

1 **NORTH CAROLINA HEALTH BENEFIT EXCHANGE ACT**

2
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17
18 **Section 1. Title**

19
20 This Act shall be known and may be cited as the North Carolina Health Benefit Exchange Act.

21
22 **Section 2. Purpose and Intent**

23
24 The purpose of this Act is to provide for the establishment of the North Carolina Health Benefit Exchange
25 (Exchange) to facilitate the purchase and sale of qualified health plans in the individual market in this State and to
26 provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified
27 small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the
28 small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent
29 marketplace and consumer education and assist individuals with access to health coverage, premium assistance tax
30 credits and cost-sharing reductions.

31
32 The federal Patient Protection and Affordable Care Act, as amended, (Federal Act) seeks to refocus competition
33 within the private health insurance and health plan markets away from risk avoidance, risk selection and market
34 segmentation and on comparative cost, value, quality of care and customer service provided by plans. The Federal
35 Act seeks to encourage greater emphasis on health promotion/illness prevention, improved care and chronic
36 condition management, self management and more active engagement of patients in their own health, care
37 management and coverage decisions. In carrying out its duties the Board of Directors of the North Carolina Health
38 Benefit Exchange shall be guided by the fundamental changes set forth by the Federal Act to promote improved
39 competition in the health care marketplace and stronger consumer engagement in care and coverage choices.

40
41 **Section 3. Definitions**

42
43 For purposes of this Act:

- 44
45 A. "Board" means the Board of Directors of the Exchange.
46 B. "Commissioner" means the Commissioner of Insurance of North Carolina or the Commissioner's
47 authorized designee.
48 C. "Educated health care consumer" means an individual who is knowledgeable about the health care system,
49 and has background or experience in making informed decisions regarding health, medical and scientific
50 matters.
51 D. "Exchange" means the North Carolina Health Benefit Exchange established pursuant to section 4 of this
52 Act.
53 E. "Executive Director" means the individual selected by a majority vote of the Board members and hired to
54 serve as the Executive Director of the Exchange.

- 1 F. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as
 2 amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and
 3 any amendments thereto, or regulations or guidance issued under, those Acts.
 4 G. "Health benefit plan" has the meaning given to the term in G.S. 58-3-167(a)(1).
 5 H. "Health insurer" or "insurer" has the meaning given to the term in G.S. 58-68-25(a)(6).
 6 I. "Plan of Operation" means the articles, bylaws, and operating rules and procedures adopted by the Board in
 7 accordance with this Act.
 8 J. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section
 9 7E of this Act.
 10 K. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one
 11 or more qualified health plans offered through the SHOP Exchange, and at the option of the employer,
 12 some or all of its part-time employees, provided that the employer:
 13 (1) Has its principal place of business in this State and elects to provide coverage through the SHOP
 14 Exchange to all of its eligible employees, wherever employed; or
 15 (2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are
 16 principally employed in this State.
 17 L. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the
 18 criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act and any
 19 additional requirements adopted by the Board pursuant to State law.
 20 M. "Qualified individual" means an individual, including a minor, who:
 21 (1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;
 22 (2) Resides in this State;
 23 (3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of
 24 charges; and
 25 (4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or
 26 national of the United States or an alien lawfully present in the United States.
 27 N. "Secretary" means the Secretary of the federal Department of Health and Human Services.
 28 O. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this
 29 Act.
 30 P. "Small employer" has the meaning given to the term in G.S. 58-50-110(22). [DISCUSSION POINT;
 31 SMALL EMPLOYER SIZE 1-50 AS DEFINED HERE, OR 1-100]
 32

33 **Section 4. Establishment of Exchange; Board of Directors; Plan of Operation**
 34

- 35 A. (1) The North Carolina Health Benefit Exchange (Exchange) is hereby established as a nonprofit
 36 entity which shall operate under the supervision and control of the Board of Directors of the Exchange
 37 (Board). Notwithstanding that the Exchange may be supported in whole or in part from federal or State
 38 funds, the Exchange is not an instrumentality of the State or of the federal government.
 39 (2) The Board shall consist of the Commissioner, who shall serve as an ex officio nonvoting member
 40 of the Board, the Director of the Division of Medical Assistance, who shall serve as an ex officio
 41 voting member of the Board, and **XX** members appointed as follows:
 42

43 **DISCUSSION POINT: A DRAFT OF THIS SECTION WILL BE COMPLETED AFTER WE**
 44 **RECEIVE FURTHER FEEDBACK FROM THE WORKGROUP ABOUT BOARD COMPOSITION**
 45
 46
 47

48 (3) The initial appointments by the Governor and the General Assembly under sub-subdivisions
 49 (2)(a) and (2)(b) of this section shall serve a term of three years. The initial appointments by the
 50 Commissioner under sub-subdivision (2)(c) of this section shall be for a term of two years. The initial
 51 appointments by the Commissioner under sub-subdivisions (2)(d) and (2)(e) of this section shall be for
 52 a term of one year. All succeeding appointments shall be for terms of three years. Members shall not
 53 serve for more than two successive terms.

54 A Board member's term shall continue until the member's successor is appointed by the
 55 original appointing authority. Vacancies shall be filled by the appointing authority for the unexpired

1 portion of the term in which they occur. A Board member may be removed by the appointing authority
2 for cause.

3 The Board shall meet at least quarterly upon the call of the chair. A majority of the total
4 membership of the Commission shall constitute a quorum.

5 The Commissioner shall appoint a chair to serve for the initial two years of the Plan's
6 operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve
7 for two-year terms.

8 (4) The Board shall submit to the Commissioner a Plan of Operation for the Exchange and any
9 amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the
10 Plan of Operation. The Plan of Operation shall become effective ninety (90) days after its submission,
11 unless sooner approved or disapproved by order of the Commissioner. If the Board fails to submit a
12 suitable Plan of Operation within 180 days after the appointment of the Board, or at any time thereafter
13 fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary
14 rules necessary or advisable to effectuate the provisions of this section. The rules shall continue in
15 force until modified by the Commissioner or superseded by a Plan of Operation submitted by the
16 Board and approved by the Commissioner.

17 **[NOTE: CONTENTS OF PLAN OF OPERATION SUBJECT TO CHANGE PENDING RESULTS**
18 **OF NC HEALTH BENEFIT EXCHANGE STUDY, DUE FEB. 2011; RFP #12-001065]**

19 The Plan of Operation shall:

- 20 (a) Establish procedures and policies for operation of the Exchange, including at least the
21 following:
22 (i) Process by which the Board sets policies and conducts business.
23 (ii) Policy governing insurer participation in the Exchange.
24 (iii) Role of the Exchange in collecting and distributing premiums.
25 (iv) Role and compensation of insurance agents and brokers in operation of the
26 Exchange.
27 (v) Promotion of the broader policy goals of the Federal Act, as set forth in Section
28 2 of this Act.
29 (vi) Determination of need for and selection of eligible entities with whom to
30 contract for performance of Exchange functions or operations.
31 (vii) Financial operations of the Exchange, addressing the collection, handling,
32 disbursing, accounting, and auditing of assets and monies of the Exchange and
33 any eligible entity with whom the Exchange contracts.
34 (viii) Creation of a fund for administrative expenses, which shall be managed by the
35 Board.
36 (ix) Statement of fiduciary duty owed by the Exchange to persons receiving health
37 benefit plan coverage through the Exchange.
- 38 (b) Provide for a comprehensive publicity campaign to raise awareness of the existence of
39 the Exchange and to disseminate information regarding eligibility criteria, enrollment
40 procedures, availability of premium subsidies and tax credits, and other relevant
41 information.
- 42 (c) Provide for review of enrollee appeals of Exchange subsidy and mandate exemption
43 determinations.
- 44 (d) Appoint qualified individuals to serve on legal, actuarial, or other committees as
45 appropriate or necessary to provide technical assistance in the operation of the Exchange,
46 the formulation and implementation of Exchange policies or procedures, and any other
47 function the Board deems relevant to the operations of the Exchange.
- 48 (e) Provide for other matters as may be necessary or proper for the execution of the
49 Executive Director's powers, duties, and obligations under this Act.

50 B. The Exchange shall:

- 51 (1) Facilitate the purchase and sale of qualified health plans;
52 (2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State
53 in facilitating the enrollment of their employees in qualified health plans;
54 (3) Provide for the establishment of an Exchange to assist qualified individuals in this State with
55 enrollment in qualified health plans;
56 (4) Meet the requirements of this Act and any regulations implemented under this Act; and

- 1 (5) Consider the impact that standardization of benefit designs would have on facilitating comparisons
2 between benefit plans offered through the Exchange, and propose and prescribe standardized,
3 defined benefit plans to be offered through the Exchange, as appropriate. [DISCUSSION POINT]
4 C. The Exchange may contract with an eligible entity for any of its functions described in this Act. For the
5 purposes of this Act, an eligible entity shall have the same meaning as set forth in Section 1311(f)(3)(B) of
6 the Federal Act, which includes, but is not limited to, the Division of Medical Assistance, the North
7 Carolina Consumer Assistance Program, or an entity that has experience in individual and small group
8 health insurance, benefit administration or other experience relevant to the responsibilities to be assumed
9 by the entity, but a health insurer or an affiliate of a health insurer is not an eligible entity.
10 D. The Exchange may enter into information-sharing agreements with federal and State agencies and other
11 State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate
12 protections with respect to the confidentiality of the information to be shared and comply with all State and
13 federal laws and regulations.
14 E. Neither the Board nor the employees of the Exchange are liable for any obligations of the Exchange. There
15 shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange or
16 its agents or employees, the Board, the Executive Director, or the Commissioner or the Commissioner's
17 representatives for any action taken by them in good faith in the performance of their powers and duties
18 under this Part.
19 F. The members of the Board are public servants under G.S. 138A-3(30) and are subject to the provisions of
20 Chapter 138A of the General Statutes.
21 G. All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes,
22 electronic data-processing records, artifacts, or other documentary material, regardless of physical form or
23 characteristics, made or received in connection with the operations of the Exchange are public records
24 under G.S. 132-1(a) and are subject to the provisions of Chapter 132 of the General Statutes.
25 [DISCUSSION POINT; PROTECTION OF PROPRIETARY/CONFIDENTIAL INFORMATION]
26 H. The Board is a public body under G.S. 143-318.10(b) and is subject to the provisions of Article 33C of
27 Chapter 143 of the General Statutes.
28

29 Section 5. General Requirements

30
31 The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning
32 with effective dates on or before January 1, 2014.

- 33 A. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.
34 (2) The Exchange shall allow health insurers to offer plans that provide limited scope dental benefits
35 meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the
36 Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric
37 dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.
38 B. Neither the Exchange nor an insurer offering health benefit plans through the Exchange may charge an
39 individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum
40 essential coverage because the individual has become newly eligible for that coverage or because the
41 individual's employer-sponsored coverage has become affordable under the standards of section
42 36B(c)(2)(C) of the Internal Revenue Code of 1986.
43

44 Section 6. Duties of Exchange

45
46 The Exchange shall:

- 47
48 A. Implement procedures for the certification, recertification and decertification, consistent with guidelines
49 developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health
50 benefit plans as qualified health plans;
51 B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
52 C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;
53 D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans,
54 Medicaid, or North Carolina Health Choice may:
55 (1) Obtain standardized comparative information on the aforementioned plans and programs, as
56 appropriate;

- 1 (2) Enter and submit information sufficient for facilitating eligibility determinations for Medicaid and
2 North Carolina Health Choice, and premium subsidy and cost-sharing reduction determinations; and
3 (3) Enter and submit information sufficient for facilitating enrollment of individuals in the plans or
4 programs appropriate to their particular circumstances or selections.
- 5 E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria
6 developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified
7 health plan's level of coverage in accordance with regulations issued by the Secretary under section
8 1302(d)(2)(A) of the Federal Act;
- 9 F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the
10 uniform outline of coverage established under section 2715 of the PHSA;
- 11 G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the
12 Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program
13 (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if
14 through screening of the application by the Exchange, the Exchange determines that any individual is
15 eligible for any such program, enroll that individual in that program;
- 16 H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after
17 application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any
18 cost-sharing reduction under section 1402 of the Federal Act;
- 19 I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees,
20 which shall enable any qualified employer to specify a level of coverage so that any of its employees may
21 enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;
- 22 J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual
23 responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt
24 from the individual responsibility requirement or from the penalty imposed by that section because:
25 (1) There is no affordable qualified health plan available through the Exchange, or the individual's
26 employer, covering the individual; or
27 (2) The individual meets the requirements for any other such exemption from the individual responsibility
28 requirement or penalty;
- 29 K. Transfer to the federal Secretary of the Treasury the following:
30 (1) A list of the individuals who are issued a certification under subsection J, including the name and
31 taxpayer identification number of each individual;
32 (2) The name and taxpayer identification number of each individual who was an employee of an employer
33 but who was determined to be eligible for the premium tax credit under section 36B of the Internal
34 Revenue Code of 1986 because:
35 (a) The employer did not provide minimum essential coverage; or
36 (b) The employer provided the minimum essential coverage, but it was determined under section
37 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not
38 provide the required minimum actuarial value; and
39 (3) The name and taxpayer identification number of:
40 (a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or
41 she has changed employers; and
42 (b) Each individual who ceases coverage under a qualified health plan during a plan year and the
43 effective date of that cessation;
- 44 L. Provide to each employer the name of each employee of the employer described in subsection K(2) who
45 ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
- 46 M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to
47 determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility
48 requirement exemptions;
- 49 N. Make recommendations for the development and implementation of a Navigator training and certification
50 program, and select entities qualified to serve as Navigators in accordance with section 1311(i) of the
51 Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:
52 (1) Conduct public education activities to raise awareness of the availability of qualified health plans;
53 (2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the
54 availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-
55 sharing reductions under section 1402 of the Federal Act;
56 (3) Facilitate enrollment in qualified health plans;

- 1 (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance
2 ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other
3 appropriate State agency or agencies, for any enrollee with a grievance, complaint or question
4 regarding their health benefit plan, coverage or a determination under that plan or coverage; and
5 (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the
6 population being served by the Exchange;
- 7 O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the
8 information in developing recommendations on how best to reduce unnecessary premium growth in the
9 individual, small group and large group markets;
- 10 P. Develop recommendations on whether to continue limiting qualified employer status to small employers,
11 and, if so, what threshold to set for small employer size;
- 12 Q. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified
13 employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited
14 from the offering employer;
- 15 R. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not
16 limited to:
17 (1) Educated health care consumers who are enrollees in qualified health plans;
18 (2) Individuals and entities with experience in facilitating enrollment in qualified health plans;
19 (3) Representatives of small businesses and self-employed individuals;
20 (4) The Division of Medical Assistance; and
21 (5) Advocates for enrolling hard to reach populations;
- 22 S. Meet the following financial integrity requirements:
23 (1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the
24 Secretary, the Governor, the Commissioner and the General Assembly a report concerning such
25 accountings;
26 (2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority
27 under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S.
28 Department of Health and Human Services, to:
29 (a) Investigate the affairs of the Exchange;
30 (b) Examine the properties and records of the Exchange; and
31 (c) Require periodic reports in relation to the activities undertaken by the Exchange; and
32 (3) In carrying out its activities under this Act, not use any funds intended for the administrative and
33 operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive
34 compensation or promotion of federal or State legislative and regulatory modifications.
- 35 T. Take legal action as necessary and appropriate to:
36 (1) Recover any amounts erroneously or improperly paid by the Exchange.
37 (2) Recover any amounts paid by the Exchange as a result of mistake of fact or law.
38 (3) Recover other amounts due the Exchange.
- 39 U. Employ and fix compensation of the Executive Director and other employees of the Exchange;
- 40 V. Adopt bylaws, policies, and procedures as may be necessary or appropriate for the implementation of this
41 Act, the Federal Act, or the operation of the Exchange; and
- 42 W. Deliver an annual report to the Speaker of the House of Representatives, the President Pro Tempore of the
43 Senate, the Commissioner, and the Joint Legislative Health Care Oversight Committee. The report shall
44 summarize the activities of the Exchange in the preceding calendar year, including the enrollment of
45 individuals in health benefit plans offered through the Exchange, the movement of individuals into and out
46 of benefit plans offered through the Exchange, the cost of operating the Exchange, and other matters
47 relating to the operation of the Exchange, as determined by the Board.

48
49 **DISCUSSION POINT: ARE THERE OTHER DUTIES THAT WE WANT TO SPECIFY FOR THE**
50 **HEALTH BENEFIT EXCHANGE?**
51
52

1 **[NOTE: THIS SECTION IS FOR REVIEW PURPOSES ONLY. WE DO NOT ANTICIPATE HAVING**
2 **ENOUGH TIME AT THE DECEMBER MEETING TO DISCUSS THESE SECTIONS. HOWEVER, IF**
3 **WE COMPLETE THE OTHER SECTIONS QUICKLY, THEN WE WILL BEGIN DISCUSSION OF THE**
4 **FOLLOWING SECTIONS. MOST OF THE LANGUAGE IN SECTION 7 IS TAKEN DIRECTLY FROM**
5 **THE MODEL ACT]**
6

7 **Section 7. Health Benefit Plan Certification**
8

9 A. The Exchange may certify a health benefit plan as a qualified health plan if:

- 10 (1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act,
11 except that the plan is not required to provide essential benefits that duplicate the minimum benefits of
12 qualified dental plans, as provided in subsection E, if:
13 (a) The Exchange has determined that at least one qualified dental plan is available to supplement the
14 plan's coverage; and
15 (b) The insurer makes prominent disclosure at the time it offers the plan, in a form approved by the
16 Exchange, that the plan does not provide the full range of essential pediatric benefits, and that
17 qualified dental plans providing those benefits and other dental benefits not covered by the plan
18 are offered through the Exchange; **[DISCUSSION POINT: THIS SECTION IS PART OF**
19 **THE MODEL ACT, BUT WE ARE SEEKING CLARIFICATION IF ALL QUALIFIED**
20 **HEALTH PLANS ARE REQUIRED TO OFFER PEDIATRIC DENTAL BENEFITS AS**
21 **PART OF THE ESSENTIAL HEALTH BENEFITS PACKAGE]**
22 (2) The premium rates and contract language have been approved by the Commissioner;
23 (3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act
24 unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act
25 for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;
26 (4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of
27 the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not
28 exceed the limits established under section 1302(c)(2) of the Federal Act;
29 (5) The health insurer offering the plan:
30 (a) Is licensed and in good standing to offer health insurance coverage in this State;
31 (b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level
32 through each component of the Exchange in which the insurer participates, where "component"
33 refers to the SHOP Exchange and the Exchange for individual coverage;
34 (c) Charges the same premium rate for each qualified health plan without regard to whether the plan is
35 offered through the Exchange and without regard to whether the plan is offered directly from the
36 insurer or through an insurance producer;
37

38 **Drafting Note: States whose licensing laws do not use the term "producer" should substitute the appropriate**
39 **terminology.**
40

- 41 (d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and
42 (e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal
43 Act and such other requirements as the Exchange may establish;
44 (6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of
45 this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not
46 limited to, minimum standards in the areas of marketing practices, network adequacy, essential
47 community providers in underserved areas, accreditation, quality improvement, uniform enrollment
48 forms and descriptions of coverage and information on quality measures for health benefit plan
49 performance; and
50 **(7) The Exchange determines that making the plan available through the Exchange is in the interest**
51 **of qualified individuals and qualified employers in this State. [DISCUSSION POINT]**
52

53 **Drafting Note: States should consider whether the Exchange should delegate all or part of plan certification function**
54 **to the commissioner pursuant to the commissioner's rate and form review responsibilities. [DISCUSSION POINT**
55 **FOR GROUP]**
56

- 1 B. The Exchange shall not exclude a health benefit plan:
2 (1) On the basis that the plan is a fee-for-service plan;
3 (2) Through the imposition of premium price controls by the Exchange; or
4 (3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in
5 circumstances the Exchange determines are inappropriate or too costly.
6 C. The Exchange shall require each health insurer seeking certification of a plan as a qualified health plan to:
7 (1) Submit a justification for any premium increase before implementation of that increase. The insurer
8 shall prominently post the information on its Internet website. The Exchange shall take this
9 information, along with the information and the recommendations provided to the Exchange by the
10 commissioner under section 2794(b) of the PHSA, into consideration when determining whether to
11 allow the insurer to make plans available through the Exchange;
12

13 **Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to**
14 **ensure that it does not conflict with other applicable State law.**
15

- 16 (2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and
17 submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the
18 following:
19 (i) Claims payment policies and practices;
20 (ii) Periodic financial disclosures;
21 (iii) Data on enrollment;
22 (iv) Data on disenrollment;
23 (v) Data on the number of claims that are denied;
24 (vi) Data on rating practices;
25 (vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
26 (viii) Information on enrollee and participant rights under title I of the Federal Act; and
27 (ix) Other information as determined appropriate by the Secretary; and
28 (b) The information required in subparagraph (a) of this paragraph shall be provided in plain
29 language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and
30 (3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-
31 sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage
32 that the individual would be responsible for paying with respect to the furnishing of a specific item or
33 service by a participating provider. At a minimum, this information shall be made available to the
34 individual through an Internet website and through other means for individuals without access to the
35 Internet.
36 D. The Exchange shall not exempt any health insurer seeking certification of a qualified health plan,
37 regardless of the type or size of the insurer, from State licensure or solvency requirements and shall apply
38 the criteria of this section in a manner that assures a level playing field between or among health insurers
39 participating in the Exchange.
40 E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent
41 relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs
42 (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;
43 (2) The insurer shall be licensed to offer dental coverage, but need not be licensed to offer other health
44 benefits;
45

46 **Drafting Note: States that do not provide for a limited scope license should review the language above and**
47 **either not include it or modify it for consistency with applicable State law and regulations.**
48

- 49 (3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the
50 benefits typically offered by health benefit plans without dental coverage and shall include, at a
51 minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section
52 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may
53 specify by regulation; and
54 (4) Insurers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are
55 provided by an insurer through a qualified dental plan and the other benefits are provided by an insurer

1 through a qualified health plan, provided that the plans are priced separately and are also made
2 available for purchase separately at the same price.
3

4 **Section 8. Funding; Publication of Costs**

5

- 6 **A.** The Exchange may charge assessments or user fees to health insurers or otherwise may generate funding
7 necessary to support its operations provided under this Act. **[DISCUSSION POINT: WE NEED**
8 **FURTHER DISCUSSION ABOUT FINANCING OPTIONS TO ENSURE THE HBE IS SELF-**
9 **SUFFICIENT]**
- 10 **B.** The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required
11 by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate
12 consumers on such costs. This information shall include information on monies lost to waste, fraud and
13 abuse.
14

15 **Section 9. Regulations**

16

17 The Board and the Commissioner may adopt rules pursuant to Chapter 150B of the General Statutes, including
18 temporary rules, to implement the provisions of this Act. Rules adopted by the Board under this section shall not
19 conflict with or prevent the application of rules adopted by the Commissioner under this Act or under Chapter 58 of
20 the General Statutes.
21

22 **Section 10. Relation to Other Laws**

23

24 Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to preempt or
25 supersede the authority of the commissioner to regulate the business of insurance within this State. Except as
26 expressly provided to the contrary in this Act, all health insurers offering qualified health plans in this State shall
27 comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the
28 commissioner.
29

30 **Drafting Note: States should be aware that section 1311(d)(3)(A) of the Federal Act states that the Exchange**
31 **“may make available a qualified health plan notwithstanding any provision of law that may require benefits**
32 **other than the essential health benefits specified under section 1302(b) of the Federal Act,” unless the State**
33 **elects, pursuant to Section 1311(d)(3)(B) of the Federal Act, to require additional benefits and to make**
34 **payments to or on behalf of enrollees to defray the cost of the additional benefits. Thus, if a State has benefit**
35 **mandates that exceed the federal essential health benefit requirements, States may choose either to: 1)**
36 **establish a mechanism under which qualified health plans may lawfully be offered through the Exchange**
37 **without being required to provide benefits in addition to the federally designated essential benefits; or 2)**
38 **establish a mechanism for evaluating and defraying the costs of the additional benefits. For States choosing to**
39 **require additional benefits and defray the cost, it is recommended that the costs of the additional benefits be**
40 **measured on a “net cost” basis to the extent permitted by federal law or regulations or guidance, considering**
41 **both the costs of the service and any associated savings, based on an evidence-based methodology to**
42 **determine the net cost, if any, of each additional benefit, and the value of the benefit to the State’s residents.**
43 **States also should be aware of the potential conflicts and opportunities for adverse selection created by**
44 **having inconsistent benefits inside an Exchange and outside an Exchange. [DISCUSSION POINT ABOUT**
45 **MANDATED BENEFITS]**
46

47 **Section 11. Effective Date**

48

49 This Act shall be effective [insert date].
50

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