Health Benefit Exchange

This SSL draft combines two California laws into one bill that establishes a Health Benefit Exchange (the Exchange) within state government. The Act requires the Exchange be governed by a board composed of the state secretary of health and human services, or their designee, and four other members appointed by the governor and the legislature. The bill requires the board of the exchange, or the state health and human services agency, if a majority of the board has not been appointed, to apply for and receive federal funds for purposes of establishing the Exchange.

The bill specifies the powers and duties of the board governing the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014. The Act imposes various requirements on participating plans and insurers and, commencing January 1, 2014, on nonparticipating plans and insurers, as specified.

This draft Act empowers a state health facilities authority to provide a working capital loan of up to $5 million to help establish and operate the Health Benefit Exchange.

The Act also requires the state director of the department of managed health care and the state insurance commissioner to consider using an Internet portal developed by the United States Department of Health and Human Services to publicize coverage through the Exchange. It requires the state director of the department of managed health care and the state insurance commissioner to jointly develop and maintain an electronic clearinghouse about available coverage in the individual and small employer markets if the federal Internet portal does not adequately achieve certain purposes.

Submitted as:

California
Chapter 655 of 2010
Status: Enacted into law in 2010.

California
Chapter 659 of 2010
Status: Enacted into law in 2010.

Suggested State Legislation

(Title, enacting clause, etc.)

Section 1. [*Short Title*.] This Act shall be cited as "An Act to Create a Health Benefit Exchange."

Section 2. [*Definitions*.] As used in this Act:

(1) "Board" means the [executive board] of the Health Benefit Exchange as defined in Section 3.

(2) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the state [insurance commissioner] or a health care service plan, as defined under [insert citation], licensed by the state [department of managed health care].

(3) "Exchange" means the state [Health Benefit Exchange] established by this Act.

(4) "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those Acts.

(5) "Fund" means the state [Health Trust Fund] established by Section 6 of this Act.

(6) "Health plan" and "qualified health plan" have the same meanings as those terms are defined in Section 1301 of the federal Act.

(7) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of the federal Act.

(8) "SHOP Program" means the [Small Business Health Options Program] established by [insert citation].

(9) "Small employer" has the same meaning as that term is defined in [insert citation].

(10) "Supplemental coverage" means coverage through a specialized health care service plan contract, as defined in [insert citation] or a specialized health insurance policy, as defined in [insert citation].

Section 3. [*Health Benefit Exchange and Governing Executive Board*.]

(A) There is created in state government a [Health Benefit Exchange], an independent public entity not affiliated with an agency or department, which shall be known as the Exchange. The Exchange shall be governed by an [executive board] consisting of [five] members who are residents of [this state]. Of the members of the [board], [two] shall be appointed by the [governor], [one] shall be appointed by the [senate committee on rules], and [one] shall be appointed by the [speaker of the assembly]. The [secretary of health and human services] or their designee shall serve as a voting, ex officio member of the [board].

(B) Members of the [board], other than an ex officio member, shall be appointed for a term of [four] years, except that the initial appointment by the [senate committee on rules] shall be for a term of [five] years, and the initial appointment by the [speaker of the assembly] shall be for a term of [two] years. Appointments by the [governor] made after [insert date], shall be subject to confirmation by the [senate]. A member of the [board] may continue to serve until the appointment and qualification of their successor. Vacancies shall be filled by appointment for the unexpired term. The [board] shall elect a chairperson on an [annual] basis.

(C) (1) Each individual appointed to the [board] shall have demonstrated and acknowledged expertise in at least two of the following areas:

(a) Individual health care coverage.

(b) Small employer health care coverage.

(c) Health benefits plan administration.

(d) Health care finance.

(e) Administering a public or private health care delivery system.

(f) Purchasing health plan coverage.

(2) Appointing authorities shall consider the expertise of the other members of the [board] and attempt to make appointments so that the [board's] composition reflects a diversity of expertise.

(D) Each member of the [board] shall have the responsibility and duty to meet the requirements of this Act, the federal Patient Protection and Affordable Care Act, and all applicable state and federal laws and regulations, to serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange, and to ensure the operational well-being and fiscal solvency of the Exchange.

(E) In making appointments to the [board], the appointing authorities shall take into consideration the cultural, ethnic, and geographical diversity of the state so that the [board's]

composition reflects the communities of [this state].

(F) (1) A member of the [board] or of the staff of the Exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the [board] or on the staff of the Exchange. A member of the [board] or of the staff of the Exchange shall not be a member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers while serving on the [board] or on the staff of the Exchange. A member of the [board] or of the staff of the Exchange shall not be a health care provider unless they receive no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(2) A [board] member shall not receive compensation for their service on the [board] but may receive a per diem and reimbursement for travel and other necessary expenses, as provided in [insert citation], while engaged in the performance of official duties of the [board].

(3) For purposes of this subdivision, "health care provider" means a individual licensed or certified pursuant to [insert citation], or licensed pursuant to the [state Osteopathic Act or the Chiropractic Act].

(G) No member of the [board] shall make, participate in making, or in any way attempt to use their official position to influence the making of any decision that they know or have reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on them or a member of their immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating [two hundred fifty dollars ($250)] or more in value provided to, received by, or promised to the member within [12] months prior to the time when the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(H) There shall not be any liability in a private capacity on the part of the [board] or any member of the [board], or any officer or employee of the [board], for or on account of any act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this Act or affairs related to this Act.

(I) The [board] shall hire an [executive director] to organize, administer, and manage the operations of the Exchange. The [executive director] shall be exempt from civil service and shall serve at the pleasure of the [board].

(J) The [board] shall be subject to state open meeting provisions as defined under [insert citation], except that the [board] may hold closed sessions when considering matters related to litigation, personnel, contracting, and rates.

(K) (1) The [board] shall apply for planning and establishment grants made available to the Exchange pursuant to Section 1311 of the federal Patient Protection and Affordable Care Act. If an [executive director] has not been hired under subdivision (I) when the United States Secretary of Health and Human Services makes the planning and establishment grants available, the state [health and human services agency] shall, upon request of the [board], submit the initial application for planning and establishment grants to the U.S. Secretary of Health and Human Services.

(2) If a majority of the [board] has not been appointed when the United States

Secretary of Health and Human Services makes the planning and establishment grants available, the state [health and human services agency] shall submit the initial application for planning and establishment grants to the United States Secretary of Health and Human Services. Any subsequent applications shall be made as described in paragraph (1) once a majority of the members have been appointed to the [board].

(3) The [board] shall be responsible for using the funds awarded by the United States Secretary of Health and Human Services for the planning and establishment of the Exchange, consistent with subdivision (b) of Section 1311 of the federal Patient Protection and Affordable Care Act.

(L) The [board] shall, at a minimum, do all of the following to implement Section 1311 of the federal Act:

(1) Implement procedures for the certification, recertification, and decertification, consistent with guidelines established by the United States Secretary of Health and Human Services, of health plans as qualified health plans. The [board] shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their Internet Web sites. The [board] shall take this information, and the information and the recommendations provided to the [board] by the state [department of insurance] or the state [department of managed health care] under paragraph (1) of subdivision (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The [board] shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the state [department of insurance] and the state [department of managed health care].

(2) (a) Make available to the public and submit to the [board], the United States Secretary of Health and Human Services, and the state [insurance commissioner] or the state [department of managed health care], as applicable, accurate and timely disclosure of the following information:

(I) Claims payment policies and practices.

(II) Periodic financial disclosures.

(III) Data on enrollment.

(IV) Data on disenrollment.

(V) Data on the number of claims that are denied.

(VI) Data on rating practices.

(VII) Information on cost sharing and payments with respect to any out-of-network coverage.

(VIII) Information on enrollee and participant rights under Title I of the federal Act.

(IX) Other information as determined appropriate by the United States Secretary of Health and Human Services.

(b) The information required under subparagraph (a) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section 1311 of the federal Act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(4) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(5) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(6) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the United States Secretary of Health and Human Services.

(7) Use a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(8) Inform individuals about eligibility requirements for the [state Medicaid Program] program, the state [Healthy Families Program], or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program.

(9) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the federal Act.

(10) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that section because of either of the following:

(a) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(b) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(11) Transfer to the state [secretary of the treasury] all of the following:

(a) A list of the individuals who are issued a certification under subdivision (10), including the name and taxpayer identification number of each person.

(b) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because of either of the following:

(I) The employer did not provide minimum essential coverage.

(II) The employer provided the minimum essential coverage but it was determined under subparagraph (C) of paragraph (2) of subsection (c) of Section 36B of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(c) The name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subsection (b) of Section 1411 of the federal Act that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(12) Provide to each employer the name of each employee of the employer described in paragraph (b) of subdivision (11) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(13) Perform duties required of, or delegated to, the Exchange by the United States Secretary of Health and Human Services or the state [secretary of the treasury] related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility

exemptions.

(14) Establish the navigator program in accordance with subdivision (i) of Section 1311 of the federal Act. Any entity chosen by the Exchange as a navigator shall do all of the following:

(a) Conduct public education activities to raise awareness of the availability of qualified health plans.

(b) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal Act.

(c) Facilitate enrollment in qualified health plans.

(d) Provide referrals to any applicable [office of health insurance consumer assistance] or [health insurance ombudsman] established under Section 2793 of the federal Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under that plan or coverage.

(e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(15) Establish a [Small Business Health Options Program], separate from the activities of the [board] related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market in a manner consistent with paragraph (2) of subdivision (a) of Section 1312 of the federal Act.

(M) In addition to meeting the minimum requirements of Section 1311 of the federal Act, the [board] shall do all of the following:

(1) Determine the criteria and process for eligibility, enrollment, and disenrollment of enrollees and potential enrollees in the Exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the state [department of health care services], the [managed risk medical insurance board], and counties in [this state], in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverage.

(2) Develop processes to coordinate with the county entities that administer eligibility for the state [Medicaid] program and the entity that determines eligibility for the [Healthy Families Program], including, but not limited to, processes for case transfer, referral, and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law.

(3) Determine the minimum requirements a carrier must meet to be considered for participation in the Exchange, and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers. The [board] shall consistently and uniformly apply these requirements, standards, and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the Exchange, the [board] shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service.

(4) Provide, in each region of the state, a choice of qualified health plans at each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal Act.

(5) Require, as a condition of participation in the Exchange, carriers to fairly and affirmatively offer, market, and sell in the Exchange at least [one] product within each of the five

levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal Act. The [board] may require carriers to offer additional products within each of those five levels of coverage. This subdivision shall not apply to a carrier that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (N) of this Section.

(6) (a) Require, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to do both of the following:

(I) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(II) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(b) For purposes of this subdivision, "product" does not include contracts entered into pursuant to [insert citation].

(7) Determine when an enrollee's coverage commences and the extent and scope of coverage.

(8) Provide for the processing of applications and the enrollment and disenrollment of enrollees.

(9) Determine and approve cost-sharing provisions for qualified health plans.

(10) Establish uniform billing and payment policies for qualified health plans offered in the Exchange to ensure consistent enrollment and disenrollment activities for individuals enrolled in the Exchange.

(11) Undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the Exchange. The [board] shall also undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the Exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency.

(12) Select and set performance standards and compensation for navigators selected under subdivision (L)(14).

(13) Employ necessary staff.

(a) The [board] shall hire a [chief fiscal officer, a chief operations officer, a director for the SHOP Exchange, a director of Health Plan Contracting, a chief technology and information officer, a general counsel], and other key executive positions, as determined by the [board], who shall be exempt from civil service.

(b) (I) The [board] shall set the salaries for the exempt positions described in subdvision (L)(13)(a) and subdivision (I) of this Section 3 in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The salaries shall be published by the [board] in the [board's] annual budget. The [board's] annual budget shall be posted on the Internet Web site of the Exchange. To determine the compensation for these positions, the [board] shall cause to be conducted, through the use of independent outside advisors, salary surveys of both of the following:

(i) Other state and federal health insurance exchanges that are most comparable to the Exchange.

(ii) Other relevant labor pools.

(II) The salaries established by the [board] under subparagraph (I) shall not exceed the highest comparable salary for a position of that type, as determined by the surveys conducted pursuant to subparagraph (I).

(III) The state [department of personnel administration]

shall review the methodology used in the surveys conducted pursuant to subparagraph (I).

(c) The positions described in paragraph (b)(I) and subdivision (I) of this Section shall not be subject to otherwise applicable provisions of [insert citation] and, for those purposes, the Exchange shall not be considered a state agency or public entity.

(14) Assess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. This charge shall not affect the requirement under Section 1301 of the federal Act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

(15) Authorize expenditures, as necessary, from the state [Health Trust Fund] created by Section 6 of this Act to pay program expenses to administer the Exchange.

(16) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the United States Secretary of Health and Human Services a report concerning that accounting. Commencing [January 1, 2016], the [board] shall conduct an annual audit.

(17) (a) Annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this Act. This report shall be transmitted to the [legislature] and the [governor] and shall be made available to the public on the Internet Web site of the Exchange. A report made to the [legislature] pursuant to this subdivision shall be submitted pursuant to [insert citation].

(b) In addition to the report described in paragraph (a), the [board] shall be responsive to requests for additional information from the [legislature], including providing testimony and commenting on proposed state legislation or policy issues. The [legislature] finds and declares that activities including, but not limited to, responding to legislative or executive inquiries, tracking and commenting on legislation and regulatory activities, and preparing reports on the implementation of this Act and the performance of the Exchange, are necessary state requirements and are distinct from the promotion of legislative or regulatory modifications referred to in Section (6)(D) of this Act.

(18) Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue in the fund established in Section 6 of this Act, and if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency.

(19) Exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this Act and the federal Act.

(20) Consult with stakeholders relevant to carrying out the activities under this Act, including, but not limited to, all of the following:

(a) Health care consumers who are enrolled in health plans.

(b) Individuals and entities with experience in facilitating enrollment in health plans.

(c) Representatives of small businesses and self-employed individuals.

(d) The state [Medicaid Director].

(e) Advocates for enrolling hard-to-reach populations.

(21) Facilitate the purchase of qualified health plans in the Exchange by qualified individuals and qualified small employers no later than [January 1, 2014].

(22) Report, or contract with an independent entity to report, to the [legislature] by [December 1, 2018], on whether to adopt the option in paragraph (3) of subdivision (c) of Section 1312 of the federal Act to merge the individual and small employer markets. In its

report, the [board] shall provide information, based on at least [two] years of data from the Exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained. Such report shall be submitted pursuant to [insert citation].

(23) With respect to the [SHOP Program], collect premiums and administer all other necessary and related tasks, including, but not limited to, enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

(24) Require carriers participating in the Exchange to immediately notify the Exchange, under the terms and conditions established by the [board] when an individual is or will be enrolled in or disenrolled from any qualified health plan offered by the carrier.

(25) Ensure that the Exchange provides oral interpretation services in any language for individuals seeking coverage through the Exchange and makes available a toll-free telephone number for the hearing and speech impaired. The [board] shall ensure that written information made available by the Exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages.

(N) The [board] may do the following:

(1) With respect to individual coverage made available in the Exchange, collect premiums and assist in the administration of subsidies.

(2) Enter into contracts.

(3) Sue and be sued.

(4) Receive and accept gifts, grants, or donations of moneys from any agency of the United States, any agency of the state, any municipality, county, or other political subdivision of the state.

(5) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, or corporations, in compliance with the conflict of interest provisions to be adopted by the [board] at a public meeting.

(6) Adopt rules and regulations, as necessary. Until [January 1, 2016], any necessary rules and regulations may be adopted as emergency regulations in accordance with the state [Administrative Procedure Act] under [insert citation]. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(7) Collaborate with the [state department of health care services] and the state [managed risk medical insurance board], to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the state [Medicaid] program or the [Healthy Families Program] established under [insert citation], or loses eligibility for the state [Medicaid] program or the [Healthy Families Program] and becomes eligible for premium tax credits through the Exchange.

(8) Share information with relevant state departments, consistent with the confidentiality provisions in Section 1411 of the federal Act, necessary for the administration of the Exchange.

(9) Require carriers participating in the Exchange to make available to the Exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the Exchange can search by health care provider name to determine which health plans in the Exchange include that health care provider in their network. The [board] may also require a carrier to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health

plan. The Exchange may provide an integrated and uniform consumer directory of health care providers indicating which carriers the providers contract with and whether the providers are currently accepting new patients. The Exchange may also establish methods by which health care providers may transmit relevant information directly to the Exchange, rather than through a carrier.

(10) Make available supplemental coverage for enrollees of the Exchange to the extent permitted by the federal Act, provided that no [General Fund] money is used to pay the cost of that coverage. Any supplemental coverage offered in the Exchange shall be subject to the charge imposed under subdivision (M)(14) of this Section.

(O) The Exchange shall only collect information from individuals or designees of individuals necessary to administer the Exchange and consistent with the federal Act.

(P) The [board] shall have the authority to standardize products to be offered through the Exchange.

(Q) The [board] shall establish and use a competitive process to select participating carriers and any other contractors under this Act. Any contract entered into pursuant to this Act shall be exempt from [insert citation], and shall be exempt from the review or approval of any [division of the state department of general services].

(R) (1) The [board] shall establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal Act concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations. In no event shall the scope of those appeals be construed to be broader than the requirements of the federal Act. Once the federal regulations concerning appeals have been issued in final form by the United States Secretary of Health and Human Services, the [board] may establish additional requirements related to appeals, provided that the [board] determines, prior to adoption, that any additional requirement results in no cost to the [General Fund] and no increase in the charge imposed under subdivision (M)(14) of this section.

(2) The [board] shall not be required to provide an appeal if the subject of the appeal is within the jurisdiction of the [department of managed health care] pursuant to [insert citation] and its implementing regulations, or within the jurisdiction of the state [department of insurance] pursuant to the state [insurance code] and its implementing regulations.

Section 4. [*Health Benefit Exchange Not Subject to Certain Licensing and Regulations*.]

(A) Notwithstanding any other provision of law, the Exchange shall not be subject to licensure or regulation by the state [department of insurance] or the state [department of managed health care].

(B) Carriers that contract with the Exchange shall have a license or certificate of authority from, and shall be in good standing with, their respective regulatory agencies.

Section 5. [*Health Benefit Exchange Records: Disclosure Exemptions*.]

(A) Records of the Exchange that reveal any of the following shall be exempt from disclosure under the state [Public Records Act] as defined under [insert citation]:

(1) The deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the Exchange, entities with which the Exchange is considering a contract, or entities with which the Exchange is considering or enters into any other arrangement under which the Exchange provides, receives, or arranges services or reimbursement.

(2) The impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the [board] or its staff, or records that provide instructions, advice, or training to employees.

(B) (1) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to this Act shall be open to inspection [one] year after their effective dates.

(2) If a contract entered into pursuant to this Act is amended, the amendment shall be open to inspection [one] year after the effective date of the amendment.

Section 6. [*Health Trust Fund and Exchange Funding*.]

(A) A state [Health Trust Fund] is hereby created in the [state treasury] for the purpose of this Act. Notwithstanding [insert citation], all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this Act. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(B) Notwithstanding any other provision of law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the [General Fund], or a county general fund or any other county fund.

(C) The [board] of the [Health Benefit Exchange] shall establish and maintain a prudent reserve in the fund.

(D) The [board or staff] of the Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(E) Notwithstanding [insert citation], all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(F) Effective [January 1, 2016], if at the end of any fiscal year, the fund has unencumbered funds in an amount that equals or is more than the [board] approved operating budget of the Exchange for the next fiscal year, the [board] shall reduce the charges imposed under subdivision (M)(14) of Section 3 of this Act during the following fiscal year in an amount that will reduce any surplus funds of the Exchange to an amount that is equal to the agency's operating budget for the next fiscal year.

(G) The [board] shall ensure that the establishment, operation, and administrative functions of the Exchange do not exceed the combination of federal funds, private donations, and other [non-General Fund] moneys available for this purpose. No state [General Fund] money shall be used for any purpose under this Act without a subsequent appropriation. No liability incurred by the Exchange or any of its officers or employees may be satisfied using moneys from the [General Fund].

(H) The implementation of the provisions of this Act, other than this section, Section 3 subdivisions (A) through (K), and paragraphs (4) and (5) of subdivision (N) of Section 3, shall be contingent on a determination by the [board] that sufficient financial resources exist or will exist in the fund. The determination shall be based on at least the following:

(1) Financial projections identifying sufficient resources exist or will exist in the fund to implement the Exchange.

(2) A comparison of the projected resources available to support the Exchange and the projected costs of activities required by this Act.

(3) The financial projections demonstrate the sufficiency of resources for at least the first [two] years of operation under this Act.

(I) The [board] shall provide notice to the [joint legislative budget committee] and the state [director of finance] that sufficient financial resources exist in the fund to implement this Act.

(J) If the [board] determines that the level of resources in the fund cannot support the actions and responsibilities described in subdivision (A), it shall provide the [department of finance] and the [joint legislative budget committee] a detailed report on the changes to the functions, contracts, or staffing necessary to address the fiscal deficiency along with any contingency plan should it be impossible to operate the Exchange without the use of [General Fund] moneys.

(K) The [board] shall assess the impact of the Exchange's operations and policies on other publicly funded health programs administered by the state and the impact of publicly funded health programs administered by the state on the Exchange's operations and policies. This assessment shall include, at a minimum, an analysis of potential cost shifts or cost increases in other programs that may be due to Exchange policies or operations. The assessment shall be completed on at least an annual basis and submitted to the Secretary of Health and Human Services and the state [director of finance].

Section 7. [*Requirements for Health Care Service Plans to Participate in the Health Benefit Exchange*.]

(A) Health care service plans participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal Act. The [board] established under this Act may require plans to sell additional products within each of those levels of coverage. This subdivision shall not apply to a plan that solely offers supplemental coverage in the Exchange under Section (3)(N)(10) of this Act.

(B) (1) Health care service plans participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(a) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(b) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to [insert citations].

(C) Commencing [January 1, 2014], a health care service plan shall, with respect to plan contracts that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal Act, except that a health care service plan that does not participate in the Exchange shall, with respect to plan contracts that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in subdivision (d) of Section 1302 of the federal Act.

(D) Commencing [January 1, 2014], a health care service plan that does not participate in the Exchange shall, with respect to plan contracts that cover hospital, medical, or surgical benefits, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subdivision (d) of Section 1302 of the federal Act. This subdivision shall only apply if the [board] of the Exchange exercises its authority under Section 3 (P) of this Act. Nothing in this subdivision shall require a plan that does not participate in the Exchange to offer standardized products in the small employer market if the plan only sells products in the individual market. Nothing in this subdivision shall require a plan that does not participate in the Exchange to offer standardized products in the individual market if the plan only sells products in the small employer market. This subdivision shall not be construed to prohibit the plan from offering other products provided that it complies with subdivision (d) of

Section 1302 of the federal Act.

Section 8. [*Requirements for Health Insurers to Participate in the Health Benefit Exchange*.]

(A) Health insurers participating in the Exchange shall fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal Act. The [board] established under this Act may require insurers to sell additional products within each of those levels of coverage. This subdivision shall not apply to an insurer that solely offers supplemental coverage in the Exchange under Section 3 (N)(10) of this Act.

(B) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(a) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(b) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, "product" does not include contracts entered into pursuant to [insert citations].

(C) Commencing [January 1, 2014], a health insurer, with respect to policies that cover hospital, medical, or surgical benefits, may only sell the five levels of coverage contained in subdivisions (d) and (e) of Section 1302 of the federal Act, except that a health insurer that does not participate in the Exchange may, with respect to policies that cover hospital, medical, or surgical benefits only sell the four levels of coverage contained in subdivision (d) of Section 1302 of the federal Act.

(D) Commencing January 1, 2014, a health insurer that does not participate in the Exchange shall, with respect to policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subdivision (d) of Section 1302 of the federal Act. This subdivision shall only apply if the [board] of the Exchange exercises its authority under Section 3 (P) of this Act. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the small employer market if the insurer only sells products in the individual market. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the individual market if the insurer only sells products in the small employer market. This subdivision shall not be construed to prohibit the insurer from offering other products provided that it complies with subdivision (d) of Section 1302 of the federal Act.

Section 9. [*Capital Loans to Establish Health Benefit Exchange*.]

(A) The state [health facilities financing authority] as defined under [insert citation], and notwithstanding any other provision of law, may provide a working capital loan of up to [five million dollars ($5,000,000)] to assist in the establishment and operation of the Health Benefit Exchange established under this Act. The [authority] may require any information it deems necessary and prudent prior to providing a loan to the Exchange and may require any term, condition, security, or repayment provision it deems necessary in the event the [authority] chooses to provide a loan. Under no circumstances shall the [authority] be required to provide a loan to the Exchange.

(B) Prior to the [authority] providing a loan to the Exchange, a majority of the [board] of

the Exchange shall be appointed and shall demonstrate, to the satisfaction of the [authority], that the federal planning and establishment grants made available to the Exchange by the United States Secretary of Health and Human Services are insufficient or will not be released in a timely manner to allow the Exchange to meet the necessary requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(C) The Exchange shall repay a loan made under this Section no later than [June 30, 2016], and shall pay interest at the rate paid on moneys in the [Pooled Money Investment Account] established under [insert citation].

Section 10. [*Review of Federal Internet Portal and Health Benefit Exchange.*] The state [director of the department of managed health care] shall, in coordination with the state [insurance commissioner], review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that Act, and any enhancements to that portal expected to be implemented by the secretary on or before [January 1, 2015]. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in [this state] to facilitate fair and affirmative marketing of all individual and small employer products, particularly outside the Health Benefit Exchange. If the [director of the department of managed health care] and the state [insurance commissioner] jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the [director of the department of managed health care] and the [insurance commissioner] shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective [departments], and shall use any other available means to maintain the clearinghouse.

Section 11. [*Severability*.] [Insert severability clause.]

Section 12. [*Repealer*.] [Insert repealer clause.]

Section 13. [*Effective Date.*] [Insert effective date.]