# HOUSE BILL 228

J1 3lr0145
CF SB 274

By: **The Speaker (By Request – Administration) and Delegates Anderson, Barve, Bobo, Carr, Carter, Cullison, Davis, Donoghue, Feldman, Glenn, Griffith, Hammen, Hubbard, Hucker, A. Kelly, Lee, McIntosh, Mizeur, Morhaim, Murphy, Nathan–Pulliam, Pena–Melnyk, Pendergrass, Reznik, V. Turner, Vallario, and M. Washington**

Introduced and read first time: January 21, 2013
Assigned to: Health and Government Operations

Committee Report: Favorable with amendments
House action: Adopted with floor amendments
Read second time: March 20, 2013

CHAPTER _____

AN ACT concerning

**Maryland Health Progress Act of 2013**

FOR the purpose of altering certain eligibility requirements for the Maryland Medical Assistance Program and a certain definition to conform to federal eligibility requirements; requiring the Department of Health and Mental Hygiene to implement certain provisions of federal law, subject to the limitations of the State budget; repealing an obsolete provision of law that requires the Governor to include certain funding in the State budget; authorizing the Secretary of Health and Mental Hygiene to provide certain grants for a certain purpose; expanding the purposes for which funds generated from a certain assessment may be used to include providing funding for a certain reinsurance program; ~~establishing the Performance Standards and Measurement Advisory Committee in the Department; providing for the purposes, membership, chair, and duties of the Committee;~~ exempting from the insurance premium tax a qualified nonprofit health insurance issuer that meets certain requirements; requiring a portion of a certain tax to be distributed, beginning on a certain date, annually to the Maryland Health Benefit Exchange Fund for a certain purpose; exempting the Maryland Health Benefit Exchange (Exchange) and its employees from certain provisions of law governing third party administrators; expanding the purposes for which the Maryland Health Insurance Plan Fund may be used to include funding a certain reinsurance program; requiring

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.

enrollment in the Maryland Health Insurance Plan (Plan) to be closed to certain individuals not enrolled in the Plan as of a certain date; prohibiting certain individuals from reenrolling in the Plan under certain circumstances; requiring the Board of the Plan, in consultation with the Exchange, to determine the appropriate date on which the Plan must decline reenrolling Plan members; requiring the Board of the Plan to provide certain notice to Plan members beginning on a certain date; requiring the Plan Administrator to deposit certain money in a certain separate account and to keep certain records; authorizing the transfer, under certain circumstances, of certain money in the separate account to the Maryland Health Benefit Exchange Fund for the purpose of funding a certain reinsurance program; requiring the Board of the Plan and the Board of Trustees of the Exchange to develop and approve a plan for the amount and timing of the use of certain funds for a certain reinsurance program; requiring the Board of the Plan and the Board of Trustees of the Exchange to report on certain matters at certain times; establishing the purpose and effect of certain provisions of this Act; exempting certain carriers that offer certain plans from a certain requirement under certain circumstances; requiring certain carriers and managed care organizations to accept a ~~prior authorization~~ preauthorization from certain carriers and managed care organizations under certain circumstances; requiring certain carriers and managed care organizations to allow a new enrollee to continue to receive certain health care services being rendered by a certain provider under certain circumstances; providing for the application of certain requirements relating to preauthorizations and continuity of health care services; exempting enrollees transitioning from a carrier to the Maryland Medical Assistance fee–for–service program from the preauthorization and continuity of health care services requirements; requiring certain providers and certain carriers or managed care organizations to agree on the compensation rates and methods of payment with respect to the provision of certain services; specifying certain requirements for the agreement; providing that if an agreement is not reached, the provider is not required to continue to provide the services and the carrier or managed care organization ~~is not required to allow the services to be provided by the provider~~ must facilitate transition of the enrollee to a provider on the provider panel of the carrier or managed care organization; authorizing a relinquishing carrier to elect to allow an enrollee to continue to receive dental services provided by a participating provider of the relinquishing carrier through a certain arrangement; providing that the requirements of certain provisions of this Act are in addition to any other legal, professional, or ethical obligations of a carrier or managed care organization to provide continuity of care; authorizing the Maryland Insurance Commissioner and the Secretary of Health and Mental Hygiene to each adopt regulations to enforce certain provisions of this Act; requiring the Commissioner, the Secretary, and the Exchange to determine the data necessary to make a certain assessment and develop a certain process ~~and to request the data from certain persons~~; requiring certain persons to provide the data on request; establishing that it is a fraudulent insurance act for a person to act or represent that the person is a SHOP Exchange navigator ~~or~~, an Individual Exchange navigator, or certain application counselor ~~to take certain~~

~~actions or make certain representations~~ under certain circumstances; exempting the Exchange from certain insurance laws; ~~requiring a carrier, under certain circumstances, to retain responsibility for ensuring that certain consumer protections are afforded to certain employers and enrollees~~ providing that a carrier is not liable or subject to certain regulatory sanction under certain circumstances; requiring the Commissioner to regulate the Exchange in taking certain actions; prohibiting the Commissioner from imposing a fine or administrative penalty on the Exchange for failing to take certain actions; authorizing the Commissioner to require the Exchange to make certain restitution to certain consumers under certain circumstances; requiring the Exchange and certain carriers to hold a consumer harmless from certain consequences caused by a certain action of the Exchange; prohibiting the Commissioner from participating in certain matters as a member of the Board of Trustees of the Exchange under certain circumstances; requiring the Board of Trustees of the Exchange to establish a certain committee; expanding the purposes of the Maryland Health Benefit Exchange Fund to include providing funding for the establishment and operation of a certain reinsurance program; altering the contents of the Fund; requiring the Board of Trustees of the Exchange to maintain certain accounts within the Fund; requiring certain funds to be placed in a certain account for a certain purpose; establishing certain restrictions on certain expenditures from the Fund; requiring certain funds in a certain account to revert to the General Fund of the State under certain circumstances; requiring certain operating expenses to be charged to a certain fund source under certain circumstances; requiring the Board of Trustees to establish a trust account for a certain purpose; requiring the Board of Trustees to maintain separate records of account for certain carriers; requiring the Governor, for certain fiscal years, to provide an appropriation in the State budget from certain funds received from a certain premium tax adequate to fully fund the operations of the Exchange; requiring ~~the appropriation to be allocated from a certain premium tax~~ a certain minimum appropriation for certain fiscal years; authorizing a certain deficiency appropriation; requiring certain funds to revert to the General Fund of the State; requiring the Exchange to comply with certain federal law in carrying out certain functions; providing that a certain employer is not required to contribute to the qualified plan premiums of its employees; requiring a certain employer to take certain actions if the employer chooses to contribute to the qualified premiums of its employees; authorizing the Exchange to establish a Consolidated Services Center (Center) under certain circumstances; applying certain provisions of law that require certain training for SHOP Exchange navigators to certain employees of the Center; authorizing an Individual Exchange navigator to be employed by the Exchange; requiring the Exchange to establish and administer a process for the issuance of Consolidated Services Center employee Individual Exchange enrollment permits; authorizing the Exchange to implement a certain process with certain assistance; applying certain provisions of law that require certain training for Individual Exchange navigators to certain employees of the Center; clarifying the circumstances of individuals whom the Individual Exchange shall assist in making a certain transition; requiring the training program for

insurance producers who sell qualified plans in the Individual Exchange to impart certain skills and expertise; authorizing, until a certain date, a captive producer without a certain certification to enroll certain individuals in a qualified plan offered in the Individual Exchange by a certain carrier; requiring a captive producer to refer certain individuals to an insurance producer under certain circumstances, with certain exceptions; requiring a captive producer to make a certain disclosure; establishing requirements a carrier and its captive producers must meet in offering information and assistance to the carrier's current enrollees; prohibiting a captive producer from providing information or services related to health benefit plans or other products not offered by the captive producer's carrier; requiring a captive producer to make certain referrals under certain circumstances; authorizing the Exchange to designate certain entities as application counselor sponsoring entities and to certify certain individuals as application counselors; establishing requirements for application counselor sponsoring entities and application counselors to provide certain services; providing that an application counselor is subject to certain requirements; authorizing the Exchange, in consultation with the Commissioner and the Department, to establish requirements for an application counselor sponsoring entity and to adopt regulations relating to application counselor sponsoring entities and application counselors; authorizing the Center to employ certain individuals; specifying the qualifications that must be met for issuance of a SHOP Exchange enrollment permit and an Individual Exchange enrollment permit; requiring the Exchange, the Center, and Center employees to assist the Health Education and Advocacy Unit of the Office of the Attorney General in carrying out certain duties; altering the requirements that must be met for a health benefit plan to be certified as a qualified health plan; altering requirements for qualified health plans relating to vision benefits; authorizing the Exchange to require children enrolling in a qualified health plan to have certain dental benefits; authorizing the Exchange to deny certification to certain plans or suspend or revoke certification of certain plans under certain circumstances; authorizing the Exchange, in addition to denying, suspending, or revoking certification, to impose certain other remedies or take other actions; requiring the Exchange to consider certain factors in determining the amount of a certain penalty; establishing a process through which a carrier or plan may appeal a certain order or decision; authorizing the Exchange, in consultation with the Maryland Health Care Commission and with the approval of the Commissioner, to establish a certain reinsurance program to take effect on or after a certain date; establishing the purpose of the program; authorizing the Exchange, with the approval of and in collaboration with the Board of the Plan, to use certain revenue to fund the program; specifying the types of discrimination the Exchange shall be designed to prevent; altering the requirements for an annual report on the activities, expenditures, and receipts of the Exchange; altering the circumstances under which the Board of Trustees of the Exchange must cooperate with certain investigations; declaring the intent of the General Assembly; requiring the Exchange, the Department of Health and Mental Hygiene, ~~and~~ the Maryland Insurance Administration, and the Maryland Health Care Commission to conduct a certain study and report to the

Governor and the General Assembly on the findings of the study and certain recommendations on or before a certain date; requiring the Exchange and the Administration to conduct a study of the impact of the Affordable Care Act's allowance of a certain tobacco use rating and to report to the Governor and the General Assembly on the findings of the study and certain recommendations on or before a certain date; authorizing the Board of Trustees of the Exchange to adopt certain interim policies, for certain purposes after receiving certain comment; requiring the interim policies to be submitted as proposed regulations within a certain period after adoption and to sunset within a certain time after submission as proposed regulations; requiring the Exchange and the Administration to conduct a study of the impact of federal regulations governing the offering and purchase of pediatric dental benefits and to report to the Governor and General Assembly on their findings and recommendations on or before a certain date; requiring the Exchange and the Administration to conduct a study of a certain captive producer program and to report to the Governor and General Assembly on their findings and recommendations on or before a certain date; defining certain terms; altering certain definitions; making certain conforming changes; ~~providing for the initial terms of the members of the Performance Standards and Measurement Advisory Committee;~~ providing for the termination of certain provisions of this Act; providing for the effective dates of this Act; and generally relating to health insurance regulation and the Maryland Health Benefit Exchange.

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

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–101(d–1), 15–103(a), 19–143(a), and 19–214(d)
Annotated Code of Maryland
(2009 Replacement Volume and 2012 Supplement)

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

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

BY repealing and reenacting, with amendments,
Article – Insurance
Section 6–101(b), 8–301(b), 14–502, 14–504, ~~15–1303(b),~~ 27–405(a), 31–101(i), (k), and (l), 31–103, 31–106(g), 31–107, 31–108(c), (d), and (e), 31–111, 31–112(h), ~~31–113(h), (i), and (k)(1) and (2)~~ 31–113(a)(5), (b), (e), (f), (g), (h), (i), (k)(1) and (2), (l)(4), (m), (o), and (p), 31–114(a), 31–115(b), (d), (h), and (i)(3), 31–116(a), 31–117, and ~~31–119(e)~~ 31–119(a), (d), and (e)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)

BY adding to
Article – Insurance
Section 6–103.2, 15–140, ~~31–101(c–1)~~ 31–101(a–1), (a–2), (c–1), and (c–2), 31–107.1, 31–107.2, 31–108(c), 31–113(p) and (r), 31–113.1, and 31–115(k)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)

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

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–1303(b)(2)
Annotated Code of Maryland
(2011 Replacement Volume and 2012 Supplement)
(As enacted by Chapter 152 of the Acts of the General Assembly of 2012)

Preamble

WHEREAS, The federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended by the federal Health Care and Education Reconciliation Act of 2010, gives states tools to expand access, enhance quality, and address the costs of health care for individuals, families, and small employers; and

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

WHEREAS, Maryland's Health Benefit Exchange, if successful, will make health care coverage accessible to hundreds of thousands of Marylanders who

otherwise would not be able to obtain the insurance necessary for financial security, health, and well–being; and

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

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

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

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

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

WHEREAS, The Maryland Health Benefit Exchange Act of 2012, enacted by Chapter 152 of the Acts of 2012, put in place many of the Exchange Board's initial policy recommendations, developed with the input of its advisory groups and in accordance with its guiding principles, necessary to establish and operate a successful Exchange; and

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

WHEREAS, In accordance with these principles, the State seeks to put in place some remaining policies, including a dedicated revenue stream to ensure the

Exchange's long–term financial sustainability, which are necessary to comply with federal requirements for certification and to complete development of the Exchange by January 1, 2014; and

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

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

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

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

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

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

**Article – Health – General**

15–101.

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

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

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

(2) Who, on the individual's 18th birthday, was in foster care under the responsibility of the State**, ANY OTHER STATE, OR THE DISTRICT OF COLUMBIA**.

15–103.

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

(2) The Program:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**[**(xi)**] (X)** ~~Shall provide, subject~~ **SUBJECT** to the limitations of the State budget, and as permitted by federal law~~,~~**:**

**1. SHALL PROVIDE** comprehensive medical care and other health care services for ~~independent~~ **FORMER** foster care adolescents~~:~~

~~1.~~ ~~Who~~ **WHO, ON THEIR 18TH BIRTHDAY, WERE IN FOSTER CARE UNDER THE RESPONSIBILITY OF THE STATE AND** are not otherwise eligible for Program benefits; and

~~2. Whose annual household income is at or below 300 percent of the poverty level~~ **MAY PROVIDE COMPREHENSIVE MEDICAL CARE AND OTHER HEALTH CARE SERVICES FOR FORMER FOSTER CARE ADOLESCENTS WHO, ON THEIR 18TH BIRTHDAY, WERE IN FOSTER CARE UNDER THE RESPONSIBILITY OF ANY OTHER STATE OR THE DISTRICT OF COLUMBIA**;

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

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

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

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

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

1. Cap enrollment; and

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

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

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

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

**(II) ADULTS WHO DO NOT MEET REQUIREMENTS, SUCH AS AGE, DISABILITY, OR PARENT OR CARETAKER RELATIVE OF A DEPENDENT CHILD, FOR A FEDERAL CATEGORY OF ELIGIBILITY FOR MEDICAID AND WHO ARE NOT ENROLLED IN THE FEDERAL MEDICARE PROGRAM, AS ENACTED BY TITLE XVII OF THE SOCIAL SECURITY ACT.**

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

**Article – Health – General**

19–143.

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

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

19–214.

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

(1) Reduce uncompensated care; and

(2) Assure the integrity of the payment system.

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

(1) Are in the public interest;

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The Commission shall ensure that the assessment:

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

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

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

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

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

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

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

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

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

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

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

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

~~**20–1501.**~~

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

~~**(B) THE PURPOSES OF THE COMMITTEE ARE TO:**~~

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

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

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

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

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

~~1. THE DEPARTMENT;~~

~~2. THE MARYLAND INSURANCE ADMINISTRATION;~~

~~3. THE MARYLAND HEALTH BENEFIT EXCHANGE;~~

~~4. THE MARYLAND HEALTH CARE COMMISSION;~~

~~5. THE MARYLAND HEALTH QUALITY AND COST COUNCIL; AND~~

~~6. THE HEALTH SERVICES COST REVIEW COMMISSION;~~

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

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

~~(V) TWO CONSUMER MEMBERS.~~

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

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

~~(3) AT THE END OF A TERM, A MEMBER CONTINUES TO SERVE UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.~~

~~(4) A MEMBER WHO IS APPOINTED AFTER A TERM HAS BEGUN SERVES ONLY FOR THE REST OF THE TERM AND UNTIL A SUCCESSOR IS APPOINTED AND QUALIFIES.~~

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

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

~~(F) THE COMMITTEE SHALL:~~

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

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

~~(3) RECOMMEND PERFORMANCE MEASURES THAT:~~

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

~~(II) INCLUDE MEASURES OF PUBLIC HEALTH OUTCOMES;~~

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

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

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

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

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

**Article – Insurance**

6–101.

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

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

(2) a fraternal benefit society;

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

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

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

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

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

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

**6–103.2.**

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

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

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

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

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

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

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

8–301.

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

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

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

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

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

(i) with respect to a particular plan:

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

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

3. is an insurance producer that solicits, procures, or negotiates a plan for a plan sponsor and that has no authority over the adjustment, payment, or settlement of benefit claims under the plan or over the investment or handling of the plan's assets;

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

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

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

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

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

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

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

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

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

14–502.

(a) There is a Maryland Health Insurance Plan.

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

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

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

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

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

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

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

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

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

**(2) ~~(I)~~ SUBJECT TO ~~SUBPARAGRAPH (II) OF THIS PARAGRAPH~~ PARAGRAPH (3) OF THIS SUBSECTION, THE BOARD, IN CONSULTATION WITH THE MARYLAND HEALTH BENEFIT EXCHANGE, SHALL DETERMINE THE APPROPRIATE DATE ON WHICH THE PLAN SHALL DECLINE TO REENROLL PLAN MEMBERS BEYOND THE TERM OF THE MEMBERS' EXISTING PLAN COVERAGE.**

**~~(II)~~ (3) THE DATE ON WHICH THE PLAN NO LONGER WILL PROVIDE COVERAGE TO ~~ANY~~ ALL PLAN ~~MEMBER~~ MEMBERS SHALL BE NO EARLIER THAN JANUARY 1, ~~2015~~ 2014, AND NO LATER THAN JANUARY 1, 2020.**

**(G) BEGINNING OCTOBER 1, 2013, AND ANNUALLY THEREAFTER UNTIL THE PLAN NO LONGER PROVIDES COVERAGE TO MEMBERS, THE BOARD SHALL PROVIDE NOTICE TO PLAN MEMBERS THAT, EFFECTIVE JANUARY 1, 2014, THE MEMBER:**

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

**(2) MAY BE ELIGIBLE TO:**

**(I) ENROLL IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM;**

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

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

14–504.

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

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

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

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

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

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

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

(b) The Fund shall consist of:

(1) premiums for coverage that the Plan issues;

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

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

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

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

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

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

(8) money donated to the Fund; and

(9) money awarded to the Fund through grants.

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

(2) The Administrator:

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

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

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

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

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

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

**(2) BEGINNING JANUARY 1, ~~2015~~ 2014, AND SUBJECT TO § 19–214(D)(5) OF THE HEALTH – GENERAL ARTICLE AND PARAGRAPH (3) OF THIS SUBSECTION, THE BOARD MAY ALLOW THE ADMINISTRATOR TO TRANSFER MONEY IN THE SEPARATE ACCOUNT INTO THE MARYLAND HEALTH BENEFIT EXCHANGE FUND FOR THE PURPOSE OF FUNDING THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS ARTICLE.**

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

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

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

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

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

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

**(5) ON OR BEFORE DECEMBER 31, 2013, AND ON OR BEFORE DECEMBER 31 OF EACH YEAR THEREAFTER UNTIL THE PLAN NO LONGER HAS ANY LIABILITY FOR CLAIMS SUBMITTED BY PLAN ENROLLEES AND THE STATE REINSURANCE PROGRAM IS TERMINATED, THE BOARD OF TRUSTEES OF THE MARYLAND HEALTH BENEFIT EXCHANGE AND THE BOARD SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON:**

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

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

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

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

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

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

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

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

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

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

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

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

**(4) (I) BEGINNING JANUARY 1, ~~2015~~ 2014, THE FUNDS COLLECTED IN ACCORDANCE WITH § 19–214(D)(1)(II) OF THE HEALTH – GENERAL ARTICLE AND DEPOSITED IN THE MARYLAND HEALTH INSURANCE PLAN ACCOUNT OF THE FUND, MAY BE USED FOR THE PURPOSES OF ESTABLISHING AND OPERATING THE STATE REINSURANCE PROGRAM AUTHORIZED UNDER § 31–117 OF THIS ARTICLE.**

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

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

~~15–1303.~~

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

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

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

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

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

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

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

27–405.

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

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

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

**(3) A NAVIGATOR OF THE INDIVIDUAL EXCHANGE OF THE MARYLAND HEALTH BENEFIT EXCHANGE IF THE PERSON HAS NOT RECEIVED THE APPROPRIATE CERTIFICATION UNDER OR OTHERWISE COMPLIED WITH § 31–113 OF THIS ARTICLE; OR**

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

31–101.

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

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

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

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

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

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

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

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

~~**(C–1)**~~ **(C–2) "CONSOLIDATED SERVICES CENTER" OR "CSC" MEANS THE CONSUMER ASSISTANCE CALL CENTER ESTABLISHED IN ACCORDANCE WITH THE REQUIREMENT TO OPERATE A TOLL–FREE HOTLINE UNDER § 1311(D)(4) OF THE AFFORDABLE CARE ACT AND § 31–108(B)(5) OF THIS TITLE.**

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

(1) holds an Individual Exchange navigator certification; and

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

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

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

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

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

31–103.

(a) The Exchange is subject to:

(1) the following provisions of the State Finance and Procurement Article:

(i) Title 12, Subtitle 4 (Policies and Procedures for Exempt Units); and

(ii) Title 14, Subtitle 3 (Minority Business Participation);

(2) the following provisions of the State Government Article:

(i) Title 10, Subtitle 1 (Governmental Procedures);

(ii) Title 10, Subtitle 5 (Meetings);

(iii) Title 10, Subtitle 6, Part III (Access to Public Records);

(iv) Title 12 (Immunity and Liability); and

(v) Title 15 (Public Ethics); and

(3) Title 5, Subtitle 3 of the State Personnel and Pensions Article.

(b) The Exchange is not subject to:

(1) taxation by the State or local government;

(2) Division II of the State Finance and Procurement Article, except as provided in subsection (a)(1) of this section;

(3) Title 10 of the State Government Article, except as provided in subsection (a)(2)(i), (ii), and (iii) of this section; **[**or**]**

(4) Division I of the State Personnel and Pensions Article, except as provided in subsection (a)(3) of this section and elsewhere in this title**; OR**

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

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

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

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

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

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

**2. MAY REQUIRE THE EXCHANGE TO:**

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

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

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

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

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

**(II) HOLDING THE CONSUMER HARMLESS SHALL INCLUDE:**

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

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

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

**(D) ~~THIS~~ EXCEPT AS PROVIDED IN SUBSECTION (C) OF THIS SECTION, THIS SECTION DOES NOT:**

**(1) AFFECT THE COMMISSIONER'S AUTHORITY TO REGULATE A CARRIER UNDER THIS ARTICLE; OR**

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

31–106.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31–107.

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

(b) **(1)** The purpose of the Fund is to**:**

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

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

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

(c) The Exchange shall administer the Fund.

(d) (1) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(2) The State Treasurer shall hold the Fund separately, and the Comptroller shall account for the Fund.

(e) The Fund consists of:

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

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

**~~(2)~~ (3) ALL REVENUE THAT IS DEPOSITED INTO THE FUND UNDER § 14–504(D) OF THIS ARTICLE FROM THE SEPARATE ACCOUNT OF THE MARYLAND HEALTH INSURANCE PLAN FUND THAT HOLDS MONEY COLLECTED UNDER § 19–214(D)(1)(II) OF THE HEALTH – GENERAL ARTICLE;**

**[**(2)**]** **~~(3)~~ (4)** income from investments made on behalf of the Fund;

**[**(3)**]** **~~(4)~~ (5)** interest on deposits or investments of money in the Fund;

**[**(4)**]** **~~(5)~~ (6)** money collected by the Board as a result of legal or other actions taken by the Board on behalf of the Exchange or the Fund;

**[**(5)**]** **~~(6)~~ (7)** money donated to the Fund;

**[**(6)**]** **~~(7)~~ (8)** money awarded to the Fund through grants; and

**[**(7)**]** **~~(8)~~ (9)** any other money from any other source accepted for the benefit of the Fund.

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

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

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

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

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

**(3) FUNDS RECEIVED FROM THE DISTRIBUTION OF THE PREMIUM TAX UNDER § 6–103.2 OF THIS ARTICLE SHALL BE PLACED IN THE ACCOUNT FOR EXCHANGE OPERATIONS AND MAY BE USED ONLY FOR THE PURPOSE OF FUNDING THE OPERATION AND ADMINISTRATION OF THE EXCHANGE.**

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

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

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

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

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

**[**(g)**]** ~~**(H)**~~ **(I)** (1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the Fund.

(3) ~~No~~ **EXCEPT AS PROVIDED IN SUBSECTION (H)(2) OF THIS SECTION, NO** part of the Fund may revert or be credited to the General Fund or any special fund of the State.

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

**31–107.1.**

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

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

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

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

**31–107.2.**

**(A) (1) FOR STATE FISCAL YEAR 2015 AND FOR EACH STATE FISCAL YEAR THEREAFTER, FROM THE FUNDS** ~~**DESCRIBED IN PARAGRAPH (2) OF THIS SUBSECTION**~~ **RECEIVED FROM THE DISTRIBUTION OF THE PREMIUM TAX UNDER § 6–103.2 OF THIS ARTICLE, THE GOVERNOR SHALL PROVIDE AN APPROPRIATION IN THE STATE BUDGET ADEQUATE TO FULLY FUND THE OPERATIONS OF THE EXCHANGE.**

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

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

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

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

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

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

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

**(D) ~~FUNDS~~ NOTWITHSTANDING § 7–304 OF THE STATE FINANCE AND PROCUREMENT ARTICLE, FUNDS ALLOCATED TO THE EXCHANGE UNDER THIS SECTION THAT REMAIN UNSPENT AT THE END OF A FISCAL YEAR SHALL REVERT TO THE GENERAL FUND OF THE STATE.**

31–108.

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

**(2) THE OBLIGATION FOR THE EXCHANGE TO COMPLY WITH § 508 OF THE FEDERAL REHABILITATION ACT OF 1973 DOES NOT AFFECT ANY OTHER REQUIREMENTS RELATING TO ACCESSIBILITY FOR PERSONS WITH DISABILITIES TO WHICH THE EXCHANGE MAY BE SUBJECT UNDER THE FEDERAL AMERICANS WITH DISABILITIES ACT OF 1990.**

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

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

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

**[**(d)**] (E)** The Exchange, through the advisory committees established under § 31–106(g) of this title or through other means, shall consult with and consider the

recommendations of the stakeholders represented on the advisory committees in the exercise of its duties under this title.

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

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

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

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

31–111.

(a) The SHOP Exchange:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**2. MAKE A CONTRIBUTION THAT IS:**

**A. A FIXED PERCENTAGE OF THE PREMIUM OF THE REFERENCE PLAN, BASED ON THE COVERAGE LEVEL SELECTED BY THE MEMBER AND THE MEMBER'S JOB CLASSIFICATION, IF OTHERWISE PERMISSIBLE; OR**

**B. A DOLLAR AMOUNT THAT ENSURES THAT ALL OF THE QUALIFIED EMPLOYER'S EMPLOYEES WITH THE SAME COVERAGE LEVEL AND JOB CLASSIFICATION WOULD PAY THE SAME AMOUNT IF THEY PURCHASED THE REFERENCE PLAN.**

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

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

**A. OFFERED BY THE CARRIER OR INSURANCE HOLDING COMPANY SYSTEM SELECTED BY THE QUALIFIED EMPLOYER; AND**

**B. AMONG THE QUALIFIED PLANS OF THE CARRIER OR INSURANCE HOLDING COMPANY SYSTEM SELECTED BY THE QUALIFIED EMPLOYER; OR**

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

**[**(e)**] (F)** On or after January 1, 2016, in order to continue to promote the SHOP Exchange's principles of accessibility, choice, affordability, and sustainability,

and as it obtains more data on adverse selection, cost, enrollment, and other factors, the SHOP Exchange:

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

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

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

31–112.

(h) (1) The SHOP Exchange**, WITH THE APPROVAL OF THE COMMISSIONER AND IN CONSULTATION WITH STAKEHOLDERS,** shall develop, implement, and, as appropriate, update training programs for:

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

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

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

(2) The training programs shall:

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

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

31–113.

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

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

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

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

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

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

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

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

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

(3) enable the Individual Exchange to:

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

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

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

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

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

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

(2) The Exchange:

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

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

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

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

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

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

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

(2) may provide:

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

(ii) any other consumer assistance services that:

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

2. do not require authorization under this subsection;

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

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

(i) consumer education and outreach; and

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

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

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

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

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

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

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

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

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

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

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

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

2. carriers and licensed insurance producers; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) An Individual Exchange navigator:

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

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

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

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

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

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

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

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

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

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

(i) The Exchange:

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

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

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

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

(2) The training program shall:

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

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

2. seeking qualified plans offered in the Individual Exchange;

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

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

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

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

(2) Under the process, the Exchange shall:

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

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

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

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

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

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

(2) The training program shall:

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

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

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

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

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

**(I) AN INDIVIDUAL WHO:**

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

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

**(II) AN INDIVIDUAL WHO:**

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

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

**(2) (I) IF AN INDIVIDUAL UNDER PARAGRAPH (1) OF THIS SUBSECTION HAS AN INSURANCE PRODUCER, A CAPTIVE PRODUCER SHALL**

**REFER THE INDIVIDUAL BACK TO THE INSURANCE PRODUCER, TOGETHER WITH ANY AVAILABLE CONTACT INFORMATION, FOR INFORMATION AND SERVICES, UNLESS:**

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

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

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

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

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

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

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

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

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

**(I) DISCLOSE TO THE INDIVIDUAL THAT:**

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

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

**(II) ON THE INDIVIDUAL'S REQUEST:**

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

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

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

**1. UNDERSTANDS THE DISCLOSURES;**

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

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

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

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

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

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

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

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

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

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

**2. A LICENSED INDEPENDENT INSURANCE PRODUCER.**

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

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

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

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

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

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

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

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

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

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

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

**(I) MAY NOT BE COMPENSATED BY THE EXCHANGE;**

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

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

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

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

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

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

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

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

**(II) APPLICATION COUNSELORS UNDER FEDERAL LAW OR REGULATION.**

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

**(I) ESTABLISH REQUIREMENTS FOR A SPONSORING ENTITY; AND**

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

**31–113.1.**

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

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

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

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

**(II) SHALL HOLD A SHOP EXCHANGE ENROLLMENT PERMIT;**

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

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

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

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

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

**1. SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;**

**2. SHALL BE AT LEAST 18 YEARS OLD;**

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

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

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

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

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

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

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

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

**(II) SHALL HOLD AN INDIVIDUAL EXCHANGE ENROLLMENT PERMIT;**

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

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

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

**(VI) SHALL INQUIRE WHETHER AN INDIVIDUAL HAS HEALTH INSURANCE OBTAINED THROUGH AN INSURANCE PRODUCER AND, IF SO, SHALL REFER THE INDIVIDUAL TO THE INSURANCE PRODUCER FOR INFORMATION AND SERVICES UNLESS:**

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

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

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

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

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

**1. SHALL BE OF GOOD CHARACTER AND TRUSTWORTHY;**

**2. SHALL BE AT LEAST 18 YEARS OLD;**

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

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

**A. A CARRIER, AN INSURANCE PRODUCER, OR A THIRD–PARTY ADMINISTRATOR IN CONNECTION WITH THE ENROLLMENT OF A QUALIFIED INDIVIDUAL IN A QUALIFIED HEALTH PLAN; OR**

**B. A MANAGED CARE ORGANIZATION THAT PARTICIPATES IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM IN CONNECTION WITH THE ENROLLMENT OF AN INDIVIDUAL IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; AND**

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

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

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

31–114.

(a) Nothing in this title requires the Maryland Medical Assistance Program or the Maryland Children's Health Program to provide any specific financial support

to the Individual Exchange for the services provided by an Individual Exchange navigator or an Individual Exchange **[**navigator**]** **CONNECTOR** entity.

31–115.

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

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

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

(3) except as provided in subsection ~~(d)~~ **(E)** of this section, provide at least a bronze level of coverage, as defined in the Affordable Care Act and determined by the Exchange under § 31–108(b)(8)(ii) of this title;

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

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

(5) be offered by a carrier that:

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

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

**1. AT A BRONZE LEVEL OF COVERAGE;**

**2. AT A SILVER LEVEL OF COVERAGE; AND**

**3. AT A GOLD LEVEL OF COVERAGE;**

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

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

~~(iv)~~ **(V)** 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)~~ **(VI)** does not charge any cancellation fees or penalties in violation of § 31–108(c) of this title; and

~~(vi)~~ **(VII)** complies with the regulations adopted by the Secretary under § 1311(d) of the Affordable Care Act and by the Exchange under § 31–106(c)(1)(iv) of this title;

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

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

(ii) the Exchange under § 31–106(c)(1)(iv) of this title;

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

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

(9) meet any other requirements established by the Exchange under this title, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) A qualified dental plan shall:

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

(ii) include at a minimum:

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

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

(4) (i) The Exchange may determine:

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

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

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

C. as a stand–alone plan; and

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

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

(5) The Exchange may:

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

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

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

**(I) IN THE QUALIFIED HEALTH PLAN;**

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

**(III) AS A STAND–ALONE DENTAL PLAN.**

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

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

(ii) include at a minimum:

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

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

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

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

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

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

**(I) ENROLLMENT;**

**(II) ESSENTIAL COMMUNITY PROVIDERS;**

**(III) COMPLAINTS AND GRIEVANCES INVOLVING THE EXCHANGE;**

**(IV) NETWORK ADEQUACY;**

**(V) QUALITY;**

**(VI) TRANSPARENCY;**

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

**(VIII) PLAN SERVICE AREA, INCLUDING DEMOGRAPHICS;**

**(IX) ACCREDITATION; AND**

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

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

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

**(II) IMPOSING A PENALTY NOT EXCEEDING ~~$100~~ $5,000 FOR EACH VIOLATION OF OR FAILURE TO COMPLY WITH STANDARDS FOR CERTIFICATION.**

**(4) IN DETERMINING THE AMOUNT OF A PENALTY UNDER PARAGRAPH (3)(II) OF THIS SUBSECTION, THE EXCHANGE SHALL CONSIDER:**

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

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

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

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

**(5) THE PENALTIES AVAILABLE TO THE EXCHANGE UNDER THIS SUBSECTION SHALL BE IN ADDITION TO ANY CRIMINAL OR CIVIL PENALTIES**

**IMPOSED FOR FRAUD OR OTHER VIOLATION UNDER ANY OTHER STATE OR FEDERAL LAW.**

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

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

**2. REQUEST A HEARING.**

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

**1. BEFORE THE EFFECTIVE DATE OF THE ORDER; OR**

**2. WITHIN 10 DAYS AFTER THE ORDER IS SERVED.**

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

31–116.

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

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

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

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

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

31–117.

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

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

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

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

**(3) (I) THE EXCHANGE, IN CONSULTATION WITH THE MARYLAND HEALTH CARE COMMISSION AND WITH THE APPROVAL OF THE COMMISSIONER, MAY ESTABLISH A STATE REINSURANCE PROGRAM TO TAKE EFFECT ON OR AFTER JANUARY 1, ~~2015~~ 2014.**

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

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

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

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

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

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

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

31–119.

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

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

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

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

(4) promote financial integrity.

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

(2) The report shall:

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

(ii) include data regarding:

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

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

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

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

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

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

(e) **(1)** The Board shall cooperate fully with any investigation into the affairs of the Exchange, including making available for examination the records of the Exchange, conducted by:

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

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

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

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

**Article – Insurance**

**15–140.**

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

**(2) "ACUTE CONDITION" MEANS A MEDICAL OR DENTAL CONDITION THAT:**

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

**(II) HAS A LIMITED DURATION.**

**(3) "CARRIER" MEANS:**

**(I) AN INSURER AUTHORIZED TO SELL HEALTH INSURANCE;**

**(II) A NONPROFIT HEALTH SERVICE PLAN;**

**(III) A HEALTH MAINTENANCE ORGANIZATION;**

**(IV) A DENTAL PLAN ORGANIZATION; OR**

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

**(4) "ENROLLEE" MEANS:**

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

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

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

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

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

**2. COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE;**

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

**4. WORKERS' COMPENSATION OR SIMILAR INSURANCE;**

**5. AUTOMOBILE MEDICAL PAYMENT INSURANCE;**

**6. CREDIT–ONLY INSURANCE;**

**7. COVERAGE FOR ON–SITE MEDICAL CLINICS; OR**

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

**(III) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THEY ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE, OR ARE OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:**

**1. LIMITED SCOPE ~~DENTAL OR~~ VISION BENEFITS;**

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

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

**(IV) "HEALTH BENEFIT PLAN" DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THE BENEFITS ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE, THERE IS NO COORDINATION BETWEEN THE PROVISION OF THE BENEFITS AND ANY EXCLUSION OF BENEFITS UNDER ANY GROUP HEALTH PLAN MAINTAINED BY THE SAME PLAN SPONSOR, AND THE BENEFITS ARE PAID WITH RESPECT TO AN EVENT WITHOUT REGARD TO WHETHER THE BENEFITS ARE PROVIDED UNDER ANY GROUP HEALTH PLAN MAINTAINED BY THE SAME PLAN SPONSOR:**

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

**2. HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.**

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

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

**2. COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER CHAPTER 55 OF TITLE 10, UNITED STATES CODE (CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)); OR**

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

**(6) (I) "HEALTH CARE PROVIDER" MEANS:**

**~~(I)~~ 1. A HEALTH CARE PRACTITIONER OR GROUP OF HEALTH CARE PRACTITIONERS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED TO ~~DELIVER~~ PROVIDE, IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION, HEALTH CARE SERVICES COVERED IN A HEALTH BENEFIT PLAN, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; OR**

**~~(II)~~ 2. A FACILITY WHERE HEALTH CARE IS PROVIDED TO PATIENTS OR RECIPIENTS~~,~~ INCLUDING:**

**A. A HOSPITAL, AS DEFINED IN § 19–301 OF THE HEALTH – GENERAL ARTICLE;**

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

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

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

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

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

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

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

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

**J. A FEDERALLY QUALIFIED HEALTH CENTER.**

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

**(7) "MANAGED CARE ORGANIZATION" MEANS:**

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

**(II) A CORPORATION THAT:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**(III) ~~REQUIRES ONGOING TREATMENT BY, OR UNDER THE SUPERVISION OF,~~ IS ACTIVELY MANAGED OR SUPERVISED BY A HEALTH CARE PROVIDER TO MAINTAIN REMISSION OR PREVENT DETERIORATION.**

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

**(B) (1) THE PURPOSE OF THIS SECTION IS TO ADVANCE THE STATE'S PROGRESS IN:**

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

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

**~~(I)~~ 1. FROM ONE CARRIER TO ANOTHER CARRIER; AND**

**~~(II)~~ 2. BETWEEN A CARRIER AND THE MARYLAND MEDICAL ASSISTANCE PROGRAM OR THE MARYLAND CHILDREN'S HEALTH PROGRAM.**

**(2) THIS SECTION:**

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

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

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

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

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

**(C) (1) WITH RESPECT TO ANY BENEFIT OR SERVICE PROVIDED THROUGH THE MARYLAND MEDICAL ASSISTANCE FEE–FOR–SERVICE PROGRAM, THIS SUBSECTION SHALL APPLY:**

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

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

**(2) SUBJECT TO PARAGRAPH ~~(2)~~ (3) OF THIS SUBSECTION, AT THE REQUEST OF AN ENROLLEE OR AN ENROLLEE'S PARENT, GUARDIAN, ~~OR~~ DESIGNEE, OR HEALTH CARE PROVIDER, A RECEIVING CARRIER OR MANAGED CARE ORGANIZATION SHALL ACCEPT A ~~PRIOR AUTHORIZATION~~ PREAUTHORIZATION FROM A RELINQUISHING CARRIER ~~OR~~, MANAGED CARE ORGANIZATION, OR THIRD–PARTY ADMINISTRATOR FOR:**

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

**(II) THE FOLLOWING TIME PERIODS:**

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

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

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

**~~(2)~~ (4) AFTER THE TIME PERIODS UNDER PARAGRAPH ~~(1)(II)~~ (2)(II) HAVE LAPSED, THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION MAY ELECT TO PERFORM ITS OWN UTILIZATION REVIEW IN ORDER TO:**

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

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

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

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

**~~(II)~~ 1. THE FOLLOWING CONDITIONS:**

**~~1.~~ A. ACUTE CONDITIONS;**

**~~2.~~ B. SERIOUS CHRONIC CONDITIONS;**

**~~3.~~ C. PREGNANCY; AND**

**~~4.~~ D. MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS; AND**

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

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

~~5.~~ **1. BONE FRACTURES;**

~~6.~~ **2. JOINT REPLACEMENTS;**

~~7.~~ **3. HEART ATTACKS ~~WITHIN THE PREVIOUS 30 DAYS~~;**

~~8.~~ **4. CANCER ~~DIAGNOSED WITHIN THE PREVIOUS 60 DAYS~~;**

~~9.~~ **5. HIV/AIDS; AND**

~~10.~~ **6. ORGAN TRANSPLANTS~~; AND~~.**

~~(II)~~ **(III) AN ENROLLEE SHALL BE ALLOWED TO CONTINUE TO RECEIVE SERVICES FOR THE CONDITIONS UNDER THIS PARAGRAPH FOR THE TIME PERIODS UNDER SUBSECTION (C)(1)(II) OF THIS SECTION.**

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

**(II) SUBJECT TO ~~PARAGRAPH (4)~~ PARAGRAPHS (4) AND (5) OF THIS SUBSECTION, ~~THE NONPARTICIPATING PROVIDER AND~~ THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION, WITH RESPECT TO THE PROVISION OF THE COVERED SERVICES, SHALL ~~AGREE ON THE COMPENSATION RATES AND METHODS OF PAYMENT THAT MAY INCLUDE:~~**

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

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

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

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

**(4) THE ~~AGREEMENT BETWEEN THE NONPARTICIPATING PROVIDER AND THE RECEIVING CARRIER OR MANAGED CARE ORGANIZATION~~ RATES AND METHODS OF PAYMENT UNDER PARAGRAPH (3)(II) AND (IV) OF THIS SUBSECTION SHALL:**

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

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

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

**(II) ENSURE THAT:**

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

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

**(5) IF THE NONPARTICIPATING PROVIDER DOES NOT ACCEPT THE RATE AND METHOD OF COMPENSATION UNDER PARAGRAPH (3)(II) OF THIS**

**SUBSECTION, AND THE CARRIER OR MANAGED CARE ORGANIZATION ~~DO~~ DOES NOT REACH AN AGREEMENT WITH THE NONPARTICIPATING PROVIDER FOR AN ALTERNATIVE RATE AND METHOD OF PAYMENT UNDER PARAGRAPH ~~(3)~~ (3)(IV) OF THIS SUBSECTION:**

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

**(II) § 14–205.3 OF THIS ARTICLE, UNDER WHICH AN ENROLLEE MAY ASSIGN BENEFITS TO A NONPREFERRED PROVIDER AND THE PROVIDER MAY BALANCE BILL THE ENROLLEE, SHALL APPLY TO THE EXTENT IT WOULD APPLY ABSENT THIS SECTION; AND**

**(III) UNLESS THE ENROLLEE HAS ASSIGNED BENEFITS TO A NONPREFERRED PROVIDER UNDER § 14–205.3 OF THIS ARTICLE, THE CARRIER OR MANAGED CARE ORGANIZATION ~~IS NOT REQUIRED TO ALLOW THE SERVICES TO BE PROVIDED BY THE NONPARTICIPATING PROVIDER~~ SHALL FACILITATE TRANSITION OF THE ENROLLEE TO A PROVIDER ON THE PROVIDER PANEL OF THE CARRIER OR MANAGED CARE ORGANIZATION.**

**(E) (1) THIS SECTION DOES NOT:**

**~~(1)~~ (I) REQUIRE A CARRIER OR MANAGED CARE ORGANIZATION TO COVER SERVICES OR PROVIDE BENEFITS THAT ARE NOT OTHERWISE COVERED UNDER THE TERMS AND CONDITIONS OF A HEALTH BENEFIT PLAN, THE MARYLAND MEDICAL ASSISTANCE PROGRAM, OR THE MARYLAND CHILDREN'S HEALTH PROGRAM; OR**

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

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

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

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

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

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

**(2) THE REQUIREMENTS OF THIS SECTION ARE:**

**(I) IN ADDITION TO ANY OTHER LEGAL, PROFESSIONAL, OR ETHICAL OBLIGATIONS OF A CARRIER OR MANAGED CARE ORGANIZATION TO PROVIDE CONTINUITY OF CARE; AND**

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

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

**(H) (1) THE COMMISSIONER, THE MARYLAND HEALTH BENEFIT EXCHANGE, AND THE SECRETARY OF HEALTH AND MENTAL HYGIENE SHALL COLLABORATE TO:**

**~~(1)~~ DETERMINE THE DATA, TO THE EXTENT ITS COLLECTION IS FEASIBLE AND PERMITTED BY LAW, THAT IS NECESSARY TO:**

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

**(II) DEVELOP A PROCESS TO EVALUATE AND MONITOR CONTINUITY OF CARE, WITH PARTICULAR FOCUS ON NEWLY ELIGIBLE POPULATIONS, ANY DISPARATE OR DISCRIMINATORY IMPACT ON SPECIFIC POPULATIONS, AND TRENDS IN HEALTH DISPARITIES~~; AND~~.**

**(2) ON REQUEST ~~THE REQUISITE DATA FROM~~ OF THE COMMISSIONER, THE MARYLAND HEALTH BENEFIT EXCHANGE, OR THE**

**SECRETARY OF HEALTH AND MENTAL HYGIENE CARRIERS, MANAGED CARE ORGANIZATIONS, AND HEALTH CARE PROVIDERS SHALL PROVIDE THE REQUISITE DATA.**

SECTION 4. AND BE IT FURTHER ENACTED, That the Laws of Maryland read as follows:

**Article – Insurance**

15–1303.

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

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

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

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

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

SECTION ~~4.~~ 5. AND BE IT FURTHER ENACTED, That:

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

(b) Using the data requested under § 15–140(h) of the Insurance Article, as enacted by Section 3 of this Act, the Maryland Health Benefit Exchange, the Department of Health and Mental Hygiene, ~~and~~ the Maryland Insurance Administration, and the Maryland Health Care Commission shall conduct a study on the implementation and efficacy of the requirements of § 15–140 of the Insurance Article, as enacted by Section 3 of this Act.

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

(1) the findings of the study, which, to the extent feasible, shall ~~including~~ include the extent to which § 15–140(d) of the Insurance Article, as enacted by Section 3 this Act, has:

(i) been effective in promoting continuity of care for Marylanders; ~~and~~

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

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

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

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

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

~~(1) three members in 2014;~~

~~(2) five members in 2015; and~~

~~(3) five members in 2016.~~

SECTION 6. AND BE IT FURTHER ENACTED, That:

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

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

(i) its effect on insurance premiums generally;

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

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

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

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

SECTION 7. AND BE IT FURTHER ENACTED, That:

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

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

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

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

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

(2) shall be made public on adoption;

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

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

SECTION 8. AND BE IT FURTHER ENACTED, That:

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

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

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

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

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

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

SECTION 9. AND BE IT FURTHER ENACTED, That:

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

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

(i) Exchange enrollment;

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

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

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

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

SECTION 10. AND BE IT FURTHER ENACTED, That the changes to § 6–101(b) of the Insurance Article, as enacted by Section 2 of this Act, shall remain

effective for a period of 5 years and 1 month and, at the end of June 30, 2018, with no further action required by the General Assembly, the changes to § 6–101(b) of the Insurance Article shall be abrogated and of no further force and effect.

SECTION ~~5.~~ ~~10.~~ 11. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2014.

SECTION ~~6.~~ ~~11.~~ 12. AND BE IT FURTHER ENACTED, That Section 3 of this Act shall take effect January 1, 2015.

SECTION 13. AND BE IT FURTHER ENACTED, That Section 4 of this Act shall take effect January 1, 2014, the effective date of Section 2 of Chapter 152 of the Acts of the General Assembly of 2012. If the effective date of Section 2 of Chapter 152 is amended, Section 4 of this Act shall take effect on the taking effect of Section 2 of Chapter 152.

SECTION ~~7.~~ ~~12.~~ 14. AND BE IT FURTHER ENACTED, That, except as provided in Sections ~~5 and 6~~ ~~10 and 11~~ 11, 12 and 13 of this Act, this Act shall take effect June 1, 2013.

Approved:

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Governor.

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Speaker of the House of Delegates.

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President of the Senate.