TO AN INDIVIDUAL OR SMALL EMPLOYER IN THE STATE TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

(2) “HEALTH BENEFIT PLAN” DOES NOT INCLUDE:

(I) COVERAGE ONLY FOR ACCIDENT OR DISABILITY INSURANCE OR ANY COMBINATION OF ACCIDENT AND DISABILITY INSURANCE;

(II) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

(III) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE;

(IV) WORKERS’ COMPENSATION OR SIMILAR INSURANCE;

(V) AUTOMOBILE MEDICAL PAYMENT INSURANCE;

(VI) CREDIT-ONLY INSURANCE;

(VII) COVERAGE FOR ON-SITE MEDICAL CLINICS; OR

(VIII) OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191, UNDER WHICH BENEFITS FOR HEALTH CARE SERVICES ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS.

(3) “HEALTH BENEFIT PLAN” DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE, OR ARE OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:

(I) LIMITED SCOPE DENTAL OR VISION BENEFITS;

(II) BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF THESE BENEFITS; OR

(III) SUCH OTHER SIMILAR LIMITED BENEFITS AS ARE SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO P.L. 104-191.

(4) “HEALTH BENEFIT PLAN” DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THE BENEFITS ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE, THERE IS NO COORDINATION BETWEEN THE PROVISION OF THE BENEFITS AND ANY EXCLUSION OF BENEFITS UNDER ANY GROUP HEALTH PLAN MAINTAINED BY

THE SAME PLAN SPONSOR, AND THE BENEFITS ARE PAID WITH RESPECT TO AN EVENT WITHOUT REGARD TO WHETHER THE BENEFITS ARE PROVIDED UNDER ANY GROUP HEALTH PLAN MAINTAINED BY THE SAME PLAN SPONSOR:

(I) COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS; OR

(II) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.

(5) “HEALTH BENEFIT PLAN” DOES NOT INCLUDE THE FOLLOWING IF OFFERED AS A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE:

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

(II) COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE (CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)); OR

(III) SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER A GROUP HEALTH PLAN.

(G) “QUALIFIED EMPLOYER” MEANS A SMALL EMPLOYER THAT ELECTS TO MAKE ITS FULL-TIME EMPLOYEES ELIGIBLE FOR ONE OR MORE QUALIFIED HEALTH PLANS OFFERED THROUGH THE SHOP EXCHANGE AND, AT THE OPTION OF THE EMPLOYER, SOME OR ALL OF ITS PART-TIME EMPLOYEES, PROVIDED THAT THE EMPLOYER:

(1) HAS ITS PRINCIPAL PLACE OF BUSINESS IN THE STATE AND ELECTS TO PROVIDE COVERAGE THROUGH THE SHOP EXCHANGE TO ALL OF ITS ELIGIBLE EMPLOYEES, WHEREVER EMPLOYED; OR

(2) ELECTS TO PROVIDE COVERAGE THROUGH THE SHOP EXCHANGE TO ALL OF ITS ELIGIBLE EMPLOYEES WHO ARE PRINCIPALLY EMPLOYED IN THE STATE.

(H) “QUALIFIED HEALTH PLAN” MEANS A HEALTH BENEFIT PLAN THAT HAS BEEN CERTIFIED TO MEET THE CRITERIA FOR CERTIFICATION DESCRIBED IN § 1311(C) OF THE AFFORDABLE CARE ACT AND § 31-109 OF THIS TITLE.

(I) “QUALIFIED INDIVIDUAL” MEANS AN INDIVIDUAL, INCLUDING A MINOR, WHO AT THE TIME OF ENROLLMENT:

(1) IS SEEKING TO ENROLL IN A QUALIFIED HEALTH PLAN OFFERED TO INDIVIDUALS THROUGH THE EXCHANGE;

(2) RESIDES IN THE STATE;

(3) IS NOT INCARCERATED, OTHER THAN INCARCERATION PENDING DISPOSITION OF CHARGES; AND

(4) IS, AND REASONABLY IS EXPECTED TO BE FOR THE ENTIRE PERIOD FOR WHICH ENROLLMENT IS SOUGHT, A CITIZEN OR NATIONAL OF THE UNITED STATES OR AN ALIEN LAWFULLY PRESENT IN THE UNITED STATES.

(J) “SECRETARY” MEANS THE SECRETARY OF THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(K) “SHOP EXCHANGE” MEANS THE SMALL BUSINESS OPTIONS PROGRAM AUTHORIZED UNDER § 31-108(B)(12) OF THIS TITLE.

(L) (1) “SMALL EMPLOYER” MEANS AN EMPLOYER THAT, DURING THE PRECEDING CALENDAR YEAR, EMPLOYED AN AVERAGE OF NOT MORE THAN:

(I) 50 EMPLOYEES IF THE PRECEDING CALENDAR YEAR ENDED ON OR BEFORE JANUARY 1, 2016; AND

(II) 100 EMPLOYEES IF THE PRECEDING CALENDAR YEAR ENDED AFTER JANUARY 1, 2016.

(2) FOR PURPOSES OF THIS SUBSECTION:

(I) ALL PERSONS TREATED AS A SINGLE EMPLOYER UNDER § 414(B), (C), (M), OR (O) OF THE INTERNAL REVENUE CODE SHALL BE TREATED AS A SINGLE EMPLOYER;

(II) AN EMPLOYER AND ANY PREDECESSOR EMPLOYER SHALL BE TREATED AS A SINGLE EMPLOYER;

(III) ALL EMPLOYEES SHALL BE COUNTED, INCLUDING PART-TIME EMPLOYEES AND EMPLOYEES WHO ARE NOT ELIGIBLE FOR COVERAGE THROUGH THE EMPLOYER;

(IV) IF AN EMPLOYER WAS NOT IN EXISTENCE THROUGHOUT THE PRECEDING CALENDAR YEAR, THE DETERMINATION OF WHETHER THE EMPLOYER IS A SMALL EMPLOYER SHALL BE BASED ON THE AVERAGE NUMBER OF EMPLOYEES THAT THE EMPLOYER IS REASONABLY EXPECTED TO EMPLOY ON BUSINESS DAYS IN THE CURRENT CALENDAR YEAR; AND

(V) AN EMPLOYER THAT MAKES ENROLLMENT IN QUALIFIED HEALTH PLANS AVAILABLE TO ITS EMPLOYEES THROUGH THE SHOP EXCHANGE, AND WOULD CEASE TO BE A SMALL EMPLOYER BY REASON OF AN INCREASE IN THE NUMBER OF ITS EMPLOYEES, SHALL CONTINUE TO BE TREATED AS A SMALL EMPLOYER FOR PURPOSES OF THIS TITLE AS LONG AS IT CONTINUOUSLY MAKES ENROLLMENT THROUGH THE SHOP EXCHANGE AVAILABLE TO ITS EMPLOYEES.

31-102.

(A) THERE IS A MARYLAND HEALTH BENEFIT EXCHANGE.

(B) (1) THE EXCHANGE IS A BODY POLITIC AND CORPORATE AND IS AN INSTRUMENTALITY OF THE STATE.

(2) THE EXCHANGE IS A UNIT OF STATE GOVERNMENT.

(3) THE EXERCISE BY THE EXCHANGE OF ITS AUTHORITY UNDER THIS TITLE IS AN ESSENTIAL GOVERNMENTAL FUNCTION.

(C) THE PURPOSES OF THE EXCHANGE ARE TO:

(1) REDUCE THE NUMBER OF UNINSURED IN THE STATE;

(2) FACILITATE THE PURCHASE AND SALE OF QUALIFIED HEALTH PLANS IN THE INDIVIDUAL MARKET IN THE STATE BY PROVIDING A TRANSPARENT MARKETPLACE;

(3) ASSIST QUALIFIED EMPLOYERS IN THE STATE IN FACILITATING THE ENROLLMENT OF THEIR EMPLOYEES IN QUALIFIED HEALTH PLANS IN THE SMALL GROUP MARKET IN THE STATE AND IN ACCESSING SMALL BUSINESS TAX CREDITS; AND

(4) ASSIST INDIVIDUALS IN ACCESSING PUBLIC PROGRAMS, PREMIUM TAX CREDITS, AND COST-SHARING REDUCTIONS.

(D) NOTHING IN THIS TITLE, AND NO REGULATION ADOPTED OR OTHER ACTION TAKEN BY THE EXCHANGE UNDER THIS TITLE, MAY BE CONSTRUED TO PREEMPT OR SUPERSEDE:

(1) THE AUTHORITY OF THE COMMISSIONER TO REGULATE INSURANCE BUSINESS IN THE STATE; OR

(2) THE REQUIREMENTS OF THE AFFORDABLE CARE ACT.

31-103.

(A) THE EXCHANGE IS SUBJECT TO:

(1) THE FOLLOWING PROVISIONS OF THE STATE FINANCE AND PROCUREMENT ARTICLE:

(I) TITLE 12, SUBTITLE 4 (POLICIES AND PROCEDURES FOR EXEMPT UNITS); AND

(II) TITLE 14, SUBTITLE 3 (MINORITY BUSINESS PARTICIPATION);

(2) THE FOLLOWING PROVISIONS OF THE STATE GOVERNMENT ARTICLE:

(I) TITLE 10, SUBTITLE 1 (GOVERNMENTAL PROCEDURES);

(II) TITLE 10, SUBTITLE 5 (MEETINGS);

(III) TITLE 10, SUBTITLE 6, PART III (ACCESS TO PUBLIC RECORDS);

(IV) TITLE 12 (IMMUNITY AND LIABILITY); AND

(V) TITLE 15 (PUBLIC ETHICS); AND

(3) TITLE 5, SUBTITLE 3 OF THE STATE PERSONNEL AND PENSIONS ARTICLE.

(B) THE EXCHANGE IS NOT SUBJECT TO:

(1) TAXATION BY THE STATE OR LOCAL GOVERNMENT;

(2) DIVISION II OF THE STATE FINANCE AND PROCUREMENT ARTICLE, EXCEPT AS PROVIDED IN SUBSECTION (A)(1) OF THIS SECTION;

(3) TITLE 10 OF THE STATE GOVERNMENT ARTICLE, EXCEPT AS PROVIDED IN SUBSECTION (A)(2)(I), (II), AND (III) OF THIS SECTION; OR

(4) DIVISION I OF THE STATE PERSONNEL AND PENSIONS ARTICLE, EXCEPT AS PROVIDED IN SUBSECTION (A)(3) OF THIS SECTION AND ELSEWHERE IN THIS TITLE.

31-104.

(A) THERE IS A BOARD OF TRUSTEES OF THE EXCHANGE.

(B) THE BOARD CONSISTS OF THE FOLLOWING MEMBERS:

(1) THE SECRETARY OF HEALTH AND MENTAL HYGIENE;

(2) THE COMMISSIONER;

(3) THE EXECUTIVE DIRECTOR OF THE MARYLAND HEALTH CARE COMMISSION; AND

(4) THE FOLLOWING MEMBERS APPOINTED BY THE GOVERNOR, WITH THE ADVICE AND CONSENT OF THE SENATE:

(I) THREE MEMBERS WHO REPRESENT THE INTERESTS OF EMPLOYERS AND INDIVIDUAL CONSUMERS OF PRODUCTS OFFERED BY THE EXCHANGE; AND

(II) THREE MEMBERS WHO HAVE DEMONSTRATED KNOWLEDGE AND EXPERTISE IN AT LEAST TWO OF THE FOLLOWING AREAS:

1. INDIVIDUAL HEALTH CARE COVERAGE;

2. SMALL EMPLOYER-SPONSORED HEALTH CARE COVERAGE;

3. HEALTH BENEFIT PLAN ADMINISTRATION;

4. HEALTH CARE FINANCE;

5. ADMINISTRATION OF PUBLIC OR PRIVATE HEALTH CARE DELIVERY SYSTEMS; AND

6. PURCHASING AND FACILITATING ENROLLMENT IN HEALTH PLAN COVERAGE.

(C) IN MAKING APPOINTMENTS OF MEMBERS UNDER SUBSECTION (B)(4) OF THIS SECTION, THE GOVERNOR SHALL ASSURE THAT:

(1) THE BOARD'S COMPOSITION REFLECTS A DIVERSITY OF EXPERTISE;

(2) THE BOARD'S COMPOSITION REFLECTS THE GENDER, RACIAL, AND ETHNIC DIVERSITY OF THE STATE; AND

(3) THE GEOGRAPHIC AREAS OF THE STATE ARE REPRESENTED.

(D) (1) FOR PURPOSES OF THIS SUBSECTION, "AFFILIATION" MEANS:

(I) A FINANCIAL INTEREST, AS DEFINED IN § 15-102 OF THE STATE GOVERNMENT ARTICLE;

(II) A POSITION OF GOVERNANCE, INCLUDING MEMBERSHIP ON A BOARD OF DIRECTORS, REGARDLESS OF COMPENSATION;

(III) A RELATIONSHIP THROUGH WHICH COMPENSATION, AS DEFINED IN § 15-102 OF THE STATE GOVERNMENT ARTICLE, IS RECEIVED; OR

(IV) A RELATIONSHIP FOR THE PROVISION OF SERVICES AS A REGULATED LOBBYIST, AS DEFINED IN § 15-102 OF THE STATE GOVERNMENT ARTICLE.

(2) A MEMBER OF THE BOARD OR OF THE STAFF OF THE EXCHANGE, WHILE SERVING ON THE BOARD OR THE STAFF, MAY NOT HAVE AN AFFILIATION WITH:

(I) A CARRIER, AN INSURANCE PRODUCER, A THIRD-PARTY ADMINISTRATOR, OR ANY OTHER PERSON DOING BUSINESS WITH THE EXCHANGE; OR

(II) A TRADE ASSOCIATION OF CARRIERS, INSURANCE PRODUCERS, THIRD-PARTY ADMINISTRATORS, OR ANY OTHER ENTITIES DOING BUSINESS WITH THE EXCHANGE.

(E) (1) THE TERM OF A MEMBER APPOINTED BY THE GOVERNOR IS 4 YEARS.

(2) THE TERMS OF MEMBERS APPOINTED BY THE GOVERNOR ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS OF THE BOARD ON JULY 1, 2011.

(3) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(4) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.

(F) AN APPOINTED MEMBER OF THE BOARD MAY NOT SERVE MORE THAN TWO CONSECUTIVE FULL TERMS.

(G) THE GOVERNOR SHALL DESIGNATE A CHAIR OF THE BOARD.

(H) (1) THE BOARD SHALL DETERMINE THE TIMES, PLACES, AND FREQUENCY OF ITS MEETINGS.

(2) FIVE MEMBERS OF THE BOARD CONSTITUTE A QUORUM.

(3) ACTION BY THE BOARD REQUIRES THE AFFIRMATIVE VOTE OF AT LEAST FIVE MEMBERS.

(I) A MEMBER OF THE BOARD IS ENTITLED TO REIMBURSEMENT FOR EXPENSES UNDER THE STANDARD STATE TRAVEL REGULATIONS, AS PROVIDED IN THE STATE BUDGET.

(J) A MEMBER SHALL:

(1) MEET THE REQUIREMENTS OF THIS TITLE, THE AFFORDABLE CARE ACT, AND ALL APPLICABLE STATE AND FEDERAL LAWS AND REGULATIONS;

(2) SERVE THE PUBLIC INTEREST OF THE INDIVIDUALS AND QUALIFIED EMPLOYERS SEEKING HEALTH CARE COVERAGE THROUGH THE EXCHANGE; AND

(3) ENSURE THE SOUND OPERATION AND FISCAL SOLVENCY OF THE EXCHANGE.

(K) A MEMBER OF THE BOARD SHALL PERFORM THE MEMBER'S DUTIES:

(1) IN GOOD FAITH;

(2) IN THE MANNER THE MEMBER REASONABLY BELIEVES TO BE IN THE BEST INTERESTS OF THE EXCHANGE; AND

(3) WITHOUT INTENTIONAL OR RECKLESS DISREGARD OF THE CARE AN ORDINARILY PRUDENT PERSON IN A LIKE POSITION WOULD USE UNDER SIMILAR CIRCUMSTANCES.

(L) A MEMBER OF THE BOARD WHO PERFORMS THE MEMBER'S DUTIES IN ACCORDANCE WITH THE STANDARD PROVIDED IN SUBSECTION (K) OF THIS SECTION MAY NOT BE LIABLE PERSONALLY FOR ACTIONS TAKEN AS A MEMBER.

(M) A MEMBER OF THE BOARD MAY BE REMOVED FOR INCOMPETENCE, MISCONDUCT, OR FAILURE TO PERFORM THE DUTIES OF THE POSITION.

(N) A MEMBER OF THE BOARD SHALL BE SUBJECT TO THE STATE ETHICS LAW, TITLE 15, SUBTITLES 1 THROUGH 7 OF THE STATE GOVERNMENT ARTICLE.

31-105.

(A) (1) WITH THE APPROVAL OF THE GOVERNOR, THE BOARD SHALL APPOINT AN EXECUTIVE DIRECTOR OF THE EXCHANGE.

(2) SUBJECT TO THE APPROVAL OF THE GOVERNOR, THE EXECUTIVE DIRECTOR SHALL SERVE AT THE PLEASURE OF THE BOARD.

(3) THE BOARD SHALL DETERMINE THE APPROPRIATE COMPENSATION FOR THE EXECUTIVE DIRECTOR.

(B) UNDER THE DIRECTION OF THE BOARD, THE EXECUTIVE DIRECTOR SHALL:

(1) BE THE CHIEF ADMINISTRATIVE OFFICER OF THE EXCHANGE;

(2) DIRECT, ADMINISTER, AND MANAGE THE OPERATIONS OF THE EXCHANGE; AND

(3) PERFORM ALL DUTIES NECESSARY TO COMPLY WITH AND CARRY OUT THE PROVISIONS OF THIS TITLE, OTHER STATE LAW AND REGULATIONS, AND THE AFFORDABLE CARE ACT.

(C) (1) THE EXECUTIVE DIRECTOR MAY EMPLOY AND RETAIN A STAFF FOR THE EXCHANGE.

(2) EXCEPT AS PROVIDED IN PARAGRAPHS (3) AND (4) OF THIS SUBSECTION, OR OTHERWISE BY LAW, THE EXECUTIVE DIRECTOR'S APPOINTMENT, RETENTION, AND REMOVAL OF STAFF OF THE EXCHANGE ARE NOT SUBJECT TO DIVISION I OF THE STATE PERSONNEL AND PENSIONS ARTICLE.

(3) IN HIRING STAFF FOR FUNCTIONS THAT MUST BE PERFORMED BY STATE PERSONNEL UNDER THE AFFORDABLE CARE ACT OR OTHER APPLICABLE FEDERAL OR STATE LAWS, THE EXECUTIVE DIRECTOR'S APPOINTMENT, RETENTION, AND REMOVAL OF SUCH STAFF SHALL BE IN ACCORDANCE WITH DIVISION I OF THE STATE PERSONNEL AND PENSIONS ARTICLE.

(4) TO THE EXTENT PRACTICABLE, IN HIRING STAFF FOR FUNCTIONS THAT HAVE BEEN AND CURRENTLY ARE PERFORMED BY STATE PERSONNEL, THE EXECUTIVE DIRECTOR'S APPOINTMENT, RETENTION, AND REMOVAL OF SUCH STAFF SHALL BE IN ACCORDANCE WITH DIVISION I OF THE STATE PERSONNEL AND PENSIONS ARTICLE.

(5) IN HIRING STAFF FOR ALL OTHER POSITIONS NECESSARY TO CARRY OUT THE PURPOSES OF THIS TITLE, THE EXECUTIVE DIRECTOR, WITH THE APPROVAL OF THE BOARD, MAY:

(I) DESIGNATE POSITIONS AS TECHNICAL OR PROFESSIONAL TO BE IN THE EXECUTIVE SERVICE OR MANAGEMENT SERVICE, OR SPECIAL APPOINTMENTS OF THE SKILLED SERVICE OR THE PROFESSIONAL SERVICE IN THE STATE PERSONNEL MANAGEMENT SYSTEM; AND

(II) RETAIN AS INDEPENDENT CONTRACTORS OR EMPLOYEES, AND SET COMPENSATION FOR, ATTORNEYS, FINANCIAL CONSULTANTS, AND ANY OTHER PROFESSIONALS OR CONSULTANTS NECESSARY TO CARRY OUT THE PLANNING, DEVELOPMENT, AND OPERATIONS OF THE EXCHANGE AND THE PROVISIONS OF THIS TITLE.

(D) THE EXECUTIVE DIRECTOR SHALL DETERMINE THE CLASSIFICATION, GRADE, AND COMPENSATION OF STAFF OF THE EXCHANGE HIRED OR DESIGNATED UNDER SUBSECTION (C)(3), (4), AND (5)(I) OF THIS SECTION:

(1) IN CONSULTATION WITH THE SECRETARY OF BUDGET AND MANAGEMENT;

(2) WITH THE APPROVAL OF THE BOARD; AND

(3) WHEN POSSIBLE, IN ACCORDANCE WITH THE STATE PAY PLAN.

(E) (1) WITH RESPECT TO STAFF OF THE EXCHANGE HIRED OR DESIGNATED UNDER SUBSECTION (C)(3), (4), AND (5)(I) OF THIS SECTION, THE EXECUTIVE DIRECTOR SHALL SUBMIT TO THE SECRETARY OF BUDGET AND MANAGEMENT, AT LEAST 45 DAYS BEFORE THE EFFECTIVE DATE OF THE CHANGE, EACH CHANGE TO THE EXCHANGE'S SALARY PLANS THAT INVOLVES INCREASES OR DECREASES IN SALARY RANGES OTHER THAN THOSE ASSOCIATED WITH ROUTINE RECLASSIFICATIONS AND PROMOTIONS OR GENERAL SALARY INCREASES APPROVED BY THE GENERAL ASSEMBLY.

(2) REPORTABLE CHANGES INCLUDE:

(I) THE CREATION OR ABOLITION OF CLASSES;

(II) THE REGRADING OF CLASSES FROM ONE ESTABLISHED RANGE TO ANOTHER; AND

(III) THE CREATION OF NEW PAY SCHEDULES OR RANGES.

(3) THE SECRETARY OF BUDGET AND MANAGEMENT SHALL:

(I) REVIEW THE PROPOSED CHANGE; AND

(II) AT LEAST 15 DAYS BEFORE THE EFFECTIVE DATE OF THE PROPOSED CHANGE:

1. ADVISE THE EXECUTIVE DIRECTOR WHETHER THE CHANGE WOULD HAVE AN ADVERSE EFFECT ON COMPARABLE STATE JOBS; AND

2. IF THERE WOULD BE AN ADVERSE EFFECT, RECOMMEND AN ALTERNATIVE CHANGE THAT WOULD NOT HAVE AN ADVERSE EFFECT ON COMPARABLE STATE JOBS.

(4) FAILURE OF THE SECRETARY OF BUDGET AND MANAGEMENT TO RESPOND IN A TIMELY MANNER IS DEEMED TO BE AGREEMENT WITH THE CHANGE AS SUBMITTED.

(F) EXCEPT AS OTHERWISE PROVIDED IN THIS TITLE, AN EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE EXCHANGE IS NOT SUBJECT TO ANY LAW, REGULATION, OR EXECUTIVE ORDER GOVERNING STATE COMPENSATION, INCLUDING FURLOUGHS, PAY CUTS, OR ANY OTHER GENERAL FUND COST SAVINGS MEASURE.

31-106.

(A) SUBJECT TO ANY LIMITATIONS UNDER THIS TITLE OR OTHER APPLICABLE LAW, THE BOARD SHALL HAVE ALL POWERS NECESSARY OR CONVENIENT TO FURTHER THE PURPOSES OF THE EXCHANGE.

(B) THE ENUMERATION OF SPECIFIC POWERS IN THIS TITLE IS NOT INTENDED TO RESTRICT THE BOARD'S POWER TO TAKE ANY LAWFUL ACTION THAT THE BOARD DETERMINES IS NECESSARY OR CONVENIENT TO FURTHER THE PURPOSES OF THE EXCHANGE.

(C) IN ADDITION TO THE POWERS SET FORTH ELSEWHERE IN THIS TITLE, THE BOARD MAY:

- (1) ADOPT AND ALTER AN OFFICIAL SEAL;**
- (2) SUE, BE SUED, PLEAD, AND BE IMPEADED;**
- (3) ADOPT BYLAWS, RULES, AND POLICIES;**
- (4) ADOPT REGULATIONS TO CARRY OUT THIS TITLE:**

(I) IN ACCORDANCE WITH TITLE 10, SUBTITLE 1 OF THE STATE GOVERNMENT ARTICLE; AND

(II) WITHOUT CONFLICTING WITH OR PREVENTING APPLICATION OF REGULATIONS ADOPTED BY THE SECRETARY UNDER TITLE 1, SUBTITLE D OF THE AFFORDABLE CARE ACT;

(5) MAINTAIN AN OFFICE AT THE PLACE DESIGNATED BY THE BOARD;

(6) APPOINT ADVISORY COMMITTEES COMPOSED OF EXPERTS AND INDIVIDUALS KNOWLEDGEABLE ABOUT INDIVIDUAL AND EMPLOYER-SPONSORED HEALTH CARE COVERAGE, HEALTH BENEFIT PLAN ADMINISTRATION, HEALTH CARE FINANCE, ADMINISTRATION OF PUBLIC AND PRIVATE HEALTH CARE DELIVERY SYSTEMS, PURCHASING AND FACILITATING ENROLLMENT IN HEALTH PLAN COVERAGE, HEALTH CARE DELIVERY MODELS

AND PAYMENT REFORMS, AND OTHER EXPERTS AND INDIVIDUALS AS APPROPRIATE;

(7) ENTER INTO ANY AGREEMENTS OR CONTRACTS AND EXECUTE THE INSTRUMENTS NECESSARY OR CONVENIENT TO MANAGE ITS OWN AFFAIRS AND CARRY OUT THE PURPOSES OF THIS TITLE;

(8) APPLY FOR AND RECEIVE GRANTS, CONTRACTS, OR OTHER PUBLIC OR PRIVATE FUNDING; AND

(9) DO ALL THINGS NECESSARY OR CONVENIENT TO CARRY OUT THE POWERS GRANTED BY THIS TITLE.

(D) (1) TO CARRY OUT THE PURPOSES OF THIS TITLE OR PERFORM ANY OF ITS FUNCTIONS UNDER THIS TITLE, THE BOARD MAY CONTRACT WITH ELIGIBLE ENTITIES, INCLUDING:

(I) THE MARYLAND MEDICAL ASSISTANCE PROGRAM;

(II) THE FAMILY INVESTMENT UNIT OF THE DEPARTMENT OF HUMAN RESOURCES;

(III) INSURANCE PRODUCERS AND THIRD PARTY ADMINISTRATORS REGISTERED IN THE STATE THAT ARE NOT AFFILIATED WITH A CARRIER; AND

(IV) ANY OTHER ENTITIES NOT AFFILIATED WITH A CARRIER THAT HAVE EXPERIENCE IN INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE PLANS AND FACILITATING ENROLLMENT IN THOSE PLANS.

(2) THE OPERATIONS OF THE EXCHANGE ARE SUBJECT TO THE PROVISIONS OF THIS TITLE WHETHER THE OPERATIONS ARE PERFORMED DIRECTLY BY THE EXCHANGE OR THROUGH AN ENTITY UNDER A CONTRACT WITH THE EXCHANGE.

(3) THE BOARD SHALL ENSURE THAT ANY ENTITY UNDER A CONTRACT WITH THE EXCHANGE COMPLIES WITH THE PROVISIONS OF THIS TITLE WHEN PERFORMING SERVICES THAT ARE SUBJECT TO THIS TITLE ON BEHALF OF THE EXCHANGE.

(E) (1) THE BOARD MAY ENTER INTO INFORMATION-SHARING AGREEMENTS WITH FEDERAL AND STATE AGENCIES, AND OTHER STATE HEALTH INSURANCE EXCHANGES, TO CARRY OUT THE PROVISIONS OF THIS TITLE.

(2) AN INFORMATION-SHARING AGREEMENT ENTERED INTO UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL:

(I) INCLUDE ADEQUATE PROTECTIONS WITH RESPECT TO THE CONFIDENTIALITY OF INFORMATION; AND

(II) COMPLY WITH ALL STATE AND FEDERAL LAWS AND REGULATIONS.

(F) (1) THE BOARD, IN ACCORDANCE WITH TITLE 12, SUBTITLE 4 OF THE STATE FINANCE AND PROCUREMENT ARTICLE, SHALL ADOPT WRITTEN POLICIES AND PROCEDURES GOVERNING ALL PROCUREMENTS OF THE EXCHANGE.

(2) TO THE FULLEST EXTENT PRACTICABLE, AND IN A MANNER THAT DOES NOT IMPAIR THE EXCHANGE'S ABILITY TO CARRY OUT THE PURPOSES OF THIS TITLE, THE BOARD'S PROCUREMENT POLICIES AND PROCEDURES SHALL ESTABLISH AN OPEN AND TRANSPARENT PROCESS THAT:

(I) PROMOTES PUBLIC CONFIDENCE IN THE PROCUREMENTS OF THE EXCHANGE;

(II) ENSURES FAIR AND EQUITABLE TREATMENT OF ALL PERSONS AND ENTITIES THAT PARTICIPATE IN THE PROCUREMENT SYSTEM OF THE EXCHANGE;

(III) FOSTERS APPROPRIATE COMPETITION AND PROVIDES SAFEGUARDS FOR MAINTAINING A PROCUREMENT SYSTEM OF QUALITY AND INTEGRITY;

(IV) PROMOTES INCREASED ECONOMIC EFFICIENCY AND RESPONSIBILITY ON THE PART OF THE EXCHANGE;

(V) ACHIEVES THE MAXIMUM BENEFIT FROM THE PURCHASING POWER OF THE EXCHANGE; AND

(VI) PROVIDES CLARITY AND SIMPLICITY IN THE RULES AND PROCEDURES GOVERNING THE PROCUREMENTS OF THE EXCHANGE.

31-107.

(A) IN THIS SECTION, "FUND" MEANS THE MARYLAND HEALTH BENEFIT EXCHANGE FUND.

(B) THERE IS A MARYLAND HEALTH BENEFIT EXCHANGE FUND.

(C) THE PURPOSE OF THE FUND IS TO PROVIDE FUNDING FOR THE OPERATION AND ADMINISTRATION OF THE EXCHANGE IN CARRYING OUT THE PURPOSES OF THE EXCHANGE UNDER THIS TITLE.

(D) THE EXCHANGE SHALL ADMINISTER THE FUND.

(E) (1) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7-302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(2) THE STATE TREASURER SHALL HOLD THE FUND SEPARATELY, AND THE COMPTROLLER SHALL ACCOUNT FOR THE FUND.

(F) THE FUND CONSISTS OF:

(1) ANY USER FEES OR OTHER ASSESSMENTS COLLECTED BY THE EXCHANGE;

(2) INCOME FROM INVESTMENTS MADE ON BEHALF OF THE FUND;

(3) INTEREST ON DEPOSITS OR INVESTMENTS OF MONEY IN THE FUND;

(4) MONEY COLLECTED BY THE BOARD AS A RESULT OF LEGAL OR OTHER ACTIONS TAKEN BY THE BOARD ON BEHALF OF THE EXCHANGE OR THE FUND;

(5) MONEY DONATED TO THE FUND;

(6) MONEY AWARDED TO THE FUND THROUGH GRANTS; AND

(7) ANY OTHER MONEY FROM ANY OTHER SOURCE ACCEPTED FOR THE BENEFIT OF THE FUND.

(G) THE FUND MAY BE USED ONLY TO PROVIDE FUNDING FOR THE OPERATION AND ADMINISTRATION OF THE EXCHANGE IN CARRYING OUT THE PURPOSES AUTHORIZED UNDER THIS TITLE.

(H) (1) THE STATE TREASURER SHALL INVEST THE MONEY OF THE FUND IN THE SAME MANNER AS OTHER STATE MONEY MAY BE INVESTED.

(2) ANY INVESTMENT EARNINGS OF THE FUND SHALL BE CREDITED TO THE FUND.

(3) NO PART OF THE FUND MAY REVERT OR BE CREDITED TO THE GENERAL FUND OR ANY SPECIAL FUND OF THE STATE.

(I) A DEBT OR AN OBLIGATION OF THE FUND IS NOT A DEBT OF THE STATE OR A PLEDGE OF CREDIT OF THE STATE.

31-108.

(A) ON OR BEFORE JANUARY 1, 2014, THE FUNCTIONS AND OPERATIONS OF THE EXCHANGE SHALL INCLUDE AT A MINIMUM ALL FUNCTIONS REQUIRED BY § 1311(D)(4) OF THE AFFORDABLE CARE ACT.

(B) ON OR BEFORE JANUARY 1, 2014, IN COMPLIANCE WITH § 1311(D)(4) OF THE AFFORDABLE CARE ACT, THE EXCHANGE SHALL:

(1) MAKE QUALIFIED HEALTH PLANS AVAILABLE TO QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS;

(2) ALLOW A CARRIER TO OFFER A QUALIFIED HEALTH PLAN THROUGH THE EXCHANGE THAT PROVIDES LIMITED SCOPE DENTAL BENEFITS UNDER § 9832(C)(2)(A) OF THE INTERNAL REVENUE CODE, EITHER SEPARATELY OR IN CONJUNCTION WITH A QUALIFIED HEALTH PLAN, PROVIDED THAT THE QUALIFIED HEALTH PLAN PROVIDES PEDIATRIC DENTAL BENEFITS THAT MEET THE REQUIREMENTS OF § 1302(B)(1)(J) OF THE AFFORDABLE CARE ACT;

(3) IMPLEMENT PROCEDURES FOR THE CERTIFICATION, RECERTIFICATION, AND DECERTIFICATION OF HEALTH BENEFIT PLANS AS QUALIFIED HEALTH PLANS, CONSISTENT WITH GUIDELINES DEVELOPED BY THE SECRETARY UNDER § 1311(C) OF THE AFFORDABLE CARE ACT;

(4) PROVIDE FOR THE OPERATION OF A TOLL-FREE TELEPHONE HOTLINE TO RESPOND TO REQUESTS FOR ASSISTANCE;

(5) PROVIDE FOR INITIAL, ANNUAL, AND SPECIAL ENROLLMENT PERIODS, IN ACCORDANCE WITH GUIDELINES ADOPTED BY THE SECRETARY UNDER § 1311(C)(6) OF THE AFFORDABLE CARE ACT;

(6) MAINTAIN A WEB SITE THROUGH WHICH ENROLLEES AND PROSPECTIVE ENROLLEES OF QUALIFIED HEALTH PLANS MAY OBTAIN STANDARDIZED COMPARATIVE INFORMATION ON QUALIFIED HEALTH PLANS;

(7) WITH RESPECT TO EACH QUALIFIED HEALTH PLAN OFFERED THROUGH THE EXCHANGE:

(I) ASSIGN A RATING FOR EACH QUALIFIED HEALTH PLAN IN ACCORDANCE WITH THE CRITERIA DEVELOPED BY THE SECRETARY UNDER § 1311(C)(3) OF THE AFFORDABLE CARE ACT AND ANY ADDITIONAL CRITERIA THAT MAY BE APPLICABLE UNDER THE LAWS OF THE STATE AND REGULATIONS ADOPTED BY THE EXCHANGE UNDER THIS TITLE; AND

(II) DETERMINE EACH QUALIFIED HEALTH PLAN'S LEVEL OF COVERAGE IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE SECRETARY UNDER § 1302(D)(2)(A) OF THE AFFORDABLE CARE ACT AND ANY ADDITIONAL REGULATIONS ADOPTED BY THE EXCHANGE UNDER THIS TITLE;

(8) PRESENT QUALIFIED HEALTH PLAN OPTIONS OFFERED BY THE EXCHANGE IN A STANDARDIZED FORMAT, INCLUDING THE USE OF THE UNIFORM OUTLINE OF COVERAGE ESTABLISHED UNDER § 2715 OF THE FEDERAL PUBLIC HEALTH SERVICE ACT;

(9) IN ACCORDANCE WITH § 1413 OF THE AFFORDABLE CARE ACT, PROVIDE INFORMATION AND MAKE DETERMINATIONS REGARDING ELIGIBILITY FOR THE FOLLOWING PROGRAMS:

(I) THE MARYLAND MEDICAL ASSISTANCE PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT;

(II) THE MARYLAND CHILDREN'S HEALTH INSURANCE PROGRAM UNDER TITLE XXI OF THE SOCIAL SECURITY ACT; AND

(III) ANY APPLICABLE STATE OR LOCAL PUBLIC HEALTH INSURANCE PROGRAM;

(10) FACILITATE THE ENROLLMENT OF ANY INDIVIDUAL WHO THE EXCHANGE DETERMINES IS ELIGIBLE FOR A PROGRAM DESCRIBED IN ITEM (9) OF THIS SUBSECTION;

(11) ESTABLISH AND MAKE AVAILABLE BY ELECTRONIC MEANS A CALCULATOR TO DETERMINE THE ACTUAL COST OF COVERAGE OF A QUALIFIED HEALTH PLAN OFFERED BY THE EXCHANGE AFTER APPLICATION OF ANY PREMIUM TAX CREDIT UNDER § 36B OF THE INTERNAL REVENUE CODE AND ANY COST-SHARING REDUCTION UNDER § 1402 OF THE AFFORDABLE CARE ACT;

(12) ESTABLISH A SHOP EXCHANGE THROUGH WHICH QUALIFIED EMPLOYERS MAY ACCESS COVERAGE FOR THEIR EMPLOYEES AT SPECIFIED LEVELS OF COVERAGE AND MEET STANDARDS FOR THE FEDERAL QUALIFIED EMPLOYER TAX CREDIT;

(13) IMPLEMENT A CERTIFICATION PROCESS FOR INDIVIDUALS EXEMPT FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT AND PENALTY UNDER § 5000A OF THE INTERNAL REVENUE CODE ON THE GROUNDS THAT:

(I) NO AFFORDABLE QUALIFIED HEALTH PLAN THAT COVERS THE INDIVIDUAL IS AVAILABLE THROUGH THE EXCHANGE OR THE INDIVIDUAL'S EMPLOYER; OR

(II) THE INDIVIDUAL MEETS OTHER REQUIREMENTS UNDER THE AFFORDABLE CARE ACT THAT MAKE THE INDIVIDUAL ELIGIBLE FOR THE EXEMPTION;

(14) IMPLEMENT A PROCESS FOR TRANSFER TO THE UNITED STATES SECRETARY OF THE TREASURY THE NAME AND TAXPAYER IDENTIFICATION NUMBER OF EACH INDIVIDUAL WHO:

(I) IS CERTIFIED AS EXEMPT FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT;

(II) IS EMPLOYED BUT DETERMINED ELIGIBLE FOR THE PREMIUM TAX CREDIT ON THE GROUNDS THAT:

1. THE INDIVIDUAL'S EMPLOYER DOES NOT PROVIDE MINIMUM ESSENTIAL COVERAGE; OR

2. THE EMPLOYER'S COVERAGE IS DETERMINED TO BE UNAFFORDABLE FOR THE INDIVIDUAL OR DOES NOT PROVIDE THE REQUISITE MINIMUM ACTUARIAL VALUE;

(III) NOTIFIES THE EXCHANGE UNDER § 1411(B)(4) OF THE AFFORDABLE CARE ACT THAT THE INDIVIDUAL HAS CHANGED EMPLOYERS; AND

(IV) CEASES COVERAGE UNDER A QUALIFIED HEALTH PLAN DURING THE PLAN YEAR, TOGETHER WITH THE DATE COVERAGE CEASED;

(15) PROVIDE NOTICE TO EMPLOYERS OF EMPLOYEES WHO CEASE COVERAGE UNDER A QUALIFIED HEALTH PLAN DURING A PLAN YEAR, TOGETHER WITH THE DATE COVERAGE CEASED;

(16) CONDUCT PROCESSES REQUIRED BY THE SECRETARY AND THE UNITED STATES SECRETARY OF THE TREASURY TO DETERMINE ELIGIBILITY FOR PREMIUM TAX CREDITS, REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY REQUIREMENT EXEMPTIONS;

(17) ESTABLISH A NAVIGATOR PROGRAM IN ACCORDANCE WITH § 1311(I) OF THE AFFORDABLE CARE ACT AND ANY REQUIREMENTS ESTABLISHED UNDER THIS TITLE;

(18) (I) ESTABLISH A PROCESS, IN ACCORDANCE WITH § 10108 OF THE AFFORDABLE CARE ACT, FOR CREDITING THE AMOUNT OF FREE CHOICE VOUCHERS TO PREMIUMS OF QUALIFIED HEALTH PLANS IN WHICH QUALIFIED EMPLOYEES ARE ENROLLED; AND

(II) COLLECT THE AMOUNT CREDITED FROM THE EMPLOYER OFFERING THE QUALIFIED HEALTH PLAN;

(19) CARRY OUT A PLAN TO PROVIDE APPROPRIATE ASSISTANCE FOR CONSUMERS SEEKING TO PURCHASE PRODUCTS THROUGH THE EXCHANGE, INCLUDING THE IMPLEMENTATION OF THE NAVIGATOR PROGRAM AND TOLL-FREE HOTLINE REQUIRED UNDER ITEM (4) OF THIS SUBSECTION; AND

(20) CARRY OUT A PUBLIC RELATIONS AND ADVERTISING CAMPAIGN TO PROMOTE THE EXCHANGE.

(C) IF THE INDIVIDUAL ENROLLS IN ANOTHER TYPE OF MINIMUM ESSENTIAL COVERAGE NEITHER THE EXCHANGE NOR A CARRIER OFFERING QUALIFIED HEALTH PLANS THROUGH THE EXCHANGE MAY CHARGE AN INDIVIDUAL A FEE OR PENALTY FOR TERMINATION OF COVERAGE ON THE GROUNDS THAT:

(1) THE INDIVIDUAL HAS BECOME NEWLY ELIGIBLE FOR THAT COVERAGE; OR

(2) THE INDIVIDUAL'S EMPLOYER-SPONSORED COVERAGE HAS BECOME AFFORDABLE UNDER THE STANDARDS OF § 36B(C)(2)(C) OF THE INTERNAL REVENUE CODE.

(D) IN CARRYING OUT ITS DUTIES UNDER THIS TITLE, THE EXCHANGE, THROUGH THE ADVISORY COMMITTEES ESTABLISHED UNDER § 31-106(C)(6) OF THIS TITLE OR THROUGH OTHER MEANS, SHALL CONSULT WITH STAKEHOLDERS, INCLUDING:

- (1) INDIVIDUAL HEALTH CARE CONSUMERS;
 - (2) SMALL AND LARGE EMPLOYERS;
 - (3) INDIVIDUALS AND ENTITIES WITH EXPERIENCE IN FACILITATING ENROLLMENT IN QUALIFIED HEALTH PLANS;
 - (4) ADVOCATES FOR SPECIAL AND HARD-TO-REACH POPULATIONS;
 - (5) REPRESENTATIVES OF HEALTH CARE PROVIDERS, CARRIERS, AND PLAN ADMINISTRATORS;
 - (6) EXPERTS IN THE ADMINISTRATION OF PUBLIC AND PRIVATE HEALTH CARE DELIVERY SYSTEMS AND HEALTH CARE FINANCE; AND
 - (7) ANY OTHER APPROPRIATE STAKEHOLDERS IDENTIFIED BY THE EXCHANGE.
- (E) THE EXCHANGE MAY NOT MAKE AVAILABLE ANY HEALTH BENEFIT PLAN THAT IS NOT A QUALIFIED HEALTH PLAN.

31-109.

- (A) THE EXCHANGE SHALL CERTIFY HEALTH BENEFIT PLANS AS QUALIFIED HEALTH PLANS.
- (B) TO BE CERTIFIED AS A QUALIFIED HEALTH PLAN, A HEALTH BENEFIT PLAN SHALL:
- (1) EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION, PROVIDE THE ESSENTIAL BENEFITS PACKAGE REQUIRED UNDER § 1302(A) OF THE AFFORDABLE CARE ACT;
 - (2) OBTAIN PRIOR APPROVAL OF PREMIUM RATES AND CONTRACT LANGUAGE FROM THE COMMISSIONER;
 - (3) EXCEPT AS PROVIDED IN SUBSECTION (D) OF THIS SECTION, PROVIDE AT LEAST A BRONZE LEVEL OF COVERAGE, AS DEFINED IN THE AFFORDABLE CARE ACT AND DETERMINED BY THE EXCHANGE UNDER § 31-108(B)(7)(II) OF THIS TITLE;

(4) (I) ENSURE THAT ITS COST-SHARING REQUIREMENTS DO NOT EXCEED THE LIMITS ESTABLISHED UNDER § 1302(C)(1) OF THE AFFORDABLE CARE ACT; AND

(II) IF THE HEALTH BENEFIT PLAN IS OFFERED THROUGH THE SHOP EXCHANGE, ENSURE THAT THE HEALTH BENEFIT PLAN'S DEDUCTIBLE DOES NOT EXCEED THE LIMITS ESTABLISHED UNDER § 1302(C)(2) OF THE AFFORDABLE CARE ACT;

(5) BE OFFERED BY A CARRIER THAT:

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

(II) IF THE CARRIER PARTICIPATES IN THE EXCHANGE'S INDIVIDUAL MARKET, OFFERS AT LEAST ONE QUALIFIED HEALTH PLAN AT THE SILVER LEVEL AND ONE AT THE GOLD LEVEL IN THE INDIVIDUAL MARKET OUTSIDE THE EXCHANGE;

(III) IF THE CARRIER PARTICIPATES IN THE SHOP EXCHANGE, OFFERS AT LEAST ONE QUALIFIED HEALTH PLAN AT THE SILVER LEVEL AND ONE AT THE GOLD LEVEL IN THE SMALL GROUP MARKET OUTSIDE THE SHOP EXCHANGE;

(IV) CHARGES THE SAME PREMIUM RATE FOR EACH QUALIFIED HEALTH PLAN REGARDLESS OF WHETHER THE QUALIFIED HEALTH PLAN IS OFFERED THROUGH THE EXCHANGE, THROUGH AN INSURANCE PRODUCER OUTSIDE THE EXCHANGE, OR DIRECTLY FROM A CARRIER;

(V) DOES NOT CHARGE ANY CANCELLATION FEES OR PENALTIES IN VIOLATION OF § 31-108(C) OF THIS TITLE; AND

(VI) COMPLIES WITH THE REGULATIONS ADOPTED BY THE SECRETARY UNDER § 1311(D) OF THE AFFORDABLE CARE ACT AND BY THE EXCHANGE UNDER § 31-106(C)(4) OF THIS TITLE;

(6) MEET THE REQUIREMENTS FOR CERTIFICATION ESTABLISHED UNDER THE REGULATIONS ADOPTED BY:

(I) THE SECRETARY UNDER § 1311(C)(1) OF THE AFFORDABLE CARE ACT, INCLUDING MINIMUM STANDARDS FOR MARKETING PRACTICES, NETWORK ADEQUACY, ESSENTIAL COMMUNITY PROVIDERS IN UNDERSERVED AREAS, ACCREDITATION, QUALITY IMPROVEMENT, UNIFORM

ENROLLMENT FORMS AND DESCRIPTIONS OF COVERAGE, AND INFORMATION ON QUALITY MEASURES FOR HEALTH PLAN PERFORMANCE; AND

(II) THE EXCHANGE UNDER § 31-106(C)(4) OF THIS TITLE;

(7) BE IN THE INTEREST OF QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS, AS DETERMINED BY THE EXCHANGE;

(8) PROVIDE ANY OTHER BENEFITS AS MAY BE REQUIRED BY THE COMMISSIONER UNDER ANY APPLICABLE STATE LAW OR REGULATION; AND

(9) MEET ANY OTHER REQUIREMENTS ESTABLISHED BY THE EXCHANGE UNDER THIS TITLE.

(C) A QUALIFIED HEALTH PLAN IS NOT REQUIRED TO PROVIDE ESSENTIAL BENEFITS THAT DUPLICATE THE MINIMUM BENEFITS OF QUALIFIED DENTAL PLANS, AS PROVIDED IN SUBSECTION (G) OF THIS SECTION, IF:

(1) THE EXCHANGE HAS DETERMINED THAT AN ADEQUATE CHOICE OF QUALIFIED DENTAL PLANS IS AVAILABLE TO SUPPLEMENT THE QUALIFIED HEALTH PLAN'S COVERAGE; AND

(2) AT THE TIME THE CARRIER OFFERS THE QUALIFIED HEALTH PLAN, THE CARRIER DISCLOSES IN A FORM APPROVED BY THE EXCHANGE THAT:

(I) THE PLAN DOES NOT PROVIDE THE FULL RANGE OF ESSENTIAL PEDIATRIC BENEFITS; AND

(II) QUALIFIED DENTAL PLANS PROVIDING THESE AND OTHER DENTAL BENEFITS ALSO NOT PROVIDED BY THE QUALIFIED HEALTH PLAN ARE OFFERED THROUGH THE EXCHANGE.

(D) A QUALIFIED HEALTH PLAN IS NOT REQUIRED TO PROVIDE AT LEAST A BRONZE LEVEL OF COVERAGE UNDER SUBSECTION (B)(3) OF THIS SECTION IF THE QUALIFIED HEALTH PLAN:

(1) MEETS THE REQUIREMENTS AND IS CERTIFIED AS A QUALIFIED CATASTROPHIC PLAN AS PROVIDED UNDER THE AFFORDABLE CARE ACT; AND

(2) WILL BE OFFERED ONLY TO INDIVIDUALS ELIGIBLE FOR CATASTROPHIC COVERAGE.

(E) A HEALTH BENEFIT PLAN MAY NOT BE DENIED CERTIFICATION:

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

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

(3) SOLELY ON THE GROUNDS THAT THE HEALTH BENEFIT PLAN PROVIDES TREATMENTS NECESSARY TO PREVENT PATIENTS' DEATHS IN CIRCUMSTANCES THE EXCHANGE DETERMINES ARE INAPPROPRIATE OR TOO COSTLY.

(F) IN ADDITION TO OTHER RATE FILING REQUIREMENTS THAT MAY BE APPLICABLE UNDER THIS ARTICLE, EACH CARRIER SEEKING CERTIFICATION OF A HEALTH BENEFIT PLAN SHALL:

(1) (I) SUBMIT TO THE EXCHANGE A JUSTIFICATION FOR ANY PREMIUM INCREASE BEFORE IMPLEMENTATION OF THE INCREASE; AND

(II) POST THE INCREASE ON THE CARRIER'S WEB SITE;

(2) SUBMIT TO THE EXCHANGE, THE SECRETARY, AND THE COMMISSIONER, AND MAKE AVAILABLE TO THE PUBLIC, IN PLAIN LANGUAGE AS REQUIRED UNDER § 1311(E)(3)(B) OF THE AFFORDABLE CARE ACT, ACCURATE AND TIMELY DISCLOSURE OF:

(I) CLAIMS PAYMENT POLICIES AND PRACTICES;

(II) FINANCIAL DISCLOSURES;

(III) DATA ON ENROLLMENT, DISENROLLMENT, NUMBER OF CLAIMS DENIED, AND RATING PRACTICES;

(IV) INFORMATION ON COST-SHARING AND PAYMENTS WITH RESPECT TO OUT-OF-NETWORK COVERAGE;

(V) INFORMATION ON ENROLLEE AND PARTICIPANT RIGHTS UNDER TITLE I OF THE AFFORDABLE CARE ACT; AND

(VI) ANY OTHER INFORMATION AS DETERMINED APPROPRIATE BY THE SECRETARY AND THE EXCHANGE; AND

(3) MAKE AVAILABLE INFORMATION ABOUT COSTS AN INDIVIDUAL WOULD INCUR UNDER THE INDIVIDUAL'S HEALTH BENEFIT PLAN

FOR SERVICES PROVIDED BY A PARTICIPATING HEALTH CARE PROVIDER, INCLUDING COST-SHARING REQUIREMENTS SUCH AS DEDUCTIBLES, CO-PAYMENTS, AND COINSURANCE, IN A MANNER DETERMINED BY THE EXCHANGE.

(G) (1) EXCEPT AS PROVIDED IN PARAGRAPHS (2), (3), AND (4) OF THIS SUBSECTION, THE REQUIREMENTS APPLICABLE TO QUALIFIED HEALTH PLANS UNDER THIS TITLE ALSO SHALL APPLY TO QUALIFIED DENTAL PLANS.

(2) A CARRIER OFFERING A QUALIFIED DENTAL PLAN SHALL BE LICENSED TO OFFER DENTAL COVERAGE BUT NEED NOT BE LICENSED TO OFFER OTHER HEALTH BENEFITS.

(3) A QUALIFIED DENTAL PLAN SHALL:

(I) BE LIMITED TO DENTAL AND ORAL HEALTH BENEFITS, WITHOUT SUBSTANTIAL DUPLICATION OF OTHER BENEFITS TYPICALLY OFFERED BY HEALTH BENEFIT PLANS WITHOUT DENTAL COVERAGE;

(II) INCLUDE AT A MINIMUM THE ESSENTIAL PEDIATRIC DENTAL BENEFITS REQUIRED BY THE SECRETARY UNDER § 1302(B)(1)(J) OF THE AFFORDABLE CARE ACT; AND

(III) INCLUDE ANY OTHER BENEFITS AS MAY BE REQUIRED BY THE SECRETARY OR THE EXCHANGE.

(4) CARRIERS JOINTLY MAY OFFER A COMPREHENSIVE PLAN THROUGH THE EXCHANGE IN WHICH DENTAL BENEFITS ARE PROVIDED BY A CARRIER THROUGH A QUALIFIED DENTAL PLAN AND OTHER BENEFITS ARE PROVIDED BY A CARRIER THROUGH A QUALIFIED HEALTH PLAN, PROVIDED THAT THE PLANS ARE PRICED SEPARATELY AND MADE AVAILABLE FOR PURCHASE SEPARATELY AT THE SAME PRICE AS WHEN OFFERED JOINTLY.

31-110.

(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, THE EXCHANGE MAY:

(1) IMPOSE USER FEES, LICENSING OR OTHER REGULATORY FEES, OR OTHER ASSESSMENTS ON PERSONS THAT BENEFIT FROM THE EXCHANGE; OR

(2) OTHERWISE GENERATE FUNDING NECESSARY TO SUPPORT ITS OPERATIONS UNDER THIS TITLE.

(B) ANY FEES, ASSESSMENTS, OR OTHER FUNDING MECHANISMS SHALL BE IMPOSED OR IMPLEMENTED, TO THE MAXIMUM EXTENT POSSIBLE, IN A MANNER THAT IS TRANSPARENT AND BROAD-BASED.

(C) FUNDS COLLECTED THROUGH ANY FEES, ASSESSMENTS, OR OTHER FUNDING MECHANISMS:

(1) SHALL BE DEPOSITED IN THE MARYLAND HEALTH BENEFIT EXCHANGE FUND;

(2) SHALL BE USED ONLY FOR THE PURPOSES AUTHORIZED UNDER THIS TITLE; AND

(3) MAY NOT BE USED FOR STAFF RETREATS, PROMOTIONAL GIVEAWAYS, EXCESSIVE EXECUTIVE COMPENSATION, OR PROMOTION OF FEDERAL OR STATE LEGISLATIVE AND REGULATORY ACTIONS.

(D) THE EXCHANGE SHALL MAINTAIN A WEB SITE ON WHICH IT SHALL PUBLISH:

(1) THE AVERAGE AMOUNTS OF ANY FEES, ASSESSMENTS, OR OTHER PAYMENTS REQUIRED BY THE EXCHANGE;

(2) THE ADMINISTRATIVE COSTS OF THE EXCHANGE; AND

(3) THE AMOUNT OF FUNDS KNOWN TO BE LOST THROUGH WASTE, FRAUD, AND ABUSE.

31-111.

(A) THE EXCHANGE SHALL BE ADMINISTERED IN A MANNER DESIGNED TO:

(1) PREVENT DISCRIMINATION;

(2) STREAMLINE ENROLLMENT AND OTHER PROCESSES TO MINIMIZE EXPENSES AND ACHIEVE MAXIMUM EFFICIENCY;

(3) PREVENT WASTE, FRAUD, AND ABUSE; AND

(4) PROMOTE FINANCIAL INTEGRITY.

(B) THE EXCHANGE SHALL KEEP AN ACCURATE ACCOUNTING OF ALL ITS ACTIVITIES, EXPENDITURES, AND RECEIPTS.

(C) (1) ON OR BEFORE DECEMBER 1 OF EACH YEAR, THE BOARD SHALL FORWARD TO THE SECRETARY, THE GOVERNOR, AND, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY, A REPORT ON THE ACTIVITIES, EXPENDITURES, AND RECEIPTS OF THE EXCHANGE.

(2) THE REPORT SHALL:

(I) BE IN THE STANDARDIZED FORMAT REQUIRED BY THE SECRETARY;

(II) INCLUDE DATA REGARDING COVERAGE, PRICE, QUALITY, BENEFITS, CONSUMER CHOICE, AND OTHER METRICS TO EVALUATE EXCHANGE PERFORMANCE, ASSURE TRANSPARENCY, AND FACILITATE RESEARCH AND ANALYSIS; AND

(III) INCLUDE DATA TO IDENTIFY DISPARITIES RELATED TO RACE, ETHNICITY, LANGUAGE, DISABILITY, OR OTHER ATTRIBUTES OF SPECIAL POPULATIONS.

(D) THE BOARD SHALL COOPERATE FULLY WITH ANY INVESTIGATION INTO THE AFFAIRS OF THE EXCHANGE, INCLUDING MAKING AVAILABLE FOR EXAMINATION THE RECORDS OF THE EXCHANGE, CONDUCTED BY:

(1) THE SECRETARY UNDER THE SECRETARY'S AUTHORITY UNDER THE AFFORDABLE CARE ACT; AND

(2) THE COMMISSIONER UNDER THE COMMISSIONER'S AUTHORITY TO REGULATE THE SALE AND PURCHASE OF INSURANCE IN THE STATE.

SECTION 2. AND BE IT FURTHER ENACTED, That, with respect to the functions of the Maryland Health Benefit Exchange established under Section 1 of this Act, and the requirements for health benefit plan certification mandated by the federal Patient Protection and Affordable Care Act and as implemented by §§ 31-108 and 31-109 of the Insurance Article, as enacted by Section 1 of this Act, that require further guidance from the Secretary of Health and Human Services before full implementation is possible, the Exchange may not implement those functions or impose those requirements until such further guidance is received.

SECTION 3. AND BE IT FURTHER ENACTED, That, with respect to the functions of the Maryland Health Benefit Exchange established under Section 1 of this

Act, and the requirements for health benefit plan certification mandated by the federal Patient Protection and Affordable Care Act and as implemented by §§ 31–108 and 31–109 of the Insurance Article, as enacted by Section 1 of this Act, that require further study and recommendations under Section 5 of this Act before full implementation is possible, including recommendations for further legislative or regulatory action, the Exchange of Trustees of the Maryland Health Benefit Exchange established under Section 1 of this Act, may not implement those functions or impose those requirements until:

(1) the Exchange conducts the studies and reports its findings and recommendations to the Governor and the General Assembly as required under Section 5 of this Act; and

(2) the findings and recommendations for further legislative or regulatory action are acted upon by the Governor and the General Assembly.

SECTION 4. AND BE IT FURTHER ENACTED, That, with respect to the Governor's appointment to the Board of Trustees of the Maryland Health Benefit Exchange established under Section 1 of this Act, of those members representing the interests of employers and consumers, it is the intent of the General Assembly that the Governor seek to appoint, where practicable and particularly in the initial appointments, members whose particular knowledge and understanding include the interests of minority-owned employers and individual consumers who come from lower-income and minority communities, have chronic diseases or disabilities, or belong to other hard-to-reach or special populations.

SECTION 5. AND BE IT FURTHER ENACTED, That the Maryland Health Benefit Exchange established under Section 1 of this Act:

(1) in consultation with the advisory committees established under § 31–106(c)(6) of the Insurance Article, as enacted by Section 1 of this Act, and with other stakeholders, shall study and make recommendations regarding:

(i) the feasibility and desirability of the Exchange engaging in:

1. selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements such as promoting patient-centered medical homes, adopting electronic health records, meeting minimum outcome standards, implementing payment reforms to reduce medical errors and preventable hospitalizations, reducing disparities, ensuring adequate reimbursements, enrolling low-risk members and underserved populations, managing chronic conditions and promoting healthy consumer lifestyles, and adhering to transparency guidelines and uniform price and quality reporting; and

2. multistate or regional contracting within the State;

(ii) the rules under which health benefit plans should be offered inside and outside the Exchange in order to mitigate adverse selection and encourage enrollment in the Exchange, including:

1. whether any benefits should be required of qualified health plans beyond those mandated by the federal Patient Protection and Affordable Care Act (Affordable Care Act), and whether any such additional benefits should be required of health benefit plans offered outside the Exchange;

2. whether carriers offering health benefit plans outside the Exchange should be required to offer either all the same health benefit plans inside the Exchange, or alternatively, at least one health benefit plan inside the Exchange; and

3. whether managed care organizations with Health Choice contracts should be required to offer products inside the Exchange, and whether carriers offering health benefit plans inside the Exchange should be required to also participate in the Maryland Medical Assistance Program;

(iii) the design and operation of the Exchange's Navigator Program and any other appropriate consumer assistance mechanisms, including:

1. how the Navigator Program could utilize, interact with, or complement private sector resources, including insurance producers;

2. what functions, in addition to those required by the Affordable Care Act, should be performed by Navigators;

3. what training and expertise should be required of Navigators, and whether different markets and populations require Navigators with different qualifications;

4. how Navigators should be retained and compensated, and how disparities between Navigator compensation and the compensation of insurance producers outside the Exchange can be minimized or avoided; and

5. what other means of consumer assistance may be appropriate and feasible, and how they should be designed and implemented;

(iv) the design and function of the SHOP Exchange beyond the requirements of the Affordable Care Act, including:

1. whether it should be a defined contribution/employee choice model or whether employers should choose the qualified health plan to offer their employees;

2. whether the current individual and small group markets should be merged; and

3. whether the SHOP Exchange should be made available to employers with 50 to 100 employees prior to 2016, as authorized by the Affordable Care Act; and

(v) how the Exchange can be self-sustaining by 2016 in compliance with the Affordable Care Act, including:

1. a recommended plan for the budget of the Exchange;
2. the user fees, licensing fees, or other assessments that should be imposed by the Exchange to fund its operations; and
3. a recommended plan for how to prevent fraud, waste, and abuse;

(2) on or before December 1, 2011, shall report its interim findings and recommendations, including initial recommendations for further legislative or regulatory action, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly; and

(3) on or before December 1, 2012, shall report its final findings and recommendations, including final recommendations for further legislative or regulatory action, to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly.

SECTION 6. AND BE IT FURTHER ENACTED, That, on or before December 1, 2015, the Maryland Health Benefit Exchange established under Section 1 of this Act, in consultation with the advisory committees established under § 31-106(c)(6) of the Insurance Article, as enacted by Section 1 of this Act, and with other stakeholders, shall conduct a study and report its findings and recommendations to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly, on whether the Exchange should remain an independent public body or should become a nongovernmental, nonprofit entity.

SECTION 7. AND BE IT FURTHER ENACTED, That the terms of the initial appointed members of the Board of Trustees of the Maryland Health Benefit Exchange, established under Section 1 of this Act, shall expire as follows:

- (1) two members in 2013;
- (2) two members in 2014; and
- (3) two members in 2015.

SECTION 8. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2011.