SENATE BILL 238

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By: **The President (By Request – Administration) and Senators King, Madaleno, Manno, Montgomery, Peters, Pinsky, Pugh, Raskin, Robey, and Rosapepe**

Introduced and read first time: January 20, 2012
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

Maryland Health Benefit Exchange Act of 2012

FOR the purpose of requiring the Maryland Health Benefit Exchange to make certain qualified dental plans available to certain individuals and employers in a certain manner and on or before a certain date; requiring the Exchange to establish and implement certain navigator programs; authorizing the Exchange to enter into certain agreements or memoranda of understanding with another state under certain circumstances; requiring the Exchange to seek to achieve a certain enrollment and use a certain market impact to pursue certain objectives; authorizing the Exchange to employ certain alternative contracting options and active purchasing strategies under certain circumstances; providing that the SHOP Exchange shall be a separate insurance market within the Exchange for small employers and may not be merged with the individual market of the Individual Exchange; requiring the SHOP Exchange to be designed in a certain manner; requiring the SHOP Exchange to allow qualified employers to designate a certain coverage level or carrier for a certain purpose; authorizing the SHOP Exchange to reassess and modify the design of the SHOP Exchange under certain circumstances; establishing certain navigator programs for the SHOP Exchange and the Individual Exchange; establishing certain requirements for the navigator programs; authorizing a SHOP Exchange navigator and an Individual Exchange navigator to take certain actions; establishing certain duties of a SHOP Exchange navigator and an Individual Exchange navigator; prohibiting a SHOP Exchange navigator and an Individual Exchange navigator from taking certain actions; establishing a certain licensing process and qualifications for SHOP Exchange navigators; requiring the SHOP Exchange and the Exchange to establish and administer certain insurance producer authorization programs; requiring the SHOP Exchange and the Exchange to develop, implement, and update certain training programs; 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.

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

BY renumbering
Article – Insurance
Section 31–110
to be Section 31–118
Annotated Code of Maryland
(2011 Replacement Volume)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1204, 15–1303, 31–101, 31–102(d), 31–108, 31–109, and 31–111
Annotated Code of Maryland
(2011 Replacement Volume)

BY adding to

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

Preamble

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

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

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

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

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

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

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

WHEREAS, These guiding principles are intended to ensure that the Exchange's policies, functions, and operations (1) make health care coverage more accessible to 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 system to support the Exchange's stability; (5) address longstanding

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

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

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

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

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

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

Article – Insurance

15–1204.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the additional benefits:

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

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

(2) the carrier:

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

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

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

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

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

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

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

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

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

15–1303.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) the Maryland Health Insurance Plan with:

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

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

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

31–101.

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

(B) "ACTUARIAL VALUE" MEANS THE RATIO OF PLAN CLAIM COSTS AFTER APPLYING ALL COST SHARING PARAMETERS TO TOTAL CLAIM COSTS PRIOR TO APPLICATION OF COST SHARING PARAMETERS.

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

[(c)**] (D)** "Board" means the Board of Trustees of the Exchange.

[(d)**] (E)** "Carrier" means:

(1) an insurer authorized to sell health insurance;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

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

(F) "COVERAGE LEVEL" MEANS A DESIGNATION THAT A QUALIFIED HEALTH PLAN'S ACTUARIAL VALUE AS DETERMINED BY THE COMMISSIONER ACCOUNTS FOR 60%, 70%, 80%, OR 90% OF TOTAL CLAIM COSTS.

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

(2) "EXCHANGE" INCLUDES:

(I) THE INDIVIDUAL EXCHANGE; AND

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

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

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

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

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

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

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

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit–only insurance;

(vii) coverage for on–site medical clinics; or

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

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

(i) limited scope dental or vision benefits;

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

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

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

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

(ii) hospital indemnity or other fixed indemnity insurance.

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

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

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

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

(J) "INDIVIDUAL EXCHANGE" MEANS THE DIVISION OF THE EXCHANGE THAT SERVES THE INDIVIDUAL HEALTH INSURANCE MARKET.

(K) "INDIVIDUAL EXCHANGE NAVIGATOR" MEANS AN INDIVIDUAL WHO:

(1) HOLDS AN INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION; AND

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

(L) "INDIVIDUAL EXCHANGE NAVIGATOR ENTITY" MEANS A COMMUNITY–BASED ORGANIZATION OR OTHER ENTITY ENGAGED BY THE INDIVIDUAL EXCHANGE WHICH EMPLOYS OR ENGAGES CERTIFIED INDIVIDUAL EXCHANGE NAVIGATORS TO PERFORM THE FUNCTIONS IN § 31–113(C) OF THIS TITLE.

(M) "INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION" MEANS A CERTIFICATE ISSUED BY THE INDIVIDUAL EXCHANGE THAT AUTHORIZES AN INDIVIDUAL TO ACT AS AN INDIVIDUAL EXCHANGE NAVIGATOR.

(N) "INSURANCE PRODUCER AUTHORIZATION" MEANS A PERMIT ISSUED BY THE SHOP EXCHANGE OR INDIVIDUAL EXCHANGE TO ALLOW AN INSURANCE PRODUCER TO SELL QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS IN THE SHOP EXCHANGE OR INDIVIDUAL EXCHANGE.

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

(P) "MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL" MEANS THE JOINT EXECUTIVE–LEGISLATIVE COUNCIL ESTABLISHED AND EXPANDED BY EXECUTIVE ORDERS 01.01.2010.07 AND 01.01.2011.10.

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

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

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

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

[(k)**] (S)** "Qualified health plan" means a health benefit plan that has been certified by the Exchange to meet the criteria for certification described in § 1311(c) of the Affordable Care Act and **[**§ 31–109**] § 31–115** of this title.

[(l)**] (T)** "Qualified individual" means an individual, including a minor, who at the time of enrollment:

(1) is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) resides in the State;

(3) is not incarcerated, other than incarceration pending disposition of charges; and

(4) is, and reasonably is expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

[(m)**] (U)** "Secretary" means the Secretary of the federal Department of Health and Human Services.

[(n)**] (V)** "SHOP Exchange" means the small business health options program authorized under § 31–108(b)(12) of this title.

(W) "SHOP EXCHANGE NAVIGATOR" MEANS AN INDIVIDUAL ENGAGED BY THE SHOP EXCHANGE TO PERFORM THE FUNCTIONS SET FORTH IN § 31–112(C)(1) OF THIS TITLE.

(X) "SHOP EXCHANGE NAVIGATOR LICENSE" MEANS A LICENSE ISSUED BY THE COMMISSIONER THAT AUTHORIZES AN INDIVIDUAL TO CARRY OUT THE FUNCTIONS SET FORTH IN § 31–112(C) OF THIS TITLE IN THE SHOP EXCHANGE.

[(o)**] (Y)** (1) "Small employer" means an employer that, during the preceding calendar year, employed an average of not more than:

(i) 50 employees if the preceding calendar year ended on or before January 1, 2016; and

(ii) 100 employees if the preceding calendar year ended after January 1, 2016.

(2) For purposes of this subsection:

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

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

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

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

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

(Z) "STATE BENCHMARK PLAN" MEANS THE HEALTH BENEFIT PLAN DESIGNATED BY THE STATE, UNDER REGULATIONS ADOPTED BY THE SECRETARY, TO SERVE AS THE STANDARD FOR THE ESSENTIAL HEALTH BENEFITS TO BE OFFERED BY:

(1) QUALIFIED HEALTH PLANS INSIDE THE EXCHANGE; AND

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

31–102.

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

(1) preempt or supersede:

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

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

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

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

31–108.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The Exchange may not make available:

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

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

31–109.

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

(1) DEVELOP JOINT OR RECIPROCAL CERTIFICATION PROCESSES;

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

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

(I) CERTIFICATION OF QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS; AND

(II) OTHER FUNCTIONS OF THE EXCHANGE.

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

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

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

31–110.

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

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

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

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

(1) THE IMPORTANCE OF SUFFICIENT ENROLLMENT AND CARRIER PARTICIPATION TO ENSURE THE EXCHANGE'S SUCCESS AND LONG–TERM VIABILITY; AND

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

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

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

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

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

(1) COMPETITIVE BIDDING;

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

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

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

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

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

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; AND

(3) THE DESIRABILITY OF PROVIDING EMPLOYEES WITH A MEANINGFUL CHOICE AMONG HIGH–QUALITY AND AFFORDABLE 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 AND A MENU OF QUALIFIED HEALTH PLANS OFFERED BY THE CARRIER IN THE SHOP EXCHANGE FROM WHICH THEIR EMPLOYEES MAY CHOOSE.

(D) 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; AND

(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.

31–112.

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

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

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

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

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

(I) CONDUCT EDUCATION AND OUTREACH TO SMALL EMPLOYERS;

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

1. OPTIONS WITH RESPECT TO EMPLOYER AND EMPLOYEE CHOICE;

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

3. THE AVAILABILITY OF APPLICABLE TAX CREDITS;

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

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

(V) CONDUCT TAX CREDIT ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS;

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

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

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

(2) A SHOP EXCHANGE NAVIGATOR MAY NOT:

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

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

(3) A SHOP EXCHANGE NAVIGATOR:

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

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

(III) SHALL BE ENGAGED BY THE SHOP EXCHANGE;

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

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

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

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

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

(I) SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;

(II) SHALL BE AT LEAST 18 YEARS OLD;

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

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

(3) THE COMMISSIONER SHALL ADOPT REGULATIONS THAT GOVERN:

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

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

(III) THE REINSTATEMENT OF AN EXPIRED LICENSE.

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

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

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

(III) HAS ENGAGED IN FRAUDULENT OR DISHONEST PRACTICES;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) AN INSURANCE PRODUCER:

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

(II) SHALL BE COMPENSATED DIRECTLY BY A CARRIER.

(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 HEALTH PLANS AND QUALIFIED DENTAL PLANS IN THE SHOP EXCHANGE.

(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 TO PROVIDE ROBUST PROTECTION OF CONSUMERS AND ADHERENCE TO HIGH QUALITY ASSURANCE STANDARDS.

31–113.

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

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

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

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

(I) ARE FAMILIAR WITH VULNERABLE AND HARD–TO–REACH POPULATIONS; AND

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

(3) ENABLE THE INDIVIDUAL EXCHANGE TO:

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

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

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

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

(1) CONDUCT EDUCATION AND OUTREACH TO INDIVIDUALS;

(2) DISTRIBUTE INFORMATION ABOUT:

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

(II) ELIGIBILITY REQUIREMENTS FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(III) PROCEDURES FOR ENROLLING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE MARYLAND CHILDREN'S HEALTH PROGRAM, OR QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS OFFERED IN THE EXCHANGE;

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

(4) FACILITATE ELIGIBILITY DETERMINATIONS FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM, SELECTION OF MANAGED CARE ORGANIZATIONS, APPLICATION PROCESSES, ENROLLMENT, AND DISENROLLMENT;

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

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

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

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

(D) AN INDIVIDUAL EXCHANGE NAVIGATOR:

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

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

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

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

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

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

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

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

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

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

(E) (1) THE EXCHANGE:

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

(II) IN CONSULTATION WITH THE COMMISSIONER, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE MARYLAND CHILDREN'S HEALTH PROGRAM, SHALL ADOPT REGULATIONS TO IMPLEMENT THIS SUBSECTION; AND

(III) MAY IMPLEMENT THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION PROGRAM WITH THE ASSISTANCE OF THE COMMISSIONER, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE MARYLAND CHILDREN'S HEALTH PROGRAM, IN ACCORDANCE WITH ONE OR MORE MEMORANDA OF UNDERSTANDING.

(2) THE COMMISSIONER MAY REQUIRE THAT THE INDIVIDUAL EXCHANGE:

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

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

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

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

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

(I) SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;

(II) SHALL BE AT LEAST 18 YEARS OLD;

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

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

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

(2) THE TRAINING PROGRAM SHALL:

(I) AFFORD INDIVIDUAL EXCHANGE NAVIGATORS 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 HEALTH PLANS AND QUALIFIED DENTAL PLANS OFFERED IN THE EXCHANGE;

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

(III) ENABLE THE EXCHANGE TO ENSURE THAT, WITH RESPECT TO INDIVIDUAL EXCHANGE NAVIGATORS 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 SHALL COMPLY WITH ALL REQUIREMENTS OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

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

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

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

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

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

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

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

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

(I) HAS VIOLATED:

1. THIS ARTICLE OR ANY REGULATION ADOPTED UNDER THIS ARTICLE; OR

2. ANY STATE OR FEDERAL LAW OR REGULATION GOVERNING THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM;

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

(III) HAS ENGAGED IN FRAUDULENT OR DISHONEST PRACTICES;

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

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

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

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

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

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

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

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

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

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

(2) UNDER THE PROGRAM, THE EXCHANGE SHALL:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) AN INSURANCE PRODUCER:

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

(II) SHALL BE COMPENSATED DIRECTLY BY A CARRIER.

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

(2) THE TRAINING PROGRAM SHALL:

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

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

(III) BE APPROVED BY THE COMMISSIONER.

31–114.

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

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

[31–109.**] 31–115.**

(a) The Exchange shall certify**:**

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

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

(I) STAND–ALONE DENTAL PLANS; OR

(II) DENTAL PLANS BUNDLED WITH QUALIFIED HEALTH PLANS.

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

(1) except as provided in subsection (c) of this section, provide the essential **HEALTH** benefits **[**package**]** 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)(7)(ii) of this title;

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

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

(5) be offered by a carrier that:

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

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

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

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

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

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

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

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

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

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

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

(9) meet any other requirements established by the Exchange under this title**, 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; AND

(II) CRITERIA THAT ENCOURAGE AND SUPPORT QUALIFIED HEALTH PLANS AND QUALIFIED DENTAL PLANS IN FACILITATING CROSS–BORDER ENROLLMENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) claims payment policies and practices;

(ii) financial disclosures;

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

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

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

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

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

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

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

(3) A qualified dental plan shall:

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

(ii) include at a minimum:

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

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

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

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

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

31–116.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) OBTAIN GUIDANCE NECESSARY TO:

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

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

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

1. APPOINTING AND CONSULTING WITH AN ADVISORY GROUP MADE UP OF A DIVERSE AND REPRESENTATIVE CROSS–SECTION OF STAKEHOLDERS; AND

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

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

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.

(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 SECRETARY, SHALL STRONGLY CONSIDER USING THE FEDERAL MODEL ADOPTED BY THE SECRETARY IN THE OPERATION OF THE STATE'S RISK ADJUSTMENT PROGRAM.

[31–111.**] 31–119.**

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

(1) prevent discrimination;

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

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

(4) promote financial integrity.

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

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

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

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

(I) ESTABLISH A FRAMEWORK FOR INTERNAL CONTROLS;

(II) IDENTIFY CONTROL CYCLES;

(III) CONDUCT RISK ASSESSMENTS;

(IV) DOCUMENT PROCESSES; AND

(V) IMPLEMENT CONTROLS.

(3) THE EXCHANGE:

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

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

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

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

(2) The report shall:

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

(ii) include data regarding:

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4. AND BE IT FURTHER ENACTED, That:

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

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

(2) the Maryland Insurance Commissioner;

(3) the Secretary of Budget and Management;

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

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

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

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

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

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

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

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

(i) ensure a stable revenue stream;

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

(iii) rely on:

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

2. additional funding from transaction fees;

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

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

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

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

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

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

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

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

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