HB0228/776480/1

BY: Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 228
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 8, after "budget;" insert "authorizing the Secretary of Health and Mental Hygiene to provide certain grants for a certain purpose;"; in line 10, after "program;" insert "establishing the Performance Standards and Measurement Advisory Committee in the Department; providing for the purposes, membership, chair, and duties of the Committee; exempting from the insurance premium tax a qualified nonprofit health insurance issuer that meets certain requirements; requiring a portion of a certain tax to be distributed, beginning on a certain date, annually to the Maryland Health Benefit Exchange Fund for a certain purpose;"; in line 16, after "date;" insert "prohibiting certain individuals from reenrolling in the Plan under certain circumstances;"; in line 18, after "members;" insert "requiring the Board of the Plan to provide certain notice to Plan members beginning on a certain date;"; in line 24, after "program;" insert "requiring the Board of the Plan and the Board of Trustees of the Exchange to report on certain matters at certain times;"; in line 25, after "Act;" insert "exempting certain carriers that offer certain plans from a certain requirement under certain circumstances;"; and in line 26, strike "prior authorization" and substitute "preauthorization".

On page 2, in line 3, after "circumstances;" insert "providing for the application of certain requirements relating to preauthorizations and continuity of health care services; exempting enrollees transitioning from a carrier to the Maryland Medical Assistance fee-for-service program from the preauthorization and continuity of health care services requirements;"; strike beginning with "is" in line 8 down through "provider" in line 9 and substitute "must facilitate transition of the enrollee to a provider on the provider panel of the carrier or managed care organization; authorizing a relinquishing carrier to elect to allow an enrollee to continue to receive dental services provided by a participating provider of the relinquishing carrier through a certain arrangement"; in lines 16 and 17, strike "and to request the data

(Over)

from certain persons" and substitute "; requiring certain persons to provide the data on request"; in line 17, after the second "a" insert "person to act or represent that the person is a"; in line 18, strike "or" and substitute a comma; in the same line, after the second "navigator" insert ", or certain application counselor"; strike beginning with "to" in line 18 down through "representations" in line 19; strike beginning with "requiring" in line 20 down through "enrollees" in line 22 and substitute "providing that a carrier is not liable or subject to certain regulatory sanction under certain circumstances; requiring the Commissioner to regulate the Exchange in taking certain actions; prohibiting the Commissioner from imposing a fine or administrative penalty on the Exchange for failing to take certain actions; authorizing the Commissioner to require the Exchange to make certain restitution to certain consumers under certain circumstances; requiring the Exchange and certain carriers to hold a consumer harmless from certain consequences caused by a certain action of the Exchange; prohibiting the Commissioner from participating in certain matters as a member of the Board of Trustees of the Exchange under certain circumstances; requiring the Board of Trustees of the Exchange to establish a certain committee"; in line 26, after "Fund;" insert "requiring certain funds to be placed in a certain account for a certain purpose; establishing certain restrictions on certain expenditures from the Fund; requiring certain funds in a certain account to revert to the General Fund of the State under certain circumstances; requiring certain operating expenses to be charged to a certain fund source under certain circumstances;"; in line 30, after "budget" insert "from certain funds received from a certain premium tax"; strike beginning with the third "the" in line 30 down through "tax" in line 31 and substitute "a certain minimum appropriation for certain fiscal years"; in line 33, after "State;" insert "requiring the Exchange to comply with certain federal law in carrying out certain functions;"; in line 37, after "(Center)" insert "under certain circumstances"; in line 44, after "Center;" insert "clarifying the circumstances of individuals whom the Individual Exchange shall assist in making a certain transition; requiring the training program for insurance producers who sell qualified plans in the Individual Exchange to impart certain skills and expertise; authorizing, until a certain date, a captive producer without a certain certification to enroll certain individuals in a qualified plan offered in the Individual Exchange by a certain carrier; requiring a captive producer to refer

certain individuals to an insurance producer under certain circumstances, with certain exceptions; requiring a captive producer to make a certain disclosure; establishing requirements a carrier and its captive producers must meet in offering information and assistance to the carrier's current enrollees; prohibiting a captive producer from providing information or services related to health benefit plans or other products not offered by the captive producer's carrier; requiring a captive producer to make certain referrals under certain circumstances; authorizing the Exchange to designate certain entities as application counselor sponsoring entities and to certify certain individuals as application counselors; establishing requirements for application counselor sponsoring entities and application counselors to provide certain services; providing that an application counselor is subject to certain requirements; authorizing the Exchange, in consultation with the Commissioner and the Department, to establish requirements for an application counselor sponsoring entity and to adopt regulations relating to application counselor sponsoring entities and application counselors;"; and in line 47, after "permit;" insert "requiring the Exchange, the Center, and Center employees to assist the Health Education and Advocacy Unit of the Office of the Attorney General in carrying out certain duties;".

On page 3, in line 2, after "plan;" insert "altering requirements for qualified health plans relating to vision benefits; authorizing the Exchange to require children enrolling in a qualified health plan to have certain dental benefits;"; in line 5, after "actions;" insert "requiring the Exchange to consider certain factors in determining the amount of a certain penalty; establishing a process through which a carrier or plan may appeal a certain order or decision;"; in line 11, after "program;" insert "specifying the types of discrimination the Exchange shall be designed to prevent; altering the requirements for an annual report on the activities, expenditures, and receipts of the Exchange;"; in line 17, after "definitions;" insert "making certain conforming changes; providing for the initial terms of the members of the Performance Standards and Measurement Advisory Committee;"; in line 14, strike "and"; in the same line, after "Administration" insert ", and the Maryland Health Care Commission"; in line 16, after "date;" insert "requiring the Exchange and the Administration to conduct a study of the impact of the Affordable Care Act's allowance of a certain tobacco use rating and

to report to the Governor and the General Assembly on the findings of the study and certain recommendations on or before a certain date; authorizing the Board of Trustees of the Exchange to adopt certain interim policies, for certain purposes after receiving certain comment; requiring the interim policies to be submitted as proposed regulations within a certain period after adoption and to sunset within a certain time after submission as proposed regulations; requiring the Exchange and the Administration to conduct a study of the impact of federal regulations governing the offering and purchase of pediatric dental benefits and to report to the Governor and General Assembly on their findings and recommendations on or before a certain date; requiring the Exchange and the Administration to conduct a study of a certain captive producer program and to report to the Governor and General Assembly on their findings and recommendations on or before a certain date;"; in line 27, after "15-103(a)," insert "19-143(a),"; after line 29, insert:

"BY adding to
Article – Health – General
Section 20-1501 to be under the new subtitle "Subtitle 15. Performance Standards and Measurement Advisory Committee"
Annotated Code of Maryland
(2009 Replacement Volume and 2012 Supplement)";

in line 37, after "Section" insert "6-101(b),"; in the same line, after "14-504," insert "15-1303(b),"; in the same line, after "27-405(a)," insert "31-101(i), (k), and (l),"; in the same line, after "31-103," insert "31-106(g),"; in the same line, after "31-107," insert "31-108(c), (d), and (e),"; in line 38, strike "31-113(h), (i), and (k)(1) and (2)" and substitute "31-113(a)(5), (b), (e), (f), (g), (h), (i), (k)(1) and (2), (l)(4), (m), (o), and (p), 31-114(a)"; in the same line, after "31-115(b)" insert ", (d), (h), and (i)(3), 31-116(a)"; in line 39, strike "31-119(e)" and substitute "31-119(a), (d), and (e)"; and strike in their entirety lines 30 through 34, inclusive.

On page 4, in line 2, after "Section" insert "6-103.2,"; in the same line, strike "31-101(c-1)" and substitute "31-101(a-1), (a-2), (c-1), and (c-2)"; in the same line, after "31-107.2," insert "31-108(c), 31-113(p) and (r)"; and after line 4, insert:

"BY repealing and reenacting, without amendments,
Article – Insurance
Section 8-301(a), 31-101(a), 31-113(a)(1), and 31-115(e)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)".

AMENDMENT NO. 2

On page 6, in line 6, strike "Independent" and substitute "**FORMER**"; and in line 9, after "State" insert "**, ANY OTHER STATE, OR THE DISTRICT OF COLUMBIA**".

On page 7, in line 34, strike "Shall provide, subject" and substitute "**SUBJECT**"; in line 35, strike the second comma and substitute "**:**

1. SHALL PROVIDE";

in line 36, strike "independent" and substitute "**FORMER**"; and in the same line, strike the colon.

On page 8, in line 1, strike "1. Who" and substitute "**WHO, ON THEIR 18TH BIRTHDAY, WERE IN FOSTER CARE UNDER THE RESPONSIBILITY OF THE STATE AND**"; and strike beginning with "Whose" in line 3 down through "level" in line 4 and substitute "**MAY PROVIDE COMPREHENSIVE MEDICAL CARE AND OTHER HEALTH CARE SERVICES FOR FORMER FOSTER CARE ADOLESCENTS WHO, ON THEIR 18TH BIRTHDAY, WERE IN FOSTER CARE UNDER THE RESPONSIBILITY OF ANY OTHER STATE OR THE DISTRICT OF COLUMBIA**".

AMENDMENT NO. 3

On page 9, after line 5, insert:

"19–143.

(a) **(1)** On or before October 1, 2009, the Commission and the Health Services Cost Review Commission shall designate a health information exchange for the State.

(2) THE SECRETARY, TO ALIGN FUNDING OPPORTUNITIES WITH THE PURPOSES OF THIS SECTION AND THE DEVELOPMENT AND EFFECTIVE OPERATION OF THE STATE'S HEALTH INFORMATION EXCHANGE, MAY PROVIDE GRANTS TO THE HEALTH INFORMATION EXCHANGE DESIGNATED UNDER PARAGRAPH (1) OF THIS SUBSECTION.".

AMENDMENT NO. 4

On page 11, after line 13, insert:

"**SUBTITLE 15. PERFORMANCE STANDARDS AND MEASUREMENT ADVISORY COMMITTEE.**

20-1501.

(A) THERE IS A PERFORMANCE STANDARDS AND MEASUREMENT ADVISORY COMMITTEE IN THE DEPARTMENT.

(B) THE PURPOSES OF THE COMMITTEE ARE TO:

(1) DEVELOP PERFORMANCE MEASURES FOR EVALUATING HEALTH INSURANCE PLANS OFFERED IN THE PRIVATE INSURANCE MARKET IN THE STATE; AND

(2) SUPPORT A SYSTEM OF PUBLIC REPORTING ON THE PERFORMANCE OF THE HEALTH INSURANCE PLANS BASED ON THE PERFORMANCE MEASURES DEVELOPED.

(C) (1) THE COMMITTEE CONSISTS OF THE FOLLOWING MEMBERS, APPOINTED BY THE GOVERNOR:

(I) THREE MEMBERS WHO REPRESENT HEALTH CARE PROVIDERS AND CARRIERS THAT OFFER HEALTH INSURANCE PLANS IN THE STATE, INCLUDING QUALIFIED HEALTH PLANS OFFERED IN THE MARYLAND HEALTH BENEFIT EXCHANGE;

(II) FOUR MEMBERS WHO REPRESENT STATE GOVERNMENT, SELECTED FROM AMONG THE FOLLOWING:

1. THE DEPARTMENT;

2. THE MARYLAND INSURANCE ADMINISTRATION;

3. THE MARYLAND HEALTH BENEFIT EXCHANGE;

4. THE MARYLAND HEALTH CARE COMMISSION;

5. THE MARYLAND HEALTH QUALITY AND COST COUNCIL; AND

6. THE HEALTH SERVICES COST REVIEW COMMISSION;

(III) THREE EXPERTS IN THE FIELD OF PERFORMANCE MEASUREMENT WHO ARE AFFILIATED WITH AN INSTITUTION OF HIGHER EDUCATION IN THE STATE OR WHO CONDUCT OR ASSESS RESEARCH ON HOW HEALTH CARE DELIVERY SYSTEMS SHOULD BE STRUCTURED TO IMPROVE HEALTH OUTCOMES;

(IV) ONE REPRESENTATIVE OF A CONSUMER HEALTH CARE ADVOCACY ORGANIZATION; AND

(V) TWO CONSUMER MEMBERS.

(D) (1) THE TERM OF A MEMBER OF THE COMMITTEE IS 3 YEARS.

(2) THE TERMS OF THE MEMBERS ARE STAGGERED AS REQUIRED BY THE TERMS PROVIDED FOR MEMBERS OF THE COMMITTEE ON JUNE 1, 2013.

(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.

(5) A MEMBER MAY NOT SERVE MORE THAN TWO 3-YEAR TERMS.

(E) THE GOVERNOR SHALL APPOINT A CHAIR FROM AMONG THE MEMBERS OF THE COMMITTEE WHO REPRESENT STATE GOVERNMENT.

(F) THE COMMITTEE SHALL:

(1) ESTABLISH AND OVERSEE A TRANSPARENT PROCESS FOR THE SELECTION OF PERFORMANCE MEASURES FOR EVALUATING HEALTH INSURANCE PLANS OFFERED IN THE PRIVATE HEALTH INSURANCE MARKET IN THE STATE;

(2) ENSURE THAT THE PROCESS PROVIDES OPPORTUNITIES FOR PUBLIC COMMENT AND A MECHANISM FOR RESPONDING TO PUBLIC COMMENT;

(3) RECOMMEND PERFORMANCE MEASURES THAT:

(I) ARE EVIDENCE-BASED, CONSISTENT WITH NATIONALLY RECOGNIZED PRACTICE GUIDELINES, RELIABLE, VALID, APPLICABLE TO AVAILABLE DATABASES, AND APPROPRIATE FOR MARYLAND CONSUMERS OF HEALTH CARE; AND

(II) INCLUDE MEASURES OF PUBLIC HEALTH OUTCOMES;

(4) ADVISE THE DEPARTMENT, THE MARYLAND HEALTH BENEFIT EXCHANGE, THE MARYLAND HEALTH CARE COMMISSION, THE HEALTH SERVICES COST REVIEW COMMISSION, AND PRIVATE INSURERS ON USE OF THE PERFORMANCE MEASURES;

(5) SUPPORT THE ALIGNMENT OF PERFORMANCE MEASURES ACROSS HEALTH CARE PROGRAMS IN THE STATE; AND

(6) PROVIDE INPUT TO THE DEPARTMENT ON THE MOST EFFECTIVE METHOD OF INTEGRATING THE PERFORMANCE MEASURES DEVELOPED BY THE COMMITTEE INTO THE STATESTAT PROCESS.

(G) (1) ON OR BEFORE DECEMBER 1 OF EACH YEAR, THE COMMITTEE SHALL REPORT TO THE GENERAL ASSEMBLY ON ITS ACTIVITIES DURING THE PREVIOUS CALENDAR YEAR TO SUPPORT HEALTH CARE PERFORMANCE AND OUTCOME MEASURES.

(2) THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL INCLUDE AN ASSESSMENT OF IMPROVEMENTS MADE IN HEALTH OUTCOMES AND CONSUMER SATISFACTION.";

and after line 14, insert:

"6–101.

(b) The following persons are not subject to taxation under this subtitle:

(1) a nonprofit health service plan corporation that meets the requirements established under §§ 14–106 and 14–107 of this article;

(2) a fraternal benefit society;

(3) a surplus lines broker, who is subject to taxation in accordance with Title 3, Subtitle 3 of this article;

(4) an unauthorized insurer, who is subject to taxation in accordance with Title 4, Subtitle 2 of this article;

(5) the Maryland Health Insurance Plan established under Title 14, Subtitle 5, Part I of this article;

(6) the Senior Prescription Drug Assistance Program established under Title 14, Subtitle 5, Part II of this article; **[**or**]**

(7) a nonprofit health maintenance organization authorized by Title 19, Subtitle 7 of the Health – General Article that is exempt from taxation under § 501(c)(3) of the Internal Revenue Code**; AND**

(8) A QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER THAT IS ESTABLISHED UNDER § 1322 OF THE AFFORDABLE CARE ACT.

6-103.2.

(A) (1) (I) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, BEGINNING JANUARY 1, 2015, FROM THE TAX DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION, A PORTION SHALL BE DISTRIBUTED ANNUALLY TO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND ESTABLISHED UNDER § 31-107 OF THIS ARTICLE FOR THE SOLE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE MARYLAND HEALTH BENEFIT EXCHANGE.

(II) THE OPERATION AND ADMINISTRATION OF THE MARYLAND HEALTH BENEFIT EXCHANGE MAY INCLUDE FUNCTIONS DELEGATED BY THE MARYLAND HEALTH BENEFIT EXCHANGE TO A THIRD PARTY UNDER LAW OR BY CONTRACT.

(2) (I) THE DISTRIBUTION UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE ALLOCATED FROM THE TAX IMPOSED ON A PERSON UNDER § 6-102 OF THIS SUBTITLE ON PREMIUMS FOR HEALTH INSURANCE.

(II) FOR PURPOSES OF THIS PARAGRAPH, "PERSON" DOES NOT INCLUDE:

1. A MANAGED CARE ORGANIZATION AUTHORIZED BY TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE; OR

2. A FOR PROFIT HEALTH MAINTENANCE ORGANIZATION AUTHORIZED BY TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE.

(B) FOR STATE FISCAL YEAR 2015 AND EACH STATE FISCAL YEAR THEREAFTER, THE AMOUNT TO BE DISTRIBUTED UNDER SUBSECTION (A) OF THIS SECTION SHALL BE SUFFICIENT TO FULLY FUND THE OPERATION AND ADMINISTRATION OF THE MARYLAND HEALTH BENEFIT EXCHANGE FOR THE STATE FISCAL YEAR.".

AMENDMENT NO. 5

On page 13, in line 14, after "**(1)**" insert "**(I)**"; after line 15, insert:

"**(II) A MEMBER ENROLLED IN THE PLAN AS OF DECEMBER 31, 2013, WHO THEREAFTER TERMINATES ENROLLMENT MAY NOT REENROLL IN THE PLAN.**";

in line 16, strike "**(I)**"; in the same line, strike "**SUBPARAGRAPH (II) OF THIS PARAGRAPH**" and substitute "**PARAGRAPH (3) OF THIS SUBSECTION**"; in line 21, strike "**(II)**" and substitute "**(3)**"; in line 22, strike "**ANY**" and substitute "**ALL**"; in the same line, strike "**MEMBER**" and substitute "**MEMBERS**"; in line 23, strike "**2015**" and substitute "**2014**"; and after line 23, insert:

"**(G) BEGINNING OCTOBER 1, 2013, AND ANNUALLY THEREAFTER UNTIL THE PLAN NO LONGER PROVIDES COVERAGE TO MEMBERS, THE BOARD SHALL**

PROVIDE NOTICE TO PLAN MEMBERS THAT, EFFECTIVE JANUARY 1, 2014, THE MEMBER:

(1) MAY NOT BE DENIED HEALTH INSURANCE BECAUSE OF A PREEXISTING HEALTH CONDITION; AND

(2) MAY BE ELIGIBLE TO:

(I) ENROLL IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM;

(II) PURCHASE A HEALTH BENEFIT PLAN OFFERED IN THE MARYLAND HEALTH BENEFIT EXCHANGE OR IN THE INSURANCE MARKET OUTSIDE THE MARYLAND HEALTH BENEFIT EXCHANGE; AND

(III) RECEIVE FEDERAL PREMIUM AND COST-SHARING ASSISTANCE FOR THE PURCHASE OF A HEALTH BENEFIT PLAN IN THE MARYLAND HEALTH BENEFIT EXCHANGE.".

On page 15, in line 26, after "**AND**" insert "**ON OR BEFORE OCTOBER 1 OF**"; and in line 27, after "**ANY**" insert "**LIABILITY FOR CLAIMS SUBMITTED BY PLAN**".

On page 16, after line 3, insert:

"**(5) ON OR BEFORE DECEMBER 31, 2013, AND ON OR BEFORE DECEMBER 31 OF EACH YEAR THEREAFTER UNTIL THE PLAN NO LONGER HAS ANY LIABILITY FOR CLAIMS SUBMITTED BY PLAN ENROLLEES AND THE STATE REINSURANCE PROGRAM IS TERMINATED, THE BOARD OF TRUSTEES OF THE MARYLAND HEALTH BENEFIT EXCHANGE AND THE BOARD SHALL REPORT TO**

THE GOVERNOR AND, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON:

(I) THE TRANSITION OF PLAN ENROLLEES OUT OF THE PLAN, INCLUDING:

1. HOW ENROLLEES ARE MADE AWARE OF CHANGES IN THEIR INSURANCE OPTIONS;

2. HOW ENROLLEES WILL BE ASSISTED THROUGH THE TRANSITION; AND

3. WHETHER ANY FUNDING WILL BE REQUIRED TO SUPPORT THE TRANSITION; AND

(II) THE USE OF THE FUND FOR THE STATE REINSURANCE PROGRAM.".

AMENDMENT NO. 6

On page 15 in line 12, on page 16 in line 23, and on page 32 in line 20, in each instance, strike "**2015**" and substitute "**2014**".

AMENDMENT NO. 7

On page 16, after line 34, insert:

"15–1303.

(b) (1) Except as provided in this subsection and § 31–110(f) of this article, a carrier may not offer individual health benefit plans in the State unless the carrier also offers qualified health plans, as defined in § 31–101 of this article, in the

Individual Exchange of the Maryland Health Benefit Exchange in compliance with the requirements of Title 31 of this article.

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

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

2. THE ONLY INDIVIDUAL HEALTH BENEFIT PLANS THAT THE CARRIER OFFERS IN THE STATE ARE STUDENT HEALTH PLANS AS DEFINED IN 45 C.F.R. § 147.145;

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

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

AMENDMENT NO. 8

On page 17, in line 9, strike "**OR**"; in line 13, after "**ARTICLE**" insert "**; OR**

(4) AN APPLICATION COUNSELOR CERTIFIED BY THE INDIVIDUAL EXCHANGE OF THE MARYLAND HEALTH BENEFIT EXCHANGE IF THE PERSON HAS NOT RECEIVED THE APPROPRIATE CERTIFICATION UNDER OR OTHERWISE COMPLIED WITH § 31-113(R) OF THIS ARTICLE";

after line 15, insert:

"**(A-1) "APPLICATION COUNSELOR" MEANS AN INDIVIDUAL WHO HOLDS AN INDIVIDUAL EXCHANGE APPLICATION COUNSELOR CERTIFICATION ISSUED UNDER § 31-113(R) OF THIS TITLE.**

(A-2) "APPLICATION COUNSELOR SPONSORING ENTITY" OR "SPONSORING ENTITY" MEANS AN ENTITY DESIGNATED BY THE INDIVIDUAL EXCHANGE AS A SPONSORING ENTITY UNDER § 31-113(R) OF THIS TITLE.

(C-1) "CAPTIVE PRODUCER" MEANS AN INSURANCE PRODUCER WHO:

(I) IS LICENSED IN THE STATE AND AUTHORIZED BY THE COMMISSIONER TO SELL, SOLICIT, OR NEGOTIATE HEALTH INSURANCE;

(II) RECEIVES AN AUTHORIZATION AND MEETS THE OTHER REQUIREMENTS SET FORTH IN § 31-113(N)(2) OF THIS TITLE;

(III) HAS A CURRENT AND EXCLUSIVE APPOINTMENT WITH A SINGLE CARRIER; AND

(IV) RECEIVES COMPENSATION AS A CAPTIVE PRODUCER ONLY FROM THAT CARRIER.";

in line 16, strike "**(C-1)**" and substitute "**(C-2)**"; after line 19, insert:

"(i) "Individual Exchange navigator" means an individual who:

(1) holds an Individual Exchange navigator certification; and

(2) provides the services described in § 31–113(d)(1) of this title for an Individual Exchange **[**navigator**]** **CONNECTOR** entity.

(k) "Individual Exchange **[**navigator**]** **CONNECTOR** entity" means a community–based organization or other entity or a partnership of entities that:

(1) is authorized by the Individual Exchange under § 31–113(f) of this title; and

(2) employs or engages Individual Exchange navigators to provide the services described in § 31–113(d)(1) of this title.

(l) "Individual Exchange **[**navigator**]** **CONNECTOR** entity authorization" means a grant of authority from the Individual Exchange to an Individual Exchange **[**navigator**]** **CONNECTOR** entity under § 31–113(f) of this title.".

AMENDMENT NO. 9

On page 18, strike in their entirety lines 15 through 23, inclusive, and substitute:

"**(C) (1) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, TO THE EXTENT THAT THE EXCHANGE, ACTING ON BEHALF OF A CARRIER OFFERING A QUALIFIED PLAN IN THE INDIVIDUAL EXCHANGE OR THE SHOP EXCHANGE, IS REQUIRED BY LAW OR CONTRACT TO COLLECT PREMIUMS, CONDUCT BILLING, SEND REQUIRED NOTICES, PROVIDE REQUIRED DISCLOSURES, OR TAKE ANY OTHER ACTION NORMALLY TAKEN BY A CARRIER UNDER THIS ARTICLE, THE CARRIER IS NOT LIABLE OR SUBJECT TO REGULATORY SANCTION BY THE COMMISSIONER FOR THE FAILURE OF THE EXCHANGE TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION UNDER THIS SUBSECTION.**

(2) (I) SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE COMMISSIONER SHALL REGULATE THE EXCHANGE IN TAKING AN ACTION UNDER THIS SUBSECTION.

(II) IF THE COMMISSIONER FINDS THAT THE EXCHANGE HAS FAILED TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION UNDER THIS SUBSECTION, THE COMMISSIONER:

1. MAY NOT IMPOSE A FINE OR AN ADMINISTRATIVE PENALTY ON THE EXCHANGE; AND

2. MAY REQUIRE THE EXCHANGE TO:

A. MAKE RESTITUTION, NOT TO EXCEED THE AMOUNT OF ACTUAL ECONOMIC DAMAGES SUSTAINED BY THE CONSUMER, TO A CONSUMER WHO HAS SUSTAINED ACTUAL ECONOMIC DAMAGES BECAUSE OF THE FAILURE OF THE EXCHANGE TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION; AND

B. MAKE RESTITUTION, NOT TO EXCEED THE AMOUNT OF ACTUAL PREMIUM, PREMIUM SUBSIDIES, OR COST-SHARING SUBSIDIES THE CARRIER DID NOT RECEIVE, TO A CARRIER THAT HAS AUTHORIZED, PROVIDED, OR PAID FOR HEALTH CARE SERVICES WITHOUT RECEIVING PREMIUM, PREMIUM SUBSIDIES, OR COST-SHARING SUBSIDIES THE CARRIER OTHERWISE WOULD HAVE RECEIVED BUT FOR THE FAILURE OF THE EXCHANGE TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION.

(3) (I) THE EXCHANGE AND THE CARRIER SHALL HOLD A CONSUMER HARMLESS FROM ANY ADVERSE CONSEQUENCE THAT IS:

1. RELATED TO THE CONSUMER'S PURCHASE OF, OR COVERAGE UNDER, A QUALIFIED PLAN; AND

2. CAUSED BY THE FAILURE OF THE EXCHANGE TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION UNDER THIS SUBSECTION.

(II) HOLDING THE CONSUMER HARMLESS SHALL INCLUDE:

1. THE EXTENSION OF DEADLINES OR OTHER ACCOMMODATIONS NECESSARY TO PROTECT THE CONSUMER; AND

2. THE CARRIER'S AUTHORIZATION OF, PROVISION OF, OR PAYMENT FOR HEALTH CARE SERVICES THE CARRIER OTHERWISE WOULD BE UNDER AN OBLIGATION TO AUTHORIZE, PROVIDE, OR PAY FOR EXCEPT FOR THE FAILURE OF THE EXCHANGE TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION UNDER THIS SUBSECTION.

(4) THE COMMISSIONER, IN THE COMMISSIONER'S ROLE AS A MEMBER OF THE BOARD, MAY NOT PARTICIPATE IN ANY MATTER THAT INVOLVES THE ALLEGED FAILURE OF THE EXCHANGE TO COMPLY WITH THE LAW OR CONTRACT IN TAKING AN ACTION UNDER THIS SUBSECTION IF, IN THE COMMISSIONER'S JUDGMENT, THE COMMISSIONER'S PARTICIPATION MIGHT CREATE A CONFLICT OF INTEREST WITH RESPECT TO THE COMMISSIONER'S REGULATORY AUTHORITY OVER THE EXCHANGE'S TAKING AN ACTION UNDER THIS SUBSECTION.";

in line 24, strike "**THIS**" and substitute "**EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION, THIS**"; in the same line, after "**NOT**" insert "**:**

(1)";

and in line 25, after "**ARTICLE**" insert "**; OR**

(2) LIMIT THE AUTHORITY OF THE COMMISSIONER TO TAKE ACTION AGAINST ANY PERSON WITH RESPECT TO ANY PROVISION OF THIS ARTICLE".

AMENDMENT NO. 10

On page 18, after line 25, insert:

"31–106.

(g) **(1)** To carry out the purposes of this title, the Board shall:

[(1)**]** **(I)** create and consult with **AD HOC** advisory committees; **AND**

[(2) have at least two standing advisory committees whose members, to the extent practicable, reflect the gender, racial, ethnic, and geographic diversity of the State; and

(3)**]** **(II)** appoint to the **AD HOC** advisory committees representatives of:

[(i)**]** **1.** insurers or health maintenance organizations offering health benefit plans in the State;

[(ii)**]** **2.** nonprofit health service plans offering health benefit plans in the State;

[(iii)**]** **3.** licensed health insurance producers and advisers;

[(iv)**]** **4.** third–party administrators;

[(v)**]** **5.** health care providers, including:

[1.**] A.** hospitals;

[2.**] B.** long–term care facilities;

[3.**] C.** mental health providers;

[4.**] D.** developmental disability providers;

[5.**] E.** substance abuse treatment providers;

[6.**] F.** Federally Qualified Health Centers;

[7.**] G.** physicians;

[8.**] H.** nurses;

[9.**] I.** experts in services and care coordination for criminal and juvenile justice populations;

[10.**] J.** licensed hospice providers; and

[11.**] K.** other health care professionals;

[(vi)**]** **6.** managed care organizations;

[(vii)**]** **7.** employers, including large, small, and minority–owned employers;

[(viii)**]** **8.** public employee unions, including public employee union members who are caseworkers in local departments of social services with direct knowledge of information technology systems used for Medicaid eligibility determination;

[(ix)**]** **9.** consumers, including individuals who:

[1.**]** **A.** reside in lower–income and racial or ethnic minority communities;

[2.**]** **B.** have chronic diseases or disabilities; or

[3.**]** **C.** belong to other hard–to–reach or special populations;

[(x)**]** **10.** individuals with knowledge and expertise in advocacy for consumers described in item **[**(ix)**]** **9** of this item;

[(xi)**]** **11.** public health researchers and other academic experts with knowledge and background relevant to the functions and goals of the Exchange, including knowledge of the health needs and health disparities among the State's diverse communities; and

[(xii)**]** **12.** any other stakeholders identified by the Exchange as having knowledge or representing interests relevant to the functions and duties of the Exchange.

(2) IN ADDITION TO THE AD HOC ADVISORY COMMITTEES CREATED UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE BOARD, ON OR BEFORE MARCH 15, 2014, SHALL CREATE A STANDING ADVISORY COMMITTEE THAT:

(I) CONSISTS OF MEMBERS WHO, TO THE EXTENT PRACTICABLE:

1. REFLECT THE GENDER, RACIAL, ETHNIC, AND GEOGRAPHIC DIVERSITY OF THE STATE;

2. CONSTITUTE A DIVERSE CROSS-SECTION OF STAKEHOLDERS BROADLY REPRESENTATIVE OF THE INDIVIDUALS AND ENTITIES DESCRIBED IN PARAGRAPH (1)(II) OF THIS SUBSECTION; AND

3. ARE APPOINTED BY THE BOARD FOR A TERM OF NO MORE THAN 3 YEARS IN A MANNER THAT PROVIDES CONTINUITY AND ROTATION;

(II) HAS A LIAISON TO THE BOARD WHO IS A MEMBER OF THE BOARD AND IS APPOINTED BY THE CHAIR OF THE BOARD; AND

(III) IS CHARGED WITH THE RESPONSIBILITY OF ADDRESSING THE BROAD RANGE OF POLICY ISSUES:

1. ON WHICH THE BOARD MAY SEEK ITS INPUT AND ADVICE; AND

2. THAT MAY BE PROPOSED BY THE LIAISON TO THE BOARD, IN CONSULTATION WITH THE STANDING ADVISORY COMMITTEE CHAIR AND MEMBERS.".

AMENDMENT NO. 11

On page 18, in line 28, after "(b)" insert "**(1)**"; and in line 29, strike "**(1)**" and substitute "**(I)**".

On page 19, in line 1, strike "**(2)**" and substitute "**(II)**"; after line 3, insert:

"**(2) THE OPERATION AND ADMINISTRATION OF THE EXCHANGE AND THE STATE REINSURANCE PROGRAM MAY INCLUDE FUNCTIONS DELEGATED BY THE EXCHANGE TO A THIRD PARTY UNDER LAW OR BY CONTRACT.**";

after line 10, insert:

"**(2) ALL REVENUE DEPOSITED INTO THE FUND THAT IS RECEIVED FROM THE DISTRIBUTION OF THE PREMIUM TAX UNDER § 6-103.2 OF THIS ARTICLE;**";

and in lines 11, 15, 16, 17, 19, 20, and 21, strike "**(2)**", "**(3)**", "**(4)**", "**(5)**", "**(6)**", "**(7)**", and "**(8)**", respectively, and substitute "**(3)**", "**(4)**", "**(5)**", "**(6)**", "**(7)**", "**(8)**", and "**(9)**", respectively.

On page 20, after line 6, insert:

"**(3) FUNDS RECEIVED FROM THE DISTRIBUTION OF THE PREMIUM TAX UNDER § 6-103.2 OF THIS ARTICLE SHALL BE PLACED IN THE ACCOUNT FOR**

EXCHANGE OPERATIONS AND MAY BE USED ONLY FOR THE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE EXCHANGE.

(H) (1) EXPENDITURES FROM THE FUND FOR THE PURPOSES AUTHORIZED BY THIS SUBTITLE MAY BE MADE ONLY:

(I) WITH AN APPROPRIATION FROM THE FUND APPROVED BY THE GENERAL ASSEMBLY IN THE STATE BUDGET; OR

(II) BY THE BUDGET AMENDMENT PROCEDURE PROVIDED FOR IN TITLE 7, SUBTITLE 2 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(2) NOTWITHSTANDING § 7-304 OF THE STATE FINANCE AND PROCUREMENT ARTICLE, IF THE AMOUNT OF THE DISTRIBUTION FROM THE PREMIUM TAX UNDER § 6-103.2 OF THIS ARTICLE EXCEEDS IN ANY STATE FISCAL YEAR THE ACTUAL EXPENDITURES INCURRED FOR THE OPERATION AND ADMINISTRATION OF THE EXCHANGE, FUNDS IN THE EXCHANGE OPERATIONS ACCOUNT FROM THE PREMIUM TAX THAT REMAIN UNSPENT AT THE END OF THE STATE FISCAL YEAR SHALL REVERT TO THE GENERAL FUND OF THE STATE.

(3) IF OPERATING EXPENSES OF THE EXCHANGE MAY BE CHARGED TO EITHER STATE OR NON-STATE FUND SOURCES, THE NON-STATE FUNDS SHALL BE CHARGED BEFORE STATE FUNDS ARE CHARGED.";

in lines 7 and 12, strike "**(H)**" and "**(I)**", respectively, and substitute "**(I)**" and "**(J)**", respectively; in line 10, strike "No" and substitute "**EXCEPT AS PROVIDED IN SUBSECTION (H)(2) OF THIS SECTION, NO**"; in line 30, after "**FOR**" insert "**STATE**"; in the same line, after "**EACH**" insert "**STATE**"; and in lines 31 and 32, strike "**DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION**" and substitute "**RECEIVED**

FROM THE DISTRIBUTION OF THE PREMIUM TAX UNDER § 6-103.2 OF THIS ARTICLE".

On page 21, strike in their entirety lines 3 through 9, inclusive, and substitute:

"**(2) (I) FOR STATE FISCAL YEAR 2015, THE APPROPRIATION SHALL BE NO LESS THAN $10,000,000.**

(II) FOR EACH STATE FISCAL YEAR THEREAFTER, THE APPROPRIATION SHALL BE NO LESS THAN $35,000,000.";

in line 12, strike "**OPERATIONS**" and substitute "**OPERATION AND ADMINISTRATION**"; in line 14, after "**ANY**" insert "**STATE**"; in line 16, after "**OPERATION**" insert "**AND ADMINISTRATION**"; and in line 18, strike "**FUNDS**" and substitute "**NOTWITHSTANDING § 7-304 OF THE STATE FINANCE AND PROCUREMENT ARTICLE, FUNDS**".

AMENDMENT NO. 12

On page 21, after line 20, insert:

"31–108.

(C) (1) IN CARRYING OUT THE FUNCTIONS UNDER SUBSECTIONS (A) AND (B) OF THIS SECTION, THE EXCHANGE SHALL COMPLY WITH § 508 OF THE FEDERAL REHABILITATION ACT OF 1973 AND ANY REGULATIONS ADOPTED UNDER § 508 OF THE ACT.

(2) THE OBLIGATION FOR THE EXCHANGE TO COMPLY WITH § 508 OF THE FEDERAL REHABILITATION ACT OF 1973 DOES NOT AFFECT ANY OTHER REQUIREMENTS RELATING TO ACCESSIBILITY FOR PERSONS WITH DISABILITIES

TO WHICH THE EXCHANGE MAY BE SUBJECT UNDER THE FEDERAL AMERICANS WITH DISABILITIES ACT OF 1990.

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

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

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

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

[(e)**] (F)** The Exchange may not make available:

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

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

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

AMENDMENT NO. 13

On page 22, in line 25, after "**PLAN**" insert "**, BASED ON THE COVERAGE LEVEL SELECTED BY THE MEMBER AND THE MEMBER'S JOB CLASSIFICATION, IF OTHERWISE PERMISSIBLE**"; and in line 27, after "**EMPLOYEES**" insert "**WITH THE SAME COVERAGE LEVEL AND JOB CLASSIFICATION**".

On page 23, in lines 3 and 5, in each instance, after "**CARRIER**" insert "**OR INSURANCE HOLDING COMPANY SYSTEM**"; and in line 24, after "Exchange" insert "**, WITH THE APPROVAL OF THE COMMISSIONER AND IN CONSULTATION WITH STAKEHOLDERS,**".

AMENDMENT NO. 14

On page 24, after line 7, insert:

"(a) (1) There is a navigator program for the Individual Exchange.

(5) The Commissioner may require the Individual Exchange to:

(i) make available to the Commissioner all records, documents, data, and other information relating to the navigator program, including the authorization of Individual Exchange **[**navigator**]** **CONNECTOR** entities and the certification of Individual Exchange navigators; and

(ii) submit a corrective plan to take appropriate action to address any problems or deficiencies identified by the Commissioner in the Individual Exchange **[**navigator**]** **CONNECTOR** entity authorization process or the Individual Exchange navigator certification process.

(b) The navigator program for the Individual Exchange shall:

(1) focus outreach efforts and services on individuals without health insurance coverage;

(2) use Individual Exchange **[**navigator**]** **CONNECTOR** entities that:

(i) have expertise in working with vulnerable and hard–to–reach populations; and

(ii) conduct outreach and provide enrollment support for these populations; and

(3) enable the Individual Exchange to:

(i) comply with the Affordable Care Act by providing seamless entry into the Maryland Medical Assistance Program, the Maryland Children's Health Program, and qualified plans;

(ii) assist individuals who**, DUE TO FORMER INCARCERATION OR OTHER CIRCUMSTANCES,** transition between the types of coverage described in item (i) of this item or have lapsed enrollment; and

(iii) meet consumer needs and demands for health insurance coverage while maintaining high standards of quality assurance and consumer protection.

(e) (1) The Exchange may authorize an Individual Exchange **[**navigator**]** **CONNECTOR** entity to provide consumer assistance services that:

(i) are required to be provided by an Individual Exchange navigator; or

(ii) subject to paragraph (2)(iii) of this subsection, result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program.

(2) The Exchange:

(i) may limit the authorization of an Individual Exchange **[**navigator**]** **CONNECTOR** entity to the provision of a subset of services, depending on the needs of the Individual Exchange navigator program and the capacity of the Individual Exchange **[**navigator**]** **CONNECTOR** entity, provided that the navigator program overall provides the totality of services required by the Affordable Care Act and this subtitle;

(ii) pursuant to contractual agreement, may require an Individual Exchange **[**navigator**]** **CONNECTOR** entity to provide education, outreach, and other consumer assistance services in addition to the services provided under the Individual Exchange **[**navigator**]** **CONNECTOR** entity's authorization in order to achieve all of the objectives of the navigator program; and

(iii) may not authorize an Individual Exchange **[**navigator**]** **CONNECTOR** entity to provide services that result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program without the approval of the Department of Health and Mental Hygiene.

(f) An Individual Exchange **[**navigator**]** **CONNECTOR** entity:

(1) shall obtain authorization from the Individual Exchange to provide services that:

(i) are required to be provided by an Individual Exchange navigator; or

(ii) result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

(2) may provide:

(i) those services that are within the scope of the Individual Exchange **[**navigator**]** **CONNECTOR** entity's authorization; and

(ii) any other consumer assistance services that:

1. are not required to be provided by an Individual Exchange navigator; or

2. do not require authorization under this subsection;

(3) to the extent the scope of its authorization includes services that must be provided by an Individual Exchange navigator, shall provide those services only through Individual Exchange navigators;

(4) in addition to the services it may provide under its authorization, may employ or engage other individuals to conduct:

(i) consumer education and outreach; and

(ii) determinations of eligibility for premium subsidies and cost–sharing assistance, the Maryland Medical Assistance Program, and the Maryland Children's Health Program;

(5) may employ or engage individuals to perform activities that:

(i) are executive, administrative, managerial, or clerical; and

(ii) relate only indirectly to services that must be provided by an Individual Exchange navigator or result in a consumer's enrollment in the Maryland Medical Assistance Program or the Maryland Children's Health Program;

(6) shall comply with all State and federal laws, regulations, and policies governing the Maryland Medical Assistance Program and the Maryland Children's Health Program;

(7) may not receive any compensation, directly or indirectly:

(i) from a carrier, an insurance producer, or a third–party administrator in connection with the enrollment of a qualified individual in a qualified health plan; or

(ii) from any managed care organization that participates in the Maryland Medical Assistance Program in connection with the enrollment of an individual in the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

(8) with respect to the insurance market outside the Exchange:

(i) may not provide any information or services related to health benefit plans or other products not offered in the Exchange, except for general information about the insurance market outside the Exchange, which shall be limited to the information provided in a consumer education document developed by the Exchange and the Commissioner;

(ii) shall refer any inquiries about health benefit plans or other products not offered in the Exchange to:

1. any resources that may be maintained by the Exchange; or

2. carriers and licensed insurance producers; and

(iii) on contact with an individual who acknowledges having existing health insurance coverage obtained through an insurance producer, shall refer the individual back to the insurance producer for information and services unless:

1. the individual is eligible for but has not obtained a federal premium subsidy and cost–sharing assistance available only through the Individual Exchange;

2. the insurance producer is not authorized to sell qualified plans in the Individual Exchange; or

3. the individual would prefer not to seek further assistance from the individual's insurance producer.

(g) (1) The Commissioner may suspend or revoke an Individual Exchange **[**navigator**]** **CONNECTOR** entity authorization after notice and opportunity for a hearing under §§ 2–210 through 2–214 of this article if the Individual Exchange **[**navigator**]** **CONNECTOR** entity:

(i) has willfully violated this article or any regulation adopted under this article;

(ii) has engaged in fraudulent or dishonest practices in conducting activities under the Individual Exchange **[**navigator**]** **CONNECTOR** entity authorization;

(iii) has had any professional license or certification suspended or revoked for a fraudulent or dishonest practice;

(iv) has been convicted of a felony, a crime of moral turpitude, or any criminal offense involving dishonesty or breach of trust; or

(v) has willfully failed to comply with or violated a proper order or subpoena of the Commissioner.

(2) Instead of or in addition to suspending or revoking an Individual Exchange **[**navigator**]** **CONNECTOR** entity authorization, the Commissioner may:

(i) impose a penalty of not less than $100 but not exceeding $500 for each violation of this article; and

(ii) require that restitution be made to any person who has suffered financial injury because of the Individual Exchange **[**navigator**]** **CONNECTOR** entity's violation of this article.

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

(4) The Commissioner shall notify the Individual Exchange of any decision affecting the authorization of an Individual Exchange **[**navigator**]** **CONNECTOR** entity or any sanction imposed on an Individual **[**navigator**]** **EXCHANGE CONNECTOR** entity under this subsection.

(5) A carrier is not responsible for the activities and conduct of Individual Exchange **[**navigator**]** **CONNECTOR** entities.";

and in lines 15, 18, and 29, in each instance, strike "navigator" and substitute "**CONNECTOR**".

On page 25, in line 13, after "Hygiene" insert "**, THE HEALTH EDUCATION AND ADVOCACY UNIT OF THE OFFICE OF THE ATTORNEY GENERAL,**"; and after line 36, insert:

"(l) (4) The Commissioner shall notify the Individual Exchange and the Individual Exchange **[**navigator**]** **CONNECTOR** entity for which the Individual Exchange navigator works of any decision affecting the certification of an Individual Exchange navigator or any sanction imposed on an Individual Exchange navigator under this subsection.

(m) (1) The Exchange shall establish and administer an insurance producer authorization process for the Individual Exchange.

(2) Under the process, the Exchange shall:

(i) provide an authorization to sell qualified plans to a licensed insurance producer who meets the requirements in subsection (n) of this section; and

(ii) require renewal of an authorization every 2 years.

(3) (i) Subject to the contested case hearing provisions of Title 10, Subtitle 2 of the State Government Article, the Exchange may suspend, revoke, or refuse to renew an authorization for good cause, which shall include a finding that the insurance producer holding the authorization has committed any act described in subsection **[**(m)(1)**] (L)(1)** of this section with respect to the authorization.

(ii) The Individual Exchange shall notify the Commissioner of any decision affecting the status of an insurance producer's authorization.

(4) The Individual Exchange, with the approval of the Commissioner, shall adopt regulations to carry out this subsection.

(o) (1) The Exchange shall develop, implement, and, as appropriate, update a training program for insurance producers who sell qualified plans in the Individual Exchange.

(2) The training program shall:

(i) impart the skills and expertise necessary to perform functions specific to the Individual Exchange, such as making premium assistance eligibility determinations;

(ii) enable the Exchange to provide robust protection of consumers and adherence to high quality assurance standards; **[**and**]**

(III) IMPART THE SKILLS AND EXPERTISE NECESSARY TO FACILITATE APPROPRIATE REFERRALS OF INDIVIDUALS AND THEIR DEPENDENTS TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE MARYLAND CHILDREN'S HEALTH PROGRAM, THE APPROPRIATE INDIVIDUAL EXCHANGE CONNECTOR ENTITY, AN INDEPENDENT INSURANCE PRODUCER, OR THE CONSOLIDATED SERVICES CENTER; AND

[(iii)**] (IV)** be approved by the Commissioner.

(P) (1) SUBJECT TO PARAGRAPHS (2) THROUGH (7) OF THIS SUBSECTION, UNTIL JANUARY 1, 2017, A CAPTIVE PRODUCER, WITHOUT BEING SEPARATELY CERTIFIED AS AN INDIVIDUAL EXCHANGE NAVIGATOR, MAY ENROLL, IN A QUALIFIED PLAN OFFERED IN THE INDIVIDUAL EXCHANGE BY THE CARRIER FROM WHICH THE CAPTIVE PRODUCER HAS AN EXCLUSIVE APPOINTMENT:

(I) AN INDIVIDUAL WHO:

1. IS CURRENTLY ENROLLED IN ONE OF THE CARRIER'S NONGROUP PLANS; AND

2. EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, DOES NOT HAVE AN INSURANCE PRODUCER OF RECORD IN CONNECTION WITH THE CARRIER'S NONGROUP PLAN; OR

(II) AN INDIVIDUAL WHO:

1. INITIATES CONTACT WITH THE CAPTIVE PRODUCER OR THE CARRIER FOR THE PURPOSE OF REQUESTING ASSISTANCE OR INQUIRING ABOUT THE CARRIER'S PLANS; AND

2. EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, DOES NOT ACKNOWLEDGE HAVING AN INSURANCE PRODUCER IN CONNECTION WITH ANY EXISTING INSURANCE COVERAGE.

(2) (I) IF AN INDIVIDUAL UNDER PARAGRAPH (1) OF THIS SUBSECTION HAS AN INSURANCE PRODUCER, A CAPTIVE PRODUCER SHALL REFER THE INDIVIDUAL BACK TO THE INSURANCE PRODUCER, TOGETHER WITH ANY AVAILABLE CONTACT INFORMATION, FOR INFORMATION AND SERVICES, UNLESS:

1. THE INDIVIDUAL IS ELIGIBLE FOR, BUT HAS NOT OBTAINED A FEDERAL PREMIUM SUBSIDY AND COST-SHARING ASSISTANCE, AND THE INSURANCE PRODUCER IS NOT AUTHORIZED TO SELL QUALIFIED PLANS IN THE INDIVIDUAL EXCHANGE; OR

2. THE INDIVIDUAL WOULD PREFER NOT TO SEEK FURTHER ASSISTANCE FROM THE INDIVIDUAL'S INSURANCE PRODUCER.

(II) IF A CAPTIVE PRODUCER IS NOT AWARE OF AN INSURANCE PRODUCER OF RECORD, THE CAPTIVE PRODUCER SHALL DISCLOSE TO AN INDIVIDUAL UNDER PARAGRAPH (1) OF THIS SUBSECTION THAT THERE MAY BE AN INSURANCE PRODUCER OF RECORD IN CONNECTION WITH AN EXISTING POLICY.

(3) (I) A CARRIER AND ITS CAPTIVE PRODUCERS, IN OFFERING INFORMATION AND ASSISTANCE TO THE CARRIER'S CURRENT ENROLLEES REGARDING QUALIFIED PLANS OFFERED IN THE INDIVIDUAL EXCHANGE:

1. SHALL COMPLY WITH FAIR MARKETING STANDARDS DEVELOPED JOINTLY BY THE EXCHANGE AND THE COMMISSIONER;

2. MAY NOT EMPLOY MARKETING PRACTICES OR OFFER INFORMATION AND ASSISTANCE ONLY TO CERTAIN ENROLLEES IN A MANNER THAT WILL HAVE THE EFFECT OF ENROLLING A DISPROPORTIONATE NUMBER OF THE CARRIER'S ENROLLEES WITH SIGNIFICANT HEALTH NEEDS IN QUALIFIED PLANS OFFERED IN THE INDIVIDUAL EXCHANGE; AND

3. SHALL ACT IN THE BEST INTEREST OF THE INDIVIDUAL TO WHOM THE CARRIER AND ITS CAPTIVE PRODUCERS PROVIDE ASSISTANCE.

(II) A CARRIER SHALL PROVIDE TO THE EXCHANGE, AND UPDATE AS NEEDED, A LIST OF ITS CURRENT CAPTIVE PRODUCERS.

(4) BEFORE PROVIDING AN INDIVIDUAL UNDER PARAGRAPH (1) OF THIS SUBSECTION ANY INFORMATION OR ASSISTANCE WITH RESPECT TO QUALIFIED PLANS OFFERED IN THE INDIVIDUAL EXCHANGE, A CAPTIVE PRODUCER IN A MANNER PRESCRIBED UNDER FAIR MARKETING STANDARDS ESTABLISHED BY THE COMMISSIONER AND THE EXCHANGE, SHALL:

(I) DISCLOSE TO THE INDIVIDUAL THAT:

1. THE CAPTIVE PRODUCER IS EMPLOYED BY THE CARRIER AND ABLE TO PROVIDE INFORMATION ABOUT AND SELL ONLY QUALIFIED PLANS OFFERED BY THE CARRIER; AND

2. THE INDIVIDUAL EXCHANGE OFFERS OTHER QUALIFIED PLANS, SOLD BY OTHER CARRIERS, THAT MAY MEET THE INDIVIDUAL'S NEEDS;

(II) ON THE INDIVIDUAL'S REQUEST:

1. REFER THE INDIVIDUAL FOR FURTHER ASSISTANCE TO AN INDEPENDENT INSURANCE PRODUCER, THE APPROPRIATE INDIVIDUAL EXCHANGE CONNECTOR ENTITY, OR THE CONSOLIDATED SERVICES CENTER; AND

2. A PROVIDE, THROUGH MAIL OR ELECTRONIC COMMUNICATION, WRITTEN INFORMATION ABOUT THE INDIVIDUAL EXCHANGE, THE CONNECTOR PROGRAM, AND THE CONSOLIDATED SERVICES CENTER; AND

(III) DOCUMENT THAT THE CAPTIVE PRODUCER HAS PROVIDED THE REQUIRED DISCLOSURES AND THE INDIVIDUAL HAS ACKNOWLEDGED THAT THE INDIVIDUAL:

1. UNDERSTANDS THE DISCLOSURES;

2. DOES NOT WANT TO BE REFERRED TO AN INDEPENDENT INSURANCE PRODUCER, AN INDIVIDUAL EXCHANGE CONNECTOR ENTITY, OR THE CONSOLIDATED SERVICES CENTER; AND

3. WANTS TO RECEIVE INFORMATION AND ASSISTANCE FROM THE CAPTIVE PRODUCER.

(5) A RECORD OF THE DOCUMENTATION REQUIRED UNDER PARAGRAPH (4)(III) OF THIS SUBSECTION SHALL BE:

(I) RETAINED BY A CAPTIVE PRODUCER FOR AT LEAST 3 YEARS;

(II) SUBJECT TO THE COMMISSIONER'S REVIEW IN A MARKET CONDUCT EXAMINATION; AND

(III) PROVIDED TO THE EXCHANGE ON A QUARTERLY BASIS.

(6) WITH RESPECT TO ANY HEALTH BENEFIT PLANS OR OTHER PRODUCTS OFFERED IN THE INDIVIDUAL EXCHANGE OR THE INSURANCE MARKET OUTSIDE THE INDIVIDUAL EXCHANGE BY CARRIERS OTHER THAN THE CARRIER WITH WHICH THE CAPTIVE PRODUCER HAS AN EXCLUSIVE APPOINTMENT, A CAPTIVE PRODUCER:

(I) MAY NOT PROVIDE ANY INFORMATION OR SERVICES RELATED TO HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED BY THE CAPTIVE PRODUCER'S CARRIER; AND

(II) SHALL REFER ANY INQUIRIES ABOUT HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED BY THE CAPTIVE PRODUCER'S CARRIER TO:

1. ANY RESOURCES THAT MAY BE MAINTAINED BY THE EXCHANGE; OR

2. A LICENSED INDEPENDENT INSURANCE PRODUCER.

(7) IF A CARRIER OR A CAPTIVE PRODUCER FAILS TO COMPLY WITH THE REQUIREMENTS OF THIS SUBSECTION, THE EXCHANGE MAY:

(I) SUSPEND, REVOKE, OR REFUSE TO RENEW THE CAPTIVE PRODUCER'S AUTHORIZATION UNDER SUBSECTION (M)(3) OF THIS SECTION; AND

(II) IMPOSE SANCTIONS AGAINST THE CARRIER UNDER § 31-115(K) OF THIS TITLE.

[(p)**] (Q)** Nothing in this section shall prohibit a community–based organization or a unit of State or local government from providing the consumer assistance services described in subsection (c) of this section that are not required to be provided by an Individual Exchange navigator, if the entity providing the services and its employees do not:

(1) receive any compensation, directly or indirectly, from a carrier, an insurance producer, or a third–party administrator in connection with the enrollment of a qualified individual in a qualified health plan;

(2) receive any compensation, directly or indirectly, from a managed care organization that participates in the Maryland Medical Assistance Program or the Maryland Children's Health Program; and

(3) identify themselves to the public as an Individual Exchange **[**navigator**]** **CONNECTOR** entities or Individual Exchange navigators.

(R) (1) TO THE EXTENT AND IN THE MANNER PERMITTED OR REQUIRED BY FEDERAL LAW OR REGULATION GOVERNING APPLICATION COUNSELORS AND OTHER EXCHANGE CONSUMER ASSISTANCE PERSONNEL, SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AND DEPENDING ON ITS NEEDS AND RESOURCES, THE EXCHANGE MAY:

(I) DESIGNATE AS AN APPLICATION COUNSELOR SPONSORING ENTITY UNDER THIS SUBSECTION A COMMUNITY-BASED ORGANIZATION, HEALTH CARE PROVIDER, UNIT OF STATE OR LOCAL GOVERNMENT, OR OTHER ENTITY; AND

(II) CERTIFY AS AN APPLICATION COUNSELOR ANY AGENT, EMPLOYEE, OR VOLUNTEER OF AN APPLICATION COUNSELOR SPONSORING ENTITY WHO MEETS THE REQUIREMENTS FOR INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION UNDER THIS SECTION.

(2) AN APPLICATION COUNSELOR SPONSORING ENTITY AND AN APPLICATION COUNSELOR AUTHORIZED TO PROVIDE SERVICES UNDER THIS SUBSECTION:

(I) MAY NOT BE COMPENSATED BY THE EXCHANGE;

(II) MAY NOT IMPOSE A FEE ON INDIVIDUALS TO WHOM THEY ARE AUTHORIZED TO PROVIDE SERVICES UNDER THIS SECTION FOR THE SERVICES;

(III) SHALL DISCLOSE TO THE EXCHANGE AND TO INDIVIDUALS TO WHOM THEY PROVIDE SERVICES ANY RELATIONSHIPS THEY HAVE WITH:

1. A CARRIER, AN INSURANCE PRODUCER, OR A THIRD-PARTY ADMINISTRATOR; OR

2. A MANAGED CARE ORGANIZATION THAT PARTICIPATES IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(IV) SHALL ACT IN THE BEST INTEREST OF THE INDIVIDUALS FOR WHOM THEY ARE AUTHORIZED TO PROVIDE SERVICES; AND

(V) MAY NOT BE COMPENSATED BY A CARRIER, INSURANCE PRODUCER, OR THIRD-PARTY ADMINISTRATOR FOR THEIR ENROLLMENT SERVICES.

(3) AN APPLICATION COUNSELOR IS SUBJECT TO ALL REQUIREMENTS, RESTRICTIONS, CONFLICT OF INTEREST RULES, AND OVERSIGHT APPLICABLE TO:

(I) INDIVIDUAL EXCHANGE CONNECTOR ENTITIES AND INDIVIDUAL EXCHANGE NAVIGATORS UNDER THIS SUBSECTION AND ANY OTHER RELEVANT STATE OR FEDERAL LAWS; AND

(II) APPLICATION COUNSELORS UNDER FEDERAL LAW OR REGULATION.

(4) THE EXCHANGE, IN CONSULTATION WITH THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, MAY:

(I) ESTABLISH REQUIREMENTS FOR A SPONSORING ENTITY; AND

(II) ADOPT REGULATIONS TO CARRY OUT THIS SUBSECTION.".

AMENDMENT NO. 15

On page 28, in line 2, strike "**AND**"; in line 3, after "**(VI)**" insert "**SHALL INQUIRE WHETHER AN INDIVIDUAL HAS HEALTH INSURANCE OBTAINED THROUGH AN INSURANCE PRODUCER AND, IF SO, SHALL REFER THE INDIVIDUAL TO THE INSURANCE PRODUCER FOR INFORMATION AND SERVICES UNLESS:**

1. THE INDIVIDUAL IS ELIGIBLE FOR, BUT HAS NOT OBTAINED A FEDERAL PREMIUM SUBSIDY AND COST-SHARING ASSISTANCE, AND THE INSURANCE PRODUCER IS NOT AUTHORIZED TO SELL QUALIFIED PLANS IN THE INDIVIDUAL EXCHANGE; OR

2. THE INDIVIDUAL WOULD PREFER NOT TO SEEK FURTHER ASSISTANCE FROM THE INDIVIDUAL'S INSURANCE PRODUCER; AND

(VII)";

and after line 32, insert:

"**(D) THE EXCHANGE, THE CSC, AND CSC EMPLOYEES SHALL ASSIST THE HEALTH EDUCATION AND ADVOCACY UNIT OF THE OFFICE OF THE ATTORNEY GENERAL IN CARRYING OUT ITS DUTIES TO ASSIST CONSUMERS UNDER TITLE 13, SUBTITLE 4A OF THE COMMERCIAL LAW ARTICLE AND TITLE 15, SUBTITLES 10A AND 10D OF THIS ARTICLE.**

31–114.

(a) Nothing in this title requires the Maryland Medical Assistance Program or the Maryland Children's Health Program to provide any specific financial support to the Individual Exchange for the services provided by an Individual Exchange navigator or an Individual Exchange **[**navigator**]** **CONNECTOR** entity.".

AMENDMENT NO. 16

On page 29, in line 8, strike "(d)" and substitute "**(E)**"; and after line 18, insert:

"**(II) OFFERS IN EACH EXCHANGE, THE INDIVIDUAL AND THE SHOP, IN WHICH THE CARRIER PARTICIPATES, AT LEAST ONE QUALIFIED HEALTH PLAN:**

1. AT A BRONZE LEVEL OF COVERAGE;

2. AT A SILVER LEVEL OF COVERAGE; AND

3. AT A GOLD LEVEL OF COVERAGE;".

On page 29, in lines 19, 24, 28, and 31, strike "(ii)", "(iii)", "(iv)", and "(v)", respectively, and substitute "**(III)**", "**(IV)**", "**(V)**", and "**(VI)**", respectively.

On page 30, in line 1, strike "(vi)" and substitute "**(VII)**"; after line 24, insert:

"(d) **[**(1) A qualified health plan is not required to provide essential benefits that duplicate the minimum benefits of qualified vision plans, as provided in subsection (i) of this section, if:

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

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

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

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

(2)**]** The Exchange may determine whether a carrier may elect to **[**include**]** **OFFER COVERAGE FOR** nonessential vision benefits in **[**a qualified health plan**]** **EITHER THE SHOP EXCHANGE OR INDIVIDUAL EXCHANGE**.

(e) 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.

(h) (1) Except as provided in paragraphs (2) through (5) of this subsection, the requirements applicable to qualified health plans under this title also shall apply to qualified dental plans to the extent relevant, whether offered in conjunction with or as an endorsement to qualified health plans or as stand–alone dental plans.

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

(3) A qualified dental plan shall:

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

(ii) include at a minimum:

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

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

(4) (i) The Exchange may determine:

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

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

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

C. as a stand–alone plan; and

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

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

(5) The Exchange may:

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

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

(6) THE EXCHANGE MAY REQUIRE CHILDREN ENROLLING IN A QUALIFIED HEALTH PLAN TO HAVE THE ESSENTIAL PEDIATRIC DENTAL BENEFITS REQUIRED BY THE SECRETARY UNDER § 1302(B)(1)(J) OF THE AFFORDABLE CARE ACT, WHETHER OFFERED:

(I) IN THE QUALIFIED HEALTH PLAN;

(II) IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO THE QUALIFIED HEALTH PLAN; OR

(III) AS A STAND–ALONE DENTAL PLAN.

(i) (3) A qualified vision plan shall:

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

(ii) include at a minimum:

1. the essential pediatric vision benefits required by the Secretary under § 1302(b)(1)(j) of the Affordable Care Act; **[**and**] OR**

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

in line 31, strike "**MEET**" and substitute "**HAS OTHERWISE VIOLATED**"; and in line 33, after "**AND**" insert "**INTERIM**".

On page 31, in line 3, strike "**MAY**" and substitute "**SHALL**"; in line 23, strike "**$100**" and substitute "**$5,000**"; in line 25, after "**(4)**" insert "**IN DETERMINING THE AMOUNT OF A PENALTY UNDER PARAGRAPH (3)(II) OF THIS SUBSECTION, THE EXCHANGE SHALL CONSIDER:**

(I) THE TYPE, SEVERITY, AND DURATION OF THE VIOLATION;

(II) WHETHER THE PLAN OR CARRIER KNEW OR SHOULD HAVE KNOWN OF THE VIOLATION;

(III) THE EXTENT TO WHICH THE PLAN OR CARRIER HAVE A HISTORY OF VIOLATIONS; AND

(IV) WHETHER THE PLAN OR CARRIER CORRECTED THE VIOLATION AS SOON AS THEY KNEW OR SHOULD HAVE KNOWN OF THE VIOLATION.

(5)";

and after line 28, insert:

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

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

2. REQUEST A HEARING.

(II) A DEMAND FOR A HEARING STAYS A DECISION OR ORDER OF THE EXCHANGE PENDING THE HEARING, AND A FINAL ORDER OF THE EXCHANGE RESULTING FROM IT, IF THE EXCHANGE RECEIVES THE DEMAND:

1. BEFORE THE EFFECTIVE DATE OF THE ORDER; OR

2. WITHIN 10 DAYS AFTER THE ORDER IS SERVED.

(III) IF A PETITION FOR JUDICIAL REVIEW IS FILED WITH THE APPROPRIATE COURT UNDER TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE, THE COURT HAS JURISDICTION OVER THE CASE AND SHALL DETERMINE WHETHER THE FILING OPERATES AS A STAY OF THE ORDER FROM WHICH THE APPEAL IS TAKEN.

31–116.

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

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

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

(i) all individual health benefit plans and health benefit plans offered to small employers, except for grandfathered health plans, as defined in the Affordable Care Act, offered outside the Exchange; and

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

AMENDMENT NO. 17

On page 33, after line 7, insert:

"(a) The Exchange shall be administered in a manner designed to:

(1) prevent discrimination **ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, DISABILITY, AGE, SEX, GENDER IDENTITY, OR SEXUAL ORIENTATION**;

(2) streamline enrollment and other processes to minimize expenses and achieve maximum efficiency;

(3) prevent waste, fraud, and abuse; and

(4) promote financial integrity.

(d) (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:

1. health plan participation, ratings, coverage, price, quality improvement measures, and benefits;

2. consumer choice, participation, and satisfaction information to the extent the information is available;

3. financial integrity, fee assessments, and status of the Fund; and

4. any other appropriate metrics related to the operation of the Exchange that may be used to evaluate Exchange performance, assure transparency, and facilitate research and analysis;

(iii) **ASSESS AND, TO THE EXTENT FEASIBLE AND PERMITTED BY LAW,** include data to identify disparities related to gender, race, ethnicity, geographic location, language, disability, **GENDER IDENTITY, SEXUAL ORIENTATION,** or other attributes of special populations; and

(iv) include information on its fraud, waste, and abuse detection and prevention program.".

AMENDMENT NO. 18

On page 33, in lines 25 and 27, in each instance, after "**MEDICAL**" insert "**OR DENTAL**".

On page 35, in line 12, strike "**DENTAL OR**".

On page 36, in line 9, after "**(6)**" insert "**(I)**"; in line 10, strike "**(I)**" and substitute "**1.**"; in line 12, strike "**DELIVER**" and substitute "**PROVIDE, IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION, HEALTH CARE**"; in line 15, strike "**(II)**" and substitute "**2. A FACILITY WHERE HEALTH CARE IS PROVIDED TO PATIENTS OR RECIPIENTS, INCLUDING:**

A.";

in the same line, strike the comma; and in line 16, after "**ARTICLE**" insert "**;**

B. A RELATED INSTITUTION AS DEFINED IN § 19-301 OF THE HEALTH - GENERAL ARTICLE;

C. A FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE;

D. A FACILITY THAT IS ORGANIZED PRIMARILY TO HELP IN THE REHABILITATION OF PERSONS WITH DISABILITIES;

E. A HOME HEALTH AGENCY AS DEFINED IN § 19-901 OF THE HEALTH - GENERAL ARTICLE;

F. A HOSPICE AS DEFINED IN § 19-901 OF THE HEALTH - GENERAL ARTICLE;

G. A FACILITY THAT PROVIDES RADIOLOGICAL OR OTHER DIAGNOSTIC IMAGERY SERVICES;

H. A MEDICAL LABORATORY AS DEFINED IN § 17-201 OF THE HEALTH - GENERAL ARTICLE;

I. AN ALCOHOL ABUSE AND DRUG ABUSE TREATMENT PROGRAM AS DEFINED IN § 8-403 OF THE HEALTH - GENERAL ARTICLE; AND

J. A FEDERALLY QUALIFIED HEALTH CENTER.

(II) "HEALTH CARE PROVIDER" INCLUDES THE AGENTS, EMPLOYEES, OFFICERS, AND DIRECTORS OF A HEALTH CARE PROVIDER DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH".

On page 38, in lines 15 and 16, in each instance, after "**MEDICAL**" insert "**OR DENTAL**"; strike beginning with "**INCLUDES**" in line 18 down through "**ACTIVITIES**" in line 20 and substitute "**IS SERIOUS IN NATURE**"; strike beginning with "**REQUIRES**" in line 23 down through the comma in line 24 and substitute "**IS ACTIVELY MANAGED OR SUPERVISED BY**"; in line 26 after "**(B)**" insert "**(1)**"; after line 25, insert:

"**(16) "THIRD-PARTY ADMINISTRATOR" MEANS AN ORGANIZATION UNDER CONTRACT WITH THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO ADMINISTER CERTAIN BENEFITS AND SERVICES PROVIDED BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM.**";

and in lines 28 and 30, strike "**(1)**" and "**(2)**", respectively, and substitute "**(I)**" and "**(II)**", respectively.

On page 39, in lines 1 and 2, strike "**(I)**" and "**(II)**", respectively, and substitute "**1.**" and "**2.**", respectively; after line 3, insert:

"**(2) THIS SECTION:**

(I) WITH RESPECT TO ANY BENEFIT OR SERVICE THAT IS PROVIDED THROUGH THE MARYLAND MEDICAL ASSISTANCE FEE-FOR-SERVICE PROGRAM:

1. SHALL NOT APPLY WHEN THE ENROLLEE IS TRANSITIONING FROM A CARRIER TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM; AND

2. EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION, SHALL APPLY WHEN THE ENROLLEE IS TRANSITIONING FROM THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO A CARRIER;

(II) SHALL APPLY TO CONTRACTS ISSUED OR RENEWED ON OR AFTER JANUARY 1, 2015; AND

(III) SUBJECT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH, WITH RESPECT TO DENTAL BENEFITS, SHALL APPLY TO COVERED SERVICES FOR WHICH A COORDINATED TREATMENT PLAN IS IN PROGRESS.";

in line 4, after "**(1)**" insert "**WITH RESPECT TO ANY BENEFIT OR SERVICE PROVIDED THROUGH THE MARYLAND MEDICAL ASSISTANCE FEE-FOR-SERVICE PROGRAM, THIS SUBSECTION SHALL APPLY:**

(I) ONLY TO ENROLLEES TRANSITIONING FROM THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO A CARRIER; AND

(II) ONLY TO BEHAVIORAL HEALTH AND DENTAL BENEFITS, TO THE EXTENT THEY ARE AUTHORIZED BY A THIRD-PARTY ADMINISTRATOR.

(2)";

in line 4, strike "**(2)**" and substitute "**(3)**"; in line 5, strike the second "**OR**"; in line 6, after the comma insert "**OR HEALTH CARE PROVIDER,**"; in line 7, strike "**PRIOR AUTHORIZATION**" and substitute "**PREAUTHORIZATION**"; in the same line, strike

"**OR**" and substitute a comma; in line 8, after "**ORGANIZATION**" insert "**, OR THIRD-PARTY ADMINISTRATOR**"; after line 16, insert:

"**(3) SUBJECT TO APPLICABLE LAWS RELATING TO THE CONFIDENTIALITY OF MEDICAL RECORDS, INCLUDING 42 C.F.R. PART 2, AT THE REQUEST AND WITH THE CONSENT OF AN ENROLLEE OR AN ENROLLEE'S PARENT, GUARDIAN, OR DESIGNEE, A RELINQUISHING CARRIER, MANAGED CARE ORGANIZATION, OR THIRD-PARTY ADMINISTRATOR, SHALL PROVIDE A COPY OF A PREAUTHORIZATION TO THE ENROLLEE'S RECEIVING CARRIER OR MANAGED CARE ORGANIZATION WITHIN 10 DAYS AFTER RECEIPT OF THE REQUEST.**";

in line 17, strike "**(2)**" and substitute "**(4)**"; in the same line, strike "**(1)(II)**" and substitute "**(2)(II)**"; in line 26, strike the first "**OR**"; in the same line, after the second comma insert "**OR HEALTH CARE PROVIDER,**"; and in line 31, after "**(2)**" insert "**(I)**".

On page 40, in line 1, strike "**(I)**" and substitute "**1.**"; in lines 2, 3, 4, and 5, strike "**1.**", "**2.**", "**3.**", and "**4.**", respectively, and substitute "**A.**", "**B.**", "**C.**", and "**D.**", respectively; in line 4, after the semicolon insert "**AND**"; in line 6, after the semicolon insert "**AND**

2. ANY OTHER CONDITION ON WHICH THE NONPARTICIPATING PROVIDER AND THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION REACH AGREEMENT.

(II) EXAMPLES OF CONDITIONS SET FORTH IN SUBPARAGRAPH (I)1A AND B OF THIS PARAGRAPH MAY INCLUDE:";

in lines 7, 8, 9, 10, 12, and 13, strike "**5.**", "**6.**", "**7.**", "**8.**", "**9.**", and "**10.**", respectively, and substitute "**1.**", "**2.**", "**3.**", "**4.**", "**5.**", and "**6.**", respectively; in line 9, strike "**WITHIN**

THE PREVIOUS 30 DAYS"; strike beginning with "**DIAGNOSED**" in line 10 down through "**DAYS**" in line 11; in line 13, strike "**; AND**" and substitute a period; in line 14, strike "**(II)**" and substitute "**(III) AN ENROLLEE SHALL BE ALLOWED TO CONTINUE TO RECEIVE SERVICES FOR THE CONDITIONS UNDER THIS PARAGRAPH FOR**"; in line 19, strike "**PARAGRAPH (4)**" and substitute "**PARAGRAPHS (4) AND (5)**"; strike beginning with "**THE**" in line 19 down through "**AND**" in line 20; strike beginning with "**AGREE**" in line 22 down through "**1.**" in line 24 and substitute "**PAY THE NONPARTICIPATING PROVIDER**"; in line 24, strike "**RATES**" and substitute "**RATE**"; and in the same line, strike "**METHODS**" and substitute "**METHOD**".

On pages 40 and 41, strike beginning with the semicolon in line 27 on page 40 down through "**SUBSECTION**" in line 2 on page 41.

On page 41, after line 2, insert:

"**(III) THE NONPARTICIPATING PROVIDER MAY DECLINE TO ACCEPT THE RATE OR METHOD OF PAYMENT UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH BY GIVING 10 DAYS' PRIOR NOTICE TO THE ENROLLEE AND RECEIVING CARRIER.**

(IV) SUBJECT TO PARAGRAPHS (4) AND (5) OF THIS SUBSECTION, IF THE NONPARTICIPATING PROVIDER DOES NOT ACCEPT THE RATE OR METHOD OF PAYMENT UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE NONPARTICIPATING PROVIDER AND THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION MAY REACH AGREEMENT ON AN ALTERNATIVE RATE OR METHOD OF PAYMENT FOR THE PROVISION OF COVERED SERVICES.";

strike beginning with "**AGREEMENT**" in line 3 down through "**ORGANIZATION**" in line 4 and substitute "**RATES AND METHODS OF PAYMENT UNDER PARAGRAPH (3)(II) AND (IV) OF THIS SUBSECTION**"; in line 15, after "**THAT**" insert "**:**

1. AN ENROLLEE IS NOT SUBJECT TO BALANCE BILLING; AND

2.";

in line 21, after "**PROVIDER**" insert "**DOES NOT ACCEPT THE RATE AND METHOD OF COMPENSATION UNDER PARAGRAPH (3)(II) OF THIS SUBSECTION,**"; in line 22, strike "**DO**" and substitute "**DOES**"; in the same line, after "**AGREEMENT**" insert "**WITH THE NONPARTICIPATING PROVIDER FOR AN ALTERNATIVE RATE AND METHOD OF PAYMENT**"; in line 23, strike "**(3)**" and substitute "**(3)(IV)**"; in line 25, strike "**AND**"; in line 26, after "**(II)**" insert "**§ 14-205.3 OF THIS ARTICLE, UNDER WHICH AN ENROLLEE MAY ASSIGN BENEFITS TO A NONPREFERRED PROVIDER AND THE PROVIDER MAY BALANCE BILL THE ENROLLEE, SHALL APPLY TO THE EXTENT IT WOULD APPLY ABSENT THIS SECTION; AND**

(III) UNLESS THE ENROLLEE HAS ASSIGNED BENEFITS TO A NONPREFERRED PROVIDER UNDER § 14-205.3 OF THIS ARTICLE,";

strike beginning with "**IS**" in line 26 down through "**PROVIDER**" in line 28 and substitute "**SHALL FACILITATE TRANSITION OF THE ENROLLEE TO A PROVIDER ON THE PROVIDER PANEL OF THE CARRIER OR MANAGED CARE ORGANIZATION**"; in line 29, after "**(E)**" insert "**(1)**"; and in line 30, strike "**(1)**" and substitute "**(I)**".

On page 42, in line 3, strike "**(2)**" and substitute "**(II)**"; after line 6, insert:

"**(2) (I) TO ENSURE CONTINUITY OF TREATMENT IN PROGRESS FOR DENTAL SERVICES PROVIDED TO AN ENROLLEE, A RELINQUISHING CARRIER MAY ELECT TO ALLOW AN ENROLLEE TO CONTINUE TO RECEIVE DENTAL SERVICES BEING PROVIDED BY A PARTICIPATING PROVIDER OF THE RELINQUISHING CARRIER THROUGH AN ARRANGEMENT IN WHICH THE RELINQUISHING CARRIER PAYS THE PARTICIPATING PROVIDER ACCORDING TO THE RATE AND METHOD OF PAYMENT THE RELINQUISHING CARRIER NORMALLY WOULD PAY AND USE FOR THE PARTICIPATING PROVIDER.**

(II) THE RATE AND METHOD OF PAYMENT UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL COMPLY WITH:

1. THE PROHIBITION ON BALANCE BILLING UNDER SUBSECTION (D)(4)(II) OF THIS SECTION; AND

2. ANY COPAYMENTS, DEDUCTIBLES, AND COINSURANCE REQUIREMENTS IN THE ENROLLEE'S HEALTH BENEFIT PLAN UNDER THE RELINQUISHING CARRIER.";

in line 7, after "**(F)**" insert "**(1) A RECEIVING CARRIER OR MANAGED CARE ORGANIZATION SHALL PROVIDE NOTICE TO A NEW ENROLLEE OF THE ENROLLEE'S OPTIONS AND RESPONSIBILITIES UNDER THIS SECTION IN A MANNER PRESCRIBED BY THE COMMISSIONER.**

(2)";

in the same line, after "**ARE**" insert "**:**

(I)";

in line 9, after the second "**CARE**" insert "**; AND**

(II) NOT INTENDED TO LIMIT OR MAKE MORE RESTRICTIVE ANY OTHER CONTINUITY OF CARE REQUIREMENTS IN STATE OR FEDERAL LAW, REGULATIONS, OR PROFESSIONAL CODES OF CONDUCT";

in line 13, after "**(H)**" insert "**(1)**"; strike beginning with the colon in line 15 down through "**(1)**" in line 16; in line 16, after "**DATA**" insert "**, TO THE EXTENT ITS COLLECTION IS FEASIBLE AND PERMITTED BY LAW, THAT IS**"; in line 21, after "**POPULATIONS**" insert "**, ANY DISPARATE OR DISCRIMINATORY IMPACT ON SPECIFIC POPULATIONS,**"; in the same line, strike "**; AND**" and substitute a period; in line 22, after "**(2)**" insert "**ON**"; in the same line, strike "**THE REQUISITE DATA FROM**" and substitute "**OF THE COMMISSIONER, THE MARYLAND HEALTH BENEFIT EXCHANGE, OR THE SECRETARY OF HEALTH AND MENTAL HYGIENE**"; and in line 23, after "**PROVIDERS**" insert "**SHALL PROVIDE THE REQUISITE DATA**".

AMENDMENT NO. 19

On page 42, in line 26, strike "reaching agreement on payment for" and substitute "providing continuity of care in"; in line 27, strike "to ensure continuity of care"; in line 30, after "regarding" insert "mandatory"; and in line 33, strike the second "and".

On page 43, in line 1, after "Administration" insert ", and the Maryland Health Care Commission"; in line 3, strike "and"; in line 4, after "Administration" insert ", and the Maryland Health Care Commission"; in line 6, after "study," insert "which, to the extent feasible, shall"; in the same line, strike "including" and substitute "include"; in line 7, after "has" insert ":

(i)";

in line 8, strike "and" and substitute:

"(ii) affected newly eligible populations and trends in health disparities;

(iii) had a disparate impact on specific populations, including individuals suffering from mental health and substance use disorders; and

(iv) had a discriminatory impact based on gender identity or sexual orientation; and";

after line 12, insert:

"SECTION 5. AND BE IT FURTHER ENACTED, That the terms of the initial members of the Performance Standards and Measurement Advisory Committee established under Section 2 of this Act shall expire as follows:

(1) three members in 2014;

(2) five members in 2015; and

(3) five members in 2016.

SECTION 6. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Benefit Exchange and the Maryland Insurance Administration shall:

(1) conduct a study of the impact of the Affordable Care Act's allowance of a tobacco use rating of 1.5 to 1, including:

(i) its effect on insurance premiums generally;

(ii) its effect on the affordability and purchase of insurance, and access to health care, for tobacco users; and

(iii) any disparate impact on specific vulnerable populations; and

(2) assess the options that may be available to the State to address any adverse consequences of the tobacco use rating.

(b) On or before September 1, 2014, the Maryland Health Benefit Exchange and the Maryland Insurance Administration shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly, on the findings of the study and any recommendations for further legislative action.

SECTION 7. AND BE IT FURTHER ENACTED, That:

(a) Pending adoption of regulations under Title 31 of the Insurance Article, and after receiving comment from the Joint Committee on Administrative, Executive, and Legislative Review, the Senate Finance Committee, the House Health and Government Operations Committee, carriers, and the public, the Board of Trustees of the Maryland Health Benefit Exchange may adopt interim policies, if necessary, to ensure that the Maryland Health Benefit Exchange:

(1) is fully prepared to begin successful operations by October 1, 2013; and

(2) is and will remain in compliance with all federal laws, regulations, policies, and deadlines.

(b) Interim policies under subsection (a) of this section:

(1) may be adopted only when necessary to ensure that the Maryland Health Benefit Exchange is in compliance with federal policies, which have been and will likely continue to be in flux;

(2) shall be made public on adoption;

(3) shall be submitted as proposed regulations to the Joint Committee on Administrative, Executive, and Legislative Review within 6 months after adoption by the Board of Trustees; and

(4) shall sunset no later than 1 year after submission as proposed regulations to the Joint Committee on Administrative, Executive, and Legislative Review.

SECTION 8. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Benefit Exchange and the Maryland Insurance Administration shall:

(1) conduct a study of the impact of federal regulations governing the manner in which pediatric dental benefits must be offered and purchased inside and outside the Maryland Health Benefit Exchange, including:

(i) their effect on the affordability and accessibility of pediatric dental benefits; and

(ii) their effect on children's access to dental care; and

(2) assess the options that may be available to the State to address any adverse consequences of the manner in which pediatric dental benefits must be offered and purchased under the federal regulations.

(b) On or before December 1, 2014, the Maryland Health Benefit Exchange and the Maryland Insurance Administration shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on the findings of the study and any recommendations for further legislative action.

SECTION 9. AND BE IT FURTHER ENACTED, That:

(a) (1) The Maryland Health Benefit Exchange and the Maryland Insurance Administration shall conduct a study of the captive producer program established under Section 2 of this Act.

(2) The study shall include an analysis of the effect of the program on:

(i) Exchange enrollment;

(ii) reduction in the percentage of the State's uninsured;

(iii) the percentage of Maryland residents eligible for federal subsidies and cost-sharing assistance who access federal affordability programs; and

(iv) the percentage of Maryland residents who transition from health benefit plans outside the Exchange to qualified health plans inside the Exchange.

(b) On or before December 1, 2015, the Maryland Health Benefit Exchange and the Maryland Insurance Administration shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on the findings of the study and any recommendations for further legislative action.";

in lines 13, 15, and 17, strike "5.", "6.", and "7.", respectively, and substitute "10.", "11.", and "12.", respectively; and in line 18, strike "5 and 6" and substitute "10 and 11".