

HOUSE BILL 443

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CF SB 238

By: **The Speaker (By Request – Administration) and Delegates Barnes, Gaines, Griffith, Hammen, Haynes, Hucker, Jones, Morhaim, Pena–Melnyk, Pendergrass, Proctor, V. Turner, and Waldstreicher**

Introduced and read first time: February 1, 2012

Assigned to: Health and Government Operations

A BILL ENTITLED

1 AN ACT concerning

2 **Maryland Health Benefit Exchange Act of 2012**

3 FOR the purpose of requiring the Maryland Health Benefit Exchange to make certain
4 qualified dental plans available to certain individuals and employers in a
5 certain manner and on or before a certain date; requiring the Exchange to
6 establish and implement certain navigator programs; authorizing the Exchange
7 to enter into certain agreements or memoranda of understanding with another
8 state under certain circumstances; requiring the Exchange to seek to achieve a
9 certain enrollment and use a certain market impact to pursue certain objectives;
10 authorizing the Exchange to employ certain alternative contracting options and
11 active purchasing strategies under certain circumstances; providing that the
12 SHOP Exchange shall be a separate insurance market within the Exchange for
13 small employers and may not be merged with the individual market of the
14 Individual Exchange; requiring the SHOP Exchange to be designed in a certain
15 manner; requiring the SHOP Exchange to allow qualified employers to
16 designate a certain coverage level or carrier for a certain purpose; authorizing
17 the SHOP Exchange to reassess and modify the design of the SHOP Exchange
18 under certain circumstances; establishing certain navigator programs for the
19 SHOP Exchange and the Individual Exchange; establishing certain
20 requirements for the navigator programs; authorizing a SHOP Exchange
21 navigator and an Individual Exchange navigator to take certain actions;
22 establishing certain duties of a SHOP Exchange navigator and an Individual
23 Exchange navigator; prohibiting a SHOP Exchange navigator and an Individual
24 Exchange navigator from taking certain actions; establishing a certain licensing
25 process and qualifications for SHOP Exchange navigators; requiring the SHOP
26 Exchange and the Exchange to establish and administer certain insurance
27 producer authorization programs; requiring the SHOP Exchange and the
28 Exchange to develop, implement, and update certain training programs;
29 requiring the Exchange to establish and administer a certain Individual

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



1 Exchange navigator certification program; establishing certain qualifications for
2 certification as an Individual Exchange navigator; authorizing the Maryland
3 Insurance Commissioner to take certain disciplinary actions against certain
4 individuals under certain circumstances; requiring the Commissioner, the
5 Exchange, the SHOP Exchange, and the Individual Exchange to adopt certain
6 regulations; providing that certain provisions of this Act do not require certain
7 programs to provide certain financial support to the Individual Exchange for
8 certain services; requiring certain financing arrangements between the
9 Exchange and certain programs to be governed by a certain memorandum of
10 agreement; requiring the Exchange to certify certain dental plans as qualified
11 dental plans; altering certain requirements for certification as a qualified health
12 plan; authorizing the Exchange to establish additional requirements for
13 qualified dental plans under certain circumstances; providing for the selection
14 of the State benchmark plan; providing for the implementation and operation of
15 certain reinsurance and risk adjustment programs; requiring the Exchange to
16 establish a certain fraud, waste, and abuse detection and prevention program;
17 prohibiting certain health insurance carriers from offering certain health
18 benefit plans in the small group market or the individual market under certain
19 circumstances; authorizing the Commissioner, in consultation with the
20 Exchange, to assess the impact of certain exemptions and alter the exemptions
21 based on the assessment; requiring certain health insurance carriers to offer a
22 certain catastrophic plan in the Exchange; defining certain terms; altering
23 certain definitions; making certain stylistic and clarifying changes; providing for
24 the construction of certain provisions of this Act; requiring the Exchange to
25 conduct certain studies, in consultation with certain entities and persons, and
26 report certain findings and recommendations to the Governor and the General
27 Assembly on or before certain dates; establishing a certain joint legislative and
28 executive committee; requiring the committee to conduct a certain study, in
29 consultation with certain entities and stakeholders, of financing mechanisms for
30 the Exchange and to report its findings and recommendations to the Governor
31 and the General Assembly on or before a certain date; and generally relating to
32 health insurance regulation and the Maryland Health Benefit Exchange.

33 BY renumbering

34 Article – Insurance

35 Section 31–110

36 to be Section 31–118

37 Annotated Code of Maryland

38 (2011 Replacement Volume)

39 BY repealing and reenacting, with amendments,

40 Article – Insurance

41 Section 15–1204, 15–1303, 31–101, 31–102(d), 31–108, 31–109, and 31–111

42 Annotated Code of Maryland

43 (2011 Replacement Volume)

44 BY adding to

1 Article – Insurance
2 Section 31–109 through 31–114, 31–116, and 31–117
3 Annotated Code of Maryland
4 (2011 Replacement Volume)

5 Preamble

6 WHEREAS, The federal Patient Protection and Affordable Care Act (Affordable
7 Care Act), as amended by the federal Health Care and Education Reconciliation Act of
8 2010, requires each state, by January 1, 2014, to establish a health benefit exchange
9 that makes available qualified health plans to qualified individuals and employers,
10 and meets certain other requirements; and

11 WHEREAS, Maryland’s Health Benefit Exchange (Exchange), if successful, will
12 make health care coverage accessible to thousands of Marylanders who have never
13 before been able to obtain the insurance necessary for financial security, health, and
14 well-being; and

15 WHEREAS, The Exchange will build on the success of the small group market
16 and make health insurance available with subsidies to certain small employers; and

17 WHEREAS, In addition to those who will secure health insurance for the first
18 time, the Exchange will benefit all Marylanders, as broader coverage results in
19 increased revenues, decreased uncompensated care, improved population health, and
20 reduced health care costs; and

21 WHEREAS, The Maryland Health Benefit Exchange Act of 2011, Chapter 2 of
22 the Acts of the General Assembly of 2011, established the governance and structure of
23 the Exchange, and directed its Board to undertake six policy studies and make
24 recommendations necessary to inform further development of its operating model and
25 functions; and

26 WHEREAS, After conducting these studies and incorporating the input of its
27 advisory groups established under the law to help guide its work, the Exchange Board
28 issued a report and recommendations to the Governor and General Assembly on
29 December 23, 2011; and

30 WHEREAS, The Board has developed a set of seven principles – accessibility,
31 affordability, sustainability, stability, health equity, flexibility, and transparency –
32 which reflect its goals for establishing a successful Exchange and which guided its
33 decision-making in the development of its recommendations; and

34 WHEREAS, These guiding principles are intended to ensure that the
35 Exchange’s policies, functions, and operations (1) make health care coverage more
36 accessible to Marylanders; (2) promote affordable coverage; (3) contribute to the
37 Exchange’s long-term sustainability; (4) build on the strengths of the State’s existing
38 health care system to support the Exchange’s stability; (5) address longstanding

1 disparities in health care access and health outcomes; (6) facilitate flexibility to enable
2 the Exchange to respond nimbly to changes in the insurance market, health care
3 delivery system, and economic conditions while also maintaining sensitivity and
4 responsiveness to consumer needs and demands; and (7) function with the
5 transparency necessary to render it accountable, accessible, and easily understood by
6 the public; and

7 WHEREAS, Pursuant to these principles, the State seeks to give effect to such
8 policies, embodied in the Board's recommendations, which are critical to the successful
9 functioning of the Exchange; and

10 WHEREAS, The State seeks to ensure that the Exchange succeed and be
11 operational in accordance with federal deadlines established by the Affordable Care
12 Act, and at the same time that it continue its step-by-step approach to the
13 development of the Exchange; and

14 WHEREAS, The State seeks to enact at this time those recommendations which
15 are necessary to ensure that development of the Exchange remains on track and in
16 compliance with federal timelines; now, therefore,

17 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
18 MARYLAND, That Section(s) 31-110 of Article – Insurance of the Annotated Code of
19 Maryland be renumbered to be Section(s) 31-118.

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

22 **Article – Insurance**

23 15-1204.

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

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

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

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

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

1 **(B) (1) EXCEPT AS PROVIDED IN THIS SUBSECTION, A CARRIER MAY**
2 **NOT OFFER HEALTH BENEFIT PLANS IN THE SMALL GROUP MARKET IN THE**
3 **STATE UNLESS THE CARRIER ALSO OFFERS QUALIFIED HEALTH PLANS IN THE**
4 **SMALL BUSINESS HEALTH OPTIONS PROGRAM OF THE MARYLAND HEALTH**
5 **BENEFIT EXCHANGE IN COMPLIANCE WITH THE REQUIREMENTS OF TITLE 31**
6 **OF THIS ARTICLE.**

7 **(2) A CARRIER THAT REPORTS LESS THAN \$20,000,000 IN**
8 **ANNUAL PREMIUMS WRITTEN FROM ALL HEALTH BENEFIT PLANS OFFERED BY**
9 **THE CARRIER IN THE SMALL GROUP MARKET IN THE STATE IS EXEMPT FROM**
10 **THE REQUIREMENT IN PARAGRAPH (1) OF THIS SUBSECTION IF:**

11 **(I) THE COMMISSIONER DETERMINES THAT THE CARRIER**
12 **COMPLIES WITH THE PROCEDURES ESTABLISHED BY THE COMMISSIONER FOR**
13 **SUBMITTING EVIDENCE EACH YEAR THAT THE CARRIER MEETS THE**
14 **REQUIREMENTS NECESSARY TO QUALIFY FOR THIS EXEMPTION; AND**

15 **(II) WHEN THE CARRIER CEASES TO MEET THE**
16 **REQUIREMENTS FOR THE EXEMPTION, THE CARRIER PROVIDES TO THE**
17 **COMMISSIONER IMMEDIATE NOTICE AND ITS PLAN FOR COMING INTO**
18 **COMPLIANCE WITH THE REQUIREMENT TO OFFER QUALIFIED HEALTH PLANS IN**
19 **THE SMALL BUSINESS HEALTH OPTIONS PROGRAM OF THE MARYLAND**
20 **HEALTH BENEFIT EXCHANGE.**

21 **(3) THE COMMISSIONER, IN CONSULTATION WITH THE**
22 **MARYLAND HEALTH BENEFIT EXCHANGE, MAY ASSESS THE IMPACT OF THE**
23 **EXEMPTION IN PARAGRAPH (2) OF THIS SUBSECTION AND, BASED ON THAT**
24 **ASSESSMENT, ALTER THE AMOUNT OF ANNUAL PREMIUMS NECESSARY TO**
25 **QUALIFY FOR THE EXEMPTION.**

26 **[(b)] (C) A person may not offer a health benefit plan in the State unless the**
27 **person offers at least the Standard Plan.**

28 **[(c)] (D) A carrier may not offer a health benefit plan that has fewer**
29 **benefits than those in the Standard Plan.**

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

32 (1) the additional benefits:

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

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

3 (2) the carrier:

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

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

8 (iii) specifies that all enhancements to the Standard Plan are not
9 required by State law.

10 [(e)] (F) Notwithstanding subsection (b) of this section, a health
11 maintenance organization may provide a point of service delivery system as an
12 additional benefit through another carrier regardless of whether the other carrier also
13 offers the Standard Plan.

14 [(f)] (G) A carrier may offer coverage for dental care and services as an
15 additional benefit.

16 [(g)] (H) (1) In this subsection, “prominent carrier” means a carrier that
17 insures at least 10% of the total lives insured in the small group market.

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

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

22 (3) A carrier may not condition the sale of a wellness benefit to a small
23 employer on participation of the eligible employees of the small employer in wellness
24 programs or activities.

25 15–1303.

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

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

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

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

3 **(B) (1) EXCEPT AS PROVIDED IN THIS SUBSECTION, A CARRIER MAY**
4 **NOT OFFER HEALTH BENEFIT PLANS IN THE INDIVIDUAL MARKET IN THE STATE**
5 **UNLESS THE CARRIER ALSO OFFERS QUALIFIED HEALTH PLANS IN THE**
6 **INDIVIDUAL EXCHANGE OF THE MARYLAND HEALTH BENEFIT EXCHANGE IN**
7 **COMPLIANCE WITH THE REQUIREMENTS OF TITLE 31 OF THIS ARTICLE.**

8 **(2) A CARRIER THAT REPORTS LESS THAN \$10,000,000 IN**
9 **ANNUAL PREMIUMS WRITTEN FROM ALL HEALTH BENEFIT PLANS OFFERED BY**
10 **THE CARRIER IN THE INDIVIDUAL MARKET IN THE STATE IS EXEMPT FROM THE**
11 **REQUIREMENT IN PARAGRAPH (1) OF THIS SUBSECTION IF:**

12 **(I) THE COMMISSIONER DETERMINES THAT THE CARRIER**
13 **COMPLIES WITH THE PROCEDURES ESTABLISHED BY THE COMMISSIONER FOR**
14 **SUBMITTING EVIDENCE EACH YEAR THAT THE CARRIER MEETS THE**
15 **REQUIREMENTS NECESSARY TO QUALIFY FOR THIS EXEMPTION; AND**

16 **(II) WHEN THE CARRIER CEASES TO MEET THE**
17 **REQUIREMENTS FOR THE EXEMPTION, THE CARRIER PROVIDES TO THE**
18 **COMMISSIONER IMMEDIATE NOTICE AND ITS PLAN FOR COMING INTO**
19 **COMPLIANCE WITH THE REQUIREMENT TO OFFER QUALIFIED HEALTH PLANS IN**
20 **THE INDIVIDUAL EXCHANGE OF THE MARYLAND HEALTH BENEFIT EXCHANGE.**

21 **(3) NOTWITHSTANDING THE EXEMPTION IN PARAGRAPH (2) OF**
22 **THIS SUBSECTION, ANY CARRIER THAT OFFERS A CATASTROPHIC PLAN, AS**
23 **DEFINED BY THE AFFORDABLE CARE ACT IN THE STATE, MUST ALSO OFFER AT**
24 **LEAST ONE CATASTROPHIC PLAN IN THE MARYLAND HEALTH BENEFIT**
25 **EXCHANGE.**

26 **(4) THE COMMISSIONER, IN CONSULTATION WITH THE**
27 **MARYLAND HEALTH BENEFIT EXCHANGE, MAY ASSESS THE IMPACT OF THE**
28 **EXEMPTION IN PARAGRAPH (2) OF THIS SUBSECTION AND, BASED ON THAT**
29 **ASSESSMENT, ALTER THE AMOUNT OF ANNUAL PREMIUMS NECESSARY TO**
30 **QUALIFY FOR THE EXEMPTION.**

31 **[(b)] (C) (1) For each calendar quarter, a carrier that offers individual**
32 **health benefit plans in the State shall submit to the Commissioner a report that**
33 **includes:**

34 **(i) the number of applications submitted to the carrier for**
35 **individual coverage; and**

1 (ii) the number of declinations issued by the carrier for
2 individual coverage.

3 (2) The report required under paragraph (1) of this subsection shall be
4 filed with the Commissioner no later than 30 days after the last day of the quarter for
5 which the information is provided.

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

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

11 (ii) the Maryland Health Insurance Plan with:

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

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

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

18 31–101.

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

20 **(B) “ACTUARIAL VALUE” MEANS THE RATIO OF PLAN CLAIM COSTS**
21 **AFTER APPLYING ALL COST SHARING PARAMETERS TO TOTAL CLAIM COSTS**
22 **PRIOR TO APPLICATION OF COST SHARING PARAMETERS.**

23 **[(b)] (C)** “Affordable Care Act” means the federal Patient Protection and
24 Affordable Care Act, as amended by the federal Health Care and Education
25 Reconciliation Act of 2010, and any regulations adopted or guidance issued under the
26 Acts.

27 **[(c)] (D)** “Board” means the Board of Trustees of the Exchange.

28 **[(d)] (E)** “Carrier” means:

29 (1) an insurer authorized to sell health insurance;

30 (2) a nonprofit health service plan;

1 (3) a health maintenance organization;

2 (4) a dental plan organization; or

3 (5) any other entity providing a plan of health insurance, health
4 benefits, or health services authorized under this article or the Affordable Care Act.

5 **(F) “COVERAGE LEVEL” MEANS A DESIGNATION THAT A QUALIFIED**
6 **HEALTH PLAN’S ACTUARIAL VALUE AS DETERMINED BY THE COMMISSIONER**
7 **ACCOUNTS FOR 60%, 70%, 80%, OR 90% OF TOTAL CLAIM COSTS.**

8 **[(e)] (G) (1)** “Exchange” means the Maryland Health Benefit Exchange
9 established as a public corporation under § 31–102 of this title.

10 **(2) “EXCHANGE” INCLUDES:**

11 **(I) THE INDIVIDUAL EXCHANGE; AND**

12 **(II) THE SMALL BUSINESS HEALTH OPTIONS PROGRAM**
13 **(SHOP EXCHANGE).**

14 **[(f)] (H)** “Fund” means the Maryland Health Benefit Exchange Fund
15 established under § 31–107 of this subtitle.

16 **[(g)] (I) (1)** “Health benefit plan” means a policy, contract, certificate, or
17 agreement offered, issued, or delivered by a carrier to an individual or small employer
18 in the State to provide, deliver, arrange for, pay for, or reimburse any of the costs of
19 health care services.

20 (2) “Health benefit plan” does not include:

21 (i) coverage only for accident or disability insurance or any
22 combination of accident and disability insurance;

23 (ii) coverage issued as a supplement to liability insurance;

24 (iii) liability insurance, including general liability insurance and
25 automobile liability insurance;

26 (iv) workers’ compensation or similar insurance;

27 (v) automobile medical payment insurance;

28 (vi) credit-only insurance;

29 (vii) coverage for on-site medical clinics; or

1 (viii) other similar insurance coverage, specified in federal
2 regulations issued pursuant to the federal Health Insurance Portability and
3 Accountability Act, under which benefits for health care services are secondary or
4 incidental to other insurance benefits.

5 (3) “Health benefit plan” does not include the following benefits if they
6 are provided under a separate policy, certificate, or contract of insurance, or are
7 otherwise not an integral part of the plan:

8 (i) limited scope dental or vision benefits;

9 (ii) benefits for long-term care, nursing home care, home health
10 care, community-based care, or any combination of these benefits; or

11 (iii) such other similar limited benefits as are specified in federal
12 regulations issued pursuant to the federal Health Insurance Portability and
13 Accountability Act.

14 (4) “Health benefit plan” does not include the following benefits if the
15 benefits are provided under a separate policy, certificate, or contract of insurance,
16 there is no coordination between the provision of the benefits and any exclusion of
17 benefits under any group health plan maintained by the same plan sponsor, and the
18 benefits are paid with respect to an event without regard to whether the benefits are
19 provided under any group health plan maintained by the same plan sponsor:

20 (i) coverage only for a specified disease or illness; or

21 (ii) hospital indemnity or other fixed indemnity insurance.

22 (5) “Health benefit plan” does not include the following if offered as a
23 separate policy, certificate, or contract of insurance:

24 (i) Medicare supplemental insurance (as defined under §
25 1882(g)(1) of the Social Security Act);

26 (ii) coverage supplemental to the coverage provided under
27 Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of
28 the Uniformed Services (CHAMPUS)); or

29 (iii) similar supplemental coverage provided to coverage under a
30 group health plan.

31 **(J) “INDIVIDUAL EXCHANGE” MEANS THE DIVISION OF THE EXCHANGE**
32 **THAT SERVES THE INDIVIDUAL HEALTH INSURANCE MARKET.**

33 **(K) “INDIVIDUAL EXCHANGE NAVIGATOR” MEANS AN INDIVIDUAL WHO:**

1 **(1) HOLDS AN INDIVIDUAL EXCHANGE NAVIGATOR**
2 **CERTIFICATION; AND**

3 **(2) PERFORMS THE FUNCTIONS UNDER § 31-113(C) OF THIS**
4 **TITLE FOR AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY.**

5 **(L) “INDIVIDUAL EXCHANGE NAVIGATOR ENTITY” MEANS A**
6 **COMMUNITY-BASED ORGANIZATION OR OTHER ENTITY ENGAGED BY THE**
7 **INDIVIDUAL EXCHANGE WHICH EMPLOYS OR ENGAGES CERTIFIED INDIVIDUAL**
8 **EXCHANGE NAVIGATORS TO PERFORM THE FUNCTIONS IN § 31-113(C) OF THIS**
9 **TITLE.**

10 **(M) “INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION” MEANS A**
11 **CERTIFICATE ISSUED BY THE INDIVIDUAL EXCHANGE THAT AUTHORIZES AN**
12 **INDIVIDUAL TO ACT AS AN INDIVIDUAL EXCHANGE NAVIGATOR.**

13 **(N) “INSURANCE PRODUCER AUTHORIZATION” MEANS A PERMIT**
14 **ISSUED BY THE SHOP EXCHANGE OR INDIVIDUAL EXCHANGE TO ALLOW AN**
15 **INSURANCE PRODUCER TO SELL QUALIFIED HEALTH PLANS AND QUALIFIED**
16 **DENTAL PLANS IN THE SHOP EXCHANGE OR INDIVIDUAL EXCHANGE.**

17 **[(h)] (O)** “Managed care organization” has the meaning stated in § 15-101
18 of the Health – General Article.

19 **(P) “MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL”**
20 **MEANS THE JOINT EXECUTIVE-LEGISLATIVE COUNCIL ESTABLISHED AND**
21 **EXPANDED BY EXECUTIVE ORDERS 01.01.2010.07 AND 01.01.2011.10.**

22 **[(i)] (Q)** “Qualified dental plan” means a **DENTAL** plan certified by the
23 Exchange that provides limited scope dental benefits, as described in § 31-108(b) of
24 this title.

25 **[(j)] (R)** “Qualified employer” means a small employer that elects to make
26 its full-time employees eligible for one or more qualified health plans offered through
27 the SHOP Exchange and, at the option of the employer, some or all of its part-time
28 employees, provided that the employer:

29 (1) has its principal place of business in the State and elects to provide
30 coverage through the SHOP Exchange to all of its eligible employees, wherever
31 employed; or

32 (2) elects to provide coverage through the SHOP Exchange to all of its
33 eligible employees who are principally employed in the State.

1 (i) all persons treated as a single employer under § 414(b), (c),
2 (m), or (o) of the Internal Revenue Code shall be treated as a single employer;

3 (ii) an employer and any predecessor employer shall be treated
4 as a single employer;

5 (iii) all employees shall be counted, including part-time
6 employees and employees who are not eligible for coverage through the employer;

7 (iv) if an employer was not in existence throughout the
8 preceding calendar year, the determination of whether the employer is a small
9 employer shall be based on the average number of employees that the employer is
10 reasonably expected to employ on business days in the current calendar year; and

11 (v) an employer that makes enrollment in qualified health plans
12 available to its employees through the SHOP Exchange, and would cease to be a small
13 employer by reason of an increase in the number of its employees, shall continue to be
14 treated as a small employer for purposes of this title as long as it continuously makes
15 enrollment through the SHOP Exchange available to its employees.

16 **(Z) “STATE BENCHMARK PLAN” MEANS THE HEALTH BENEFIT PLAN**
17 **DESIGNATED BY THE STATE, UNDER REGULATIONS ADOPTED BY THE**
18 **SECRETARY, TO SERVE AS THE STANDARD FOR THE ESSENTIAL HEALTH**
19 **BENEFITS TO BE OFFERED BY:**

20 **(1) QUALIFIED HEALTH PLANS INSIDE THE EXCHANGE; AND**

21 **(2) HEALTH BENEFIT PLANS OFFERED IN THE INDIVIDUAL AND**
22 **SMALL GROUP MARKETS OUTSIDE THE EXCHANGE.**

23 31–102.

24 (d) Nothing in this title, and no regulation adopted or other action taken by
25 the Exchange under this title, may be construed to:

26 (1) preempt or supersede:

27 (i) the authority of the Commissioner to regulate insurance
28 business in the State; or

29 (ii) the requirements of the Affordable Care Act; [or]

30 (2) authorize the Exchange to carry out any function not authorized by
31 the Affordable Care Act; **OR**

1 **(3) AUTHORIZE THE EXCHANGE TO OFFER ANY PRODUCTS OR**
2 **SERVICES EXCEPT QUALIFIED HEALTH PLANS OR QUALIFIED DENTAL PLANS.**

3 31–108.

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

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

9 (1) make qualified health plans **AND QUALIFIED DENTAL PLANS**
10 available to qualified individuals and qualified employers;

11 (2) allow a carrier to offer a qualified dental plan through the
12 Exchange that provides limited scope dental benefits that meet the requirements of §
13 9832(c)(2)(a) of the Internal Revenue Code, either separately or in conjunction with a
14 qualified health plan, provided that the qualified health plan provides pediatric dental
15 benefits that meet the requirements of § 1302(b)(1)(j) of the Affordable Care Act;

16 (3) implement procedures for the certification, recertification, and
17 decertification of health benefit plans as qualified health plans **AND DENTAL PLANS**
18 **AS QUALIFIED DENTAL PLANS**, consistent with guidelines developed by the
19 Secretary under § 1311(c) of the Affordable Care Act;

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

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

25 (6) maintain a Web site through which enrollees and prospective
26 enrollees of qualified health plans **AND QUALIFIED DENTAL PLANS** may obtain
27 standardized comparative information on qualified health plans and qualified dental
28 plans;

29 (7) with respect to each qualified health **PLAN AND QUALIFIED**
30 **DENTAL** plan offered through the Exchange:

31 (i) assign a rating [for] **TO** each qualified health **PLAN AND**
32 **QUALIFIED DENTAL** plan in accordance with the criteria developed by the Secretary
33 under § 1311(c)(3) of the Affordable Care Act and any additional criteria that may be
34 applicable under the laws of the State and regulations adopted by the Exchange under
35 this title; and

1 (ii) determine each qualified health plan's [level of] coverage
2 **LEVELS** in accordance with regulations adopted by the Secretary under § 1302(d)(2)(a)
3 of the Affordable Care Act and any additional regulations adopted by the Exchange
4 under this title;

5 (8) present qualified health **PLAN AND QUALIFIED DENTAL** plan
6 options offered by the Exchange in a standardized format, including the use of the
7 uniform outline of coverage established under § 2715 of the federal Public Health
8 Service Act;

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

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

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

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

17 (10) facilitate the enrollment of any individual who the Exchange
18 determines is eligible for a program described in item (9) of this subsection;

19 (11) establish and make available by electronic means a calculator to
20 determine the actual cost of coverage of a qualified health plan and a qualified dental
21 plan offered by the Exchange after application of any premium tax credit under § 36b
22 of the Internal Revenue Code and any cost-sharing reduction under § 1402 of the
23 Affordable Care Act;

24 (12) **IN ACCORDANCE WITH THIS TITLE**, establish a SHOP Exchange
25 through which qualified employers may access coverage for their employees at
26 specified [levels of] coverage **LEVELS** and meet standards for the federal qualified
27 employer tax credit;

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

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

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

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

3 (i) is certified as exempt from the individual responsibility
4 requirement;

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

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

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

12 (iii) notifies the Exchange under § 1411(b)(4) of the Affordable
13 Care Act that the individual has changed employers; [and] OR

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

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

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

21 (17) establish a Navigator Program in accordance with § 1311(i) of the
22 Affordable Care Act and [any requirements established under] this title;

23 (18) (i) establish a process, in accordance with § 10108 of the
24 Affordable Care Act, for crediting the amount of free choice vouchers to premiums of
25 qualified health plans and qualified dental plans in which qualified employees are
26 enrolled; and

27 (ii) collect the amount credited from the employer offering the
28 qualified health plan;

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

31 **(I) the [Navigator Program] A NAVIGATOR PROGRAM FOR**
32 **THE SHOP EXCHANGE AND A NAVIGATOR PROGRAM FOR THE INDIVIDUAL**
33 **EXCHANGE;** and

1 **(II) THE** toll-free hotline required under item (4) of this
2 subsection; and

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

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

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

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

12 (d) The Exchange, through the advisory committees established under §
13 31-106(g) of this title or through other means, shall consult with and consider the
14 recommendations of the stakeholders represented on the advisory committees in the
15 exercise of its duties under this title.

16 (e) The Exchange may not make available:

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

18 (2) any dental plan that is not a qualified dental plan.

19 **31-109.**

20 **(A) SUBJECT TO SUBSECTION (B) OF THIS SECTION, THE EXCHANGE**
21 **MAY ENTER INTO AGREEMENTS OR MEMORANDA OF UNDERSTANDING WITH**
22 **ANOTHER STATE TO:**

23 **(1) DEVELOP JOINT OR RECIPROCAL CERTIFICATION PROCESSES;**

24 **(2) DEVELOP CONSISTENCY IN QUALIFIED HEALTH PLANS AND**
25 **QUALIFIED DENTAL PLANS OFFERED ACROSS STATES; AND**

26 **(3) COORDINATE RESOURCES FOR ADMINISTRATIVE PROCESSES**
27 **NECESSARY TO SUPPORT:**

28 **(I) CERTIFICATION OF QUALIFIED HEALTH PLANS AND**
29 **QUALIFIED DENTAL PLANS; AND**

1 **(II) OTHER FUNCTIONS OF THE EXCHANGE.**

2 **(B) ANY INTERSTATE AGREEMENTS OR MEMORANDA OF**
3 **UNDERSTANDING ENTERED INTO UNDER SUBSECTION (A) OF THIS SECTION**
4 **SHALL COMPLY WITH AND ADVANCE:**

5 **(1) THE PURPOSES AND REQUIREMENTS OF THIS TITLE AND THE**
6 **AFFORDABLE CARE ACT; AND**

7 **(2) THE POLICIES AND REGULATIONS ADOPTED BY THE**
8 **EXCHANGE UNDER THIS TITLE.**

9 **31-110.**

10 **(A) IN MAKING QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL**
11 **PLANS AVAILABLE TO INDIVIDUALS AND EMPLOYERS THROUGH CONTRACTS**
12 **WITH CARRIERS, THE EXCHANGE SHALL SEEK TO:**

13 **(1) ACHIEVE A ROBUST AND STABLE ENROLLMENT IN THE**
14 **EXCHANGE; AND**

15 **(2) USE THE MARKET IMPACT ATTAINED THROUGH A ROBUST AND**
16 **STABLE ENROLLMENT TO PURSUE KEY OBJECTIVES SUCH AS HIGH QUALITY**
17 **STANDARDS OF CARE, DELIVERY SYSTEM REFORMS, HEALTH EQUITY,**
18 **IMPROVED PATIENT EXPERIENCE AND OUTCOMES, AND MEANINGFUL COST**
19 **CONTROLS WITHIN THE HEALTH CARE SYSTEM.**

20 **(B) IN EMPLOYING CONTRACTING STRATEGIES TO IMPLEMENT**
21 **SUBSECTION (A) OF THIS SECTION, THE EXCHANGE SHALL CONSIDER THE NEED**
22 **TO BALANCE:**

23 **(1) THE IMPORTANCE OF SUFFICIENT ENROLLMENT AND**
24 **CARRIER PARTICIPATION TO ENSURE THE EXCHANGE'S SUCCESS AND**
25 **LONG-TERM VIABILITY; AND**

26 **(2) ITS PROMOTION OF THE KEY OBJECTIVES STATED IN**
27 **SUBSECTION (A)(2) OF THIS SECTION.**

28 **(C) BEGINNING JANUARY 1, 2014, THE EXCHANGE:**

29 **(1) SHALL ALLOW ANY QUALIFIED HEALTH PLANS AND QUALIFIED**
30 **DENTAL PLANS THAT MEET THE MINIMUM STANDARDS ESTABLISHED BY THE**
31 **EXCHANGE UNDER THIS TITLE TO BE OFFERED IN THE EXCHANGE; AND**

1 **(2) MAY EXERCISE ITS AUTHORITY UNDER § 31-115(B)(9) OF THIS**
2 **TITLE TO ESTABLISH MINIMUM STANDARDS FOR QUALIFIED HEALTH PLANS AND**
3 **QUALIFIED DENTAL PLANS IN ADDITION TO THOSE REQUIRED BY THE**
4 **AFFORDABLE CARE ACT.**

5 **(D) AFTER DECEMBER 31, 2014, IN ADDITION TO ESTABLISHING**
6 **MINIMUM STANDARDS FOR QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL**
7 **PLANS, THE EXCHANGE MAY EMPLOY ALTERNATIVE CONTRACTING OPTIONS**
8 **AND ACTIVE PURCHASING STRATEGIES, INCLUDING:**

9 **(1) COMPETITIVE BIDDING;**

10 **(2) NEGOTIATION WITH CARRIERS TO ACHIEVE OPTIMAL**
11 **PARTICIPATION AND PLAN OFFERINGS IN THE EXCHANGE; AND**

12 **(3) PARTNERING WITH CARRIERS TO PROMOTE CHOICE AND**
13 **AFFORDABILITY FOR INDIVIDUALS AND SMALL EMPLOYERS AMONG QUALIFIED**
14 **HEALTH PLANS AND QUALIFIED DENTAL PLANS OFFERING HIGH VALUE,**
15 **PATIENT-CENTERED, TEAM-BASED CARE, AND OTHER HIGH QUALITY AND**
16 **AFFORDABLE OPTIONS.**

17 **(E) IN EMPLOYING ALTERNATIVE CONTRACTING OPTIONS AND ACTIVE**
18 **PURCHASING STRATEGIES, THE EXCHANGE SHALL:**

19 **(1) CONTINUALLY ASSESS AND ADJUST FOR THE IMPACT OF THE**
20 **OPTIONS AND STRATEGIES ON ITS SUSTAINABILITY, THE QUALITY AND**
21 **AFFORDABILITY OF ITS QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL**
22 **PLANS, AND THE ACHIEVEMENT OF ITS OTHER KEY OBJECTIVES; AND**

23 **(2) WORK WITH THE COMMISSIONER TO REASSESS, IN LIGHT OF**
24 **ITS CONTRACTING STRATEGIES, THE PARTICIPATION REQUIREMENTS FOR**
25 **CARRIERS IN THE INDIVIDUAL AND SMALL GROUP MARKETS OUTSIDE THE**
26 **EXCHANGE AS SET FORTH IN §§ 15-1204(B) AND 15-1303(B) OF THIS ARTICLE.**

27 **31-111.**

28 **(A) THE SHOP EXCHANGE:**

29 **(1) SHALL BE A SEPARATE INSURANCE MARKET WITHIN THE**
30 **EXCHANGE FOR SMALL EMPLOYERS; AND**

1 **(2) MAY NOT BE MERGED WITH THE INDIVIDUAL MARKET OF THE**
2 **INDIVIDUAL EXCHANGE.**

3 **(B) THE SHOP EXCHANGE SHALL BE DESIGNED TO BALANCE:**

4 **(1) THE VIABILITY OF THE SHOP EXCHANGE AS AN**
5 **ALTERNATIVE FOR QUALIFIED EMPLOYERS AND THEIR EMPLOYEES WHO HAVE**
6 **NOT BEEN ABLE HISTORICALLY TO ACCESS AND AFFORD INSURANCE IN THE**
7 **SMALL GROUP MARKET;**

8 **(2) THE NEED FOR STABILITY AND PREDICTABILITY IN**
9 **EMPLOYERS' HEALTH INSURANCE COSTS INCURRED ON BEHALF OF THEIR**
10 **EMPLOYEES; AND**

11 **(3) THE DESIRABILITY OF PROVIDING EMPLOYEES WITH A**
12 **MEANINGFUL CHOICE AMONG HIGH-QUALITY AND AFFORDABLE HEALTH**
13 **BENEFIT PLANS.**

14 **(C) THE SHOP EXCHANGE SHALL ALLOW QUALIFIED EMPLOYERS TO:**

15 **(1) AS REQUIRED BY REGULATIONS ADOPTED BY THE SECRETARY**
16 **UNDER THE AFFORDABLE CARE ACT, DESIGNATE A COVERAGE LEVEL WITHIN**
17 **WHICH THEIR EMPLOYEES MAY CHOOSE ANY QUALIFIED HEALTH PLAN; OR**

18 **(2) DESIGNATE A CARRIER AND A MENU OF QUALIFIED HEALTH**
19 **PLANS OFFERED BY THE CARRIER IN THE SHOP EXCHANGE FROM WHICH**
20 **THEIR EMPLOYEES MAY CHOOSE.**

21 **(D) ON OR AFTER JANUARY 1, 2016, IN ORDER TO CONTINUE TO**
22 **PROMOTE THE SHOP EXCHANGE'S PRINCIPLES OF ACCESSIBILITY, CHOICE,**
23 **AFFORDABILITY, AND SUSTAINABILITY, AND AS IT OBTAINS MORE DATA ON**
24 **ADVERSE SELECTION, COST, ENROLLMENT, AND OTHER FACTORS, THE SHOP**
25 **EXCHANGE:**

26 **(1) MAY REASSESS AND MODIFY THE MANNER IN WHICH THE**
27 **SHOP EXCHANGE ALLOWS QUALIFIED EMPLOYERS TO OFFER, AND THEIR**
28 **EMPLOYEES TO CHOOSE, QUALIFIED HEALTH PLANS AND COVERAGE LEVELS;**
29 **AND**

30 **(2) IN REASSESSING EMPLOYER AND EMPLOYEE CHOICE, MAY**
31 **CONSIDER OPTIONS WHICH WOULD PROMOTE THE ADDITIONAL OBJECTIVE OF**
32 **INCREASING THE PORTABILITY OF EMPLOYEES' HEALTH INSURANCE AS**

1 EMPLOYEES MOVE FROM EMPLOYER TO EMPLOYER OR TRANSITION IN AND OUT
2 OF EMPLOYMENT.

3 31-112.

4 (A) THERE IS A NAVIGATOR PROGRAM FOR THE SHOP EXCHANGE.

5 (B) THE NAVIGATOR PROGRAM FOR THE SHOP EXCHANGE SHALL:

6 (1) FOCUS OUTREACH EFFORTS AND PROVIDE HEALTH
7 INSURANCE ENROLLMENT AND ELIGIBILITY SERVICES TO SMALL EMPLOYERS
8 THAT DO NOT OFFER HEALTH INSURANCE TO THEIR EMPLOYEES; AND

9 (2) RELY ON THE STATE'S INSURANCE PRODUCER COMMUNITY TO
10 CONTINUE TO PROVIDE WIDESPREAD AND COMPREHENSIVE ENROLLMENT AND
11 CONSUMER ASSISTANCE SERVICES TO SMALL EMPLOYERS BOTH INSIDE AND
12 OUTSIDE THE SHOP EXCHANGE.

13 (C) (1) TO ACHIEVE THESE OBJECTIVES AND IN COMPLIANCE WITH
14 THE AFFORDABLE CARE ACT, A SHOP EXCHANGE NAVIGATOR, WITH RESPECT
15 ONLY TO QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS OFFERED
16 IN THE SHOP EXCHANGE, MAY:

17 (I) CONDUCT EDUCATION AND OUTREACH TO SMALL
18 EMPLOYERS;

19 (II) DISTRIBUTE INFORMATION ABOUT THE SHOP
20 EXCHANGE, INCLUDING:

21 1. OPTIONS WITH RESPECT TO EMPLOYER AND
22 EMPLOYEE CHOICE;

23 2. PROCEDURES FOR ENROLLING IN QUALIFIED
24 HEALTH PLANS AND QUALIFIED DENTAL PLANS; AND

25 3. THE AVAILABILITY OF APPLICABLE TAX CREDITS;

26 (III) SELL QUALIFIED HEALTH PLANS AND QUALIFIED
27 DENTAL PLANS OFFERED IN THE SHOP EXCHANGE;

28 (IV) FACILITATE QUALIFIED HEALTH PLAN AND QUALIFIED
29 DENTAL PLAN SELECTION, APPLICATION PROCESSES, ENROLLMENT,
30 RENEWALS, AND DISENROLLMENT;

1 (V) CONDUCT TAX CREDIT ELIGIBILITY DETERMINATIONS
2 AND REDETERMINATIONS;

3 (VI) PROVIDE REFERRALS TO APPROPRIATE AGENCIES FOR
4 ENROLLEES WITH GRIEVANCES, COMPLAINTS, APPEALS, OR QUESTIONS;

5 (VII) PROVIDE ALL INFORMATION AND SERVICES IN A
6 MANNER THAT IS CULTURALLY AND LINGUISTICALLY APPROPRIATE AND
7 ENSURES ACCESSIBILITY FOR INDIVIDUALS WITH DISABILITIES; AND

8 (VIII) PROVIDE ONGOING SUPPORT WITH RESPECT TO THE
9 FUNCTIONS SET FORTH IN THIS SECTION, INCLUDING ELIGIBILITY,
10 ENROLLMENT, RENEWAL, AND DISENROLLMENT IN QUALIFIED HEALTH PLANS
11 AND QUALIFIED DENTAL PLANS OFFERED IN THE SHOP EXCHANGE.

12 (2) A SHOP EXCHANGE NAVIGATOR MAY NOT:

13 (I) PROVIDE ANY INFORMATION OR SERVICES RELATED TO
14 HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED IN THE SHOP
15 EXCHANGE; OR

16 (II) SEEK TO REPLACE ANY HEALTH BENEFIT PLAN
17 ALREADY OFFERED BY A SMALL EMPLOYER UNLESS THE SMALL EMPLOYER IS
18 ELIGIBLE FOR A FEDERAL TAX CREDIT AVAILABLE ONLY THROUGH THE SHOP
19 EXCHANGE.

20 (3) A SHOP EXCHANGE NAVIGATOR:

21 (I) SHALL HOLD A SHOP EXCHANGE NAVIGATOR LICENSE
22 ISSUED UNDER SUBSECTION (D) OF THIS SECTION;

23 (II) MAY NOT BE REQUIRED TO HOLD AN INSURANCE
24 PRODUCER LICENSE;

25 (III) SHALL BE ENGAGED BY THE SHOP EXCHANGE;

26 (IV) SHALL REFER ANY INQUIRIES ABOUT INFORMATION OR
27 SERVICES RELATED TO HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT
28 OFFERED IN THE SHOP EXCHANGE TO LICENSED INSURANCE PRODUCERS;

1 (V) SHALL COMPLETE AND COMPLY WITH ANY ONGOING
2 REQUIREMENTS OF THE TRAINING PROGRAM ESTABLISHED UNDER
3 SUBSECTION (F) OF THIS SECTION; AND

4 (VI) SHALL RECEIVE COMPENSATION ONLY THROUGH THE
5 SHOP EXCHANGE AND NOT FROM A CARRIER OR AN INSURANCE PRODUCER.

6 (D) (1) THE COMMISSIONER SHALL ISSUE A SHOP EXCHANGE
7 NAVIGATOR LICENSE TO EACH APPLICANT WHO MEETS THE REQUIREMENTS OF
8 THIS SUBSECTION.

9 (2) TO QUALIFY FOR A SHOP EXCHANGE NAVIGATOR LICENSE,
10 AN APPLICANT:

11 (I) SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;

12 (II) SHALL BE AT LEAST 18 YEARS OLD;

13 (III) SHALL PASS A WRITTEN EXAMINATION GIVEN BY THE
14 COMMISSIONER UNDER THIS SUBSECTION; AND

15 (IV) MAY NOT HAVE COMMITTED ANY ACT THAT THE
16 COMMISSIONER FINDS WOULD WARRANT DENIAL OF A LICENSE UNDER
17 SUBSECTION (E) OF THIS SECTION.

18 (3) THE COMMISSIONER SHALL ADOPT REGULATIONS THAT
19 GOVERN:

20 (I) THE SCOPE, TYPE, CONDUCT, FREQUENCY, AND
21 ASSESSMENT OF THE WRITTEN EXAMINATION REQUIRED FOR A LICENSE;

22 (II) THE EXPERIENCE REQUIRED FOR AN INDIVIDUAL
23 APPLICANT TO BE ELIGIBLE TO TAKE THE WRITTEN EXAMINATION; AND

24 (III) THE REINSTATEMENT OF AN EXPIRED LICENSE.

25 (E) (1) THE COMMISSIONER MAY DENY A LICENSE TO AN APPLICANT
26 FOR A SHOP EXCHANGE NAVIGATOR LICENSE, OR SUSPEND, REVOKE, OR
27 REFUSE TO RENEW OR REINSTATE A SHOP EXCHANGE NAVIGATOR LICENSE
28 AFTER NOTICE AND OPPORTUNITY FOR A HEARING UNDER §§ 2-210 THROUGH
29 2-214 OF THIS ARTICLE, IF THE APPLICANT OR LICENSEE:

1 **(I) HAS VIOLATED THIS ARTICLE OR ANY REGULATION**
2 **ADOPTED UNDER THIS ARTICLE;**

3 **(II) HAS MADE A MATERIAL MISSTATEMENT IN THE**
4 **APPLICATION FOR THE LICENSE;**

5 **(III) HAS ENGAGED IN FRAUDULENT OR DISHONEST**
6 **PRACTICES;**

7 **(IV) HAS MISAPPROPRIATED, CONVERTED, OR UNLAWFULLY**
8 **WITHHELD MONEY;**

9 **(V) HAS MATERIALLY MISREPRESENTED THE PROVISIONS**
10 **OF A QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL PLAN;**

11 **(VI) HAS BEEN CONVICTED OF A FELONY, A CRIME OF MORAL**
12 **TURPITUDE, OR ANY CRIMINAL OFFENSE INVOLVING DISHONESTY OR BREACH**
13 **OF TRUST; OR**

14 **(VII) HAS FAILED TO COMPLY WITH OR VIOLATED A PROPER**
15 **ORDER OF THE COMMISSIONER.**

16 **(2) INSTEAD OF OR IN ADDITION TO SUSPENDING OR REVOKING A**
17 **LICENSE, THE COMMISSIONER MAY:**

18 **(I) IMPOSE A PENALTY OF NOT LESS THAN \$100 BUT NOT**
19 **EXCEEDING \$500 FOR EACH VIOLATION OF THIS ARTICLE; AND**

20 **(II) REQUIRE THAT RESTITUTION BE MADE TO ANY PERSON**
21 **WHO HAS SUFFERED FINANCIAL INJURY BECAUSE OF A VIOLATION OF THIS**
22 **ARTICLE.**

23 **(3) IF THE COMMISSIONER SUSPENDS A SHOP EXCHANGE**
24 **NAVIGATOR LICENSE, THE COMMISSIONER MAY REQUIRE THE INDIVIDUAL TO**
25 **PASS AN EXAMINATION AND FILE A NEW APPLICATION BEFORE THE SUSPENSION**
26 **IS LIFTED.**

27 **(4) THE PENALTIES AVAILABLE TO THE COMMISSIONER UNDER**
28 **THIS SUBSECTION SHALL BE IN ADDITION TO ANY CRIMINAL OR CIVIL**
29 **PENALTIES IMPOSED FOR FRAUD OR OTHER MISCONDUCT UNDER ANY OTHER**
30 **STATE OR FEDERAL LAW.**

1 **(5) THE COMMISSIONER SHALL NOTIFY THE EXCHANGE OF ANY**
2 **DECISION AFFECTING THE LICENSE OF A SHOP EXCHANGE NAVIGATOR OR ANY**
3 **SANCTION IMPOSED ON THE SHOP EXCHANGE NAVIGATOR UNDER THIS**
4 **SUBSECTION.**

5 **(F) (1) THE SHOP EXCHANGE SHALL ESTABLISH AND ADMINISTER**
6 **AN INSURANCE PRODUCER AUTHORIZATION PROGRAM.**

7 **(2) UNDER THE PROGRAM, THE SHOP EXCHANGE SHALL:**

8 **(I) PROVIDE AN AUTHORIZATION TO SELL QUALIFIED**
9 **HEALTH PLANS AND QUALIFIED DENTAL PLANS TO A LICENSED INSURANCE**
10 **PRODUCER WHO MEETS THE REQUIREMENTS IN SUBSECTION (G) OF THIS**
11 **SECTION; AND**

12 **(II) REQUIRE RENEWAL OF AN AUTHORIZATION EVERY 2**
13 **YEARS.**

14 **(3) (I) SUBJECT TO THE CONTESTED CASE HEARING**
15 **PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE,**
16 **THE SHOP EXCHANGE MAY DENY, SUSPEND, REVOKE, OR REFUSE TO RENEW**
17 **AN AUTHORIZATION FOR GOOD CAUSE, WHICH SHALL INCLUDE A FINDING THAT**
18 **THE INSURANCE PRODUCER HOLDING THE AUTHORIZATION HAS:**

19 **1. MADE A MATERIAL MISSTATEMENT IN THE**
20 **APPLICATION FOR THE AUTHORIZATION;**

21 **2. ENGAGED IN FRAUDULENT OR DISHONEST**
22 **PRACTICES IN CONDUCTING OF ACTIVITIES UNDER THE AUTHORIZATION;**

23 **3. MATERIALLY MISREPRESENTED THE PROVISIONS**
24 **OF A QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL PLAN; OR**

25 **4. COMMITTED ANY ACT IN VIOLATION OF**
26 **SUBSECTION (E) OF THIS SUBSECTION.**

27 **(II) THE SHOP EXCHANGE SHALL NOTIFY THE**
28 **COMMISSIONER OF ANY DECISION AFFECTING THE STATUS OF AN INSURANCE**
29 **PRODUCER'S AUTHORIZATION.**

30 **(4) THE SHOP EXCHANGE, IN CONSULTATION WITH THE**
31 **COMMISSIONER, SHALL ADOPT REGULATIONS TO CARRY OUT THIS SUBSECTION.**

1 **(G) (1) SUBJECT TO THE REQUIREMENTS IN PARAGRAPH (2) OF THIS**
2 **SUBSECTION, AN INSURANCE PRODUCER WHO IS LICENSED IN THE STATE AND**
3 **AUTHORIZED BY THE COMMISSIONER TO SELL, SOLICIT, OR NEGOTIATE HEALTH**
4 **INSURANCE MAY SELL ANY QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL**
5 **PLAN OFFERED IN THE SHOP EXCHANGE WITHOUT BEING SEPARATELY**
6 **LICENSED AS A SHOP EXCHANGE NAVIGATOR.**

7 **(2) TO SELL QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL**
8 **PLANS IN THE SHOP EXCHANGE, AN INSURANCE PRODUCER SHALL:**

9 **(I) REGISTER AND APPLY FOR AN AUTHORIZATION FROM**
10 **THE SHOP EXCHANGE; AND**

11 **(II) COMPLETE AND COMPLY WITH ANY ONGOING**
12 **REQUIREMENTS OF THE TRAINING PROGRAM ESTABLISHED UNDER**
13 **SUBSECTION (H) OF THIS SECTION.**

14 **(3) AN INSURANCE PRODUCER:**

15 **(I) MAY NOT BE COMPENSATED BY THE SHOP EXCHANGE**
16 **FOR THE SALE OF A QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL PLAN IN**
17 **THE SHOP EXCHANGE; AND**

18 **(II) SHALL BE COMPENSATED DIRECTLY BY A CARRIER.**

19 **(H) (1) THE SHOP EXCHANGE SHALL DEVELOP, IMPLEMENT, AND,**
20 **AS APPROPRIATE, UPDATE TRAINING PROGRAMS FOR:**

21 **(I) SHOP EXCHANGE NAVIGATORS; AND**

22 **(II) LICENSED INSURANCE PRODUCERS WHO SEEK**
23 **AUTHORIZATION TO SELL QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL**
24 **PLANS IN THE SHOP EXCHANGE.**

25 **(2) THE TRAINING PROGRAMS SHALL:**

26 **(I) IMPART THE SKILLS AND EXPERTISE NECESSARY TO**
27 **PERFORM FUNCTIONS SPECIFIC TO THE SHOP EXCHANGE, SUCH AS MAKING**
28 **TAX CREDIT ELIGIBILITY DETERMINATIONS; AND**

29 **(II) ENABLE THE SHOP EXCHANGE'S NAVIGATOR**
30 **PROGRAM TO PROVIDE ROBUST PROTECTION OF CONSUMERS AND ADHERENCE**
31 **TO HIGH QUALITY ASSURANCE STANDARDS.**

1 31-113.

2 (A) THERE IS A NAVIGATOR PROGRAM FOR THE INDIVIDUAL
3 EXCHANGE.

4 (B) THE NAVIGATOR PROGRAM FOR THE INDIVIDUAL EXCHANGE
5 SHALL:

6 (1) FOCUS OUTREACH EFFORTS AND PROVIDE ENROLLMENT AND
7 ELIGIBILITY SERVICES TO INDIVIDUALS WITHOUT HEALTH INSURANCE
8 COVERAGE;

9 (2) USE, AS INDIVIDUAL EXCHANGE NAVIGATOR ENTITIES,
10 COMMUNITY-BASED ORGANIZATIONS AND OTHER ENTITIES THAT:

11 (I) ARE FAMILIAR WITH VULNERABLE AND
12 HARD-TO-REACH POPULATIONS; AND

13 (II) CONDUCT OUTREACH AND PROVIDE ENROLLMENT
14 SUPPORT FOR THESE POPULATIONS; AND

15 (3) ENABLE THE INDIVIDUAL EXCHANGE TO:

16 (I) COMPLY WITH THE AFFORDABLE CARE ACT BY
17 PROVIDING SEAMLESS ENTRY INTO THE MARYLAND MEDICAL ASSISTANCE
18 PROGRAM, THE MARYLAND CHILDREN'S HEALTH PROGRAM, QUALIFIED
19 HEALTH PLANS, AND QUALIFIED DENTAL PLANS;

20 (II) ASSIST INDIVIDUALS WHO TRANSITION BETWEEN THE
21 PROGRAM PLANS; AND

22 (III) MEET CONSUMER NEEDS AND DEMANDS FOR HEALTH
23 INSURANCE COVERAGE WHILE MAINTAINING HIGH STANDARDS OF QUALITY
24 ASSURANCE AND CONSUMER PROTECTION.

25 (C) TO ACHIEVE THESE OBJECTIVES AND IN COMPLIANCE WITH THE
26 AFFORDABLE CARE ACT, AN INDIVIDUAL EXCHANGE NAVIGATOR, WITH
27 RESPECT ONLY TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE
28 MARYLAND CHILDREN'S HEALTH PROGRAM, AND QUALIFIED HEALTH PLANS
29 AND QUALIFIED DENTAL PLANS OFFERED IN THE EXCHANGE, MAY:

30 (1) CONDUCT EDUCATION AND OUTREACH TO INDIVIDUALS;

1 **(2) DISTRIBUTE INFORMATION ABOUT:**

2 **(I) THE INDIVIDUAL EXCHANGE, INCLUDING ELIGIBILITY**
3 **REQUIREMENTS FOR APPLICABLE FEDERAL PREMIUM SUBSIDIES;**

4 **(II) ELIGIBILITY REQUIREMENTS FOR THE MARYLAND**
5 **MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN’S HEALTH**
6 **PROGRAM; AND**

7 **(III) PROCEDURES FOR ENROLLING IN THE MARYLAND**
8 **MEDICAL ASSISTANCE PROGRAM, THE MARYLAND CHILDREN’S HEALTH**
9 **PROGRAM, OR QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS**
10 **OFFERED IN THE EXCHANGE;**

11 **(3) FACILITATE QUALIFIED HEALTH PLAN AND QUALIFIED**
12 **DENTAL PLAN SELECTION, APPLICATION PROCESSES, ENROLLMENT,**
13 **RENEWALS, AND DISENROLLMENT;**

14 **(4) FACILITATE ELIGIBILITY DETERMINATIONS FOR THE**
15 **MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND**
16 **CHILDREN’S HEALTH PROGRAM, SELECTION OF MANAGED CARE**
17 **ORGANIZATIONS, APPLICATION PROCESSES, ENROLLMENT, AND**
18 **DISENROLLMENT;**

19 **(5) CONDUCT ELIGIBILITY DETERMINATIONS AND**
20 **REDETERMINATIONS FOR PREMIUM SUBSIDIES;**

21 **(6) PROVIDE REFERRALS TO APPROPRIATE AGENCIES FOR**
22 **ENROLLEES WITH GRIEVANCES, COMPLAINTS, QUESTIONS, OR THE NEED FOR**
23 **OTHER SOCIAL SERVICES;**

24 **(7) PROVIDE ALL INFORMATION AND SERVICES IN A MANNER**
25 **THAT IS CULTURALLY AND LINGUISTICALLY APPROPRIATE AND ENSURES**
26 **ACCESSIBILITY FOR INDIVIDUALS WITH DISABILITIES; AND**

27 **(8) PROVIDE ONGOING SUPPORT WITH RESPECT TO ISSUES**
28 **RELATING TO ELIGIBILITY, ENROLLMENT, RENEWAL, AND DISENROLLMENT IN**
29 **THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE MARYLAND**
30 **CHILDREN’S HEALTH PROGRAM, AND QUALIFIED HEALTH PLANS AND**
31 **QUALIFIED DENTAL PLANS OFFERED IN THE EXCHANGE.**

32 **(D) AN INDIVIDUAL EXCHANGE NAVIGATOR:**

1 **(1) SHALL HOLD AN INDIVIDUAL EXCHANGE NAVIGATOR**
2 **CERTIFICATION ISSUED UNDER SUBSECTION (F) OF THIS SECTION;**

3 **(2) MAY NOT BE REQUIRED TO HOLD AN INSURANCE PRODUCER**
4 **LICENSE;**

5 **(3) SHALL BE EMPLOYED OR ENGAGED BY AN INDIVIDUAL**
6 **EXCHANGE NAVIGATOR ENTITY;**

7 **(4) SHALL RECEIVE COMPENSATION ONLY THROUGH THE**
8 **INDIVIDUAL EXCHANGE OR AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY AND**
9 **NOT FROM A CARRIER OR AN INSURANCE PRODUCER;**

10 **(5) MAY NOT PROVIDE ANY INFORMATION OR SERVICES RELATED**
11 **TO HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED IN THE**
12 **INDIVIDUAL EXCHANGE;**

13 **(6) SHALL REFER ANY INQUIRIES ABOUT HEALTH BENEFIT PLANS**
14 **AND OTHER PRODUCTS NOT OFFERED IN THE INDIVIDUAL EXCHANGE TO**
15 **LICENSED INSURANCE PRODUCERS;**

16 **(7) ON CONTACT WITH AN INDIVIDUAL WHO HAS EXISTING**
17 **HEALTH INSURANCE COVERAGE OBTAINED THROUGH AN INSURANCE**
18 **PRODUCER, SHALL REFER THE INDIVIDUAL BACK TO THE INSURANCE**
19 **PRODUCER FOR INFORMATION AND SERVICES UNLESS:**

20 **(I) THE INDIVIDUAL IS ELIGIBLE FOR FEDERAL PREMIUM**
21 **SUBSIDIES AVAILABLE ONLY IN THE INDIVIDUAL EXCHANGE; AND**

22 **(II) THE INSURANCE PRODUCER IS NOT AUTHORIZED TO**
23 **SELL QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS IN THE**
24 **INDIVIDUAL EXCHANGE; AND**

25 **(8) SHALL COMPLY WITH ALL STATE AND FEDERAL LAWS AND**
26 **REGULATIONS GOVERNING THE MARYLAND MEDICAL ASSISTANCE PROGRAM**
27 **AND THE MARYLAND CHILDREN'S HEALTH PROGRAM.**

28 **(E) (1) THE EXCHANGE:**

29 **(I) SHALL ESTABLISH AND ADMINISTER AN INDIVIDUAL**
30 **EXCHANGE NAVIGATOR CERTIFICATION PROGRAM;**

1 **(II) IN CONSULTATION WITH THE COMMISSIONER, THE**
2 **MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE MARYLAND**
3 **CHILDREN’S HEALTH PROGRAM, SHALL ADOPT REGULATIONS TO IMPLEMENT**
4 **THIS SUBSECTION; AND**

5 **(III) MAY IMPLEMENT THE INDIVIDUAL EXCHANGE**
6 **NAVIGATOR CERTIFICATION PROGRAM WITH THE ASSISTANCE OF THE**
7 **COMMISSIONER, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE**
8 **MARYLAND CHILDREN’S HEALTH PROGRAM, IN ACCORDANCE WITH ONE OR**
9 **MORE MEMORANDA OF UNDERSTANDING.**

10 **(2) THE COMMISSIONER MAY REQUIRE THAT THE INDIVIDUAL**
11 **EXCHANGE:**

12 **(I) MAKE AVAILABLE TO THE COMMISSIONER ALL**
13 **RECORDS, DOCUMENTS, DATA, AND OTHER INFORMATION RELATING TO THE**
14 **CERTIFICATION PROGRAM AND THE CERTIFICATION OF INDIVIDUAL EXCHANGE**
15 **NAVIGATORS; AND**

16 **(II) SUBMIT A CORRECTIVE PLAN TO TAKE APPROPRIATE**
17 **ACTION TO ADDRESS ANY PROBLEMS OR DEFICIENCIES IN THE CERTIFICATION**
18 **PROGRAM THAT THE COMMISSIONER IDENTIFIES.**

19 **(3) A CERTIFICATION SHALL BE RENEWED EVERY 2 YEARS.**

20 **(F) (1) THE EXCHANGE SHALL ISSUE AN INDIVIDUAL EXCHANGE**
21 **NAVIGATOR CERTIFICATION TO EACH APPLICANT WHO MEETS THE**
22 **REQUIREMENTS OF THIS SUBSECTION.**

23 **(2) TO QUALIFY FOR AN INDIVIDUAL EXCHANGE NAVIGATOR**
24 **CERTIFICATION, AN APPLICANT:**

25 **(I) SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;**

26 **(II) SHALL BE AT LEAST 18 YEARS OLD;**

27 **(III) SHALL COMPLETE, AND COMPLY WITH ANY ONGOING**
28 **REQUIREMENTS OF, THE TRAINING PROGRAM ESTABLISHED UNDER**
29 **SUBSECTION (G) OF THIS SECTION; AND**

30 **(IV) SHALL COMPLY WITH ALL APPLICABLE REQUIREMENTS**
31 **OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.**

1 **(G) (1) THE EXCHANGE, WITH THE APPROVAL OF THE**
2 **COMMISSIONER AND IN CONSULTATION WITH THE MARYLAND MEDICAL**
3 **ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN’S HEALTH PROGRAM,**
4 **SHALL DEVELOP, IMPLEMENT, AND, AS APPROPRIATE, UPDATE A TRAINING**
5 **PROGRAM FOR THE CERTIFICATION OF INDIVIDUAL EXCHANGE NAVIGATORS.**

6 **(2) THE TRAINING PROGRAM SHALL:**

7 **(I) AFFORD INDIVIDUAL EXCHANGE NAVIGATORS THE**
8 **FULL RANGE OF SKILLS, KNOWLEDGE, AND EXPERTISE NECESSARY TO MEET**
9 **THE CONSUMER ASSISTANCE, ELIGIBILITY, ENROLLMENT, RENEWAL, AND**
10 **DISENROLLMENT NEEDS OF INDIVIDUALS:**

11 **1. ELIGIBLE FOR THE MARYLAND MEDICAL**
12 **ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN’S HEALTH PROGRAM;**
13 **OR**

14 **2. SEEKING QUALIFIED HEALTH PLANS AND**
15 **QUALIFIED DENTAL PLANS OFFERED IN THE EXCHANGE;**

16 **(II) ENABLE THE NAVIGATOR PROGRAM FOR THE**
17 **INDIVIDUAL EXCHANGE TO PROVIDE ROBUST PROTECTION OF CONSUMERS AND**
18 **ADHERENCE TO HIGH QUALITY ASSURANCE STANDARDS; AND**

19 **(III) ENABLE THE EXCHANGE TO ENSURE THAT, WITH**
20 **RESPECT TO INDIVIDUAL EXCHANGE NAVIGATORS WHO OFFER ANY FORM OF**
21 **ASSISTANCE TO INDIVIDUALS REGARDING THE MARYLAND MEDICAL**
22 **ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN’S HEALTH PROGRAM,**
23 **THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION PROGRAM SHALL**
24 **COMPLY WITH ALL REQUIREMENTS OF THE DEPARTMENT OF HEALTH AND**
25 **MENTAL HYGIENE.**

26 **(3) NOTWITHSTANDING THE REQUIREMENTS OF THE TRAINING**
27 **PROGRAM, INDIVIDUAL EXCHANGE NAVIGATORS AND INDIVIDUAL EXCHANGE**
28 **NAVIGATOR ENTITIES:**

29 **(I) ARE NOT REQUIRED TO PROVIDE THE FULL SCOPE OF**
30 **SERVICES AND FUNCTIONS SET FORTH IN THIS SECTION; AND**

31 **(II) MAY BE ENGAGED TO PROVIDE A SUBSET OF THE**
32 **SERVICES AND FUNCTIONS AS LONG AS THE INDIVIDUAL EXCHANGE**
33 **NAVIGATOR PROGRAM OVERALL PROVIDES THE TOTALITY OF SERVICES AND**
34 **FUNCTIONS REQUIRED.**

1 **(4) THE INDIVIDUAL EXCHANGE, IN CONSULTATION WITH THE**
2 **COMMISSIONER, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE**
3 **MARYLAND CHILDREN’S HEALTH PROGRAM, SHALL ADOPT REGULATIONS**
4 **THAT GOVERN:**

5 **(I) THE SCOPE, TYPE, CONDUCT, FREQUENCY, AND**
6 **ASSESSMENT OF THE TRAINING REQUIRED FOR A CERTIFICATION;**

7 **(II) THE EXPERIENCE REQUIREMENTS, IF ANY, FOR AN**
8 **INDIVIDUAL APPLICANT TO BE ELIGIBLE TO PARTICIPATE IN THE TRAINING**
9 **PROGRAM; AND**

10 **(III) THE REINSTATEMENT OF AN EXPIRED CERTIFICATE OR**
11 **THE REACTIVATION OF A CERTIFICATE RENDERED INACTIVE BECAUSE THE**
12 **CERTIFIED INDIVIDUAL EXCHANGE NAVIGATOR TERMINATED ENGAGEMENT**
13 **WITH AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY.**

14 **(H) (1) THE COMMISSIONER MAY SUSPEND OR REVOKE AN**
15 **INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION AFTER NOTICE AND**
16 **OPPORTUNITY FOR A HEARING UNDER §§ 2-210 THROUGH 2-214 OF THIS**
17 **ARTICLE IF THE APPLICANT OR CERTIFIED INDIVIDUAL EXCHANGE NAVIGATOR:**

18 **(I) HAS VIOLATED:**

19 **1. THIS ARTICLE OR ANY REGULATION ADOPTED**
20 **UNDER THIS ARTICLE; OR**

21 **2. ANY STATE OR FEDERAL LAW OR REGULATION**
22 **GOVERNING THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE**
23 **MARYLAND CHILDREN’S HEALTH PROGRAM;**

24 **(II) HAS MADE A MATERIAL MISSTATEMENT IN THE**
25 **APPLICATION FOR THE CERTIFICATION;**

26 **(III) HAS ENGAGED IN FRAUDULENT OR DISHONEST**
27 **PRACTICES;**

28 **(IV) HAS MISAPPROPRIATED, CONVERTED, OR UNLAWFULLY**
29 **WITHHELD MONEY;**

30 **(V) HAS MATERIALLY MISREPRESENTED THE PROVISIONS**
31 **OF A QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL PLAN;**

1 (VI) HAS BEEN CONVICTED OF A FELONY, A CRIME OF MORAL
2 TURPITUDE, OR ANY CRIMINAL OFFENSE INVOLVING DISHONESTY OR BREACH
3 OF TRUST; OR

4 (VII) HAS FAILED TO COMPLY WITH OR VIOLATED A PROPER
5 ORDER OF THE COMMISSIONER.

6 (2) INSTEAD OF OR IN ADDITION TO SUSPENDING OR REVOKING A
7 CERTIFICATION, THE COMMISSIONER MAY:

8 (I) IMPOSE A PENALTY OF NOT LESS THAN \$100 BUT NOT
9 EXCEEDING \$500 FOR EACH VIOLATION OF THIS ARTICLE; AND

10 (II) REQUIRE THAT RESTITUTION BE MADE TO ANY PERSON
11 WHO HAS SUFFERED FINANCIAL INJURY BECAUSE OF A VIOLATION OF THIS
12 ARTICLE.

13 (3) THE PENALTIES AVAILABLE TO THE COMMISSIONER UNDER
14 THIS SUBSECTION SHALL BE IN ADDITION TO ANY CRIMINAL OR CIVIL
15 PENALTIES IMPOSED FOR FRAUD OR OTHER MISCONDUCT UNDER ANY OTHER
16 STATE OR FEDERAL LAW.

17 (4) THE COMMISSIONER SHALL NOTIFY THE INDIVIDUAL
18 EXCHANGE OF ANY DECISION AFFECTING THE CERTIFICATION OF AN
19 INDIVIDUAL EXCHANGE NAVIGATOR OR ANY SANCTION IMPOSED ON AN
20 INDIVIDUAL EXCHANGE NAVIGATOR UNDER THIS SUBSECTION.

21 (1) (1) THE EXCHANGE SHALL ESTABLISH AND ADMINISTER AN
22 INSURANCE PRODUCER AUTHORIZATION PROGRAM FOR THE INDIVIDUAL
23 EXCHANGE.

24 (2) UNDER THE PROGRAM, THE EXCHANGE SHALL:

25 (I) PROVIDE AN AUTHORIZATION TO SELL QUALIFIED
26 HEALTH PLANS AND QUALIFIED DENTAL PLANS TO A LICENSED INSURANCE
27 PRODUCER WHO MEETS THE REQUIREMENTS IN SUBSECTION (J) OF THIS
28 SECTION; AND

29 (II) REQUIRE RENEWAL OF AN AUTHORIZATION EVERY 2
30 YEARS.

1 **(3) (I) SUBJECT TO THE CONTESTED CASE HEARING**
2 **PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE,**
3 **THE EXCHANGE MAY DENY, SUSPEND, REVOKE, OR REFUSE TO RENEW AN**
4 **AUTHORIZATION FOR GOOD CAUSE, WHICH SHALL INCLUDE A FINDING THAT**
5 **THE INSURANCE PRODUCER HOLDING THE AUTHORIZATION HAS:**

6 **1. MADE A MATERIAL MISSTATEMENT IN THE**
7 **APPLICATION FOR THE AUTHORIZATION;**

8 **2. ENGAGED IN FRAUDULENT OR DISHONEST**
9 **PRACTICES IN CONDUCTING ACTIVITIES UNDER THE AUTHORIZATION;**

10 **3. MATERIALLY MISREPRESENTED THE PROVISIONS**
11 **OF A QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL PLAN; OR**

12 **4. COMMITTED ANY ACT IN VIOLATION OF**
13 **SUBSECTION (H) OF THIS SECTION.**

14 **(II) THE INDIVIDUAL EXCHANGE SHALL NOTIFY THE**
15 **COMMISSIONER OF ANY DECISION AFFECTING THE STATUS OF AN INSURANCE**
16 **PRODUCER'S AUTHORIZATION.**

17 **(4) THE INDIVIDUAL EXCHANGE, IN CONSULTATION WITH THE**
18 **COMMISSIONER, SHALL ADOPT REGULATIONS TO CARRY OUT THIS SUBSECTION.**

19 **(J) (1) SUBJECT TO THE REQUIREMENTS IN PARAGRAPH (2) OF THIS**
20 **SUBSECTION, AN INSURANCE PRODUCER WHO IS LICENSED IN THE STATE AND**
21 **AUTHORIZED BY THE COMMISSIONER TO SELL, SOLICIT, OR NEGOTIATE HEALTH**
22 **INSURANCE MAY SELL ANY QUALIFIED HEALTH PLAN OR QUALIFIED DENTAL**
23 **PLAN OFFERED IN THE INDIVIDUAL EXCHANGE WITHOUT BEING SEPARATELY**
24 **LICENSED AS AN INDIVIDUAL EXCHANGE NAVIGATOR.**

25 **(2) TO SELL QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL**
26 **PLANS IN THE INDIVIDUAL EXCHANGE, AN INSURANCE PRODUCER SHALL:**

27 **(I) REGISTER AND APPLY FOR AN AUTHORIZATION FROM**
28 **THE EXCHANGE;**

29 **(II) COMPLETE AND COMPLY WITH ANY ONGOING**
30 **REQUIREMENTS OF THE TRAINING PROGRAM ESTABLISHED UNDER**
31 **SUBSECTION (K) OF THIS SECTION; AND**

1 (III) REFER INDIVIDUALS SEEKING INSURANCE WHO MAY BE
2 ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE
3 MARYLAND CHILDREN'S HEALTH PROGRAM TO THE NAVIGATOR PROGRAM FOR
4 THE INDIVIDUAL EXCHANGE.

5 (3) AN INSURANCE PRODUCER:

6 (I) MAY NOT BE COMPENSATED BY THE INDIVIDUAL
7 EXCHANGE FOR THE SALE OF A QUALIFIED HEALTH PLAN OR A QUALIFIED
8 DENTAL PLAN OFFERED IN THE INDIVIDUAL EXCHANGE; AND

9 (II) SHALL BE COMPENSATED DIRECTLY BY A CARRIER.

10 (K) (1) THE EXCHANGE SHALL DEVELOP, IMPLEMENT, AND, AS
11 APPROPRIATE, UPDATE A TRAINING PROGRAM FOR INSURANCE PRODUCERS
12 WHO SELL QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS IN THE
13 INDIVIDUAL EXCHANGE.

14 (2) THE TRAINING PROGRAM SHALL:

15 (I) IMPART THE SKILLS AND EXPERTISE NECESSARY TO
16 PERFORM FUNCTIONS SPECIFIC TO THE INDIVIDUAL EXCHANGE, SUCH AS
17 MAKING PREMIUM ASSISTANCE ELIGIBILITY DETERMINATIONS;

18 (II) ENABLE THE EXCHANGE TO PROVIDE ROBUST
19 PROTECTION OF CONSUMERS AND ADHERENCE TO HIGH QUALITY ASSURANCE
20 STANDARDS; AND

21 (III) BE APPROVED BY THE COMMISSIONER.

22 31-114.

23 (A) NOTHING IN THIS TITLE REQUIRES THE MARYLAND MEDICAL
24 ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM TO
25 PROVIDE ANY SPECIFIC FINANCIAL SUPPORT TO THE INDIVIDUAL EXCHANGE
26 FOR THE SERVICES PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR.

27 (B) THE FINANCING ARRANGEMENTS BETWEEN THE INDIVIDUAL
28 EXCHANGE, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE
29 MARYLAND CHILDREN'S HEALTH PROGRAM SHALL BE GOVERNED BY A
30 MEMORANDUM OF AGREEMENT BETWEEN THE EXCHANGE AND THE
31 DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

1 [31-109.] **31-115.**

2 (a) The Exchange shall certify:

3 (1) health benefit plans as qualified health plans; AND

4 (2) **DENTAL PLANS AS QUALIFIED DENTAL PLANS, WHICH MAY BE**
5 **OFFERED BY CARRIERS AS:**

6 (I) **STAND-ALONE DENTAL PLANS; OR**

7 (II) **DENTAL PLANS BUNDLED WITH QUALIFIED HEALTH**
8 **PLANS.**

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

10 (1) except as provided in subsection (c) of this section, provide the
11 essential **HEALTH** benefits [package] required under § 1302(a) of the Affordable Care
12 Act **AND § 31-116 OF THIS TITLE;**

13 (2) obtain prior approval of premium rates and contract language from
14 the Commissioner;

15 (3) except as provided in subsection (d) of this section, provide at least
16 a bronze level of coverage, as defined in the Affordable Care Act and determined by
17 the Exchange under § 31-108(b)(7)(ii) of this title;

18 (4) (i) ensure that its cost-sharing requirements do not exceed the
19 limits established under § 1302(c)(1) of the Affordable Care Act; and

20 (ii) if the health benefit plan is offered through the SHOP
21 Exchange, ensure that the health benefit plan's deductible does not exceed the limits
22 established under § 1302(c)(2) of the Affordable Care Act;

23 (5) be offered by a carrier that:

24 (i) is licensed and in good standing to offer health insurance
25 coverage in the State;

26 (ii) if the carrier participates in the **INDIVIDUAL** Exchange's
27 individual market, offers at least one qualified health plan at the silver level and one
28 at the gold level in the individual market outside the Exchange;

29 (iii) if the carrier participates in the SHOP Exchange, offers at
30 least one qualified health plan at the silver level and one at the gold level in the small
31 group market outside the SHOP Exchange;

1 (iv) charges the same premium rate for each qualified health
2 plan regardless of whether the qualified health plan is offered through the Exchange,
3 through an insurance producer outside the Exchange, or directly from a carrier;

4 (v) does not charge any cancellation fees or penalties in
5 violation of § 31–108(c) of this title; and

6 (vi) complies with the regulations adopted by the Secretary
7 under § 1311(d) of the Affordable Care Act and by the Exchange under § 31–106(c)(4)
8 of this title;

9 (6) meet the requirements for certification established under the
10 regulations adopted by:

11 (i) the Secretary under § 1311(c)(1) of the Affordable Care Act,
12 including minimum standards for marketing practices, network adequacy, essential
13 community providers in underserved areas, accreditation, quality improvement,
14 uniform enrollment forms and descriptions of coverage, and information on quality
15 measures for health plan performance; and

16 (ii) the Exchange under § 31–106(c)(4) of this title;

17 (7) be in the interest of qualified individuals and qualified employers,
18 as determined by the Exchange;

19 (8) provide any other benefits as may be required by the
20 Commissioner under any applicable State law or regulation; and

21 (9) meet any other requirements established by the Exchange under
22 this title, **INCLUDING:**

23 **(I) TRANSITION OF CARE LANGUAGE IN CONTRACTS AS**
24 **DETERMINED APPROPRIATE BY THE EXCHANGE TO ENSURE CARE CONTINUITY**
25 **AND REDUCE DUPLICATION AND COSTS OF CARE; AND**

26 **(II) CRITERIA THAT ENCOURAGE AND SUPPORT QUALIFIED**
27 **HEALTH PLANS AND QUALIFIED DENTAL PLANS IN FACILITATING**
28 **CROSS-BORDER ENROLLMENT.**

29 (c) A qualified health plan is not required to provide essential benefits that
30 duplicate the minimum benefits of qualified dental plans, as provided in subsection (g)
31 of this section, if:

32 (1) the Exchange has determined that at least one qualified dental
33 plan is available to supplement the qualified health plan's coverage; and

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

3 (i) the plan does not provide the full range of essential pediatric
4 benefits; and

5 (ii) qualified dental plans providing these and other dental
6 benefits also not provided by the qualified health plan are offered through the
7 Exchange.

8 (d) A qualified health plan is not required to provide at least a bronze level of
9 coverage under subsection (b)(3) of this section if the qualified health plan:

10 (1) meets the requirements and is certified as a qualified catastrophic
11 plan as provided under the Affordable Care Act; and

12 (2) will be offered only to individuals eligible for catastrophic coverage.

13 (e) A health benefit plan may not be denied certification:

14 (1) solely on the grounds that the health benefit plan is a
15 fee-for-service plan;

16 (2) through the imposition of premium price controls by the Exchange;
17 or

18 (3) solely on the grounds that the health benefit plan provides
19 treatments necessary to prevent patients' deaths in circumstances the Exchange
20 determines are inappropriate or too costly.

21 (f) In addition to other rate filing requirements that may be applicable
22 under this article, each carrier seeking certification of a health benefit plan shall:

23 (1) (i) submit to the Exchange [a justification for] **NOTICE OF** any
24 premium increase before implementation of the increase; and

25 (ii) post the increase on the carrier's Web site;

26 (2) submit to the Exchange, the Secretary, and the Commissioner, and
27 make available to the public, in plain language as required under § 1311(e)(3)(b) of the
28 Affordable Care Act, accurate and timely disclosure of:

29 (i) claims payment policies and practices;

30 (ii) financial disclosures;

1 (iii) data on enrollment, disenrollment, number of claims denied,
2 and rating practices;

3 (iv) information on cost-sharing and payments with respect to
4 out-of-network coverage;

5 (v) information on enrollee and participant rights under Title I
6 of the Affordable Care Act; and

7 (vi) any other information as determined appropriate by the
8 Secretary and the Exchange; and

9 (3) make available information about costs an individual would incur
10 under the individual's health benefit plan for services provided by a participating
11 health care provider, including cost-sharing requirements such as deductibles,
12 co-payments, and coinsurance, in a manner determined by the Exchange.

13 (g) (1) Except as provided in paragraphs (2), (3), [and] (4), AND (5) of this
14 subsection, the requirements applicable to qualified health plans under this title also
15 shall apply to qualified dental plans.

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

18 (3) A qualified dental plan shall:

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

22 (ii) include at a minimum:

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

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

27 (4) Carriers jointly may offer a comprehensive plan through the
28 Exchange in which dental benefits are provided by a carrier through a qualified dental
29 plan and other benefits are provided by a carrier through a qualified health plan,
30 provided that the plans are priced separately and made available for purchase
31 separately at the same price as when offered jointly.

32 (5) THE EXCHANGE MAY ESTABLISH ADDITIONAL
33 REQUIREMENTS FOR QUALIFIED DENTAL PLANS IN CONJUNCTION WITH ITS

1 ESTABLISHMENT OF ADDITIONAL REQUIREMENTS FOR QUALIFIED HEALTH
2 PLANS UNDER SUBSECTION (B)(9) OF THIS SECTION.

3 31-116.

4 (A) THE ESSENTIAL HEALTH BENEFITS REQUIRED UNDER § 1302(A) OF
5 THE AFFORDABLE CARE ACT:

6 (1) SHALL BE THE BENEFITS IN THE STATE BENCHMARK PLAN,
7 SELECTED IN ACCORDANCE WITH THIS SECTION; AND

8 (2) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, SHALL
9 BE THE BENEFITS REQUIRED IN:

10 (I) ALL HEALTH BENEFIT PLANS, EXCEPT FOR
11 GRANDFATHERED PLANS AS DEFINED IN THE AFFORDABLE CARE ACT,
12 OFFERED IN THE INDIVIDUAL AND SMALL GROUP MARKET OUTSIDE THE
13 EXCHANGE; AND

14 (II) ALL QUALIFIED HEALTH PLANS OFFERED IN THE
15 EXCHANGE.

16 (B) IN SELECTING THE STATE BENCHMARK PLAN, THE STATE SEEKS
17 TO:

18 (1) BALANCE COMPREHENSIVENESS OF BENEFITS WITH PLAN
19 AFFORDABILITY TO PROMOTE OPTIMAL ACCESS TO CARE FOR ALL RESIDENTS
20 OF THE STATE;

21 (2) ACCOMMODATE TO THE EXTENT PRACTICABLE THE DIVERSE
22 HEALTH NEEDS ACROSS THE DIVERSE POPULATIONS WITHIN THE STATE; AND

23 (3) ENSURE THE BENEFIT OF INPUT FROM THE STAKEHOLDERS
24 AND THE PUBLIC.

25 (C) (1) THE STATE BENCHMARK PLAN SHALL BE SELECTED BY THE
26 MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL THROUGH AN
27 OPEN, TRANSPARENT, AND INCLUSIVE PROCESS.

28 (2) ANY ACTION OF THE COUNCIL MAY BE TAKEN ONLY BY THE
29 AFFIRMATIVE VOTE OF AT LEAST NINE MEMBERS OF THE MARYLAND HEALTH
30 CARE REFORM COORDINATING COUNCIL.

1 **(3) IN SELECTING THE STATE BENCHMARK PLAN, THE**
2 **MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL MAY EXCLUDE:**

3 **(I) A HEALTH CARE SERVICE, BENEFIT, COVERAGE, OR**
4 **REIMBURSEMENT FOR COVERED HEALTH CARE SERVICES THAT IS REQUIRED**
5 **UNDER THIS ARTICLE OR THE HEALTH – GENERAL ARTICLE TO BE PROVIDED**
6 **OR OFFERED IN A HEALTH BENEFIT PLAN THAT IS ISSUED OR DELIVERED IN**
7 **THE STATE BY A CARRIER; OR**

8 **(II) REIMBURSEMENT REQUIRED BY STATUTE, BY A HEALTH**
9 **BENEFIT PLAN FOR A SERVICE WHEN THAT SERVICE IS PERFORMED BY A**
10 **HEALTH CARE PROVIDER WHO IS LICENSED UNDER THE HEALTH OCCUPATIONS**
11 **ARTICLE AND WHOSE SCOPE OF PRACTICE INCLUDES THAT SERVICE.**

12 **(4) IN SELECTING THE STATE BENCHMARK PLAN, THE**
13 **MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL SHALL:**

14 **(I) OBTAIN GUIDANCE NECESSARY TO:**

15 **1. DETERMINE THE 10 HEALTH BENEFIT PLANS**
16 **DEEMED ELIGIBLE BY THE SECRETARY TO BE THE STATE BENCHMARK PLAN;**
17 **AND**

18 **2. CONDUCT A COMPARATIVE ANALYSIS OF THE**
19 **BENEFITS OF EACH PLAN; AND**

20 **(II) SOLICIT THE INPUT OF STAKEHOLDERS IN THE STATE**
21 **AND MEMBERS OF THE PUBLIC BY:**

22 **1. APPOINTING AND CONSULTING WITH AN**
23 **ADVISORY GROUP MADE UP OF A DIVERSE AND REPRESENTATIVE**
24 **CROSS-SECTION OF STAKEHOLDERS; AND**

25 **2. ESTABLISHING A MECHANISM FOR MEMBERS OF**
26 **THE PUBLIC TO PROVIDE COMMENT.**

27 **(5) ON OR BEFORE SEPTEMBER 30, 2012, THE MARYLAND**
28 **HEALTH CARE REFORM COORDINATING COUNCIL SHALL SELECT THE STATE**
29 **BENCHMARK PLAN FOR COVERAGE BEGINNING JANUARY 1, 2014.**

30 **31-117.**

1 **(A) THE EXCHANGE, WITH THE APPROVAL OF THE COMMISSIONER,**
2 **SHALL IMPLEMENT OR OVERSEE THE IMPLEMENTATION OF THE**
3 **STATE-SPECIFIC REQUIREMENTS OF §§ 1341 AND 1343 OF THE AFFORDABLE**
4 **CARE ACT RELATING TO TRANSITIONAL REINSURANCE AND RISK ADJUSTMENT.**

5 **(B) THE EXCHANGE MAY NOT ASSUME RESPONSIBILITY FOR THE**
6 **PROGRAM CORRIDORS FOR HEALTH BENEFIT PLANS IN THE INDIVIDUAL**
7 **EXCHANGE AND THE SHOP EXCHANGE ESTABLISHED UNDER § 1342 OF THE**
8 **AFFORDABLE CARE ACT.**

9 **(C) (1) IN COMPLIANCE WITH § 1341 OF THE AFFORDABLE CARE**
10 **ACT, THE EXCHANGE, IN CONSULTATION WITH THE MARYLAND HEALTH CARE**
11 **COMMISSION AND WITH THE APPROVAL OF THE COMMISSIONER, SHALL**
12 **OPERATE OR OVERSEE THE OPERATION OF A TRANSITIONAL REINSURANCE**
13 **PROGRAM IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE SECRETARY**
14 **FOR COVERAGE YEARS 2014 THROUGH 2016.**

15 **(2) AS REQUIRED BY THE AFFORDABLE CARE ACT AND**
16 **REGULATIONS ADOPTED BY THE SECRETARY, THE TRANSITIONAL**
17 **REINSURANCE PROGRAM SHALL BE DESIGNED TO PROTECT CARRIERS THAT**
18 **OFFER INDIVIDUAL HEALTH BENEFIT PLANS INSIDE AND OUTSIDE THE**
19 **EXCHANGE AGAINST EXCESSIVE HEALTH CARE EXPENSES INCURRED BY**
20 **HIGH-RISK INDIVIDUALS.**

21 **(D) (1) IN COMPLIANCE WITH § 1343 OF THE AFFORDABLE CARE**
22 **ACT, THE EXCHANGE, WITH THE APPROVAL OF THE COMMISSIONER, SHALL**
23 **OPERATE OR OVERSEE THE OPERATION OF A RISK ADJUSTMENT PROGRAM**
24 **DESIGNED TO:**

25 **(I) REDUCE THE INCENTIVE FOR CARRIERS TO MANAGE**
26 **THEIR RISK BY SEEKING TO ENROLL INDIVIDUALS WITH A LOWER THAN**
27 **AVERAGE HEALTH RISK;**

28 **(II) INCREASE THE INCENTIVE FOR CARRIERS TO ENHANCE**
29 **THE QUALITY AND COST-EFFECTIVENESS OF THEIR ENROLLEES' HEALTH CARE**
30 **SERVICES; AND**

31 **(III) REQUIRE APPROPRIATE ADJUSTMENTS AMONG ALL**
32 **HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL GROUP MARKETS**
33 **INSIDE AND OUTSIDE THE EXCHANGE TO COMPENSATE FOR THE ENROLLMENT**
34 **OF HIGH-RISK INDIVIDUALS.**

1 **(2) BEGINNING IN 2014, THE EXCHANGE, WITH THE APPROVAL**
2 **OF THE SECRETARY, SHALL STRONGLY CONSIDER USING THE FEDERAL MODEL**
3 **ADOPTED BY THE SECRETARY IN THE OPERATION OF THE STATE'S RISK**
4 **ADJUSTMENT PROGRAM.**

5 **[31-111.] 31-119.**

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

7 (1) prevent discrimination;

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

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

11 (4) promote financial integrity.

12 **(B) (1) THE EXCHANGE SHALL ESTABLISH A FULL-SCALE FRAUD,**
13 **WASTE, AND ABUSE DETECTION AND PREVENTION PROGRAM DESIGNED TO:**

14 **(I) ENSURE THE EXCHANGE'S COMPLIANCE WITH FEDERAL**
15 **AND STATE LAWS FOR THE DETECTION AND PREVENTION OF FRAUD, WASTE,**
16 **AND ABUSE, INCLUDING WHISTLEBLOWER AND CONFIDENTIALITY**
17 **PROTECTIONS AND FEDERAL ANTI-KICKBACK PROHIBITIONS; AND**

18 **(II) PROMOTE TRANSPARENCY, CREDIBILITY, AND TRUST**
19 **ON THE PART OF THE PUBLIC IN THE INTEGRITY OF ITS OPERATIONS.**

20 **(2) THE FRAUD, WASTE, AND ABUSE DETECTION AND**
21 **PREVENTION PROGRAM SHALL:**

22 **(I) ESTABLISH A FRAMEWORK FOR INTERNAL CONTROLS;**

23 **(II) IDENTIFY CONTROL CYCLES;**

24 **(III) CONDUCT RISK ASSESSMENTS;**

25 **(IV) DOCUMENT PROCESSES; AND**

26 **(V) IMPLEMENT CONTROLS.**

27 **(3) THE EXCHANGE:**

1 **(I) SHALL, IN ACCORDANCE WITH § 2-1246 OF THE STATE**
2 **GOVERNMENT ARTICLE, SUBMIT ITS PLAN FOR THE FRAUD, WASTE, AND ABUSE**
3 **DETECTION AND PREVENTION PROGRAM TO THE SENATE FINANCE COMMITTEE**
4 **AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE; AND**

5 **(II) SHALL ALLOW THE COMMITTEES 60 DAYS FOR REVIEW**
6 **AND COMMENT BEFORE ESTABLISHING THE PROGRAM.**

7 **[(b)] (C)** The Exchange shall keep an accurate accounting of all its
8 activities, expenditures, and receipts.

9 **[(c)] (D)** (1) On or before December 1 of each year, the Board shall
10 forward to the Secretary, the Governor, and, in accordance with § 2-1246 of the State
11 Government Article, the General Assembly, a report on the activities, expenditures,
12 and receipts of the Exchange.

13 (2) The report shall:

14 (i) be in the standardized format required by the Secretary;

15 (ii) include data regarding:

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

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

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

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

25 (iii) include data to identify disparities related to gender, race,
26 ethnicity, geographic location, language, disability, or other attributes of special
27 populations; **AND**

28 **(IV) INCLUDE INFORMATION ON ITS FRAUD, WASTE, AND**
29 **ABUSE DETECTION AND PREVENTION PROGRAM.**

30 **[(d)] (E)** The Board shall cooperate fully with any investigation into the
31 affairs of the Exchange, including making available for examination the records of the
32 Exchange, conducted by:

1 (1) the Secretary under the Secretary's authority under the Affordable
2 Care Act; and

3 (2) the Commissioner under the Commissioner's authority to regulate
4 the sale and purchase of insurance in the State.

5 SECTION 3. AND BE IT FURTHER ENACTED, That, on or before December 1,
6 2015, the Maryland Health Benefit Exchange, in consultation with the Maryland
7 Insurance Administration, shall conduct a study and report its findings and
8 recommendations to the Governor and, in accordance with § 2-1246 of the State
9 Government Article, the General Assembly, on:

10 (1) whether the State should develop a Maryland-specific risk
11 adjustment program that would provide more effective protection than the federal
12 model against adverse risk selection that could threaten the viability of the Maryland
13 Health Benefit Exchange and the affordability of its plan offerings; and

14 (2) if so, how the Maryland risk adjustment program should be
15 designed and when it should be implemented.

16 SECTION 4. AND BE IT FURTHER ENACTED, That:

17 (a) There is joint legislative and executive committee that consists of the
18 following members:

19 (1) the chair of the Maryland Health Benefit Exchange and two
20 additional members of its Board to be selected by the chair;

21 (2) the Maryland Insurance Commissioner;

22 (3) the Secretary of Budget and Management;

23 (4) the chair of the Health Services Cost Review Commission or the
24 chair's designee;

25 (5) the chair of the Maryland Health Care Commission or the chair's
26 designee;

27 (6) two members of the Senate, appointed by the President of the
28 Senate; and

29 (7) two members of the House of Delegates, appointed by the Speaker
30 of the House.

31 (b) On or before December 1, 2012, the joint legislative and executive
32 committee, in consultation with the Maryland Health Benefit Exchange, its Financing
33 and Sustainability Advisory Committee established under § 31-106(c)(6) of the

1 Insurance Article, and other stakeholders, shall conduct a study and report its
2 findings and recommendations to the Governor and, in accordance with § 2–1246 of
3 the State Government Article, the General Assembly, on the financing mechanisms
4 which should be used to enable the Exchange to be self–sustaining by 2015. The study
5 and report shall:

6 (1) build on the recommendations of the 2011 Report and
7 Recommendations of Maryland Health Benefit Exchange and the 2011 report of the
8 Finance and Sustainability Advisory Committee of the Exchange;

9 (2) examine a combination of funding mechanisms for the Exchange
10 with the goal of developing an approach that will:

11 (i) ensure a stable revenue stream;

12 (ii) allow the Exchange to adjust revenue levels to accommodate
13 fluctuations in enrollment and other factors affecting its fixed and variable costs; and

14 (iii) rely on:

15 1. a consistent, broad–based assessment that can be
16 adjusted to scale in order to reduce the Exchange’s vulnerability to enrollment
17 fluctuations; and

18 2. additional funding from transaction fees;

19 (3) consider existing broad–based financing of health programs such
20 as the Maryland Health Care Commission’s assessments on health care industry
21 sectors;

22 (4) consider whether an assessment or transaction fee cap, formula, or
23 other mechanism should be used to align the revenues and expenditures of the
24 Exchange; and

25 (5) develop recommendations on the specific mechanisms that should
26 be used to finance the Exchange for consideration by the General Assembly during the
27 2013 session.

28 SECTION 5. AND BE IT FURTHER ENACTED, That, on or before December 1,
29 2015, the Maryland Health Benefit Exchange, in consultation with its advisory
30 committees established under § 31–106(c)(6) of the Insurance Article, and with other
31 stakeholders, shall conduct a study and report its findings and recommendations to
32 the Governor and, in accordance with § 2–1246 of the State Government Article, the
33 General Assembly, on whether the Exchange should remain an independent public
34 body or should become a nongovernmental, nonprofit entity.

1 SECTION 6. AND BE IT FURTHER ENACTED, That, on or before December 1,
2 2016, the Maryland Health Benefit Exchange, in consultation with its advisory
3 committees established under § 31-106(c)(6) of the Insurance Article, and with other
4 stakeholders, shall conduct a study and report its findings and recommendations to
5 the Governor and, in accordance with § 2-1246 of the State Government Article, the
6 General Assembly, on whether to continue to maintain separate small group and
7 individual markets or to merge the two markets.

8 SECTION 7. AND BE IT FURTHER ENACTED, That, on or before December 1,
9 2012, the Maryland Health Benefit Exchange, in consultation with its advisory
10 committees established under § 31-106(c)(6) of the Insurance Article, and with other
11 stakeholders, shall conduct a study, including a cost benefit analysis, and report its
12 findings and recommendations to the Governor and, in accordance with § 2-1246 of
13 the State Government Article, the General Assembly, of the establishment of
14 requirements for continuity of care in the State's health insurance markets, including:

15 (1) the Maryland Medical Assistance Program and the Maryland
16 Children's Health Program; and

17 (2) health benefit plans offered in the individual and small group
18 markets, both inside and outside the Maryland Health Benefit Exchange.

19 SECTION 8. AND BE IT FURTHER ENACTED, That this Act shall take effect
20 June 1, 2012.