SENATE BILL 274

J1 3lr0144
CF 3lr0145

By: **The President (By Request – Administration) and Senators Currie, Ferguson, Forehand, Frosh, Jones–Rodwell, Kelley, King, Klausmeier, Madaleno, Middleton, Montgomery, Peters, Pinsky, Pugh, Ramirez, Raskin, Robey, Rosapepe, Stone, and Young**

Introduced and read first time: January 18, 2013
Assigned to: Finance and Budget and Taxation

A BILL ENTITLED

AN ACT concerning

Maryland Health Progress Act of 2013

FOR the purpose of altering certain eligibility requirements for the Maryland Medical Assistance Program and a certain definition to conform to federal eligibility requirements; requiring the Department of Health and Mental Hygiene to implement certain provisions of federal law, subject to the limitations of the State budget; repealing an obsolete provision of law that requires the Governor to include certain funding in the State budget; expanding the purposes for which funds generated from a certain assessment may be used to include providing funding for a certain reinsurance program; exempting the Maryland Health Benefit Exchange (Exchange) and its employees from certain provisions of law governing third party administrators; expanding the purposes for which the Maryland Health Insurance Plan Fund may be used to include funding a certain reinsurance program; requiring enrollment in the Maryland Health Insurance Plan (Plan) to be closed to certain individuals not enrolled in the Plan as of a certain date; requiring the Board of the Plan, in consultation with the Exchange, to determine the appropriate date on which the Plan must decline reenrolling Plan members; requiring the Plan Administrator to deposit certain money in a certain separate account and to keep certain records; authorizing the transfer, under certain circumstances, of certain money in the separate account to the Maryland Health Benefit Exchange Fund for the purpose of funding a certain reinsurance program; requiring the Board of the Plan and the Board of Trustees of the Exchange to develop and approve a plan for the amount and timing of the use of certain funds for a certain reinsurance program; establishing the purpose and effect of certain provisions of this Act; requiring certain carriers and managed care organizations to accept a prior authorization from certain carriers and managed care organizations under certain circumstances; requiring certain carriers and managed care organizations to

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

allow a new enrollee to continue to receive certain health care services being rendered by a certain provider under certain circumstances; requiring certain providers and certain carriers or managed care organizations to agree on the compensation rates and methods of payment with respect to the provision of certain services; specifying certain requirements for the agreement; providing that if an agreement is not reached, the provider is not required to continue to provide the services and the carrier or managed care organization is not required to allow the services to be provided by the provider; providing that the requirements of certain provisions of this Act are in addition to any other legal, professional, or ethical obligations of a carrier or managed care organization to provide continuity of care; authorizing the Maryland Insurance Commissioner and the Secretary of Health and Mental Hygiene to each adopt regulations to enforce certain provisions of this Act; requiring the Commissioner, the Secretary, and the Exchange to determine the data necessary to make a certain assessment and develop a certain process and to request the data from certain persons; establishing that it is a fraudulent insurance act for a SHOP Exchange navigator or an Individual Exchange navigator to take certain actions or make certain representations under certain circumstances; exempting the Exchange from certain insurance laws; requiring a carrier, under certain circumstances, to retain responsibility for ensuring that certain consumer protections are afforded to certain employers and enrollees; expanding the purposes of the Maryland Health Benefit Exchange Fund to include providing funding for the establishment and operation of a certain reinsurance program; altering the contents of the Fund; requiring the Board of Trustees of the Exchange to maintain certain accounts within the Fund; requiring the Board of Trustees to establish a trust account for a certain purpose; requiring the Board of Trustees to maintain separate records of account for certain carriers; requiring the Governor, for certain fiscal years, to provide an appropriation in the State budget adequate to fully fund the operations of the Exchange; requiring the appropriation to be allocated from a certain premium tax; authorizing a certain deficiency appropriation; requiring certain funds to revert to the General Fund of the State; providing that a certain employer is not required to contribute to the qualified plan premiums of its employees; requiring a certain employer to take certain actions if the employer chooses to contribute to the qualified premiums of its employees; authorizing the Exchange to establish a Consolidated Services Center (Center); applying certain provisions of law that require certain training for SHOP Exchange navigators to certain employees of the Center; authorizing an Individual Exchange navigator to be employed by the Exchange; requiring the Exchange to establish and administer a process for the issuance of Consolidated Services Center employee Individual Exchange enrollment permits; authorizing the Exchange to implement a certain process with certain assistance; applying certain provisions of law that require certain training for Individual Exchange navigators to certain employees of the Center; authorizing the Center to employ certain individuals; specifying the qualifications that must be met for issuance of a SHOP Exchange enrollment permit and an Individual Exchange enrollment permit; altering the requirements that must be met for a health benefit plan to be certified as a

qualified health plan; authorizing the Exchange to deny certification to certain plans or suspend or revoke certification of certain plans under certain circumstances; authorizing the Exchange, in addition to denying, suspending, or revoking certification, to impose certain other remedies or take other actions; authorizing the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, to establish a certain reinsurance program to take effect on or after a certain date; establishing the purpose of the program; authorizing the Exchange, with the approval of and in collaboration with the Board of the Plan, to use certain revenue to fund the program; altering the circumstances under which the Board of Trustees of the Exchange must cooperate with certain investigations; declaring the intent of the General Assembly; requiring the Exchange, the Department of Health and Mental Hygiene, and the Maryland Insurance Administration to conduct a certain study and report to the Governor and the General Assembly on the findings of the study and certain recommendations on or before a certain date; defining certain terms; altering certain definitions; providing for the effective dates of this Act; and generally relating to health insurance regulation and the Maryland Health Benefit Exchange.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 15–101(a) and 19–214(a) through (c)
Annotated Code of Maryland
(2009 Replacement Volume and 2012 Supplement)

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–101(d–1), 15–103(a), and 19–214(d)
Annotated Code of Maryland
(2009 Replacement Volume and 2012 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 8–301(a) and 31–101(a)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 8–301(b), 14–502, 14–504, 27–405(a), 31–103, 31–107, 31–111, 31–112(h), 31–113(h), (i), and (k)(1) and (2), 31–115(b), 31–117, and 31–119(e)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)

BY adding to
Article – Insurance

Section 15–140, 31–101(c–1), 31–107.1, 31–107.2, 31–113.1, and 31–115(k)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 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, gives states tools to expand access, enhance quality, and address the costs of health care for individuals, families, and small employers; and

WHEREAS, To this end, the Affordable Care Act requires, by January 1, 2014, the establishment of a health benefit exchange in each state that makes available qualified health plans to qualified individuals and employers, and meets certain other requirements; and

WHEREAS, Maryland's Health Benefit Exchange, if successful, will make health care coverage accessible to hundreds of thousands of Marylanders who otherwise would not be able to obtain the insurance necessary for financial security, health, and well–being; and

WHEREAS, To ensure that each state's lowest–income individuals and families also have access to care, the Affordable Care Act affords states the opportunity to expand eligibility for their Medicaid programs beginning January 1, 2014; and

WHEREAS, Maryland's expansion of Medicaid will enable the State to cover for the first time hundreds of thousands of Maryland citizens with incomes below 138% of federal poverty guidelines who have never before had coverage; and

WHEREAS, The federal government will fund this expansion of Medicaid eligibility in full for the first 3 years, and in 2017 will require the State gradually to contribute up to 10% by 2020; and

WHEREAS, In addition to those who will secure access to health coverage for the first time, Maryland's Health Benefit Exchange and Medicaid expansion will benefit all Marylanders, as broader coverage results in decreased uncompensated care, improved population health, increased premium and hospital revenues, and reduced health care costs; and

WHEREAS, The Maryland Health Benefit Exchange Act of 2011, enacted by Chapter 2 of the Acts of 2011, established the governance and structure of the Maryland Health Benefit Exchange (Exchange); and

WHEREAS, The Maryland Health Benefit Exchange Act of 2012, enacted by Chapter 152 of the Acts of 2012, put in place many of the Exchange Board's initial policy recommendations, developed with the input of its advisory groups and in

accordance with its guiding principles, necessary to establish and operate a successful Exchange; and

WHEREAS, These guiding principles – accessibility, affordability, sustainability, stability, health equity, flexibility, and transparency – reflect the State's goals for establishing a successful Exchange and ensuring that the Exchange's policies, functions and operations (1) make health care coverage more accessible to more Marylanders; (2) promote affordable coverage; (3) contribute to the Exchange's long–term sustainability; (4) build on the strengths of the State's existing health care, health insurance, and health insurance distribution systems to support the Exchange's stability; (5) address longstanding disparities in health care access and outcomes; (6) facilitate flexibility for the Exchange to respond to changes in the insurance market, health care delivery system, and economic conditions while also maintaining sensitivity and responsiveness to consumer needs; and (7) function with the transparency necessary to render it accountable, accessible, and easily understood by the public; and

WHEREAS, In accordance with these principles, the State seeks to put in place some remaining policies, including a dedicated revenue stream to ensure the Exchange's long–term financial sustainability, which are necessary to comply with federal requirements for certification and to complete development of the Exchange by January 1, 2014; and

WHEREAS, The State also seeks a stable, minimally disruptive transition of its high–risk population currently covered by the Maryland Health Insurance Plan into the Exchange; and

WHEREAS, The State also seeks the flexibility to establish a State reinsurance program to enhance the affordability of health insurance by mitigating the rate impact of high–risk enrollees in the individual insurance market inside and outside the Exchange; and

WHEREAS, The State seeks to take full advantage of the opportunity to expand Medicaid coverage for its most financially vulnerable individuals and families; and

WHEREAS, Recognizing also that many Marylanders will transition among qualified health plans inside and outside the Exchange, and between the Exchange and Medicaid, and in accordance with the recommendations of the study mandated by the Maryland Health Benefit Exchange Act of 2012, the State seeks to advance its progress in preventing harmful disruptions of care; and

WHEREAS, The State seeks to enact at this time those Exchange policies, changes in Medicaid eligibility, and continuity of care recommendations that are necessary to ensure that the full benefits of the Affordable Care Act are available to all Marylanders; now, therefore,

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

Article – Health – General

15–101.

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

(d–1) "Independent foster care adolescent" means an individual:

(1) Who is under **[**21**]** **26** years of age; and

(2) Who, on the individual's 18th birthday, was in foster care under the responsibility of the State.

15–103.

(a) (1) The Secretary shall administer the Maryland Medical Assistance Program.

(2) The Program:

(i) Subject to the limitations of the State budget, shall provide medical and other health care services for indigent individuals or medically indigent individuals or both;

(ii) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all eligible pregnant women whose family income is at or below 250 percent of the poverty level, as permitted by the federal law;

(iii) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all eligible children currently under the age of 1 whose family income falls below 185 percent of the poverty level, as permitted by federal law;

(iv) Beginning on January 1, 2012, shall provide, subject to the limitations of the State budget, family planning services to all women whose family income is at or below 200 percent of the poverty level, as permitted by federal law;

(v) Shall provide, subject to the limitations of the State budget, comprehensive medical and other health care services for all children from the age of 1 year up through and including the age of 5 years whose family income falls below 133 percent of the poverty level, as permitted by the federal law;

(vi) **[**Shall**]** **BEGINNING ON JANUARY 1, 2014, SHALL** provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all children who are at least 6 years of age but are under 19 years of age whose family income falls below **[**100**]** **133** percent of the poverty level, as permitted by federal law;

(vii) Shall provide, subject to the limitations of the State budget, comprehensive medical care and other health care services for all legal immigrants who meet Program eligibility standards and who arrived in the United States before August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act, as permitted by federal law;

(viii) Shall provide, subject to the limitations of the State budget and any other requirements imposed by the State, comprehensive medical care and other health care services for all legal immigrant children under the age of 18 years and pregnant women who meet Program eligibility standards and who arrived in the United States on or after August 22, 1996, the effective date of the federal Personal Responsibility and Work Opportunity Reconciliation Act;

[(ix) Beginning on July 1, 2008, shall provide, subject to the limitations of the State budget, and as permitted by federal law, comprehensive medical care and other health care services for all parents and caretaker relatives:

1. Who have a dependent child living in the parents' or caretaker relatives' home; and

2. Whose annual household income is at or below 116 percent of the poverty level;

(x)**]** **(IX)** Beginning on **[**July 1, 2008**]** **JANUARY 1, 2014**, shall provide, subject to the limitations of the State budget, and as permitted by federal law, medical care and other health care services for adults**[**:

1. Who do not meet requirements, such as age, disability, or parent or caretaker relative of a dependent child, for a federal category of eligibility for Medicaid;

2. Whose**]** **WHOSE** annual household income is at or below **[**116**]** **133** percent of the poverty level; **[**and

3. Who are not enrolled in the federal Medicare program, as enacted by Title XVIII of the Social Security Act;**]**

[(xi)**]** **(X)** Shall provide, subject to the limitations of the State budget, and as permitted by federal law, comprehensive medical care and other health care services for independent foster care adolescents:

1. Who are not otherwise eligible for Program benefits; and

2. Whose annual household income is at or below 300 percent of the poverty level;

[(xii)**] (XI)** May include bedside nursing care for eligible Program recipients; and

[(xiii)**] (XII)** Shall provide services in accordance with funding restrictions included in the annual State budget bill.

(3) Subject to restrictions in federal law or waivers, the Department may:

(i) Impose cost–sharing on Program recipients; and

(ii) For adults who do not meet requirements for a federal category of eligibility for Medicaid:

1. Cap enrollment; and

2. Limit the benefit package**[**, except that substance abuse services shall be provided that are at least equivalent to the substance abuse services provided to adults under paragraph (2)(ix) of this subsection**]**.

[(4) In fiscal year 2011 and each fiscal year thereafter, the Governor shall include in the State budget funding sufficient to provide the substance abuse benefits required under paragraph (3)(ii)2 of this subsection.**]**

(4) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET, THE DEPARTMENT SHALL IMPLEMENT THE PROVISIONS OF TITLE II OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010, TO INCLUDE:

(I) PARENTS AND CARETAKER RELATIVES WHO HAVE A DEPENDENT CHILD LIVING IN THE PARENTS' OR CARETAKER RELATIVES' HOME; AND

(II) ADULTS WHO DO NOT MEET REQUIREMENTS, SUCH AS AGE, DISABILITY, OR PARENT OR CARETAKER RELATIVE OF A DEPENDENT CHILD, FOR A FEDERAL CATEGORY OF ELIGIBILITY FOR MEDICAID AND WHO

ARE NOT ENROLLED IN THE FEDERAL MEDICARE PROGRAM, AS ENACTED BY TITLE XVII OF THE SOCIAL SECURITY ACT.

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

Article – Health – General

19–214.

(a) The Commission shall assess the underlying causes of hospital uncompensated care and make recommendations to the General Assembly on the most appropriate alternatives to:

(1) Reduce uncompensated care; and

(2) Assure the integrity of the payment system.

(b) The Commission may adopt regulations establishing alternative methods for financing the reasonable total costs of hospital uncompensated care and the disproportionate share hospital payment provided that the alternative methods:

(1) Are in the public interest;

(2) Will equitably distribute the reasonable costs of uncompensated care and the disproportionate share hospital payment;

(3) Will fairly determine the cost of reasonable uncompensated care and the disproportionate share hospital payment included in hospital rates;

(4) Will continue incentives for hospitals to adopt fair, efficient, and effective credit and collection policies; and

(5) Will not result in significantly increasing costs to Medicare or the loss of Maryland's Medicare Waiver under § 1814(b) of the Social Security Act.

(c) Any funds generated through hospital rates under an alternative method adopted by the Commission in accordance with subsection (b) of this section may only be used to finance the delivery of hospital uncompensated care and the disproportionate share hospital payment.

(d) (1) Each year, the Commission shall assess a uniform, broad–based, and reasonable amount in hospital rates to:

(i) Reflect the aggregate reduction in hospital uncompensated care realized from the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly; and

(ii) Operate and administer the Maryland Health Insurance Plan established under Title 14, Subtitle 5 of the Insurance Article.

(2) (i) For the portion of the assessment under paragraph (1)(i) of this subsection:

1. The Commission shall ensure that the assessment amount equals 1.25% of projected regulated net patient revenue; and

2. Each hospital shall remit its assessment amount to the Health Care Coverage Fund established under § 15–701 of this article.

(ii) Any savings realized in averted uncompensated care as a result of the expansion of health care coverage under Chapter 7 of the Acts of the 2007 Special Session of the General Assembly that are not subject to the assessment under paragraph (1)(i) of this subsection shall be shared among purchasers of hospital services in a manner that the Commission determines is most equitable.

(3) For the portion of the assessment under paragraph (1)(ii) of this subsection:

(i) The Commission shall ensure that the assessment:

1. Shall be included in the reasonable costs of each hospital when establishing the hospital's rates;

2. May not be considered in determining the reasonableness of rates or hospital financial performance under Commission methodologies; and

3. May not be less as a percentage of net patient revenue than the assessment of 0.8128% that was in existence on July 1, 2007; and

(ii) Each hospital shall remit monthly one–twelfth of the amount assessed under paragraph (1)(ii) of this subsection to the Maryland Health Insurance Plan Fund established under Title 14, Subtitle 5 of the Insurance Article, for the purpose of operating and administering the Maryland Health Insurance Plan.

(4) The assessment authorized under paragraph (1) of this subsection may not exceed 3% in the aggregate of any hospital's total net regulated patient revenue.

(5) **(I)** Funds generated from the assessment under this subsection may be used only as follows:

[(i)**]** **1.** To supplement coverage under the Medical Assistance Program beyond the eligibility requirements in existence on January 1, 2008; **AND**

[(ii)**]** **2.** To provide funding for the operation and administration of the Maryland Health Insurance Plan, including reimbursing the Department for subsidizing the plan costs of members of the Maryland Health Insurance Plan under a Medicaid waiver program**[**; and**].**

[(iii)**] (II)** Any funds remaining after expenditures under **[**items (i) and (ii)**]** **SUBPARAGRAPH (I)** of this paragraph have been made may be used**[**for**]:**

1. FOR the general operations of the Medicaid program**; AND**

2. TO PROVIDE FUNDING FOR THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THE INSURANCE ARTICLE.

Article – Insurance

8–301.

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

(b) (1) "Administrator" means a person that, to the extent that the person acting for an insurer or plan sponsor, has:

(i) control over or custody of premiums, contributions, or any other money with respect to a plan, for any period of time; or

(ii) discretionary authority over the adjustment, payment, or settlement of benefit claims under a plan or over the investment of a plan's assets.

(2) "Administrator" does not include a person that:

(i) with respect to a particular plan:

1. is, or is an employee of, the plan sponsor;

2. is, or is an employee, insurance producer, managing general agent of, an insurer or health maintenance organization that insures or administers the plan; or

3. is an insurance producer that solicits, procures, or negotiates a plan for a plan sponsor and that has no authority over the adjustment,

payment, or settlement of benefit claims under the plan or over the investment or handling of the plan's assets;

(ii) is retained by the Life and Health Insurance Guaranty Corporation to administer a plan underwritten by an impaired insurer that is subject to an order of conservation, liquidation, or rehabilitation;

(iii) is a participant or beneficiary of a plan that provides for individual accounts and allows a participant or beneficiary to exercise investment control over assets in the participant's or beneficiary's account, and the participant or beneficiary exercises that investment control;

(iv) administers only plans that are subject to ERISA and that do not provide benefits through insurance, unless any of the plans administered is a multiple employer welfare arrangement as defined in § 514(b)(6)(A)(ii) of ERISA;

(v) is, or is an employee of, a bank, savings bank, trust company, savings and loan association, or credit union that is regulated under the laws of this State, another state, or the United States; **[**or**]**

(vi) is, or is an employee of, a person that is registered as:

1. an investment adviser under the Investment Advisers Act of 1940 or the Maryland Securities Act;

2. a broker–dealer or transfer agent under the Securities Exchange Act of 1934 or the Maryland Securities Act; or

3. an investment company under the Investment Company Act of 1940**; OR**

(VII) IS, OR IS AN EMPLOYEE OF, THE MARYLAND HEALTH BENEFIT EXCHANGE, INCLUDING THE MARYLAND HEALTH BENEFIT EXCHANGE'S CONSOLIDATED SERVICES CENTER.

14–502.

(a) There is a Maryland Health Insurance Plan.

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

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

(d) It is the intent of the General Assembly that the Plan operate as a nonprofit entity and that Fund revenue, to the extent consistent with good business practices, be used to**:**

(1) subsidize health insurance coverage for medically uninsurable individuals**; AND**

(2) FUND THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS ARTICLE.

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

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

(F) (1) ENROLLMENT IN THE PLAN SHALL BE CLOSED TO ANY INDIVIDUAL WHO IS NOT ENROLLED IN THE PLAN AS OF DECEMBER 31, 2013.

(2) (I) SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE BOARD, IN CONSULTATION WITH THE MARYLAND HEALTH BENEFIT EXCHANGE, SHALL DETERMINE THE APPROPRIATE DATE ON WHICH THE PLAN SHALL DECLINE TO REENROLL PLAN MEMBERS BEYOND THE TERM OF THE MEMBERS' EXISTING PLAN COVERAGE.

(II) THE DATE ON WHICH THE PLAN NO LONGER WILL PROVIDE COVERAGE TO ANY PLAN MEMBER SHALL BE NO EARLIER THAN JANUARY 1, 2015, AND NO LATER THAN JANUARY 1, 2020.

14–504.

(a) (1) There is a Maryland Health Insurance Plan Fund.

(2) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(3) The Treasurer shall separately hold and the Comptroller shall account for the Fund.

(4) The Fund shall be invested and reinvested at the direction of the Board in a manner that is consistent with the requirements of Title 5, Subtitle 6 of this article.

(5) Any investment earnings shall be retained to the credit of the Fund.

(6) On an annual basis, the Fund shall be subject to an independent actuarial review setting forth an opinion relating to reserves and related actuarial items held in support of policies and contracts.

(7) The Fund shall be used only to provide funding for the purposes authorized under this subtitle.

(b) The Fund shall consist of:

(1) premiums for coverage that the Plan issues;

(2) money collected in accordance with § 19–214(d) of the Health – General Article;

(3) money deposited by a nonprofit health service plan in accordance with § 14–513 of this subtitle;

(4) income from investments that the Board makes or authorizes on behalf of the Fund;

(5) interest on deposits or investments of money from the Fund;

(6) premium tax revenue collected under § 14–107 of this title;

(7) money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Fund;

(8) money donated to the Fund; and

(9) money awarded to the Fund through grants.

(c) (1) The Board may allow the Administrator to use premiums collected by the Administrator from Plan enrollees to pay claims for Plan enrollees.

(2) The Administrator:

(i) shall deposit all premiums for Plan enrollees in a separate account, titled in the name of the State of Maryland, for the Maryland Health Insurance Plan; and

(ii) may use money in the account only to pay claims for Plan enrollees.

(3) The Administrator shall keep complete and accurate records of all transactions for the separate account.

(4) By the 15th of the following month, if monthly premiums collected by the Administrator exceed monthly claims received, the Administrator shall deposit the remaining balance, including interest, for that month in the Fund.

(D) (1) (I) THE ADMINISTRATOR SHALL DEPOSIT ALL MONEY COLLECTED IN ACCORDANCE WITH § 19–214(D)(1)(II) OF THE HEALTH – GENERAL ARTICLE IN A SEPARATE ACCOUNT, TITLED IN THE NAME OF THE STATE OF MARYLAND, FOR THE MARYLAND HEALTH INSURANCE PLAN.

(II) THE ADMINISTRATOR SHALL KEEP COMPLETE AND SEPARATE RECORDS OF ALL TRANSACTIONS FOR THE SEPARATE ACCOUNT.

(2) BEGINNING JANUARY 1, 2015, AND SUBJECT TO § 19–214(D)(5) OF THE HEALTH – GENERAL ARTICLE AND PARAGRAPH (3) OF THIS SUBSECTION, THE BOARD MAY ALLOW THE ADMINISTRATOR TO TRANSFER MONEY IN THE SEPARATE ACCOUNT INTO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSE OF FUNDING THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS ARTICLE.

(3) A TRANSFER OF MONEY UNDER PARAGRAPH (2) OF THIS SUBSECTION:

(I) SHALL BE BASED ON THE DETERMINATION OF FUNDING NEEDS OF THE PLAN AND THE STATE REINSURANCE PROGRAM MADE UNDER PARAGRAPH (4) OF THIS SUBSECTION; AND

(II) MAY BE MADE ONLY FROM MONEY IN THE SEPARATE ACCOUNT IN EXCESS OF THE AMOUNT DETERMINED UNDER PARAGRAPH (4)(I) OF THIS SUBSECTION.

(4) ON OR BEFORE OCTOBER 1, 2013, AND EACH YEAR THEREAFTER UNTIL THE PLAN NO LONGER HAS ANY ENROLLEES, THE BOARD OF TRUSTEES OF THE MARYLAND HEALTH BENEFIT EXCHANGE AND THE BOARD OF THE PLAN SHALL DETERMINE:

(I) THE AMOUNT OF MONEY IN THE SEPARATE ACCOUNT THAT WILL BE NEEDED TO PAY CLAIMS OF PLAN ENROLLEES, SUPPORT PLAN OPERATIONS, AND OTHERWISE MEET THE OBLIGATIONS OF THE PLAN FOR THE FOLLOWING CALENDAR YEAR; AND

(II) THE AMOUNT OF MONEY THAT WILL BE NEEDED TO FUND THE OPERATIONS OF THE STATE REINSURANCE PROGRAM FOR THE FOLLOWING CALENDAR YEAR.

[(d)**] (E)** (1) The Board shall take steps necessary to ensure that Plan enrollment does not exceed the number of enrollees the Plan has the financial capacity to insure.

(2) The Board may adopt regulations to limit the enrollment of otherwise eligible medically uninsurable individuals whose premium is paid for by a pharmaceutical manufacturer or its affiliate if the Board determines that their enrollment would have an adverse financial impact on the Plan.

[(e)**] (F)** (1) In addition to the operation and administration of the Plan, the Fund shall be used:

(i) for the operation and administration of the Senior Prescription Drug Assistance Program established under Part II of this subtitle; and

(ii) to support the Department of Health and Mental Hygiene for the provision of mental health services to the uninsured under Title 10, Subtitle 2 of the Health – General Article.

(2) The Board shall maintain separate accounts within the Fund for the Senior Prescription Drug Assistance Program and the Maryland Health Insurance Plan.

(3) Accounts within the Fund shall contain those moneys that are intended to support the operation of the Program for which the account is designated.

(4) (I) BEGINNING JANUARY 1, 2015, THE FUNDS COLLECTED IN ACCORDANCE WITH § 19–214(D)(1)(II) OF THE HEALTH – GENERAL ARTICLE AND DEPOSITED IN THE MARYLAND HEALTH INSURANCE PLAN ACCOUNT OF THE FUND, MAY BE USED FOR THE PURPOSES OF ESTABLISHING AND OPERATING THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS ARTICLE.

(II) THE BOARD AND THE BOARD OF TRUSTEES OF THE MARYLAND HEALTH BENEFIT EXCHANGE SHALL DEVELOP AND APPROVE A PLAN FOR THE APPROPRIATE AMOUNT AND TIMING OF THE USE OF THE FUNDS FOR THE STATE REINSURANCE PROGRAM.

[(f)**] (G)** A debt or obligation of the Plan is not a debt of the State or a pledge of credit of the State.

27–405.

(a) It is a fraudulent insurance act for a person to act as or represent to the public that the person is**:**

(1) an insurance producer or a public adjuster in the State if the person has not received the appropriate license under or otherwise complied with Title 10 of this article**;**

(2) A NAVIGATOR OF THE SMALL BUSINESS HEALTH OPTIONS PROGRAM OF THE MARYLAND HEALTH BENEFIT EXCHANGE IF THE PERSON HAS NOT RECEIVED THE APPROPRIATE LICENSE UNDER OR OTHERWISE COMPLIED WITH § 31–112 OF THIS ARTICLE; OR

(3) A NAVIGATOR OF 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 OF THIS ARTICLE.

31–101.

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

(C–1) "CONSOLIDATED SERVICES CENTER" OR "CSC" MEANS THE CONSUMER ASSISTANCE CALL CENTER ESTABLISHED IN ACCORDANCE WITH THE REQUIREMENT TO OPERATE A TOLL–FREE HOTLINE UNDER § 1311(D)(4) OF THE AFFORDABLE CARE ACT AND § 31–108(B)(5) OF THIS TITLE.

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**; OR**

(5) THIS ARTICLE, EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION AND ELSEWHERE IN THIS TITLE.

(C) TO THE EXTENT THAT THE EXCHANGE, ACTING ON BEHALF OF A CARRIER OFFERING A QUALIFIED PLAN IN THE INDIVIDUAL EXCHANGE OR THE SHOP EXCHANGE, ASSUMES AN OBLIGATION BY CONTRACT OR OTHER AGREEMENT TO COLLECT PREMIUMS, CONDUCT BILLING, SEND REQUIRED NOTICES, PROVIDE REQUIRED DISCLOSURES, OR PERFORM ANY OTHER FUNCTION NORMALLY PERFORMED BY A CARRIER UNDER THIS ARTICLE, THE CARRIER SHALL RETAIN THE RESPONSIBILITY FOR ENSURING THAT THE CONSUMER PROTECTIONS REQUIRED BY THIS ARTICLE ARE AFFORDED THE SMALL EMPLOYER AND THE ENROLLEES IN THE QUALIFIED PLAN.

(D) THIS SECTION DOES NOT AFFECT THE COMMISSIONER'S AUTHORITY TO REGULATE A CARRIER UNDER THIS ARTICLE.

31–107.

(a) There is a Maryland Health Benefit Exchange Fund.

(b) The purpose of the Fund is to**:**

(1) provide funding for the operation and administration of the Exchange in carrying out the purposes of the Exchange under this title**; AND**

(2) PROVIDE FUNDING FOR THE ESTABLISHMENT AND OPERATION OF THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS TITLE.

(c) The Exchange shall administer the Fund.

(d) (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.

(e) The Fund consists of:

(1) any user fees or other assessments collected by the Exchange;

(2) ALL REVENUE THAT IS DEPOSITED INTO THE FUND UNDER § 14–504(D) OF THIS ARTICLE FROM THE SEPARATE ACCOUNT OF THE MARYLAND HEALTH INSURANCE PLAN FUND THAT HOLDS MONEY COLLECTED UNDER § 19–214(D)(1)(II) OF THE HEALTH – GENERAL ARTICLE;

[(2)**] (3)** income from investments made on behalf of the Fund;

[(3)**] (4)** interest on deposits or investments of money in the Fund;

[(4)**] (5)** 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)**] (6)** money donated to the Fund;

[(6)**] (7)** money awarded to the Fund through grants; and

[(7)**] (8)** any other money from any other source accepted for the benefit of the Fund.

(f) The Fund may be used only **[**to provide funding**]:**

(1) for the operation and administration of the Exchange in carrying out the purposes authorized under this title**; AND**

(2) FOR THE ESTABLISHMENT AND OPERATION OF THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS TITLE.

(G) (1) THE BOARD SHALL MAINTAIN SEPARATE ACCOUNTS WITHIN THE FUND FOR EXCHANGE OPERATIONS AND FOR THE STATE REINSURANCE PROGRAM.

(2) ACCOUNTS WITHIN THE FUND SHALL CONTAIN THOSE MONEYS THAT ARE INTENDED TO SUPPORT THE PURPOSE FOR WHICH EACH ACCOUNT IS DESIGNATED.

[(g)**] (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.

[(h)**] (I)** A debt or an obligation of the Fund is not a debt of the State or a pledge of credit of the State.

31–107.1.

(A) THE BOARD SHALL ESTABLISH A TRUST ACCOUNT TO HOLD PREMIUM PAYMENTS ACCEPTED FROM QUALIFIED PLAN ENROLLEES AND SMALL EMPLOYERS BY THE EXCHANGE ON BEHALF OF A CARRIER UNDER CONTRACT OR OTHER AGREEMENT.

(B) THE TRUST ACCOUNT MAY BE USED ONLY TO HOLD A PREMIUM PAYMENT UNTIL THE EXCHANGE TRANSMITS THE PREMIUM PAYMENT TO THE CARRIER ON WHOSE BEHALF THE EXCHANGE ACCEPTED THE PREMIUM PAYMENT.

(C) THE EXCHANGE SHALL MAINTAIN SEPARATE RECORDS OF ACCOUNT FOR EACH CARRIER ON WHOSE BEHALF IT ACCEPTS PREMIUM PAYMENTS.

(D) THE PAYMENT OF A PREMIUM BY AN ENROLLEE OR A SMALL EMPLOYER TO THE EXCHANGE IS DEEMED TO BE A PAYMENT TO THE CARRIER ON WHOSE BEHALF THE EXCHANGE ACCEPTED THE PREMIUM PAYMENT.

31–107.2.

(A) (1) FOR FISCAL YEAR 2015 AND FOR EACH FISCAL YEAR THEREAFTER, FROM THE FUNDS DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION, THE GOVERNOR SHALL PROVIDE AN APPROPRIATION IN THE

STATE BUDGET ADEQUATE TO FULLY FUND THE OPERATIONS OF THE EXCHANGE.

(2) THE APPROPRIATION UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE ALLOCATED FROM THE PREMIUM TAX ASSESSED UNDER § 6–102 OF THIS ARTICLE THAT IS PAID BY:

(I) AN INSURER THAT OFFERS, ISSUES, OR DELIVERS A HEALTH BENEFIT PLAN IN THE STATE; AND

(II) A FOR–PROFIT HEALTH MAINTENANCE ORGANIZATION AUTHORIZED BY TITLE 19, SUBTITLE 7 OF THE HEALTH – GENERAL ARTICLE.

(B) FUNDS ALLOCATED FROM THE PREMIUM TAX UNDER SUBSECTION (A) OF THIS SECTION TO PROVIDE THE APPROPRIATION TO THE EXCHANGE MAY BE USED ONLY FOR THE PURPOSE OF FUNDING THE OPERATIONS OF THE EXCHANGE.

(C) IF, IN ANY FISCAL YEAR, THE AMOUNT OF THE ALLOCATION FROM THE PREMIUM TAX IS INSUFFICIENT TO MEET THE ACTUAL EXPENDITURES INCURRED FOR THE OPERATION OF THE EXCHANGE, THE GOVERNOR MAY PROVIDE AN ADDITIONAL APPROPRIATION BY DEFICIENCY APPROPRIATION.

(D) FUNDS ALLOCATED TO THE EXCHANGE UNDER THIS SECTION THAT REMAIN UNSPENT AT THE END OF A FISCAL YEAR SHALL REVERT TO THE GENERAL FUND OF THE STATE.

31–111.

(a) The SHOP Exchange:

(1) shall be a separate insurance market within the Exchange for small employers; and

(2) may not be merged with the individual market of the Individual Exchange.

(b) The SHOP Exchange shall be designed to balance:

(1) the viability of the SHOP Exchange as an alternative for qualified employers and their employees who have not been able historically to access and afford insurance in the small group market;

(2) the need for stability and predictability in employers' health insurance costs incurred on behalf of their employees;

(3) the desirability of providing employees with a meaningful choice among high–quality and affordable health benefit plans; and

(4) the need to facilitate continuity of care for employees who change employers or health benefit plans.

(c) The SHOP Exchange shall allow qualified employers to:

(1) as required by regulations adopted by the Secretary under the Affordable Care Act, designate a coverage level within which their employees may choose any qualified health plan; or

(2) designate a carrier or an insurance holding company system, as defined in § 7–101 of this article, and a menu of qualified health plans offered by the carrier or the insurance holding company system in the SHOP Exchange from which their employees may choose.

(d) In addition to the options set forth in subsection (c) of this section, the SHOP Exchange also may allow qualified employers to designate one or more qualified dental plans and qualified vision plans to be made available to their employees.

(E) (1) A QUALIFIED EMPLOYER IS NOT REQUIRED TO CONTRIBUTE TO THE QUALIFIED PLAN PREMIUMS OF ITS EMPLOYEES.

(2) (I) IF A QUALIFIED EMPLOYER CHOOSES TO CONTRIBUTE TO THE QUALIFIED PLAN PREMIUMS OF ITS EMPLOYEES, THE QUALIFIED EMPLOYER SHALL:

1. SELECT A REFERENCE PLAN ON WHICH THE CONTRIBUTIONS WILL BE BASED; AND

2. MAKE A CONTRIBUTION THAT IS:

A. A FIXED PERCENTAGE OF THE PREMIUM OF THE REFERENCE PLAN; OR

B. A DOLLAR AMOUNT THAT ENSURES THAT ALL OF THE QUALIFIED EMPLOYER'S EMPLOYEES WOULD PAY THE SAME AMOUNT IF THEY PURCHASED THE REFERENCE PLAN.

(II) A REFERENCE PLAN SELECTED UNDER SUBPARAGRAPH (I)1 OF THIS PARAGRAPH:

1. UNDER THE EMPLOYER CHOICE MODEL, SHALL BE A QUALIFIED PLAN THAT IS:

A. OFFERED BY THE CARRIER SELECTED BY THE QUALIFIED EMPLOYER; AND

B. AMONG THE QUALIFIED PLANS OF THE CARRIER SELECTED BY THE QUALIFIED EMPLOYER; OR

2. UNDER THE EMPLOYEE CHOICE MODEL, SHALL BE A QUALIFIED PLAN OFFERED BY ANY CARRIER AT THE METAL LEVEL SELECTED BY THE QUALIFIED EMPLOYER.

[(e)**] (F)** On or after January 1, 2016, in order to continue to promote the SHOP Exchange's principles of accessibility, choice, affordability, and sustainability, and as it obtains more data on adverse selection, cost, enrollment, and other factors, the SHOP Exchange:

(1) may reassess and modify the manner in which the SHOP Exchange allows qualified employers to offer, and their employees to choose, qualified health plans and coverage levels;

(2) in reassessing employer and employee choice, may consider options which would promote the additional objective of increasing the portability of employees' health insurance as employees move from employer to employer or transition in and out of employment; and

(3) shall implement any modification of offerings and choice through regulations adopted by the SHOP Exchange.

31–112.

(h) (1) The SHOP Exchange shall develop, implement, and, as appropriate, update training programs for:

(i) SHOP Exchange navigators; **[**and**]**

(ii) licensed insurance producers who seek authorization to sell qualified plans in the SHOP Exchange**; AND**

(III) CONSOLIDATED SERVICES CENTER EMPLOYEES REQUIRED TO HOLD A SHOP EXCHANGE ENROLLMENT PERMIT.

(2) The training programs shall:

(i) impart the skills and expertise necessary to perform functions specific to the SHOP Exchange, such as making tax credit eligibility determinations; and

(ii) enable the SHOP Exchange's navigator program **AND THE CONSOLIDATED SERVICES CENTER** to provide robust protection of consumers and adherence to high quality assurance standards.

31–113.

(h) An Individual Exchange navigator:

(1) shall hold an Individual Exchange navigator certification issued under subsection (j) of this section;

(2) may provide consumer assistance services that are required to be provided by an Individual Exchange navigator under subsection (d)(1) of this section;

(3) may not be required to hold an insurance producer or adviser license;

(4) shall be employed or engaged by an Individual Exchange navigator entity **OR BY THE EXCHANGE**;

(5) shall receive compensation only through the Individual Exchange or an Individual Exchange navigator entity and not from a carrier or an insurance producer;

(6) 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 a 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;

(7) with respect to the insurance market outside the Exchange, is subject to the same requirements applicable to Individual Exchange navigator entities as set forth in subsection (f)(8) of this section; and

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

(i) The Exchange:

(1) shall establish and administer **[**an**]** **A PROCESS FOR** Individual Exchange navigator certification **[**process**]** **AND THE ISSUANCE OF CONSOLIDATED SERVICES CENTER EMPLOYEE INDIVIDUAL EXCHANGE ENROLLMENT PERMITS**;

(2) in consultation with the Commissioner and the Department of Health and Mental Hygiene, shall adopt regulations to implement this subsection; and

(3) may implement the **PROCESS FOR** Individual Exchange navigator certification **[**process**]** **AND THE ISSUANCE OF CONSOLIDATED SERVICES CENTER EMPLOYEE INDIVIDUAL EXCHANGE ENROLLMENT PERMITS** with the assistance of the Commissioner and the Department of Health and Mental Hygiene, in accordance with one or more memoranda of understanding.

(k) (1) The Exchange, with the approval of the Commissioner and in consultation with the Department of Health and Mental Hygiene and stakeholders, shall develop, implement, and, as appropriate, update a training program for the certification of Individual Exchange navigators **AND THE ISSUANCE OF INDIVIDUAL EXCHANGE ENROLLMENT PERMITS FOR CONSOLIDATED SERVICES CENTER EMPLOYEES**.

(2) The training program shall:

(i) provide Individual Exchange navigators **AND CONSOLIDATED SERVICES CENTER EMPLOYEES** with the full range of skills, knowledge, and expertise necessary to meet the consumer assistance, eligibility, enrollment, renewal, and disenrollment needs of individuals:

1. eligible for the Maryland Medical Assistance Program and the Maryland Children's Health Program; or

2. seeking qualified plans offered in the Individual Exchange;

(ii) enable the navigator program for the Individual Exchange **AND THE EXCHANGE'S CONSOLIDATED SERVICES CENTER** to provide robust protection of consumers and adherence to high quality assurance standards; and

(iii) enable the Individual Exchange to ensure that, with respect to Individual Exchange navigators **AND CONSOLIDATED SERVICES CENTER EMPLOYEES** who offer any form of assistance to individuals regarding the Maryland Medical Assistance Program or the Maryland Children's Health Program, the Individual Exchange navigator certification program **AND CONSOLIDATED SERVICES CENTER** shall comply with all requirements of the Department of Health and Mental Hygiene.

31–113.1.

(A) IN ACCORDANCE WITH THE REQUIREMENT TO OPERATE A TOLL–FREE HOTLINE UNDER § 1311(D)(4) OF THE AFFORDABLE CARE ACT AND § 31–108(B)(5) OF THIS TITLE, THE EXCHANGE MAY ESTABLISH A CONSOLIDATED SERVICES CENTER.

(B) (1) THE CSC MAY EMPLOY INDIVIDUALS TO ASSIST THE SHOP EXCHANGE.

(2) A CSC EMPLOYEE AUTHORIZED TO ASSIST THE SHOP EXCHANGE:

(I) MAY PROVIDE THE SERVICES SET FORTH IN § 31–112(C)(1) OF THIS TITLE, BUT MAY NOT INITIATE CONTACT WITH A SMALL EMPLOYER FOR THE PURPOSE OF SOLICITING THE SMALL EMPLOYER TO PROVIDE QUALIFIED PLANS OFFERED BY THE SHOP EXCHANGE TO ITS EMPLOYEES;

(II) SHALL HOLD A SHOP EXCHANGE ENROLLMENT PERMIT;

(III) IS NOT A SHOP EXCHANGE NAVIGATOR AND MAY NOT HOLD A SHOP EXCHANGE NAVIGATOR LICENSE;

(IV) MAY NOT BE REQUIRED TO HOLD AN INSURANCE PRODUCER LICENSE; AND

(V) SHALL COMPLY WITH THE LIMITATIONS SET FORTH IN § 31–112(C)(3) OF THIS TITLE.

(3) (I) THE COMMISSIONER SHALL ISSUE A SHOP EXCHANGE ENROLLMENT PERMIT TO EACH APPLICANT WHO MEETS THE REQUIREMENTS OF THIS PARAGRAPH.

(II) TO QUALIFY FOR A SHOP EXCHANGE ENROLLMENT PERMIT, AN APPLICANT:

1. SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;

2. SHALL BE AT LEAST 18 YEARS OLD;

3. SHALL PASS THE WRITTEN EXAMINATION GIVEN BY THE COMMISSIONER TO APPLICANTS FOR A SHOP NAVIGATOR LICENSE UNDER § 31–112(D)(2)(III) OF THIS TITLE;

4. SHALL BE ENGAGED BY, AND RECEIVE COMPENSATION ONLY THROUGH, THE CSC;

5. MAY NOT RECEIVE COMPENSATION FROM OR OTHERWISE BE AFFILIATED WITH A CARRIER, AN INSURANCE PRODUCER, A THIRD–PARTY ADMINISTRATOR, OR ANY OTHER PERSON CONNECTED TO THE INSURANCE INDUSTRY; AND

6. SHALL COMPLETE, AND COMPLY WITH ANY ONGOING REQUIREMENTS OF, THE TRAINING PROGRAM ESTABLISHED UNDER § 31–112(H) OF THIS TITLE.

(4) THE COMMISSIONER'S DUTIES AND AUTHORITY UNDER § 31–112(D)(3) AND (E) OF THIS TITLE SHALL APPLY TO CSC EMPLOYEES WHO HOLD A SHOP EXCHANGE ENROLLMENT PERMIT ISSUED UNDER THIS SUBSECTION.

(C) (1) THE CSC MAY EMPLOY INDIVIDUALS TO ASSIST THE INDIVIDUAL EXCHANGE.

(2) A CSC EMPLOYEE AUTHORIZED TO ASSIST THE INDIVIDUAL EXCHANGE:

(I) MAY PROVIDE THE SERVICES SET FORTH IN § 31–113(D) OF THIS TITLE, BUT MAY NOT INITIATE CONTACT WITH AN INDIVIDUAL FOR THE PURPOSE OF SOLICITING THE INDIVIDUAL TO ENROLL IN A QUALIFIED PLAN OFFERED BY THE INDIVIDUAL EXCHANGE;

(II) SHALL HOLD AN INDIVIDUAL EXCHANGE ENROLLMENT PERMIT;

(III) IS NOT AN INDIVIDUAL EXCHANGE NAVIGATOR AND MAY NOT HOLD AN INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION;

(IV) MAY NOT BE REQUIRED TO HOLD AN INSURANCE PRODUCER OR ADVISER LICENSE;

(V) WITH RESPECT TO THE INSURANCE MARKET OUTSIDE THE EXCHANGE, SHALL COMPLY WITH § 31–113(F)(8) OF THIS TITLE; AND

(VI) SHALL COMPLY WITH ALL STATE AND FEDERAL LAWS, REGULATIONS, AND POLICIES GOVERNING THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(3) (I) THE EXCHANGE SHALL ISSUE AN INDIVIDUAL EXCHANGE ENROLLMENT PERMIT TO EACH APPLICANT WHO MEETS THE REQUIREMENTS OF THIS PARAGRAPH.

(II) TO QUALIFY FOR AN INDIVIDUAL EXCHANGE ENROLLMENT PERMIT, AN APPLICANT:

1. SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;

2. SHALL BE AT LEAST 18 YEARS OLD;

3. SHALL BE ENGAGED BY, AND RECEIVE COMPENSATION ONLY THROUGH, THE CSC;

4. MAY NOT RECEIVE ANY COMPENSATION, DIRECTLY OR INDIRECTLY, FROM:

A. 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

B. A 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

5. SHALL COMPLETE, AND COMPLY WITH ANY ONGOING REQUIREMENTS OF, THE TRAINING PROGRAM ESTABLISHED UNDER § 31–113(K) OF THIS TITLE.

(4) THE COMMISSIONER'S DUTIES AND AUTHORITY UNDER § 31–113(L) OF THIS TITLE SHALL APPLY TO CSC EMPLOYEES WHO HOLD AN INDIVIDUAL EXCHANGE ENROLLMENT PERMIT ISSUED UNDER THIS SUBSECTION.

31–115.

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

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

(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)(8)(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 Individual **[**Exchange's individual market**]** **EXCHANGE AND OFFERS ANY HEALTH BENEFIT PLAN IN THE INDIVIDUAL MARKET OUTSIDE THE EXCHANGE**, offers at least one qualified health plan at the silver level and one at the gold level in the individual market outside the Exchange;

(iii) if the carrier participates in the SHOP Exchange **AND OFFERS ANY HEALTH BENEFIT PLAN IN THE SMALL GROUP MARKET OUTSIDE THE SHOP EXCHANGE**, offers at least one qualified health plan at the silver level and one at the gold level in the small group market outside the SHOP Exchange;

(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)(1)(iv) 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)(1)(iv) 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, including:

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

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

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

(K) (1) SUBJECT TO THE CONTESTED CASE HEARING PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE, AND SUBSECTION (F) OF THIS SECTION, THE EXCHANGE MAY DENY CERTIFICATION TO A HEALTH BENEFIT PLAN, A DENTAL PLAN, OR A VISION PLAN, OR SUSPEND OR REVOKE THE CERTIFICATION OF A QUALIFIED PLAN, BASED ON A FINDING THAT THE HEALTH BENEFIT PLAN, DENTAL PLAN, VISION PLAN, OR QUALIFIED PLAN DOES NOT SATISFY REQUIREMENTS OR MEET STANDARDS FOR CERTIFICATION THAT ARE:

(I) ESTABLISHED UNDER THE REGULATIONS AND POLICIES ADOPTED BY THE EXCHANGE TO CARRY OUT THIS TITLE; AND

(II) NOT OTHERWISE UNDER THE REGULATORY AND ENFORCEMENT AUTHORITY OF THE COMMISSIONER.

(2) CERTIFICATION REQUIREMENTS MAY INCLUDE PROVIDING DATA AND MEETING STANDARDS RELATED TO:

(I) ENROLLMENT;

(II) ESSENTIAL COMMUNITY PROVIDERS;

(III) COMPLAINTS AND GRIEVANCES INVOLVING THE EXCHANGE;

(IV) NETWORK ADEQUACY;

(V) QUALITY;

(VI) TRANSPARENCY;

(VII) RACE, ETHNICITY, LANGUAGE, INTERPRETER NEED, AND CULTURAL COMPETENCY (RELICC);

(VIII) PLAN SERVICE AREA, INCLUDING DEMOGRAPHICS;

(IX) ACCREDITATION; AND

(X) COMPLYING WITH FAIR MARKETING STANDARDS DEVELOPED JOINTLY BY THE EXCHANGE AND THE COMMISSIONER.

(3) INSTEAD OF OR IN ADDITION TO DENYING, SUSPENDING, OR REVOKING CERTIFICATION, THE EXCHANGE MAY IMPOSE OTHER REMEDIES OR TAKE OTHER ACTIONS, INCLUDING:

(I) TAKING CORRECTIVE ACTION TO REMEDY A VIOLATION OF OR FAILURE TO COMPLY WITH STANDARDS FOR CERTIFICATION; AND

(II) IMPOSING A PENALTY NOT EXCEEDING $100 FOR EACH VIOLATION OF OR FAILURE TO COMPLY WITH STANDARDS FOR CERTIFICATION.

(4) THE PENALTIES AVAILABLE TO THE EXCHANGE UNDER THIS SUBSECTION SHALL BE IN ADDITION TO ANY CRIMINAL OR CIVIL PENALTIES IMPOSED FOR FRAUD OR OTHER VIOLATION UNDER ANY OTHER STATE OR FEDERAL LAW.

31–117.

(a) The Exchange, with the approval of the Commissioner, shall implement or oversee the implementation of the state–specific requirements of §§ 1341 and 1343 of the Affordable Care Act relating to transitional reinsurance and risk adjustment.

(b) The Exchange may not assume responsibility for the program corridors for health benefit plans in the Individual Exchange and the SHOP Exchange established under § 1342 of the Affordable Care Act.

(c) (1) In compliance with § 1341 of the Affordable Care Act, the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, shall operate or oversee the operation of a transitional reinsurance program in accordance with regulations adopted by the Secretary for coverage years 2014 through 2016.

(2) As required by the Affordable Care Act and regulations adopted by the Secretary, the transitional reinsurance program shall be designed to protect carriers that offer individual health benefit plans inside and outside the Exchange against excessive health care expenses incurred by high–risk individuals.

(3) (I) THE EXCHANGE, IN CONSULTATION WITH THE MARYLAND HEALTH CARE COMMISSION AND WITH THE APPROVAL OF THE COMMISSIONER, MAY ESTABLISH A STATE REINSURANCE PROGRAM TO TAKE EFFECT ON OR AFTER JANUARY 1, 2015.

(II) THE PURPOSE OF THE STATE REINSURANCE PROGRAM IS TO MITIGATE THE IMPACT OF HIGH–RISK INDIVIDUALS ON RATES IN THE INDIVIDUAL INSURANCE MARKET INSIDE AND OUTSIDE THE EXCHANGE.

(III) WITH THE APPROVAL OF AND IN COLLABORATION WITH THE BOARD OF THE MARYLAND HEALTH INSURANCE PLAN, THE EXCHANGE MAY USE REVENUE RECEIVED FROM THE MARYLAND HEALTH INSURANCE PLAN FUND UNDER § 14–504(D) OF THIS ARTICLE TO FUND THE STATE REINSURANCE PROGRAM.

(d) (1) In compliance with § 1343 of the Affordable Care Act, the Exchange, with the approval of the Commissioner, shall operate or oversee the operation of a risk adjustment program designed to:

(i) reduce the incentive for carriers to manage their risk by seeking to enroll individuals with a lower than average health risk;

(ii) increase the incentive for carriers to enhance the quality and cost–effectiveness of their enrollees' health care services; and

(iii) require appropriate adjustments among all health benefit plans in the individual and small group markets inside and outside the Exchange to compensate for the enrollment of high–risk individuals.

(2) Beginning in 2014, the Exchange, with the approval of the Commissioner, shall strongly consider using the federal model adopted by the Secretary in the operation of the State's risk adjustment program.

31–119.

(e) **(1)** 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)**]** **(I)** the Secretary under the Secretary's authority under the Affordable Care Act; and

[(2)**]** **(II)** the Commissioner under the Commissioner's authority **[**to regulate the sale and purchase of insurance in the State**]** **UNDER THIS ARTICLE**.

(2) THE COMMISSIONER MAY ADOPT REGULATIONS ESTABLISHING THE MINIMUM LENGTH OF TIME FOR WHICH, AND THE MANNER IN WHICH, THE EXCHANGE IS REQUIRED TO MAINTAIN RECORDS OF INSURANCE TRANSACTIONS CONDUCTED BY THE EXCHANGE.

SECTION 3. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

Article – Insurance

15–140.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "ACUTE CONDITION" MEANS A MEDICAL CONDITION THAT:

(I) INVOLVES A SUDDEN ONSET OF SYMPTOMS DUE TO AN ILLNESS, AN INJURY, OR ANY OTHER MEDICAL PROBLEM THAT REQUIRES PROMPT MEDICAL ATTENTION; AND

(II) HAS A LIMITED DURATION.

(3) "CARRIER" MEANS:

(I) AN INSURER AUTHORIZED TO SELL HEALTH INSURANCE;

(II) A NONPROFIT HEALTH SERVICE PLAN;

(III) A HEALTH MAINTENANCE ORGANIZATION;

(IV) A DENTAL PLAN ORGANIZATION; OR

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

(4) "ENROLLEE" MEANS:

(I) A PERSON ENTITLED TO HEALTH CARE BENEFITS FROM A CARRIER; OR

(II) A PROGRAM RECIPIENT WHO IS ENROLLED IN A MANAGED CARE ORGANIZATION.

(5) (I) "HEALTH BENEFIT PLAN" MEANS A POLICY, A CONTRACT, A CERTIFICATE, OR AN AGREEMENT OFFERED, ISSUED, OR DELIVERED BY A CARRIER TO AN INDIVIDUAL OR A GROUP IN THE STATE TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

(II) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE:

1. COVERAGE ONLY FOR ACCIDENT OR DISABILITY INSURANCE OR ANY COMBINATION OF ACCIDENT AND DISABILITY INSURANCE;

2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;

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

4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;

5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;

6. CREDIT–ONLY INSURANCE;

7. COVERAGE FOR ON–SITE MEDICAL CLINICS; OR

8. OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, UNDER WHICH BENEFITS FOR HEALTH CARE SERVICES ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS.

(III) "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:

1. LIMITED SCOPE DENTAL OR VISION BENEFITS;

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

3. SUCH OTHER SIMILAR LIMITED BENEFITS AS ARE SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

(IV) "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:

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

2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.

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

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

2. 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

3. SIMILAR SUPPLEMENTAL COVERAGE PROVIDED TO COVERAGE UNDER A GROUP HEALTH PLAN.

(6) "HEALTH CARE PROVIDER" MEANS:

(I) A HEALTH CARE PRACTITIONER OR GROUP OF HEALTH CARE PRACTITIONERS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO DELIVER SERVICES COVERED IN A HEALTH BENEFIT PLAN, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; OR

(II) A HOSPITAL, AS DEFINED IN § 19–301 OF THE HEALTH – GENERAL ARTICLE.

(7) "MANAGED CARE ORGANIZATION" MEANS:

(I) A CERTIFIED HEALTH MAINTENANCE ORGANIZATION THAT IS AUTHORIZED TO RECEIVE MEDICAL ASSISTANCE PREPAID CAPITATION PAYMENTS;

(II) A CORPORATION THAT:

1. IS A MANAGED CARE SYSTEM THAT IS AUTHORIZED TO RECEIVE MEDICAL ASSISTANCE PREPAID CAPITATION PAYMENTS;

2. ENROLLS ONLY PROGRAM RECIPIENTS OR INDIVIDUALS OR FAMILIES SERVED UNDER THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

3. IS SUBJECT TO THE REQUIREMENTS OF § 15–102.4 OF THE HEALTH – GENERAL ARTICLE; OR

(III) A PREPAID DENTAL PLAN THAT RECEIVES FEES TO MANAGE DENTAL SERVICES.

(8) "NONPARTICIPATING PROVIDER" MEANS A HEALTH CARE PROVIDER WHO IS NOT ON THE PROVIDER PANEL OF A CARRIER OR MANAGED CARE ORGANIZATION.

(9) "PARTICIPATING PROVIDER" MEANS A HEALTH CARE PROVIDER WHO IS ON THE PROVIDER PANEL OF A CARRIER OR MANAGED CARE ORGANIZATION.

(10) "PRIOR AUTHORIZATION" MEANS A UTILIZATION MANAGEMENT TECHNIQUE THAT:

(I) IS USED BY CARRIERS AND MANAGED CARE ORGANIZATIONS;

(II) REQUIRES PRIOR APPROVAL FOR A PROCEDURE, TREATMENT, MEDICATION, OR SERVICE BEFORE AN ENROLLEE IS ELIGIBLE FOR FULL PAYMENT OF THE BENEFIT; AND

(III) IS USED TO DETERMINE WHETHER THE PROCEDURE, TREATMENT, MEDICATION, OR SERVICE IS MEDICALLY NECESSARY.

(11) "PROGRAM RECIPIENT" MEANS AN INDIVIDUAL WHO RECEIVES BENEFITS UNDER THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

(12) (I) "PROVIDER PANEL" MEANS THE HEALTH CARE PROVIDERS THAT CONTRACT EITHER DIRECTLY OR THROUGH A SUBCONTRACTING ENTITY WITH A CARRIER OR MANAGED CARE ORGANIZATION TO PROVIDE HEALTH CARE SERVICES TO THE ENROLLEES OF THE CARRIER OR MANAGED CARE ORGANIZATION.

(II) "PROVIDER PANEL" DOES NOT INCLUDE AN ARRANGEMENT IN WHICH ANY HEALTH CARE PROVIDER MAY PARTICIPATE SOLELY BY CONTRACTING WITH THE CARRIER OR MANAGED CARE ORGANIZATION TO PROVIDE HEALTH CARE SERVICES AT A DISCOUNTED FEE–FOR–SERVICE RATE.

(13) "RECEIVING CARRIER OR MANAGED CARE ORGANIZATION" MEANS:

(I) THE CARRIER THAT ISSUES THE NEW HEALTH BENEFIT PLAN WHEN AN ENROLLEE TRANSITIONS FROM ANOTHER CARRIER OR A MANAGED CARE ORGANIZATION; OR

(II) THE MANAGED CARE ORGANIZATION THAT ACCEPTS THE ENROLLEE WHEN THE ENROLLEE TRANSITIONS FROM ANOTHER MANAGED CARE ORGANIZATION OR A CARRIER.

(14) "RELINQUISHING CARRIER OR MANAGED CARE ORGANIZATION" MEANS:

(I) THE CARRIER THAT ISSUED THE PRIOR HEALTH BENEFIT PLAN WHEN AN ENROLLEE TRANSITIONS TO A NEW CARRIER OR A MANAGED CARE ORGANIZATION; OR

(II) THE MANAGED CARE ORGANIZATION IN WHICH AN ENROLLEE HAD BEEN ENROLLED PRIOR TO THE ENROLLEE'S TRANSITION TO A NEW MANAGED CARE ORGANIZATION OR A CARRIER.

(15) "SERIOUS CHRONIC CONDITION" MEANS A MEDICAL CONDITION DUE TO A DISEASE, AN ILLNESS, OR ANY OTHER MEDICAL PROBLEM THAT:

(I) INCLUDES PERIODS DURING WHICH AN INDIVIDUAL IS UNABLE TO WORK, ATTEND SCHOOL, OR PERFORM OTHER REGULAR DAILY ACTIVITIES;

(II) PERSISTS WITHOUT FULL CURE OR WORSENS OVER AN EXTENDED PERIOD OF TIME; AND

(III) REQUIRES ONGOING TREATMENT BY, OR UNDER THE SUPERVISION OF, A HEALTH CARE PROVIDER TO MAINTAIN REMISSION OR PREVENT DETERIORATION.

(B) THE PURPOSE OF THIS SECTION IS TO ADVANCE THE STATE'S PROGRESS IN:

(1) PROTECTING MARYLANDERS FROM HARMFUL DISRUPTIONS IN HEALTH CARE SERVICES; AND

(2) PROMOTING REASONABLE CONTINUITY OF HEALTH CARE FOR MARYLANDERS WHEN TRANSITIONING:

(I) FROM ONE CARRIER TO ANOTHER CARRIER; AND

(II) BETWEEN A CARRIER AND THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(C) (1) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AT THE REQUEST OF AN ENROLLEE OR AN ENROLLEE'S PARENT, GUARDIAN, OR DESIGNEE, A RECEIVING CARRIER OR MANAGED CARE ORGANIZATION SHALL ACCEPT A PRIOR AUTHORIZATION FROM A RELINQUISHING CARRIER OR MANAGED CARE ORGANIZATION FOR:

(I) THE PROCEDURES, TREATMENTS, MEDICATIONS, OR SERVICES COVERED BY THE BENEFITS OFFERED BY THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION; AND

(II) THE FOLLOWING TIME PERIODS:

1. THE LESSER OF THE COURSE OF TREATMENT OR 90 DAYS; AND

2. THE DURATION OF THE THREE TRIMESTERS OF A PREGNANCY AND THE INITIAL POSTPARTUM VISIT.

(2) AFTER THE TIME PERIODS UNDER PARAGRAPH (1)(II) HAVE LAPSED, THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION MAY ELECT TO PERFORM ITS OWN UTILIZATION REVIEW IN ORDER TO:

(I) REASSESS AND MAKE ITS OWN DETERMINATION REGARDING THE NEED FOR CONTINUED TREATMENT; AND

(II) AUTHORIZE ANY CONTINUED PROCEDURE, TREATMENT, MEDICATION, OR SERVICE DETERMINED TO BE MEDICALLY NECESSARY.

(D) (1) SUBJECT TO PARAGRAPHS (2) THROUGH (5) OF THIS SUBSECTION, AT THE REQUEST OF AN ENROLLEE OR AN ENROLLEE'S PARENT, GUARDIAN, OR DESIGNEE, A RECEIVING CARRIER OR MANAGED CARE ORGANIZATION SHALL ALLOW A NEW ENROLLEE TO CONTINUE TO RECEIVE HEALTH CARE SERVICES BEING RENDERED BY A NONPARTICIPATING PROVIDER AT THE TIME OF THE ENROLLEE'S TRANSITION TO THE RECEIVING HEALTH BENEFIT PLAN OR MANAGED CARE ORGANIZATION.

(2) THE SERVICES AN ENROLLEE SHALL BE ALLOWED TO CONTINUE TO RECEIVE ARE SERVICES FOR:

(I) THE FOLLOWING CONDITIONS:

1. ACUTE CONDITIONS;

2. SERIOUS CHRONIC CONDITIONS;

3. PREGNANCY;

4. MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS;

5. BONE FRACTURES;

6. JOINT REPLACEMENTS;

7. HEART ATTACKS WITHIN THE PREVIOUS 30 DAYS;

8. CANCER DIAGNOSED WITHIN THE PREVIOUS 60 DAYS;

9. HIV/AIDS; AND

10. ORGAN TRANSPLANTS; AND

(II) THE TIME PERIODS UNDER SUBSECTION (C)(1)(II) OF THIS SECTION.

(3) (I) THIS PARAGRAPH DOES NOT APPLY TO COMPENSATION RATES OR METHODS OF PAYMENT ESTABLISHED UNDER § 14–205.2 OF THIS ARTICLE OR § 19–710.1 OF THE HEALTH – GENERAL ARTICLE.

(II) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, THE NONPARTICIPATING PROVIDER AND THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION, WITH RESPECT TO THE PROVISION OF THE COVERED SERVICES, SHALL AGREE ON THE COMPENSATION RATES AND METHODS OF PAYMENT THAT MAY INCLUDE:

1. THE RATES AND METHODS OF PAYMENT THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION NORMALLY WOULD PAY AND USE FOR PARTICIPATING PROVIDERS WHO PROVIDE SIMILAR SERVICES IN THE SAME OR SIMILAR GEOGRAPHIC AREA; OR

2. ANY OTHER RATES AND METHODS OF PAYMENT OTHERWISE IN COMPLIANCE WITH THIS SUBSECTION.

(4) THE AGREEMENT BETWEEN THE NONPARTICIPATING PROVIDER AND THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION SHALL:

(I) BE SUBJECT TO ANY STATE OR FEDERAL REQUIREMENTS APPLICABLE TO REIMBURSEMENT FOR HEALTH CARE PROVIDER SERVICES, INCLUDING:

1. § 1302(G) OF THE AFFORDABLE CARE ACT, WHICH APPLIES TO REIMBURSEMENT RATES FOR FEDERALLY QUALIFIED HEALTH CENTERS; AND

2. TITLE 19, SUBTITLE 2 OF THE HEALTH – GENERAL ARTICLE, UNDER WHICH THE HEALTH SERVICES COST REVIEW COMMISSION ESTABLISHES PROVIDER RATES; AND

(II) ENSURE THAT THE COPAYMENTS, DEDUCTIBLES, AND ANY COINSURANCE REQUIRED OF AN ENROLLEE FOR THE SERVICES RENDERED IN ACCORDANCE WITH THIS SECTION ARE THE SAME AS THOSE THAT WOULD BE REQUIRED IF THE ENROLLEE WERE RECEIVING THE SERVICES FROM A PARTICIPATING PROVIDER OF THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION.

(5) IF THE NONPARTICIPATING PROVIDER AND THE CARRIER OR MANAGED CARE ORGANIZATION DO NOT REACH AN AGREEMENT UNDER PARAGRAPH (3) OF THIS SUBSECTION:

(I) THE NONPARTICIPATING PROVIDER IS NOT REQUIRED TO CONTINUE TO PROVIDE THE SERVICES; AND

(II) THE CARRIER OR MANAGED CARE ORGANIZATION IS NOT REQUIRED TO ALLOW THE SERVICES TO BE PROVIDED BY THE NONPARTICIPATING PROVIDER.

(E) THIS SECTION DOES NOT:

(1) REQUIRE A CARRIER OR MANAGED CARE ORGANIZATION TO COVER SERVICES OR PROVIDE BENEFITS THAT ARE NOT OTHERWISE COVERED UNDER THE TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN, THE

MARYLAND MEDICAL ASSISTANCE PROGRAM, OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; OR

(2) PRECLUDE A CARRIER OR MANAGED CARE ORGANIZATION FROM PROVIDING CONTINUITY OF CARE BEYOND THE REQUIREMENTS OF THIS SECTION WITHIN THE PARAMETERS OF THE APPROVED RATES OF THE CARRIER OR MANAGED CARE ORGANIZATION.

(F) THE REQUIREMENTS OF THIS SECTION ARE IN ADDITION TO ANY OTHER LEGAL, PROFESSIONAL, OR ETHICAL OBLIGATIONS OF A CARRIER OR MANAGED CARE ORGANIZATION TO PROVIDE CONTINUITY OF CARE.

(G) THE COMMISSIONER AND THE SECRETARY OF HEALTH AND MENTAL HYGIENE EACH MAY ADOPT REGULATIONS TO ENFORCE THE REQUIREMENTS OF THIS SECTION.

(H) THE COMMISSIONER, THE MARYLAND HEALTH BENEFIT EXCHANGE, AND THE SECRETARY OF HEALTH AND MENTAL HYGIENE SHALL COLLABORATE TO:

(1) DETERMINE THE DATA NECESSARY TO:

(I) ASSESS THE IMPLEMENTATION AND EFFICACY OF THE REQUIREMENTS OF THIS SECTION; AND

(II) DEVELOP A PROCESS TO EVALUATE AND MONITOR CONTINUITY OF CARE, WITH PARTICULAR FOCUS ON NEWLY ELIGIBLE POPULATIONS AND TRENDS IN HEALTH DISPARITIES; AND

(2) REQUEST THE REQUISITE DATA FROM CARRIERS, MANAGED CARE ORGANIZATIONS, AND HEALTH CARE PROVIDERS.

SECTION 4. AND BE IT FURTHER ENACTED, That:

(a) It is the intent of the General Assembly that carriers, managed care organizations, and providers shall succeed in reaching agreement on payment for the provision of covered services to ensure continuity of care, as required under § 15–140(d) of the Insurance Article, as enacted by Section 3 of this Act, in order to minimize harmful disruptions in care for Marylanders without requiring further legislative directive regarding rates of compensation and methods of payment.

(b) Using the data requested under § 15–140(h) of the Insurance Article, as enacted by Section 3 of this Act, the Maryland Health Benefit Exchange, the Department of Health and Mental Hygiene, and the Maryland Insurance

Administration shall conduct a study on the implementation and efficacy of the requirements of § 15–140 of the Insurance Article, as enacted by Section 3 of this Act.

(c) On or before December 1, 2017, the Exchange, the Department, and the Administration shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly on:

(1) the findings of the study, including the extent to which § 15–140(d) of the Insurance Article, as enacted by Section 3 this Act, has been effective in promoting continuity of care for Marylanders; and

(2) recommendations as to additional legislation, if any, that should be considered regarding rates of compensation and methods of payment, or any other measures that would increase the effectiveness of the State's efforts to promote continuity of care.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2014.

SECTION 6. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect January 1, 2015.

SECTION 7. AND BE IT FURTHER ENACTED, That, except as provided in Sections 5 and 6 of this Act, this Act shall take effect June 1, 2013.