SENATE BILL 238

C3 2lr0128
CF HB 443

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

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

Committee Report: Favorable with amendments
Senate action: Adopted with floor amendments
Read second time: March 21, 2012

CHAPTER _____

AN ACT concerning

Maryland Health Benefit Exchange Act of 2012

FOR the purpose of requiring the Board of Trustees of the Maryland Health Benefit Exchange, subject to a certain waiver, to submit certain regulations to certain legislative committees under certain circumstances; requiring the Board to have a certain number of standing advisory committees; requiring the Maryland Health Benefit Exchange to make certain qualified dental plans and qualified vision plans available to certain individuals and employers in a certain manner and on or before a certain date; requiring the Exchange, to the extent necessary, to modify a certain format to accommodate differences in certain plan options; requiring the Exchange to establish and implement certain navigator programs; prohibiting the Exchange from making available any vision plan that is not a qualified vision plan; 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~~ decrease the number of State residents without health insurance coverage; authorizing the Exchange to employ certain alternative contracting options and active purchasing strategies under certain circumstances and for a certain purpose; requiring certain participation requirements for certain carriers to be suspended under certain circumstances; requiring the Exchange, before employing an alternative contracting option or active purchasing strategy, to submit a certain plan, within a certain timeframe, to certain legislative

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

committees for review and comment; 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~~, or a carrier or a certain insurance holding company system, for a certain purpose; authorizing the SHOP Exchange to allow qualified employers to designate certain qualified dental plans and qualified vision plans to be made available to their employees; authorizing the SHOP Exchange to reassess and modify the design of the SHOP Exchange under certain circumstances; requiring the SHOP Exchange to implement any modification of offerings and choice through regulations adopted by the SHOP Exchange; establishing certain navigator programs for the SHOP Exchange and the Individual Exchange; establishing certain requirements for the navigator programs; ~~authorizing~~ requiring a SHOP Exchange navigator program and an Individual Exchange navigator program 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; prohibiting the Maryland Insurance Commissioner, in the Commissioner's role as a member of the Board, from participating in certain matters under certain circumstances; providing that a carrier is not responsible for the activities and conduct of a SHOP Exchange navigator, an Individual Exchange navigator entity, or an Individual Exchange navigator; 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~~ processes; requiring the SHOP Exchange and the Exchange to develop, implement, and update certain training programs; requiring the Individual Exchange to consult with the Commissioner and the Department of Health and Mental Hygiene for a certain purpose; requiring the Commissioner to enter into certain memoranda of understanding; authorizing the Commissioner to require the Individual Exchange to make certain information available to the Commissioner and submit a certain corrective plan under certain circumstances; requiring the Exchange to establish and administer a certain Individual Exchange navigator certification program; specifying the consumer assistance services that are required, and are not required, to be provided by an Individual Exchange navigator; providing for the authorization of Individual Exchange navigator entities; specifying the scope of the authorization; authorizing and requiring an Individual Exchange navigator entity to take certain actions; prohibiting an Individual Exchange navigator entity from receiving certain compensation and providing certain information or services; authorizing the Commissioner to take certain disciplinary actions against an Individual Exchange navigator entity under certain circumstances; 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 may not prohibit certain organizations or units of government from providing certain services, subject to certain requirements; 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 and certain vision plans as qualified vision plans; altering certain requirements for certification as a qualified health plan; authorizing the Exchange to determine whether a carrier may elect to include certain nonessential benefits in a qualified health plan; providing that a qualified health plan is not required to provide certain essential benefits under certain circumstances; altering certain provisions of law relating to the offering and pricing of oral and dental benefits; establishing certain requirements for qualified vision plans offered through the Exchange; providing that a managed care organization may not be required to offer a certain plan in the Exchange; 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~~ unless the carriers also offer certain health benefit plans in the SHOP Exchange and the Individual Exchange; establishing certain exemptions to the requirement that the carriers offer the plans; requiring the Commissioner to establish certain procedures for a carrier to submit certain evidence relating to certain exemptions; 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; repealing and altering certain definitions; making certain stylistic ~~and~~, clarifying, and conforming 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; providing that certain requirements of this Act shall be subject to certain clarification; authorizing the Board to adopt interim policies for a certain purpose, pending adoption of regulations and after receiving certain comment; providing for the effective dates of this Act; 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 – Health – General
Section 15–101.1
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1204, 15–1205, 15–1303, 31–101, 31–102(d), 31–106(c) and (g), 31–108, 31–109, and 31–111
Annotated Code of Maryland
(2011 Replacement Volume)

BY adding to
Article – Insurance
Section 15–1204.1, 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 – Health – General

15–101.1.

(A) Except as otherwise provided in this subtitle, a managed care organization is not subject to the insurance laws of the State or to the provisions of Title 19 of this article.

(B) A MANAGED CARE ORGANIZATION MAY NOT BE REQUIRED TO OFFER A QUALIFIED PLAN, AS DEFINED IN § 31–101 OF THE INSURANCE ARTICLE, IN THE MARYLAND HEALTH BENEFIT EXCHANGE.

Article – Insurance

15–1204.

(A) THIS SECTION APPLIES TO A CARRIER WITH RESPECT TO ANY HEALTH BENEFIT PLAN THAT IS:

~~(1)~~ A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT;

~~(2) ISSUED, DELIVERED, OR RENEWED IN THE STATE ON OR BEFORE DECEMBER 31, 2013; AND~~

~~(3) RENEWED IN THE STATE AFTER DECEMBER 31, 2013.~~

~~(a)~~ **(B)** 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)~~ **(C)** 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.

15–1204.1.

(A) THIS SECTION APPLIES TO A CARRIER WITH RESPECT TO ANY HEALTH BENEFIT PLAN THAT:

(1) IS NOT A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT; AND

(2) IS ISSUED, DELIVERED, OR RENEWED IN THE STATE ON OR AFTER JANUARY 1, 2014.

(B) (1) EXCEPT AS PROVIDED IN THIS SUBSECTION AND § 31–110(F) OF THIS ARTICLE, A CARRIER MAY NOT OFFER HEALTH BENEFIT PLANS TO SMALL EMPLOYERS IN THE STATE UNLESS THE CARRIER ALSO OFFERS

QUALIFIED HEALTH PLANS, AS DEFINED IN § 31–101 OF THIS ARTICLE, 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 IS EXEMPT FROM THE REQUIREMENT IN PARAGRAPH (1) OF THIS SUBSECTION IF:

(I) THE REPORTED TOTAL AGGREGATE ANNUAL EARNED PREMIUM FROM ALL HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS IN THE STATE FOR THE CARRIER AND ANY OTHER CARRIERS IN THE SAME INSURANCE HOLDING COMPANY SYSTEM, AS DEFINED IN § 7–101 OF THIS ARTICLE, IS LESS THAN $20,000,000;

(II) THE COMMISSIONER DETERMINES THAT THE CARRIER COMPLIES WITH THE PROCEDURES ESTABLISHED UNDER PARAGRAPH (3) OF THIS SUBSECTION; AND

(III) WHEN THE CARRIER CEASES TO MEET THE REQUIREMENTS FOR THE EXEMPTION, THE CARRIER PROVIDES TO THE COMMISSIONER IMMEDIATE NOTICE AND ITS PLAN FOR COMPLYING WITH THE REQUIREMENT IN PARAGRAPH (1) OF THIS SUBSECTION.

(3) THE COMMISSIONER SHALL ESTABLISH PROCEDURES FOR A CARRIER TO SUBMIT EVIDENCE EACH YEAR THAT THE CARRIER MEETS THE REQUIREMENTS NECESSARY TO QUALIFY FOR AN EXEMPTION UNDER PARAGRAPH (2) OF THIS SUBSECTION.

(4) NOTWITHSTANDING THE EXEMPTION PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE COMMISSIONER, IN CONSULTATION WITH THE MARYLAND HEALTH BENEFIT EXCHANGE:

(I) MAY ASSESS THE IMPACT OF THE EXEMPTION PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION AND, BASED ON THAT ASSESSMENT, ALTER THE LIMIT ON THE AMOUNT OF ANNUAL PREMIUMS THAT MAY NOT BE EXCEEDED TO QUALIFY FOR THE EXEMPTION; AND

(II) SHALL MAKE ANY CHANGE IN THE EXEMPTION REQUIREMENT BY REGULATION.

15–1205.

(a) **(1) THIS SUBSECTION APPLIES TO A CARRIER WITH RESPECT TO ANY HEALTH BENEFIT PLAN THAT IS:**

~~(I)~~ A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT;

(II) ISSUED, DELIVERED, OR RENEWED IN THE STATE ON OR BEFORE DECEMBER 31, 2013~~; AND~~

~~(III) RENEWED IN THE STATE AFTER DECEMBER 31, 2013~~.

[(1)**] (2)** In establishing a community rate for a health benefit plan, a carrier shall use a rating methodology that is based on the experience of all risks covered by that health benefit plan without regard to any factor not specifically authorized under this subsection or subsection **[**(f)**] (G)** of this section.

[(2)**] (3)** A carrier may adjust the community rate only for:

(i) age;

(ii) geography based on the following contiguous areas of the State:

1. the Baltimore metropolitan area;

2. the District of Columbia metropolitan area;

3. Western Maryland; and

4. Eastern and Southern Maryland; and

(iii) health status, as provided in subsection **[**(f)**] (G)** of this section.

[(3)**] (4)** Rates for a health benefit plan may vary based on family composition as approved by the Commissioner.

[(4)**] (5)** (i) Subject to subparagraph (ii) of this paragraph, after applying the risk adjustment factors under paragraph **[**(2)**] (3)** of this subsection, a carrier may offer a discount not to exceed 20% to a small employer for participation in a wellness program.

(ii) A discount offered under subparagraph (i) of this paragraph shall be:

1. applied to reduce the rate otherwise payable by the small employer;

2. actuarially justified;

3. offered uniformly to all small employers; and

4. approved by the Commissioner.

(B) (1) THIS SUBSECTION APPLIES TO A CARRIER WITH RESPECT TO ANY HEALTH BENEFIT PLAN THAT:

(I) IS NOT A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT; AND

(II) IS ISSUED, DELIVERED, OR RENEWED IN THE STATE ON OR AFTER JANUARY 1, 2014.

(2) IN ESTABLISHING A PREMIUM RATE FOR A HEALTH BENEFIT PLAN, A CARRIER SHALL USE A RATING METHODOLOGY THAT IS BASED ON THE EXPERIENCE OF ALL RISKS COVERED BY THAT HEALTH BENEFIT PLAN WITHOUT REGARD TO ANY FACTOR NOT SPECIFICALLY AUTHORIZED UNDER THIS SUBSECTION.

(3) IN ACCORDANCE WITH § 2701(A) OF THE AFFORDABLE CARE ACT, A PREMIUM RATE MAY VARY ONLY BY:

(I) WHETHER THE HEALTH BENEFIT PLAN COVERS AN INDIVIDUAL OR A FAMILY;

(II) RATING AREA;

(III) AGE, EXCEPT THAT A RATE MAY NOT VARY BY MORE THAN 3 TO 1 FOR ADULTS; AND

(IV) TOBACCO USE, EXCEPT THAT A RATE MAY NOT VARY BY MORE THAN 1.5 TO 1.

(4) A RATE MAY NOT VARY BY ANY FACTOR THAT IS NOT SPECIFIED IN PARAGRAPH (3) OF THIS SUBSECTION.

[(b)**] (C) (1)** A carrier shall apply all risk adjustment factors under subsections (a) and **[**(f)**] (G)** of this section consistently with respect to all health benefit plans that are**:**

(I) issued, delivered, or renewed in the State**; AND**

(II) GRANDFATHERED HEALTH PLANS, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT.

(2) A CARRIER SHALL APPLY ALL RISK ADJUSTMENT FACTORS UNDER SUBSECTION (B) OF THIS SECTION CONSISTENTLY WITH RESPECT TO ALL HEALTH BENEFIT PLANS THAT ARE:

(I) ISSUED, DELIVERED, OR RENEWED IN THE STATE; AND

(II) ~~ARE~~ NOT GRANDFATHERED HEALTH PLANS, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT.

[(c)**] (D)** (1) **THIS SUBSECTION APPLIES TO A CARRIER WITH RESPECT TO ANY HEALTH BENEFIT PLAN THAT IS A GRANDFATHERED HEALTH PLAN.**

(2) Based on the adjustments allowed under subsection **[**(a)(2)(i)**] (A)(3)(I)** and (ii) of this section, a carrier may charge a rate that is 50% above or 50% below the community rate.

~~(2)~~ **(3)** (i) On or before October 1, 2007, the Commission shall adopt regulations that require carriers to collect and report to the Commission data on participation, by rate band, in health benefit plans issued, delivered, or renewed under this subtitle.

(ii) On or before January 1, 2013, the Commission shall report to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee regarding the effect of the 50% rate adjustments authorized under paragraph (1) of this subsection and the effect of the adjustment to the community rate for health status authorized under subsection **[**(f)**] (G)** of this section on participation in health benefit plans issued, delivered, or renewed under this subtitle.

[(d)**] (E)** (1) A carrier shall base its rating methods and practices on commonly accepted actuarial assumptions and sound actuarial principles.

(2) A carrier that is a health maintenance organization and that includes a subrogation provision in its contract as authorized under § 19–713.1(d) of the Health – General Article shall:

(i) use in its rating methodology an adjustment that reflects the subrogation; and

(ii) identify in its rate filing with the Administration, and annually in a form approved by the Commissioner, all amounts recovered through subrogation.

[(e)**] (F) (1) THIS SUBSECTION APPLIES TO A CARRIER WITH RESPECT TO ANY HEALTH BENEFIT PLAN THAT IS:**

~~(I)~~ A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT;

~~(II) ISSUED, DELIVERED, OR RENEWED IN THE STATE ON OR BEFORE DECEMBER 31, 2013; AND~~

~~(III) RENEWED IN THE STATE AFTER DECEMBER 31, 2013~~.

[(1)**] (2)** A carrier may offer an administrative discount to a small employer if the small employer elects to purchase, for its employees, an annuity, dental insurance, disability insurance, life insurance, long–term care insurance, vision insurance, or, with the approval of the Commissioner, any other insurance sold by the carrier.

[(2)**] (3)** The administrative discount shall be offered under the same terms and conditions for all qualifying small employers.

[(f)**] (G)** (1) A carrier may adjust the community rate for a health benefit plan **THAT IS A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT,** for health status only if a small employer has not offered a health benefit plan issued under this subtitle to its employees in the 12 months prior to the initial enrollment of the small employer in the health benefit plan.

(2) (i) Based on the adjustment allowed under paragraph (1) of this subsection, in addition to the adjustments allowed under subsection **[**(c)(1)**] (D)(1)** of this section, a carrier may charge:

1. in the first year of enrollment, a rate that is 10% above or below the community rate;

2. in the second year of enrollment, a rate that is 5% above or below the community rate; and

3. in the third year of enrollment, a rate that is 2% above or below the community rate.

(ii) A carrier may not make any adjustment for health status in the community rate of a health benefit plan issued under this subtitle after the third year of enrollment of a small employer in the health benefit plan.

(3) **[**A**] FOR A HEALTH BENEFIT PLAN THAT IS A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE**

CARE ACT, A carrier may use health statements, in a form approved by the Commissioner, and health screenings to establish an adjustment to the community rate for health status as provided in this subsection.

(4) A carrier may not limit coverage offered by the carrier, or refuse to issue a health benefit plan to any small employer that meets the requirements of this subtitle, based on a health status–related factor.

(5) It is an unfair trade practice for a carrier knowingly to provide coverage to a small employer that discriminates against an employee or applicant for employment, based on the health status of the employee or applicant or a dependent of the employee or applicant, with respect to participation in a health benefit plan sponsored by the small employer.

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 AND § 31–110(F) OF THIS ARTICLE, A CARRIER MAY NOT OFFER INDIVIDUAL HEALTH BENEFIT PLANS ~~IN THE INDIVIDUAL MARKET~~ IN THE STATE UNLESS THE CARRIER ALSO OFFERS QUALIFIED HEALTH PLANS, AS DEFINED IN § 31–101 OF THIS ARTICLE, IN THE INDIVIDUAL EXCHANGE OF THE MARYLAND HEALTH BENEFIT EXCHANGE IN COMPLIANCE WITH THE REQUIREMENTS OF TITLE 31 OF THIS ARTICLE.

(2) A CARRIER ~~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 REPORTED TOTAL AGGREGATE ANNUAL EARNED PREMIUM FROM ALL INDIVIDUAL HEALTH BENEFIT PLANS IN THE STATE FOR THE CARRIER AND ANY OTHER CARRIERS IN THE SAME INSURANCE HOLDING COMPANY SYSTEM, AS DEFINED IN § 7–101 OF THIS ARTICLE, IS LESS THAN $10,000,000;

~~(II)~~ (II) 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~~ UNDER PARAGRAPH (3) OF THIS SUBSECTION; AND

~~(III)~~ (III) 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~~ COMPLYING WITH THE REQUIREMENT IN PARAGRAPH (1) OF THIS SUBSECTION.

(3) THE COMMISSIONER SHALL ESTABLISH PROCEDURES FOR A CARRIER TO SUBMIT EVIDENCE EACH YEAR THAT THE CARRIER MEETS THE REQUIREMENTS NECESSARY TO QUALIFY FOR AN EXEMPTION UNDER PARAGRAPH (2) OF THIS SUBSECTION.

~~(3)~~ (4) NOTWITHSTANDING THE EXEMPTION PROVIDED 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~~ ALSO MUST OFFER AT LEAST ONE CATASTROPHIC PLAN IN THE MARYLAND HEALTH BENEFIT EXCHANGE.

~~(4)~~ (5) ~~THE~~ NOTWITHSTANDING THE EXEMPTION PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE COMMISSIONER, IN CONSULTATION WITH THE MARYLAND HEALTH BENEFIT EXCHANGE~~,~~:

(I) MAY ASSESS THE IMPACT OF THE EXEMPTION PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION AND, BASED ON THAT ASSESSMENT, ALTER THE ~~AMOUNT OF ANNUAL PREMIUMS NECESSARY~~ LIMIT ON THE AMOUNT OF ANNUAL PREMIUMS THAT MAY NOT BE EXCEEDED TO QUALIFY FOR THE EXEMPTION; AND

(II) SHALL MAKE ANY CHANGE IN THE EXEMPTION REQUIREMENT BY REGULATION.

[(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.

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

Article – Insurance

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)**~~ **(B)** "Board" means the Board of Trustees of the Exchange.

[(d)**]** ~~(E)~~ **(C)** "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)~~ **(D) "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~~ **A LEVEL OF COVERAGE, AS DEFINED IN § 1302 OF THE AFFORDABLE CARE ACT AND AS DETERMINED IN REGULATIONS ADOPTED BY THE SECRETARY, FOR A QUALIFIED HEALTH PLAN.**

~~[~~(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)~~ (H) "INDIVIDUAL EXCHANGE" MEANS THE DIVISION OF THE EXCHANGE THAT SERVES THE INDIVIDUAL HEALTH INSURANCE MARKET.

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

(1) HOLDS AN INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION; AND

(2) ~~PERFORMS THE FUNCTIONS UNDER § 31–113(C)~~ PROVIDES THE SERVICES DESCRIBED IN § 31–113(D)(1) OF THIS TITLE FOR AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY.

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

~~(L)~~ (K) "INDIVIDUAL EXCHANGE NAVIGATOR ENTITY" MEANS A COMMUNITY–BASED ORGANIZATION OR OTHER ENTITY ~~ENGAGED~~ OR A PARTNERSHIP OF ENTITIES THAT:

(1) IS AUTHORIZED BY THE INDIVIDUAL EXCHANGE ~~WHICH~~ UNDER § 31–113(F) OF THIS TITLE; AND

(2) EMPLOYS OR ENGAGES ~~CERTIFIED~~ INDIVIDUAL EXCHANGE NAVIGATORS TO ~~PERFORM THE FUNCTIONS IN § 31–113(C)~~ PROVIDE THE SERVICES DESCRIBED IN § 31–113(D)(1) OF THIS TITLE.

(L) "INDIVIDUAL EXCHANGE NAVIGATOR ENTITY AUTHORIZATION" MEANS A GRANT OF AUTHORITY FROM THE INDIVIDUAL EXCHANGE TO AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY UNDER § 31–113(F) 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)~~ (M) "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)~~** **(N)** "Managed care organization" has the meaning stated in § 15–101 of the Health – General Article.

~~(P)~~ **(O)** **"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)~~** **(P)** "Qualified dental plan" means a **DENTAL** plan certified by the Exchange that provides limited scope dental benefits, as described in ~~§ 31–108(b)~~ **§ 31–108(B)(2)** of this title.

[(j)**]** **~~(R)~~** **(Q)** "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)~~** **(R)** "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)~~** **(S)** "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.

(T) "QUALIFIED PLAN" MEANS A:

(1) QUALIFIED HEALTH PLAN;

(2) QUALIFIED DENTAL PLAN; AND

(3) QUALIFIED VISION PLAN.

(U) "QUALIFIED VISION PLAN" MEANS A VISION PLAN CERTIFIED BY THE EXCHANGE THAT PROVIDES LIMITED SCOPE VISION BENEFITS, AS DESCRIBED IN § 31–108(B)(3) OF THIS TITLE.

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

[(n)**]** ~~**(V)**~~ **(W)** "SHOP Exchange" means the small business health options program authorized under ~~§ 31–108(b)(12)~~ **§ 31–108(B)(13)** of this title.

~~**(W)**~~ **(X) "SHOP EXCHANGE NAVIGATOR" MEANS AN INDIVIDUAL ENGAGED BY THE SHOP EXCHANGE AND AUTHORIZED BY THE COMMISSIONER TO** ~~**PERFORM THE FUNCTIONS SET FORTH**~~ **PROVIDE THE SERVICES DESCRIBED IN § 31–112(C)(1) OF THIS TITLE.**

~~**(X)**~~ **(Y) "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)**~~ **(Z)** (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)~~ (AA) **"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**~~

(2) INDIVIDUAL HEALTH BENEFIT PLANS, EXCEPT GRANDFATHERED HEALTH PLANS, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT; AND

(3) HEALTH BENEFIT PLANS OFFERED TO SMALL EMPLOYERS, EXCEPT GRANDFATHERED HEALTH PLANS, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT.

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, AND QUALIFIED VISION PLANS.

31–106.

(c) **(1)** In addition to the powers set forth elsewhere in this title, the Board may:

[(1)**]** **(I)** adopt and alter an official seal;

[(2)**]** **(II)** sue, be sued, plead, and be impleaded;

[(3)**]** **(III)** adopt bylaws, rules, and policies;

[(4)**]** **(IV) SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION,** adopt regulations to carry out this title:

[(i)**]** **1.** in accordance with Title 10, Subtitle 1 of the State Government Article; and

[(ii)**]** **2.** without conflicting with or preventing application of regulations adopted by the Secretary under Title 1, Subtitle D of the Affordable Care Act;

[(5)**]** **(V)** maintain an office at the place designated by the Board;

[(6)**]** **(VI)** enter into any agreements or contracts and execute the instruments necessary or convenient to manage its own affairs and carry out the purposes of this title;

[(7)**]** **(VII)** apply for and receive grants, contracts, or other public or private funding; and

[(8)**]** **(VIII)** do all things necessary or convenient to carry out the powers granted by this title.

(2) UNLESS WAIVED BY THE CHAIRS OF THE COMMITTEES, AT LEAST 30 DAYS BEFORE SUBMITTING ANY PROPOSED REGULATION TO THE MARYLAND REGISTER FOR PUBLICATION, THE BOARD SHALL SUBMIT THE PROPOSED REGULATION TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE.

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

(1) create and consult with advisory committees; **[**and**]**

(2) HAVE AT LEAST TWO STANDING ADVISORY COMMITTEES WHOSE MEMBERS, TO THE EXTENT PRACTICABLE, REFLECT THE GENDER, RACIAL, ETHNIC, AND GEOGRAPHIC DIVERSITY OF THE STATE; AND

[(2)**] (3)** appoint to the advisory committees representatives of:

(i) insurers or health maintenance organizations offering health benefit plans in the State;

(ii) nonprofit health service plans offering health benefit plans in the State;

(iii) licensed health insurance producers and advisers;

(iv) third–party administrators;

(v) health care providers, including:

1. hospitals;

2. long–term care facilities;

3. mental health providers;

4. developmental disability providers;

5. substance abuse treatment providers;

6. Federally Qualified Health Centers;

7. physicians;

8. nurses;

9. experts in services and care coordination for criminal and juvenile justice populations;

10. licensed hospice providers; and

11. other health care professionals;

(vi) managed care organizations;

(vii) employers, including large, small, and minority–owned employers;

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

(ix) consumers, including individuals who:

1. reside in lower–income and racial or ethnic minority communities;

2. have chronic diseases or disabilities; or

3. belong to other hard–to–reach or special populations;

(x) individuals with knowledge and expertise in advocacy for consumers described in item (ix) of this item;

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

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

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

~~(3)~~ **(4) CONSISTENT WITH THE GUIDELINES DEVELOPED BY THE SECRETARY UNDER § 1311(C) OF THE AFFORDABLE CARE ACT,** implement procedures for the certification, recertification, and decertification of**:**

(I) health benefit plans as qualified health plans ~~**AND;**~~

(II) DENTAL PLANS AS QUALIFIED DENTAL PLANS~~, consistent with guidelines developed by the Secretary under § 1311(c) of the Affordable Care Act~~**; AND**

(III) VISION PLANS AS QUALIFIED VISION PLANS;

~~(4)~~ **(5)** provide for the operation of a toll–free telephone hotline to respond to requests for assistance;

~~(5)~~ **(6)** 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)~~ **(7)** 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**, AND QUALIFIED VISION PLANS**;

~~(7)~~ **(8)** 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~~ **LEVEL** 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)~~ **(9) (I)** 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; **AND**

(II) TO THE EXTENT NECESSARY, MODIFY THE STANDARDIZED FORMAT TO ACCOMMODATE DIFFERENCES IN QUALIFIED HEALTH PLAN, QUALIFIED DENTAL PLAN, AND QUALIFIED VISION PLAN OPTIONS;

~~(9)~~ **(10)** 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)~~ **(11)** facilitate the enrollment of any individual who the Exchange determines is eligible for a program described in item ~~(9)~~ **(10)** of this subsection;

~~(11)~~ **(12)** 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)~~ **(13) 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)~~ **(14)** 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)~~ **(15)** 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)~~ **(16)** 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)~~ **(17)** 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)~~ **(18)** 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;~~

~~(10)~~ **(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)~~ **(5)** of this subsection; and

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

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

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

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

(d) 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**; OR**

(3) ANY VISION PLAN THAT IS NOT A QUALIFIED VISION 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 FIRST SHALL SEEK TO:

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

(2) DECREASE THE NUMBER OF STATE RESIDENTS WITHOUT HEALTH INSURANCE COVERAGE.

~~(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) (1) SUBJECT TO SUBSECTION (E) OF THIS SECTION, THE EXCHANGE, WITH THE MARKET IMPACT AND LEVERAGE ATTAINED THROUGH A ROBUST AND STABLE ENROLLMENT, MAY USE ALTERNATIVE CONTRACTING

OPTIONS AND ACTIVE PURCHASING STRATEGIES TO INCREASE AFFORDABILITY AND QUALITY OF CARE FOR CONSUMERS AND LOWER COSTS IN THE HEALTH CARE SYSTEM OVERALL.

(2) THE EXCHANGE'S EFFORTS TO INCREASE AFFORDABILITY AND QUALITY OF CARE AND TO LOWER COSTS MAY INCLUDE PURSUING KEY OBJECTIVES SUCH AS HIGHER STANDARDS OF CARE, CONTINUITY OF CARE, DELIVERY SYSTEM REFORMS, HEALTH EQUITY, IMPROVED PATIENT EXPERIENCE AND OUTCOMES, AND MEANINGFUL COST CONTROLS WITHIN THE HEALTH CARE SYSTEM.

~~(B)~~ (C) IN EMPLOYING CONTRACTING STRATEGIES TO IMPLEMENT ~~SUBSECTION (A) OF~~ THIS SECTION, THE EXCHANGE SHALL CONSIDER, ON A CONTINUING BASIS, 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~~ PROGRESS IN ACHIEVING THE KEY OBJECTIVES STATED IN SUBSECTION ~~(A)(2)~~ (B)(2) OF THIS SECTION.

~~(C)~~ (D) 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)~~ (E) ~~AFTER DECEMBER 31, 2014,~~ SUBJECT TO SUBSECTIONS (F) AND (G) OF THIS SECTION, BEGINNING JANUARY 1, 2016, 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, VALUE–BASED INSURANCE DESIGN, 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.**~~

(F) DURING ANY YEAR IN WHICH THE EXCHANGE EMPLOYS ALTERNATIVE CONTRACTING OPTIONS AND ACTIVE PURCHASING STRATEGIES, THE PARTICIPATION REQUIREMENTS SET FORTH IN §§ 15–1204.1(B) AND 15–1303(B) OF THIS ARTICLE FOR CARRIERS IN THE INDIVIDUAL AND SMALL GROUP MARKETS OUTSIDE THE EXCHANGE SHALL BE SUSPENDED.

(G) BEFORE EMPLOYING AN ALTERNATIVE CONTRACTING OPTION OR ACTIVE PURCHASING STRATEGY, THE EXCHANGE:

(1) ON OR AFTER DECEMBER 1, BUT NOT LATER THAN THE FIRST DAY OF THE NEXT REGULAR SESSION OF THE GENERAL ASSEMBLY, SHALL SUBMIT TO THE SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, A PLAN FOR THE USE OF THE ALTERNATIVE CONTRACTING OPTION OR ACTIVE PURCHASING STRATEGY, INCLUDING AN ANALYSIS OF:

(I) THE OBJECTIVES TO BE ACHIEVED THROUGH USE OF THE ALTERNATIVE CONTRACTING OPTION OR ACTIVE PURCHASING STRATEGY; AND

(II) THE IMPACT ON THE INSURANCE MARKETS INSIDE AND OUTSIDE THE EXCHANGE AND ON CONSUMERS; AND

(2) SHALL ALLOW THE COMMITTEES TO HAVE 90 DAYS FOR REVIEW AND COMMENT.

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; AND

(4) THE NEED TO FACILITATE CONTINUITY OF CARE FOR EMPLOYEES WHO CHANGE EMPLOYERS OR HEALTH BENEFIT PLANS.

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

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

(2) DESIGNATE A CARRIER OR AN INSURANCE HOLDING COMPANY SYSTEM, AS DEFINED IN § 7–101 OF THIS ARTICLE, AND A MENU OF QUALIFIED HEALTH PLANS OFFERED BY THE CARRIER OR THE INSURANCE HOLDING COMPANY SYSTEM IN THE SHOP EXCHANGE FROM WHICH THEIR EMPLOYEES MAY CHOOSE.

(D) IN ADDITION TO THE OPTIONS SET FORTH IN SUBSECTION (C) OF THIS SECTION, THE SHOP EXCHANGE ALSO MAY ALLOW QUALIFIED EMPLOYERS TO DESIGNATE ONE OR MORE QUALIFIED DENTAL PLANS AND QUALIFIED VISION PLANS TO BE MADE AVAILABLE TO THEIR EMPLOYEES.

~~(D)~~ (E) 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; AND

(3) SHALL IMPLEMENT ANY MODIFICATION OF OFFERINGS AND CHOICE THROUGH REGULATIONS ADOPTED BY THE SHOP EXCHANGE.

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~~ CARRY OUT ITS PURPOSE 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~~ THE

SHOP EXCHANGE NAVIGATOR PROGRAM, WITH RESPECT ONLY TO QUALIFIED PLANS OFFERED IN THE SHOP EXCHANGE, SHALL PROVIDE COMPREHENSIVE CONSUMER ASSISTANCE SERVICES, INCLUDING:

(I) ~~CONDUCT~~ CONDUCTING EDUCATION AND OUTREACH TO SMALL EMPLOYERS;

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

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)~~ (III) ~~FACILITATE~~ FACILITATING:

1. QUALIFIED ~~HEALTH PLAN AND QUALIFIED DENTAL~~ PLAN SELECTION, BASED ON THE NEEDS OF THE EMPLOYEE;

2. APPLICATION PROCESSES~~,~~;

3. ENROLLMENT~~,~~;

4. RENEWALS~~,~~; AND

5. DISENROLLMENT;

~~(V)~~ (IV) ~~CONDUCT~~ CONDUCTING ~~TAX CREDIT~~ ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR TAX CREDITS;

~~(VI)~~ (V) ~~PROVIDE~~ PROVIDING REFERRALS TO APPROPRIATE AGENCIES ~~FOR~~, INCLUDING THE ATTORNEY GENERAL'S HEALTH EDUCATION AND ADVOCACY UNIT AND THE ADMINISTRATION, FOR APPLICANTS AND ENROLLEES WITH GRIEVANCES, COMPLAINTS, ~~APPEALS,~~ OR QUESTIONS;

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

~~(VIII)~~ (VII) ~~PROVIDE~~ PROVIDING ONGOING SUPPORT WITH RESPECT TO THE FUNCTIONS SET FORTH IN THIS SECTION, INCLUDING ELIGIBILITY~~,~~ AND ENROLLMENT~~, RENEWAL,~~ AND DISENROLLMENT IN AND RENEWAL OF 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)~~ (2) 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 AND RECEIVE COMPENSATION ONLY THROUGH 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;~~ MAY NOT RECEIVE COMPENSATION FROM OR OTHERWISE BE AFFILIATED WITH A CARRIER, AN INSURANCE PRODUCER, A THIRD–PARTY ADMINISTRATOR, OR ANY OTHER PERSON CONNECTED TO THE INSURANCE INDUSTRY; AND

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

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

(3) WITH RESPECT TO THE INSURANCE MARKET OUTSIDE THE EXCHANGE, A SHOP EXCHANGE NAVIGATOR:

(I) MAY NOT PROVIDE ANY INFORMATION OR SERVICES RELATED TO HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED IN THE EXCHANGE, EXCEPT FOR GENERAL INFORMATION ABOUT THE INSURANCE MARKET OUTSIDE THE EXCHANGE, WHICH SHALL BE LIMITED TO THE INFORMATION PROVIDED IN A CONSUMER EDUCATION DOCUMENT DEVELOPED BY THE EXCHANGE AND THE COMMISSIONER;

(II) SHALL REFER ANY INQUIRIES ABOUT HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED IN THE EXCHANGE TO:

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

2. CARRIERS AND LICENSED INSURANCE PRODUCERS;

(III) MAY NOT 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; AND

(IV) SHALL REFER TO THE INDIVIDUAL EXCHANGE NAVIGATOR PROGRAM ANY INQUIRIES ABOUT INFORMATION OR SERVICES RELATED TO:

1. QUALIFIED PLANS OFFERED IN THE INDIVIDUAL EXCHANGE; OR

2. THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(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~~ SUSPENSION OR REVOCATION 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 WILLFULLY VIOLATED THIS ARTICLE OR ANY REGULATION ADOPTED UNDER THIS ARTICLE;

(II) HAS ~~MADE A MATERIAL MISSTATEMENT~~ INTENTIONALLY MISREPRESENTED OR CONCEALED A MATERIAL FACT IN THE APPLICATION FOR THE LICENSE;

(III) HAS OBTAINED THE LICENSE BY MISREPRESENTATION, CONCEALMENT, OR OTHER FRAUD;

~~(III)~~ (IV) HAS ENGAGED IN FRAUDULENT OR DISHONEST PRACTICES IN CONDUCTING ACTIVITIES UNDER THE LICENSE;

~~(IV)~~ (V) HAS MISAPPROPRIATED, CONVERTED, OR UNLAWFULLY WITHHELD MONEY IN CONDUCTING ACTIVITIES UNDER THE LICENSE;

(VI) HAS FAILED OR REFUSED TO PAY OVER ON DEMAND MONEY THAT BELONGS TO A PERSON ENTITLED TO THE MONEY;

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

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

(IX) HAS FAILED AN EXAMINATION REQUIRED BY THIS ARTICLE OR REGULATIONS ADOPTED UNDER THIS ARTICLE;

(X) HAS FORGED ANOTHER'S NAME ON AN APPLICATION FOR A QUALIFIED PLAN OR ON ANY OTHER DOCUMENT IN CONDUCTING ACTIVITIES UNDER THE LICENSE;

(XI) HAS OTHERWISE SHOWN A LACK OF TRUSTWORTHINESS OR COMPETENCE TO ACT AS A SHOP EXCHANGE NAVIGATOR; OR

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

(2) INSTEAD OF OR IN ADDITION TO SUSPENDING OR REVOKING 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 SHOP EXCHANGE OF ANY DECISION AFFECTING THE LICENSE OF A SHOP EXCHANGE NAVIGATOR OR ANY SANCTION IMPOSED ON ~~THE~~ A SHOP EXCHANGE NAVIGATOR UNDER THIS SUBSECTION.

(6) THE COMMISSIONER, IN THE COMMISSIONER'S ROLE AS A MEMBER OF THE BOARD, MAY NOT PARTICIPATE IN ANY MATTER THAT INVOLVES THE SHOP EXCHANGE'S NAVIGATOR PROGRAM IF, IN THE COMMISSIONER'S JUDGMENT, THE COMMISSIONER'S PARTICIPATION MIGHT CREATE A CONFLICT OF INTEREST WITH RESPECT TO THE COMMISSIONER'S REGULATORY AUTHORITY OVER THE SHOP EXCHANGE'S NAVIGATOR PROGRAM.

(7) A CARRIER IS NOT RESPONSIBLE FOR THE ACTIVITIES AND CONDUCT OF A SHOP EXCHANGE NAVIGATOR.

(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~~ DESCRIBED IN SUBSECTION ~~(E)~~ (E)(1) OF THIS ~~SUBSECTION~~ SECTION WITH RESPECT TO THE AUTHORIZATION.**

(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; AND

(III) IN PROVIDING ASSISTANCE TO A SMALL EMPLOYER SEEKING INFORMATION ABOUT OFFERING HEALTH INSURANCE, INFORM THE SMALL EMPLOYER OF:

1. ALL QUALIFIED HEALTH PLANS AVAILABLE TO EMPLOYEES IN THE SHOP EXCHANGE; AND

2. ALL OPTIONS AVAILABLE TO THE SMALL EMPLOYER IN THE SHOP EXCHANGE FOR OFFERING QUALIFIED HEALTH PLANS TO EMPLOYEES.

(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 OFFERED 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) (1) THERE IS A NAVIGATOR PROGRAM FOR THE INDIVIDUAL EXCHANGE.

(2) THE NAVIGATOR PROGRAM FOR THE INDIVIDUAL EXCHANGE SHALL BE:

(I) ADMINISTERED BY THE INDIVIDUAL EXCHANGE; AND

(II) REGULATED BY THE COMMISSIONER.

(3) IN ADMINISTERING THE NAVIGATOR PROGRAM, THE INDIVIDUAL EXCHANGE SHALL CONSULT WITH THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE TO ENSURE CONSISTENCY AND COMPLIANCE WITH ALL LAWS, REGULATIONS, AND POLICIES GOVERNING:

(I) THE SALE, SOLICITATION, AND NEGOTIATION OF HEALTH INSURANCE; AND

(II) THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(4) IN REGULATING THE NAVIGATOR PROGRAM, THE COMMISSIONER SHALL ENTER INTO ONE OR MORE MEMORANDA OF UNDERSTANDING WITH THE EXCHANGE AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE TO FACILITATE ENFORCEMENT OF THIS SECTION.

(5) THE COMMISSIONER MAY REQUIRE THE INDIVIDUAL EXCHANGE TO:

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

(II) SUBMIT A CORRECTIVE PLAN TO TAKE APPROPRIATE ACTION TO ADDRESS ANY PROBLEMS OR DEFICIENCIES IDENTIFIED BY THE COMMISSIONER IN THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY AUTHORIZATION PROCESS OR THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION PROCESS.

(6) THE COMMISSIONER, IN THE COMMISSIONER'S ROLE AS A MEMBER OF THE BOARD, MAY NOT PARTICIPATE IN ANY MATTER THAT INVOLVES THE INDIVIDUAL EXCHANGE'S NAVIGATOR PROGRAM IF, IN THE COMMISSIONER'S JUDGMENT, THE COMMISSIONER'S PARTICIPATION MIGHT CREATE A CONFLICT OF INTEREST WITH RESPECT TO THE COMMISSIONER'S REGULATORY AUTHORITY OVER THE INDIVIDUAL EXCHANGE'S NAVIGATOR PROGRAM.

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

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

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

(I) ~~ARE FAMILIAR~~ HAVE EXPERTISE IN WORKING WITH VULNERABLE AND HARD–TO–REACH POPULATIONS; AND

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

(3) ENABLE THE INDIVIDUAL EXCHANGE TO:

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

(II) ASSIST INDIVIDUALS WHO TRANSITION BETWEEN THE ~~PROGRAM PLANS~~ TYPES OF COVERAGE DESCRIBED IN ITEM (I) OF THIS ITEM OR HAVE LAPSED ENROLLMENT; AND

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

(C) TO ~~ACHIEVE THESE OBJECTIVES~~ CARRY OUT ITS PURPOSES AND IN COMPLIANCE WITH THE AFFORDABLE CARE ACT, ~~AN~~ THE INDIVIDUAL EXCHANGE NAVIGATOR PROGRAM, 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~~ SHALL PROVIDE COMPREHENSIVE CONSUMER ASSISTANCE SERVICES, INCLUDING:

(1) ~~CONDUCT~~ CONDUCTING EDUCATION AND OUTREACH TO INDIVIDUALS;

(2) ~~DISTRIBUTE~~ DISTRIBUTING INFORMATION ABOUT:

(I) THE INDIVIDUAL EXCHANGE, INCLUDING ELIGIBILITY REQUIREMENTS FOR APPLICABLE FEDERAL PREMIUM SUBSIDIES AND COST–SHARING ASSISTANCE;

(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 INDIVIDUAL EXCHANGE;

(3) ~~FACILITATE QUALIFIED HEALTH PLAN AND QUALIFIED DENTAL PLAN SELECTION, APPLICATION PROCESSES, ENROLLMENT, RENEWALS, AND DISENROLLMENT~~ WITH RESPECT TO QUALIFIED PLANS, FACILITATING:

(I) PLAN SELECTION, BASED ON THE NEEDS OF THE INDIVIDUAL SEEKING TO ENROLL;

(II) ASSESSMENT OF TAX IMPLICATIONS AND PREMIUM AND COST–SHARING REQUIREMENTS; AND

(III) APPLICATION, ENROLLMENT, RENEWAL, AND DISENROLLMENT PROCESSES;

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

(5) ~~CONDUCT~~ CONDUCTING ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR PREMIUM SUBSIDIES AND COST–SHARING ASSISTANCE;

(6) ~~PROVIDE~~ PROVIDING REFERRALS TO APPROPRIATE AGENCIES ~~FOR~~, INCLUDING THE ATTORNEY GENERAL'S HEALTH EDUCATION AND ADVOCACY UNIT AND THE ADMINISTRATION, FOR APPLICANTS AND ENROLLEES WITH GRIEVANCES, COMPLAINTS, QUESTIONS, OR THE NEED FOR OTHER SOCIAL SERVICES;

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

(8) ~~PROVIDE~~ PROVIDING 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 INDIVIDUAL EXCHANGE.

(D) (1) THE CONSUMER ASSISTANCE SERVICES DESCRIBED IN SUBSECTION (C) OF THIS SECTION THAT MUST BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR ARE THOSE SERVICES THAT INVOLVE THE SALE,

SOLICITATION, AND NEGOTIATION OF QUALIFIED PLANS OFFERED IN THE INDIVIDUAL EXCHANGE, INCLUDING:

(I) EXAMINING OR OFFERING TO EXAMINE A QUALIFIED PLAN FOR THE PURPOSE OF GIVING, OR OFFERING TO GIVE, ADVICE OR INFORMATION ABOUT THE TERMS, CONDITIONS, BENEFITS, COVERAGE, OR PREMIUM OF A QUALIFIED PLAN;

(II) FACILITATING:

1. QUALIFIED PLAN SELECTION;

2. THE APPLICATION OF PREMIUM TAX SUBSIDIES TO SELECTED QUALIFIED HEALTH PLANS;

3. PLAN APPLICATION, ENROLLMENT, RENEWAL, AND DISENROLLMENT PROCESSES; AND

(III) PROVIDING ONGOING SUPPORT WITH RESPECT TO ISSUES RELATING TO QUALIFIED PLAN ENROLLMENT, APPLICATION OF PREMIUM TAX SUBSIDIES, RENEWAL, AND DISENROLLMENT.

(2) THE CONSUMER ASSISTANCE SERVICES DESCRIBED IN SUBSECTION (C) OF THIS SECTION THAT DO NOT HAVE TO BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR ARE:

(I) CONDUCTING GENERAL EDUCATION AND OUTREACH;

(II) FACILITATING ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR PREMIUM TAX SUBSIDIES, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(III) FACILITATING AND PROVIDING ONGOING SUPPORT WITH RESPECT TO THE SELECTION OF MANAGED CARE ORGANIZATIONS, APPLICATION PROCESSES, ENROLLMENT, AND DISENROLLMENT FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(E) (1) THE EXCHANGE MAY AUTHORIZE AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY TO PROVIDE CONSUMER ASSISTANCE SERVICES THAT:

(I) ARE REQUIRED TO BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR; OR

(II) SUBJECT TO PARAGRAPH (2)(III) OF THIS SUBSECTION, RESULT IN A CONSUMER'S ENROLLMENT IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM.

(2) THE EXCHANGE:

(I) MAY LIMIT THE AUTHORIZATION OF AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY TO THE PROVISION OF A SUBSET OF SERVICES, DEPENDING ON THE NEEDS OF THE INDIVIDUAL EXCHANGE NAVIGATOR PROGRAM AND THE CAPACITY OF THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY, PROVIDED THAT THE NAVIGATOR PROGRAM OVERALL PROVIDES THE TOTALITY OF SERVICES REQUIRED BY THE AFFORDABLE CARE ACT AND THIS SUBTITLE;

(II) PURSUANT TO CONTRACTUAL AGREEMENT, MAY REQUIRE AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY TO PROVIDE EDUCATION, OUTREACH, AND OTHER CONSUMER ASSISTANCE SERVICES IN ADDITION TO THE SERVICES PROVIDED UNDER THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY'S AUTHORIZATION IN ORDER TO ACHIEVE ALL OF THE OBJECTIVES OF THE NAVIGATOR PROGRAM; AND

(III) MAY NOT AUTHORIZE AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY TO PROVIDE SERVICES THAT RESULT IN A CONSUMER'S ENROLLMENT IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM WITHOUT THE APPROVAL OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(F) AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY:

(1) SHALL OBTAIN AUTHORIZATION FROM THE INDIVIDUAL EXCHANGE TO PROVIDE SERVICES THAT:

(I) ARE REQUIRED TO BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR; OR

(II) RESULT IN A CONSUMER'S ENROLLMENT IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM;

(2) MAY PROVIDE:

(I) THOSE SERVICES THAT ARE WITHIN THE SCOPE OF THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY'S AUTHORIZATION; AND

(II) ANY OTHER CONSUMER ASSISTANCE SERVICES THAT:

1. ARE NOT REQUIRED TO BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR; OR

2. DO NOT REQUIRE AUTHORIZATION UNDER THIS SUBSECTION;

(3) TO THE EXTENT THE SCOPE OF ITS AUTHORIZATION INCLUDES SERVICES THAT MUST BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR, SHALL PROVIDE THOSE SERVICES ONLY THROUGH INDIVIDUAL EXCHANGE NAVIGATORS;

(4) IN ADDITION TO THE SERVICES IT MAY PROVIDE UNDER ITS AUTHORIZATION, MAY EMPLOY OR ENGAGE OTHER INDIVIDUALS TO CONDUCT:

(I) CONSUMER EDUCATION AND OUTREACH; AND

(II) DETERMINATIONS OF ELIGIBILITY FOR PREMIUM SUBSIDIES AND COST–SHARING ASSISTANCE, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE MARYLAND CHILDREN'S HEALTH PROGRAM;

(5) MAY EMPLOY OR ENGAGE INDIVIDUALS TO PERFORM ACTIVITIES THAT:

(I) ARE EXECUTIVE, ADMINISTRATIVE, MANAGERIAL, OR CLERICAL; AND

(II) RELATE ONLY INDIRECTLY TO SERVICES THAT MUST BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR OR RESULT IN A CONSUMER'S ENROLLMENT IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM;

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

(7) MAY NOT RECEIVE ANY COMPENSATION, DIRECTLY OR INDIRECTLY:

(I) FROM A CARRIER, AN INSURANCE PRODUCER, OR A THIRD–PARTY ADMINISTRATOR IN CONNECTION WITH THE ENROLLMENT OF A QUALIFIED INDIVIDUAL IN A QUALIFIED HEALTH PLAN; OR

(II) FROM ANY MANAGED CARE ORGANIZATION THAT PARTICIPATES IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM IN CONNECTION WITH THE ENROLLMENT OF AN INDIVIDUAL IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(8) WITH RESPECT TO THE INSURANCE MARKET OUTSIDE THE EXCHANGE:

(I) MAY NOT PROVIDE ANY INFORMATION OR SERVICES RELATED TO HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED IN THE EXCHANGE, EXCEPT FOR GENERAL INFORMATION ABOUT THE INSURANCE MARKET OUTSIDE THE EXCHANGE, WHICH SHALL BE LIMITED TO THE INFORMATION PROVIDED IN A CONSUMER EDUCATION DOCUMENT DEVELOPED BY THE EXCHANGE AND THE COMMISSIONER;

(II) SHALL REFER ANY INQUIRIES ABOUT HEALTH BENEFIT PLANS OR OTHER PRODUCTS NOT OFFERED IN THE EXCHANGE TO:

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

2. CARRIERS AND LICENSED INSURANCE PRODUCERS; AND

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

1. THE INDIVIDUAL IS ELIGIBLE FOR BUT HAS NOT OBTAINED A FEDERAL PREMIUM SUBSIDY AND COST–SHARING ASSISTANCE AVAILABLE ONLY THROUGH THE INDIVIDUAL EXCHANGE;

2. THE INSURANCE PRODUCER IS NOT AUTHORIZED TO SELL QUALIFIED PLANS IN THE INDIVIDUAL EXCHANGE; OR

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

(G) (1) THE COMMISSIONER MAY SUSPEND OR REVOKE AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY AUTHORIZATION AFTER NOTICE

AND OPPORTUNITY FOR A HEARING UNDER §§ 2–210 THROUGH 2–214 OF THIS ARTICLE IF THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY:

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

(II) HAS ENGAGED IN FRAUDULENT OR DISHONEST PRACTICES IN CONDUCTING ACTIVITIES UNDER THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY AUTHORIZATION;

(III) HAS HAD ANY PROFESSIONAL LICENSE OR CERTIFICATION SUSPENDED OR REVOKED FOR A FRAUDULENT OR DISHONEST PRACTICE;

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

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

(2) INSTEAD OF OR IN ADDITION TO SUSPENDING OR REVOKING AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY AUTHORIZATION, THE COMMISSIONER MAY:

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

(II) REQUIRE THAT RESTITUTION BE MADE TO ANY PERSON WHO HAS SUFFERED FINANCIAL INJURY BECAUSE OF THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY'S VIOLATION OF THIS ARTICLE.

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

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

(5) A CARRIER IS NOT RESPONSIBLE FOR THE ACTIVITIES AND CONDUCT OF INDIVIDUAL EXCHANGE NAVIGATOR ENTITIES.

(H) AN INDIVIDUAL EXCHANGE NAVIGATOR:

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

(2) MAY PROVIDE CONSUMER ASSISTANCE SERVICES THAT ARE REQUIRED TO BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR UNDER SUBSECTION (D)(1) OF THIS SECTION;

~~(2)~~ (3) MAY NOT BE REQUIRED TO HOLD AN INSURANCE PRODUCER OR ADVISER LICENSE;

~~(3)~~ (4) SHALL BE EMPLOYED OR ENGAGED BY AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITY;

~~(4)~~ (5) 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~~

(6) MAY NOT RECEIVE ANY COMPENSATION, DIRECTLY OR INDIRECTLY:

(I) FROM A CARRIER, AN INSURANCE PRODUCER, OR A THIRD–PARTY ADMINISTRATOR IN CONNECTION WITH THE ENROLLMENT OF A QUALIFIED INDIVIDUAL IN A QUALIFIED HEALTH PLAN; OR

(II) FROM A MANAGED CARE ORGANIZATION THAT PARTICIPATES IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM IN CONNECTION WITH THE ENROLLMENT OF AN INDIVIDUAL IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM;

(7) WITH RESPECT TO THE INSURANCE MARKET OUTSIDE THE EXCHANGE, IS SUBJECT TO THE SAME REQUIREMENTS APPLICABLE TO INDIVIDUAL EXCHANGE NAVIGATOR ENTITIES AS SET FORTH IN SUBSECTION (F)(8) OF THIS SECTION; AND

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

~~(E)~~ ~~(1)~~ (I) THE EXCHANGE:

~~(I)~~ (1) SHALL ESTABLISH AND ADMINISTER AN INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION ~~PROGRAM~~ PROCESS;

~~**(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) IN CONSULTATION WITH THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, SHALL ADOPT REGULATIONS TO IMPLEMENT THIS SUBSECTION; AND

(3) MAY IMPLEMENT THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION PROCESS WITH THE ASSISTANCE OF THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, 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)~~ (J) (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)~~ (K) OF THIS SECTION; AND

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

(3) A CERTIFICATION SHALL EXPIRE 2 YEARS AFTER THE DATE IT IS ISSUED UNLESS IT IS RENEWED.

~~(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.~~

(K) (1) THE EXCHANGE, WITH THE APPROVAL OF THE COMMISSIONER AND IN CONSULTATION WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND STAKEHOLDERS, SHALL DEVELOP, IMPLEMENT,

AND, AS APPROPRIATE, UPDATE A TRAINING PROGRAM FOR THE CERTIFICATION OF INDIVIDUAL EXCHANGE NAVIGATORS.

(2) THE TRAINING PROGRAM SHALL:

(I) ~~AFFORD~~ PROVIDE INDIVIDUAL EXCHANGE NAVIGATORS WITH THE FULL RANGE OF SKILLS, KNOWLEDGE, AND EXPERTISE NECESSARY TO MEET THE CONSUMER ASSISTANCE, ELIGIBILITY, ENROLLMENT, RENEWAL, AND DISENROLLMENT NEEDS OF INDIVIDUALS:

1. ELIGIBLE FOR THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM; OR

2. SEEKING QUALIFIED ~~HEALTH PLANS AND QUALIFIED DENTAL~~ PLANS OFFERED IN THE INDIVIDUAL 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 INDIVIDUAL 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)~~ (3) THE INDIVIDUAL EXCHANGE, IN CONSULTATION WITH THE ~~COMMISSIONER, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, AND THE MARYLAND CHILDREN'S HEALTH PROGRAM~~ THE DEPARTMENT OF

HEALTH AND MENTAL HYGIENE AND WITH THE APPROVAL OF THE COMMISSIONER, SHALL ADOPT REGULATIONS THAT GOVERN:

(I) THE SCOPE, TYPE, CONDUCT, FREQUENCY, AND ASSESSMENT OF THE TRAINING REQUIRED FOR ~~A~~ AN INDIVIDUAL EXCHANGE NAVIGATOR 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~~ INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION OR THE REACTIVATION OF AN INACTIVE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION.

~~(II)~~ (L) (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 WILLFULLY 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~~

(II) HAS INTENTIONALLY MISREPRESENTED OR CONCEALED A MATERIAL FACT IN THE APPLICATION FOR THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION;

(III) HAS OBTAINED THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION BY MISREPRESENTATION, CONCEALMENT, OR OTHER FRAUD;

(IV) HAS ENGAGED IN FRAUDULENT OR DISHONEST PRACTICES IN CONDUCTING ACTIVITIES UNDER THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION;

(V) HAS MISAPPROPRIATED, CONVERTED, OR UNLAWFULLY WITHHELD MONEY IN CONDUCTING ACTIVITIES UNDER THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION;

(VI) HAS FAILED OR REFUSED TO PAY OVER ON DEMAND MONEY THAT BELONGS TO A PERSON ENTITLED TO THE MONEY;

(VII) HAS WILLFULLY AND MATERIALLY MISREPRESENTED THE PROVISIONS OF A QUALIFIED PLAN;

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

(IX) HAS FAILED AN EXAMINATION REQUIRED BY THIS ARTICLE OR REGULATIONS ADOPTED UNDER THIS ARTICLE;

(X) HAS FORGED ANOTHER'S NAME ON AN APPLICATION FOR A QUALIFIED PLAN OR ON ANY OTHER DOCUMENT IN CONDUCTING ACTIVITIES UNDER THE INDIVIDUAL EXCHANGE NAVIGATOR CERTIFICATION;

(XI) HAS OTHERWISE SHOWN A LACK OF TRUSTWORTHINESS OR COMPETENCE TO ACT AS AN INDIVIDUAL EXCHANGE NAVIGATOR; OR

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

(2) INSTEAD OF OR IN ADDITION TO SUSPENDING OR REVOKING 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 AND THE INDIVIDUAL EXCHANGE NAVIGATOR ENTITY FOR WHICH THE INDIVIDUAL EXCHANGE NAVIGATOR WORKS OF ANY DECISION AFFECTING THE CERTIFICATION OF AN INDIVIDUAL EXCHANGE NAVIGATOR OR ANY SANCTION IMPOSED ON AN INDIVIDUAL EXCHANGE NAVIGATOR UNDER THIS SUBSECTION.

(5) A CARRIER IS NOT RESPONSIBLE FOR THE ACTIVITIES AND CONDUCT OF INDIVIDUAL EXCHANGE NAVIGATORS.

~~(H)~~ (M) (1) THE EXCHANGE SHALL ESTABLISH AND ADMINISTER AN INSURANCE PRODUCER AUTHORIZATION ~~PROGRAM~~ PROCESS FOR THE INDIVIDUAL EXCHANGE.

(2) UNDER THE ~~PROGRAM~~ PROCESS, 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)~~ (N) OF THIS SECTION; AND

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

(3) (I) SUBJECT TO THE CONTESTED CASE HEARING PROVISIONS OF TITLE 10, SUBTITLE 2 OF THE STATE GOVERNMENT ARTICLE,

THE EXCHANGE MAY ~~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~~ DESCRIBED IN SUBSECTION ~~(H)~~ (M)(1) OF THIS SECTION WITH RESPECT TO THE AUTHORIZATION.

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

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

~~(J)~~ (N) (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~~ CERTIFIED 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)~~ (O) 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)~~ (O) (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.

(P) NOTHING IN THIS SECTION SHALL PROHIBIT A COMMUNITY–BASED ORGANIZATION OR A UNIT OF STATE OR LOCAL GOVERNMENT FROM PROVIDING THE CONSUMER ASSISTANCE SERVICES DESCRIBED IN SUBSECTION (C) OF THIS SECTION THAT ARE NOT REQUIRED TO BE PROVIDED BY AN INDIVIDUAL EXCHANGE NAVIGATOR, IF THE ENTITY PROVIDING THE SERVICES AND ITS EMPLOYEES DO NOT:

(1) RECEIVE ANY COMPENSATION, DIRECTLY OR INDIRECTLY, FROM A CARRIER, AN INSURANCE PRODUCER, OR A THIRD–PARTY ADMINISTRATOR IN CONNECTION WITH THE ENROLLMENT OF A QUALIFIED INDIVIDUAL IN A QUALIFIED HEALTH PLAN;

(2) RECEIVE ANY COMPENSATION, DIRECTLY OR INDIRECTLY, FROM A MANAGED CARE ORGANIZATION THAT PARTICIPATES IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND

(3) IDENTIFY THEMSELVES TO THE PUBLIC AS AN INDIVIDUAL EXCHANGE NAVIGATOR ENTITIES OR INDIVIDUAL EXCHANGE NAVIGATORS.

31–114.

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

(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~~ SOLD IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO QUALIFIED HEALTH PLANS; AND

(3) VISION PLANS AS QUALIFIED VISION PLANS, WHICH MAY BE OFFERED BY CARRIERS AS:

(I) STAND–ALONE VISION PLANS; OR

(II) VISION PLANS SOLD IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO 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; AND

(III) DEMONSTRATING COMPLIANCE WITH THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008.

(c) **(1)** 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)~~ **(H)** of this section, if:

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

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

~~(i)~~ **1.** the plan does not provide the full range of essential pediatric **DENTAL** benefits; and

~~(ii)~~ **2.** qualified dental plans providing these and other dental benefits also not provided by the qualified health plan are offered through the Exchange.

(2) THE EXCHANGE MAY DETERMINE WHETHER A CARRIER MAY ELECT TO INCLUDE NONESSENTIAL ORAL AND DENTAL BENEFITS IN A QUALIFIED HEALTH PLAN.

(D) (1) A QUALIFIED HEALTH PLAN IS NOT REQUIRED TO PROVIDE ESSENTIAL BENEFITS THAT DUPLICATE THE MINIMUM BENEFITS OF QUALIFIED VISION PLANS, AS PROVIDED IN SUBSECTION (I) OF THIS SECTION, IF:

(I) THE EXCHANGE HAS DETERMINED THAT AT LEAST ONE QUALIFIED VISION PLAN IS AVAILABLE TO SUPPLEMENT THE QUALIFIED HEALTH PLAN'S COVERAGE; AND

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

1. THE PLAN DOES NOT PROVIDE THE FULL RANGE OF ESSENTIAL PEDIATRIC VISION BENEFITS; AND

2. QUALIFIED VISION PLANS PROVIDING THESE AND OTHER VISION BENEFITS ALSO NOT PROVIDED BY THE QUALIFIED HEALTH PLAN ARE OFFERED THROUGH THE EXCHANGE.

(2) THE EXCHANGE MAY DETERMINE WHETHER A CARRIER MAY ELECT TO INCLUDE NONESSENTIAL VISION BENEFITS IN A QUALIFIED HEALTH PLAN.

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

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

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

~~(e)~~ **(F)** 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)~~ **(G)** 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)~~ **(H)** (1) Except as provided in paragraphs ~~(2), (3), [and] (4), AND (5)~~ **(2) THROUGH (5)** of this subsection, the requirements applicable to qualified health plans under this title also shall apply to qualified dental plans **TO THE EXTENT RELEVANT, WHETHER OFFERED IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO QUALIFIED HEALTH PLANS OR AS STAND–ALONE DENTAL PLANS**.

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

(3) A qualified dental plan shall:

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

(ii) include at a minimum:

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

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

(4) **(I)** ~~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~~ **THE EXCHANGE MAY DETERMINE:**

1. THE MANNER IN WHICH CARRIERS MUST DISCLOSE THE PRICE OF ORAL AND DENTAL BENEFITS AND, TO THE EXTENT RELEVANT, MEDICAL BENEFITS, WHEN OFFERED:

A. TO THE EXTENT PERMITTED BY THE EXCHANGE, IN A QUALIFIED HEALTH PLAN;

B. IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO A QUALIFIED HEALTH PLAN; OR

C. AS A STAND–ALONE PLAN; AND

2. WHEN A CARRIER OFFERS A QUALIFIED DENTAL PLAN IN CONJUNCTION WITH A QUALIFIED HEALTH PLAN, WHETHER THE CARRIER ALSO MUST MAKE THE QUALIFIED HEALTH PLAN, THE QUALIFIED DENTAL PLAN, OR BOTH QUALIFIED PLANS AVAILABLE ON A STAND–ALONE BASIS.

(II) IN DETERMINING THE MANNER IN WHICH CARRIERS MUST OFFER AND DISCLOSE THE PRICE OF MEDICAL, ORAL, AND DENTAL BENEFITS UNDER THIS PARAGRAPH, THE EXCHANGE SHALL BALANCE THE OBJECTIVES OF TRANSPARENCY AND AFFORDABILITY FOR CONSUMERS.

(5) THE EXCHANGE MAY:

(I) EXEMPT QUALIFIED DENTAL PLANS FROM A REQUIREMENT APPLICABLE TO QUALIFIED HEALTH PLANS UNDER THIS TITLE TO THE EXTENT THE EXCHANGE DETERMINES THE REQUIREMENT IS NOT RELEVANT TO QUALIFIED DENTAL PLANS; AND

(II) ESTABLISH ADDITIONAL REQUIREMENTS FOR QUALIFIED DENTAL PLANS IN CONJUNCTION WITH ITS ESTABLISHMENT OF ADDITIONAL REQUIREMENTS FOR QUALIFIED HEALTH PLANS UNDER SUBSECTION (B)(9) OF THIS SECTION.

(I) (1) EXCEPT AS PROVIDED IN PARAGRAPHS (2) THROUGH (5) OF THIS SUBSECTION, THE REQUIREMENTS APPLICABLE TO QUALIFIED HEALTH PLANS UNDER THIS TITLE ALSO SHALL APPLY TO QUALIFIED VISION PLANS TO THE EXTENT RELEVANT, WHETHER OFFERED IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO QUALIFIED HEALTH PLANS OR AS STAND–ALONE VISION PLANS.

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

(3) A QUALIFIED VISION PLAN SHALL:

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

(II) INCLUDE AT A MINIMUM:

1. THE ESSENTIAL PEDIATRIC VISION BENEFITS REQUIRED BY THE SECRETARY UNDER § 1302(B)(1)(J) OF THE AFFORDABLE CARE ACT; AND

2. OTHER VISION BENEFITS REQUIRED BY THE SECRETARY OR THE EXCHANGE.

(4) (I) THE EXCHANGE MAY DETERMINE:

1. THE MANNER IN WHICH CARRIERS MUST DISCLOSE THE PRICE OF VISION BENEFITS AND, TO THE EXTENT RELEVANT, MEDICAL BENEFITS, WHEN OFFERED:

A. TO THE EXTENT PERMITTED BY THE EXCHANGE, IN A QUALIFIED HEALTH PLAN;

B. IN CONJUNCTION WITH OR AS AN ENDORSEMENT TO A QUALIFIED HEALTH PLAN; OR

C. AS A STAND–ALONE PLAN; AND

2. WHEN A CARRIER OFFERS A QUALIFIED VISION PLAN IN CONJUNCTION WITH A QUALIFIED HEALTH PLAN, WHETHER THE CARRIER ALSO MUST MAKE THE QUALIFIED HEALTH PLAN, THE QUALIFIED VISION PLAN, OR BOTH QUALIFIED PLANS AVAILABLE ON A STAND–ALONE BASIS.

(II) IN DETERMINING THE MANNER IN WHICH CARRIERS MUST OFFER AND DISCLOSE THE PRICE OF MEDICAL AND VISION BENEFITS UNDER THIS PARAGRAPH, THE EXCHANGE SHALL BALANCE THE OBJECTIVES OF TRANSPARENCY AND AFFORDABILITY FOR CONSUMERS.

(5) THE EXCHANGE MAY:

(I) EXEMPT QUALIFIED VISION PLANS FROM A REQUIREMENT APPLICABLE TO QUALIFIED HEALTH PLANS UNDER THIS TITLE TO THE EXTENT THE EXCHANGE DETERMINES THE REQUIREMENT IS NOT RELEVANT TO QUALIFIED VISION PLANS; AND

(II) ESTABLISH ADDITIONAL REQUIREMENTS FOR QUALIFIED VISION PLANS IN CONJUNCTION WITH ITS ESTABLISHMENT OF ADDITIONAL REQUIREMENTS FOR QUALIFIED HEALTH PLANS UNDER SUBSECTION (B)(9) OF THIS SECTION.

(J) A MANAGED CARE ORGANIZATION MAY NOT BE REQUIRED TO OFFER A QUALIFIED PLAN IN THE EXCHANGE.

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~~ BENEFITS MANDATED BY STATE LAW, SHALL BE THE BENEFITS REQUIRED IN:

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

(II) SUBJECT TO § 31–115(C) AND (D) OF THIS TITLE, 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)~~ (D) IN SELECTING THE STATE BENCHMARK PLAN, THE MARYLAND HEALTH CARE REFORM COORDINATING COUNCIL SHALL:

~~(I)~~ (1) OBTAIN GUIDANCE NECESSARY TO:

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

~~2.~~ (II) CONDUCT A COMPARATIVE ANALYSIS OF THE BENEFITS OF EACH PLAN; ~~AND~~

~~(II)~~ (2) SOLICIT THE INPUT OF STAKEHOLDERS IN THE STATE, INCLUDING MEMBERS OF THE GENERAL ASSEMBLY AND MEMBERS OF THE PUBLIC, BY:

~~1.~~ (I) APPOINTING AND CONSULTING WITH AN ADVISORY GROUP MADE UP OF A DIVERSE AND REPRESENTATIVE CROSS–SECTION OF STAKEHOLDERS, INCLUDING:

1. INDIVIDUALS WITH KNOWLEDGE OF AND EXPERTISE IN ADVOCATING FOR CONSUMERS REPRESENTING LOWER INCOME, RACIAL, ETHNIC, OR OTHER MINORITIES, INDIVIDUALS WITH CHRONIC DISEASES AND OTHER DISABILITIES, AND VULNERABLE POPULATIONS;

2. PUBLIC HEALTH RESEARCHERS AND OTHER ACADEMIC EXPERTS WITH RELEVANT KNOWLEDGE AND BACKGROUND, INCLUDING KNOWLEDGE AND BACKGROUND RELATING TO DISPARITIES AND THE HEALTH NEEDS OF DIVERSE POPULATIONS; AND

3. CARRIERS, HEALTH CARE PROVIDERS, AND OTHER INDUSTRY REPRESENTATIVES WITH KNOWLEDGE AND EXPERTISE RELEVANT TO HEALTH PLAN BENEFITS AND DESIGN;

(II) TO THE EXTENT PRACTICABLE, APPOINTING INDIVIDUALS TO THE ADVISORY GROUP WHO REFLECT THE GENDER, RACIAL, ETHNIC, AND GEOGRAPHIC DIVERSITY OF THE STATE; AND

~~2.~~ (III) ESTABLISHING A MECHANISM FOR MEMBERS OF THE GENERAL ASSEMBLY AND MEMBERS OF THE PUBLIC TO:

1. BE KEPT INFORMED BY ELECTRONIC MAIL; AND

2. PROVIDE COMMENT; AND

(3) SELECT A PLAN THAT COMPLIES WITH ALL REQUIREMENTS OF THIS TITLE AND THE AFFORDABLE CARE ACT, THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AND ANY OTHER FEDERAL LAWS,

REGULATIONS, POLICIES, OR GUIDANCE APPLICABLE TO STATE BENCHMARK PLANS AND ESSENTIAL HEALTH BENEFITS.

~~(5)~~ (E) 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~~ COMMISSIONER, 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.~~ 4. 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) (i) whether the State should develop a ~~Maryland–specific~~ risk adjustment program as an alternative to the federal or Maryland–specific model selected under Title 31 of the Insurance Article 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)~~ (ii) if so, how the ~~Maryland~~ alternative risk adjustment program should be designed and when it should be implemented;

(2) whether strategies should be implemented to mitigate the impact of the inclusion in the individual market of individuals enrolled in the Maryland Health Insurance Plan; and

(3) whether the State should develop a Maryland–specific reinsurance program to ensure the affordability of premiums in the individual market.

SECTION ~~4.~~ 5. 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; and

(8) the Attorney General, or the Attorney General's designee.

(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) (i) 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; and

(ii) in assessing total funds needed to sustain the Exchange and to minimize duplication of functions and costs, consider the expertise of and functions already performed by the Department of Health and Mental Hygiene, the Maryland Health Care Commission, the Maryland Insurance Administration, and the Health Services Cost Review Commission;

(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) taking into account all of the ramifications of and funding available under the Affordable Care Act and changes in the State's health care delivery system, consider the impact of any funding mechanism on health insurance premiums and the State's Medicare waiver;

~~(4)~~ (5) 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)~~ (6) 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.~~ 6. 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.~~ 7. 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.~~ 8. AND BE IT FURTHER ENACTED, That, on or before December 1, 2012, the Maryland Health Benefit Exchange, in consultation with the Maryland Insurance Commissioner, the Department of Health and Mental Hygiene, 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.~~ 9. AND BE IT FURTHER ENACTED, That, except as provided in Section 11 of this Act, the requirements of § 31–116(a)(2)(i) of the Insurance Article, as enacted by Section 2 of this Act, shall be subject to any clarification regarding essential pediatric benefits that may be provided by the U.S. Department of Health and Human Services.

SECTION ~~9.~~ 10. AND BE IT FURTHER ENACTED, That, with respect to the preparation and certification of qualified plans to be offered through the Maryland Health Benefit Exchange in 2014, pending adoption of regulations under Title 31 of the Insurance Article, and after receiving comment from the Joint Committee on Administrative, Executive, and Legislative Review, the Senate Finance Committee, the House Health and Government Operations Committee, carriers, and the public, the Board of Trustees of the Exchange may adopt interim policies, if necessary, to:

(1) comply with federal law and regulations; and

(2) allow carriers offering qualified plans in the Exchange in 2014 sufficient time to design and develop qualified plans and file rates with the Maryland Insurance Administration.

SECTION 11. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall take effect January 1, 2014.

SECTION ~~8.~~ ~~10.~~ 12. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2012.

Approved:

_____

Governor.

_____

President of the Senate.

_____

Speaker of the House of Delegates.