

RFP No. 12-001065

Bidder/Offeror: _____

THIS PAGE IS TO BE FILLED OUT AND RETURNED WITH YOUR BID. FAILURE TO DO SO MAY SUBJECT YOUR BID TO REJECTION.

ATTENTION:

Federal Employer Identification Number or alternate identification number (e.g., Social Security Number) is used for internal processing, including bid tabulation.

Enter ID number here: _____

Pursuant to N.C.G.S. 132-1.10(b) this identification number shall not be released to the public.

Please do not include a Social Security Number and/or Federal Employer Identification Number anywhere else in the bid proposal.

This page will be removed and shredded, or otherwise kept confidential, before the procurement file is made available for public inspection.

**STATE OF NORTH CAROLINA
REQUEST FOR PROPOSALS**

RFP #12-001065

TITLE: NC Health Benefit Exchange Study
USING AGENCY: North Carolina Department of Insurance
ISSUE DATE: Thursday, November 18, 2010
ISSUING AGENCY: North Carolina Department of Insurance

Sealed Proposals subject to the conditions made a part hereof will be received until **Monday, December 13, 2010, at 2:00 p.m. EST** for furnishing services described herein.

SEND ALL PROPOSALS DIRECTLY TO THE ISSUING AGENCY ADDRESS AS SHOWN BELOW: Mail one (1) original and three (3) copies of the proposal per envelope. Address envelope and insert RFP number as shown below. It is the responsibility of the bidder to have the proposal in this office by the specified time and date of opening.

<u>DELIVERED BY US POSTAL SERVICE</u>	<u>DELIVERED BY ANY OTHER MEANS</u>
RFP NO. 12-001065 North Carolina Department of Insurance Attention: Lorraine Richardson 1201 Mail Service Center Raleigh, NC 27699-1201	RFP NO. 12-001065 North Carolina Department of Insurance Attention: Lorraine Richardson 430 North Salisbury Street, Room 4092J Raleigh, NC 27603-5926

IMPORTANT NOTE: Indicate firm name and RFP number on the front of each sealed proposal envelope or package, along with the date for receipt of proposals specified above.

Proposals may not be submitted by any electronic means, including telegraph, facsimile (FAX) machine, telephone, or e-mail. However, this RFP is available electronically on the N.C. Interactive Purchasing System (IPS) Website at <http://www.ips.state.nc.us/ips/pubmain.asp> and can be obtained by selecting one of the "Bid" links.

Bids submitted via telegraph, facsimile (FAX) machine, telephone, or electronic means, including but not limited to e-mail, in response to this Request for Proposals will not be acceptable.

Please direct all inquiries regarding **RFP requirements** to Lorraine Richardson, Purchasing Officer at one of the addresses shown above, at 919-733-3355 or via email at lorraine.richardson@ncdoi.gov.

Written questions concerning the **RFP specifications** will be received until **Wednesday, November 24, 2010 at 4:00 p.m. EST** and may be sent via e-mail to Jean Holliday at jean.holliday@ncdoi.gov. No additional questions will be accepted after this deadline. A summary of all questions and answers will be posted on the internet as an addendum, located under the RFP, by **Wednesday, December 1, 2010, at 4:00 p.m. EST**. Should a proposal conference be needed, it will be scheduled and posted on the internet by **Thursday, December 2, 2010, at 4:00 p.m. EST**. The internet address is the same as above. **It is the offeror's responsibility to ensure that all addenda have been reviewed and, if need be, signed and returned.**

Proposal Time Frame:

<u>ACTIVITY</u>	<u>DATE/DEADLINE</u>
Issue RFP	Thursday, November 18, 2010
Last day to receive written questions	Wednesday, November 24, 2010, 4:00 p.m. EST
Response to questions posted	Wednesday, December 1, 2010, 4:00 p.m. EST
Proposal conference schedule posted as addendum, if necessary	Thursday, December 2, 2010, 4:00 p.m. EST
Proposal due and public opening	Monday, December 13, 2010, 2:00 p.m. EST
Notification and contract execution	Tuesday, December 21, 2010
Effective date of new contract	Tuesday, December 21, 2010

<http://www.pandc.nc.gov/>

Within two days after notification of award of a contract, the vendor must register in NC E-Procurement @ Your Service (<http://vendor.ncgov.com>).

It is highly recommended to get registered as soon as possible. The Help Desk telephone number is 1-888-211-7440.

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I. INTRODUCTION

A. PURPOSE

The Selected Offeror shall conduct a Health Benefit Exchange Planning study for North Carolina. The Offeror selected will provide a written report and present the information contained therein to the Department of Insurance (Department) and other entities as identified by the Department, and to any relevant Legislative committee upon request.

PLEASE NOTE – Minimum Qualifications

Offerors submitting proposals to complete this project shall have the following minimum qualifications:

1. The Offeror's team leader for this project must meet the Qualification Standards of the American Academy of Actuaries for issuing a Statement of Actuarial Opinion regarding the work product contained in the Scope of Work.
2. The Offeror is preferred to have prior experience working with health benefit exchanges or similar health coverage mechanisms or entities.
3. The Offeror must have access to data that is of sufficient quality and detail to produce reliable analytical results. Specifically, the analysis will require that the selected Offeror's database contain characteristics specific to the issues related to healthcare and all analyses will include consideration of the population and environment of North Carolina and not just national information.

Offerors that submit a proposal to perform the work contemplated by this project shall review the entire text of this RFP, including the Scope of Work, and also review each of the following, which are contained in Appendix A:

1. The terms and conditions of Federal Grant No. 1 HBEIE100042-01-00.
2. Affordable Care Act Sections 1311 - 1313 (collectively "Consumer Choices and Insurance Competition Through Health Benefit Exchanges") and Sections 1321-1324 (collectively "State Flexibility Relating to Exchanges").

Offerors shall also review the National Association of Insurance Commissioner's (NAIC's) American Health Benefit Exchange Model Act (Draft dated 11/15/10 or later). Copies of the Model Act may be obtained from the NAIC website at www.naic.org.

B. BACKGROUND

Policymakers in North Carolina need this Exchange Planning Study to make informed decisions regarding the potential adoption of one or more Health Benefit Exchanges by the State.

The President signed into law the Patient Protection and Affordable Care Act on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 on March 30, 2010. The two laws are collectively referred to as the Affordable Care Act (the "Act"). The Act includes a wide variety of provisions designed to expand coverage, to provide more health care choices, to enhance the quality of health care for all Americans, to hold insurance companies more accountable, and to lower health care costs. Among its provisions, the law provides grant funding to assist States in implementing parts of the Act, such as grants for insurance rate review and consumer assistance.

Section 1311 of the Act provides funding assistance to the States for the planning and establishment of an American Health Benefit Exchanges ("Exchange"). The Act provides that each state may elect to establish Exchanges that would: 1) facilitate the purchase of qualified health plans; 2) provide for the establishment of a Small Business Health Options Program ("SHOP Exchange") designed to assist qualified employers in facilitating the enrollment of their employees in qualified health plans offered in the SHOP Exchange; and 3) meet other requirements specified in the Act.

Beginning in 2014, tens of millions of Americans will have access to health coverage through the newly established Exchanges. Individuals and small businesses will be able to use the Exchanges to purchase affordable health insurance from a choice of products offered by qualified health plans. The Exchanges will ensure that participating health plans meet certain standards and facilitate competition and choices by rating health plans' quality. Individuals and families purchasing health insurance through Exchanges may qualify for premium tax credits and reduced cost-sharing if their household income is between 138 percent and 400 percent of the federal poverty level. The Exchanges will coordinate eligibility and enrollment with State Medicaid and Children's Health Insurance Programs to ensure that all Americans have affordable health coverage.

In response to the adoption of the Act, the State has organized several work groups to assist and guide the State in implementing the Act's provisions. One such group is focusing on the Exchange(s) and will provide input on the development of the Exchange(s) and ensure that the decisions made about implementing the Exchange(s) are in the best interests of the State as a whole. The goal of this study is to provide information to assist the workgroup, the Departments of Insurance and Health and Human Services, and legislators with the consideration of establishing one or more Exchanges in the State.

C. RESOURCE AVAILABILITY

The Selected Offeror must:

1. Be capable of staffing the assignment as soon as possible after the effective date of the contract which is December 21, 2010.
2. Possess sufficient professional human resources to complete a report containing the analysis and recommendations related to the Planning for Health Benefit Exchanges by February 14, 2011. Please note that in no event shall the report be issued later than February 21, 2011.
3. Possess research resources capable of rendering professionally sound analysis of complex technical issues.

The Department reserves the right to approve assigned staff for all work performed under the terms of this contract.

D. SCOPE OF WORK

Note: Unless noted otherwise, the term "Exchange" refers to an entity (regardless of the governance structure) that operates a marketplace that is intended to provide affordable, high-quality health insurance coverage options to individuals and small businesses.

The Offeror selected to conduct the study will accomplish the following.

1. Provide impact analyses (to include the measures defined in #2 and #3 below) of the following scenarios and time periods with respect to the impact of the Act in North Carolina. For purposes of this analysis, assume that the State does not impose any mandated benefits above those defined as an Essential Benefit through the Act:
 - a. Baseline estimates for 2009 and projections for each year 2013 – 2016 assuming status quo (no Act provisions).
 - b. Estimates for each year 2010 – 2013 assuming insurance reforms included in the Act.
 - c. Estimates for each year 2014 – 2016 assuming the State implements the Exchanges with separate risk pools for the individual and small group (up to 50 employees) markets.
 - d. Estimates for each year 2014 – 2016 assuming the State implements the Exchanges with separate risk pools for the individual and small group (up to 100 employees) markets.
 - e. Estimates for each year 2014 – 2016 assuming the State implements the Exchange with a single risk pool for the individual and small group (up to 50 employees) market.
 - f. Estimates for each year 2014 – 2016 assuming the State implements the Exchange with a single risk pool for the individual and small group (up to 100 employees) market.

2. Population Impact: For each scenario in #1 above, analysis should include estimates of the following measures for each demographic group defined in #3 below:
 - a. Number and percent of non-elderly (age 19 – 64) North Carolinians eligible for each of the following:
 - i. Medicaid/ Children’s Health Insurance Program (CHIP).
 - ii. Other government program (VA, TriCare, etc.).
 - iii. Employer sponsored insurance (large group).
 - iv. Employer sponsored insurance (small group).
 - v. Individual subsidies through the Exchange.
 - vi. None of the above.
 - b. Number and percent of non-elderly North Carolinians in each of the following insurance categories:
 - i. Medicaid/CHIP.
 - ii. Other government program.
 - iii. Self-funded employer sponsored insurance (large group) – own employer.
 - iv. Fully-insured employer sponsored insurance (large group) – own employer.
 - v. Employer sponsored insurance (small group) not through the Exchange – own employer.
 - vi. Employer sponsored insurance through the Exchange – own employer.
 - vii. Self-funded employer sponsored insurance (large group) – dependent.
 - viii. Fully-insured employer sponsored insurance (large group) – dependent.
 - ix. Employer sponsored insurance (small group) not through the Exchange – dependent.
 - x. Employer sponsored insurance through the Exchange – dependent.
 - xi. Individual market not through the Exchange.
 - xii. Individual market through the Exchange with subsidies.
 - xiii. Individual market through the Exchange without subsidies.
 - xiv. Uninsured.
 - c. For each of scenarios 1.c - f, number of individuals migrating between the following coverage types from 2013 - 2014:
 - i. Medicaid/Children’s Health Insurance Program (CHIP).
 - ii. Other government program.
 - iii. Individual market.
 - iv. Employer sponsored insurance.
 - v. Uninsured.
 - d. For each of scenarios 1.c – f, number of individuals enrolled and average premiums (or expected range) in the Exchange in each of the following benefit levels (show separately for individual and small group coverage):
 - i. Platinum.
 - ii. Gold.
 - iii. Silver.
 - iv. Bronze.
 - v. Catastrophic.
 - e. For each of scenarios 1. c – f, the average per capita premium subsidy provided to individuals purchasing insurance through the Exchange.
 - f. For each of scenarios 1. c – f, the average per capita cost sharing subsidy provided to individuals purchasing insurance through the Exchange.
 - g. Measures in #2 should be provided for each of the following demographic groups:
 - i. Income Level:
 1. Below 138% of the Federal Poverty Level (FPL).
 2. 138% to 200% of the FPL.
 3. 201% to 300% of the FPL.
 4. 301% to 400% of the FPL.
 5. 401% or more of the FPL.
 - ii. Employment status:
 1. Full-time (working 30 or more hours per week).
 2. Part-time (working less than 30 hours per week).
 3. Unemployed.
 4. Not in the job market.

- iii. Employer size:
 - 1. Employed by an employer with 50 or less employees.
 - 2. Employed by an employer with 51 to 100 employees.
 - 3. Employed by an employer with 101 or more employees.
 - iv. Age:
 - 1. Under age 19.
 - 2. 19 through 24.
 - 3. 25 through 29.
 - 4. 30 through 39.
 - 5. 40 through 49.
 - 6. 50 through 59.
 - 7. 60 through 64.
 - v. Gender.
 - vi. Race.
 - vii. Ethnicity.
- 3. Employer Impact: For each scenario in #1 above, analysis should include the following measures for employer groups:
 - a. Number and percent of employers offering health insurance to their employees for each of the following employer group sizes:
 - i. Up to 50.
 - ii. 51 – 100.
 - iii. More than 100.
 - b. Percent of employers offering health insurance to employees (from 3.a.) that are
 - i. Self-funded.
 - ii. Insured through the Exchange.
 - iii. Insured outside of the Exchange.
 - c. Average employee take-up of health insurance for each group size in 3.a.
 - d. Average per employee per month health insurance cost to the employer and the employee for each group size in 3.a.
 - e. Number of small employers eligible for small group tax credit, percent take up, and average tax credit (dollar amount and as a percent of employer cost)
- 4. Based on the analysis above and other relevant factors provide a descriptive analysis of the impact of merging the individual and the small employer markets for purposes of creating a single rating pool. Include in the analysis the pros and cons of merging the risk pools as well as a recommendation. Provide best and worst case scenarios. If the impact of merging the markets is dramatic, provide scenarios and recommendations of how to phase in revisions to rating methodology between now and 2014.
- 5. Based on the analysis above and other relevant factors, provide a descriptive analysis of the impact of defining a small employer to include those with up to 100 employees on January 1, 2014 and the impact of delaying that change until January 1, 2016. Include in the analysis the pros and cons of each approach as well as a recommendation.
- 6. Study the issues of anti-selection in the health insurance markets under the rules established for Exchanges in the Act. Provide recommendations on how to reduce or eliminate anti-selection against participation in the Exchanges (i.e., disproportionate number of people who are in poorer health and have high health expenses enroll in coverage through the Exchanges, while healthier, lower-cost people disproportionately enroll in plans offered in the individual and small group markets outside the Exchanges) when various Exchange structures are established. Provide the pros and cons of each approach including the impact on insurer participation, consumer choice, and the ability of the Exchanges to influence the quality and delivery of health care in North Carolina.
- 7. Study the issue of adverse selection among benefit tiers within the Exchange, such as between the Silver plan and those with leaner benefits (Bronze and catastrophic). Provide recommendations for how to monitor and adjust plan pricing to offset any anticipated biased selection among benefit tiers.
- 8. According to the Act, the Exchange must be self-supporting (i.e. no State or federal assistance) by January 1, 2015. Provide options as to which functions and/or informational services of the Exchange would lend themselves to quality and transparency, benefiting the larger population as a whole, and which could be assessed to the broader health insurance industry as a whole. Specifically include alternatives to funding all of the Exchange administration through premium for coverage obtained through the Exchange.

9. Project the cost to run an Exchange for the first 3 years of operation (beginning January 1, 2014) using the projections for enrollment/participation produced in this report. Base assumptions for the activities, functions and expenses of the Exchange upon the activities, functions, and expenses of the Massachusetts Connector. The analysis should include suggested staffing needs and capabilities, as well as proposed methodologies (e.g. assessments, user fees, etc.) for generating funds sufficient to support operation of the Exchange and its related services, as provided by the Act (e.g. Navigator grants, IT operations, out reach, etc.) along with the costs associated with each method.
10. Study the expected impact of establishment of an Exchange upon insured grandfathered plans and the individuals and employers who keep coverage in them. This should include analysis of the expected impact upon the premium rates for such plans, and an estimate of the percentage of larger employers who may dump employer group coverage and push employees to the Exchange. Include recommendations for safeguards that should be considered by the State to address this issue.
11. Study the possible governance structures for the Exchange (state government agency, non-profit entity, independent pseudo-government agency, federal government agency) and provide analysis relating to the challenges for the state associated with each structure.
12. Provide two examples of cost-sharing provisions (copayments, deductibles, out-of-pocket limits) for each of the five levels of benefits for qualified health plans as defined by the Act. Indicate how the plans would compare to typical individual and group medical plans currently available in t.
13. Estimate the range of commission that has historically been paid to agents/brokers/producers by insurers in the individual and small group health insurance markets. Include a separate range for commissions that have been paid in other creative purchasing arrangements or pools (public or private). Analyze and provide the pros and cons of flat fee compensation to agents/brokers/producers versus a percent of premium. Provide some judgment as to the additional (or lessened) work expected for agents/brokers/producers under the reforms given the probable increase in business from the individual mandate and government subsidies and the new information, comparability, and online eligibility functionality associated with the Exchange.
14. Given the list of mandated benefits provided in Appendix B and using your estimate of participation in the Exchange, estimate the cost (on a per member per month basis) of each of the mandated benefits for coverage sold through the Exchange.
15. Identify and analyze the challenges (i.e. risks) and rewards of joining with one or more other states to establish a regional interstate Exchange. Primarily focus on what functionalities of the Exchange lend themselves to economies of scale, and what are the cost savings associated with what levels of scale. (Such an Exchange should be assumed to provide the administration of the marketplace only and should not be assumed to be a merging of the health insurance markets (rating pool, etc.) in one or more states.)
16. Identify and analyze the challenges and rewards of establishing regional Exchanges within the State, including a recommendation for the number of regional Exchanges and their locations. Include an analysis of the range of current expected premiums (as of January 1, 2011) across the State, and provide the basis for your recommendations, i.e. demographics, risk factors, medical costs, medical referral patterns, etc.
17. Provide analysis of whether State law should require that all comprehensive health insurers participate in the Exchange. Identify the issues and rewards of such a requirement and the impact, if any, such a requirement would have upon insurers' decisions to market health insurance in North Carolina. Include analysis of how this requirement may or may not be used to alleviate anti-selection as described in #7.
18. Provide analysis of the pros and cons of requiring that qualified health plans offered in the Exchange use standardized benefit designs. Provide the analysis for each market place (individual and small employer group) as well as for a combined market place.
19. Provide an overall assessment specifically identifying how the Exchange(s) might separately or collectively with other public and private payers in the State drive system efficiencies, promote quality of care improvement and a more engaged consumer as well as a more competitive health care payer marketplace.

20. Provide a cost analysis of the Basic Health Plan option, whereby North Carolina could provide a Basic Health Plan to individuals with family incomes between 138% and 200% FPL in lieu of subsidized coverage through the Exchange. Include an estimate of the aggregate and per capita amount of federal funding that could be redirected to this program in North Carolina. Include analysis of having a fourth benefit plan in the Medicaid realm (Medicaid, CHIP, the Basic Health Plan and the Exchange) providing the pros and cons of such a move.

All analyses shall include consideration of the population and environment of North Carolina and not just national information, and should use existing data sources, if available.

The Offeror selected shall provide to the Department a written report on items 1 through 20 in Section I.D above, including supporting exhibits. The written report shall be delivered in accordance with the following schedule:

Action Item	Date
Project Start Date	As soon as possible, after the effective date of the contract – December 21, 2010
Meet with Department staff by teleconference call to review project and deliverables	By January 7, 2011
Progress Reports	Weekly beginning with December 27, 2010
Draft Report	One week before the final report is issued
Final report to Department staff	Monday, February 14, 2011

If requested by the Department, the Offeror shall travel to Raleigh, North Carolina to present its report and answer questions posed by legislative committees or other entities, as designated by the Department. Up to four trips may be requested.

E. PROFESSIONAL WORK PAPERS

The Department retains ownership of all work papers generated by the work performed under this contract. The selected vendor is encouraged to retain work paper copies for the completion of their internal files.

Work papers are all records generated by the contracted professional documenting procedures followed, tests performed, information obtained and conclusions reached. Work papers, accordingly, may include work programs, analyses, memoranda, letters, abstracts of company documents and schedules, or commentaries prepared or obtained by the contracted professional in the course of the assignment that support the professionals' conclusions.

F. PROHIBITED COMMUNICATIONS: From the issuance date of this RFP through the date the contract is awarded, each offeror (including its subcontractors and/or suppliers) is prohibited from having any communications with any person inside or outside the using agency, issuing agency, other government agency office, or body (including the purchaser named above, department secretary, agency head, members of the general assembly and/or governor's office), or private entity, and the communication discusses the content of offeror's proposal or qualifications, the contents of another offeror's proposal, another offeror's qualifications or ability to perform the contract, and/or the transmittal of any other communication of information that has the effect of directly or indirectly influencing the evaluation of proposals and/or the award of the contract. Offerors not in compliance with this provision shall be disqualified from contract award, unless it is determined that the best interest of the state would not be served by the disqualification. An offeror's proposal may be disqualified if its subcontractor and supplier engage in any of the foregoing communications during the time that the procurement is active (i.e., the issuance date of the procurement to the date of contract award). Only the discussions, communications or transmittals of information authorized by the issuing agency in this RFP or general inquiries to the purchaser regarding the status of the contract award are exempt from this provision.

II. THE PROCUREMENT AND EVALUATION PROCESS

A. OVERVIEW OF THE PROCUREMENT PROCESS

The following is a general description of the process by which a firm will be selected to provide services.

1. Request for Proposals (RFP) is issued to prospective contractors.
2. A pre-proposal conference and/or deadline for written questions is set. (See the cover sheet of this RFP for details.)
3. Proposals in one (1) original and three (3) copies will be received from each offeror in a sealed envelope or package. Each original shall be signed and dated by an official authorized to bind the firm. Unsigned proposals will not be considered.
4. All proposals must be received by the issuing agency not later than the date and time specified on the cover sheet of this RFP.
5. At that date and time the package containing the proposals from each responding firm will be opened publicly and the name of the offeror and cost(s) offered will be announced. Interested parties are cautioned that these costs and their components are subject to further evaluation for completeness and correctness and therefore may not be an exact indicator of an offeror's pricing position.
6. At their option, the evaluators may request oral presentations or discussion with any or all offerors for the purpose of clarification or to amplify the materials presented in any part of the proposal. However, offerors are cautioned that the evaluators are not required to request clarification; therefore, all proposals should be complete and reflect the most favorable terms available from the offeror.
7. Proposals will be evaluated according to completeness, content, experience with similar projects, the technical ability of the offeror and its staff, the offeror's ability to complete the project within the required time frame, the offeror's technical approach, and cost. Refer to Section II. B. and C of this RFP for additional information on the evaluation process and criteria. Award of a contract to one offeror does not mean that the other proposals lacked merit, but that, all factors considered, the selected proposal was most advantageous to the State.

In addition to any other evaluation criteria identified in the State agency's solicitation document, the agency shall, for purposes of evaluating proposed or actual contract performance outside of the United States, consider the following factors to ensure that any award will be in the best interest of the State:

- a) Total cost to the State.
- b) Level of quality provided by the vendor.
- c) Process capability across multiple jurisdictions.
- d) Protection of the State's information and intellectual property.
- e) Availability of pertinent skills.
- f) Ability to understand the State's business requirements and internal operational culture.
- g) Risk factors such as the security of the State's information technology.
- h) Relations with citizens and employees.
- i) Contract enforcement jurisdictional issues.
- j) Offerors are cautioned that this is a request for offers, not a request to contract, and the State reserves the unqualified right to reject any and all offers when such rejection is deemed to be in the best interest of the State.

B. OVERVIEW OF THE EVALUATION PROCESS

1. A team of at least three employees from the Department will evaluate all proposals. The team may request an interview or oral/personal presentation from any offerors for the purpose of clarifying any part of the proposal.
2. Offerors are reminded that the Department is not obligated to ask for, or accept after the closing date for receipt of proposals, information that is essential for a complete and thorough evaluation of the proposal. Accordingly, proposals should be submitted in accordance with the requirements of this RFP and in complete detail.
3. The evaluation team, upon a review of the quality of services offered within each proposal and based on the costs of those qualifying proposals, will determine which proposal best satisfies the requirements of this RFP.

C. EVALUATION CRITERIA

The evaluation team will determine which proposals satisfy the requirements of this RFP by considering the following criteria on a "points earned" basis, as follows:

1. Technical Ability of firm and staff – Up to 20 points
2. Experience with similar projects – Up to 20 points
3. Proposal completeness and content – Up to 15 points
4. Technical approach to accomplishing the research, including the sources of or methods for collecting the data underlying the Offeror's recommendations – Up to 15 points
5. Responsiveness (ability to staff and complete the project within the time frame) – Up to 15 points
6. The value of the proposal in terms of the fee quoted by the Offeror in relation to the work to be performed, i.e. cost – Up to 15 points

III. INSTRUCTIONS TO VENDORS

A. PROPOSAL INSTRUCTIONS

Offerors are strongly encouraged to use the outline of this Section for their proposal and include all items in the order listed. All information must be provided for the primary offeror as well as for any sub-contracting offerors. If any information is not provided, the offer shall be rejected from consideration. The response to this RFP will consist of separate packages for the technical and cost proposals and each shall consist of the following sections, respectively:

1. Technical Proposal Content

- a. Cover Letter – This letter shall highlight the contents of the proposal, and bear the authorized offeror's signature who can bind the firm to a contract.
- b. Corporate Background and Experience – This section should include background information on the organization and provide the following information:
 - i. Full name, address, and telephone number of the organization.
 - ii. Date established.
 - iii. Ownership form (public company, partnership, subsidiary, etc.).
 - iv. If incorporated, the state of incorporation must be included. (Note: In order to execute a contract, the firm must be licensed in North Carolina.)

This section must also provide details of experience with similar projects and include a list of references, in the format of Attachment A to this RFP, for whom similar work has been performed.

- c. Financial Statement – The offeror's most recent audited financial statement or similar evidence of financial stability shall be provided. (This is required of all offerors, whether publicly or privately held.)

All financial information, statements and/or documents provided in response to this proposal requirement shall be kept confidential, **if the Offeror complies with paragraph 13 of the General Information on Submitting Proposals by marking the financial information, statements and/or documents confidential.**

- d. Project Organization – This section must include the proposed staffing, deployment and organization of personnel that can be assigned to projects.

The offeror shall provide information as to the qualifications and experience of all executive, managerial, legal, and professional personnel to be assigned to projects, including resumes citing experience with similar projects and the responsibilities to be assigned to each person. This section shall include a statement which details experience of the Offeror and of any member of the proposed project team with health benefit exchanges or similar health coverage mechanisms.

This section should also address the offeror's ability to staff and begin the project, as soon as possible, after the effective date of the new contract which is December 21 2010, with the goal of finalizing a report by February 14, 2011. In no event shall the report be issued later than February 21, 2011. This will permit time for the submission of legislation should it be warranted. Please note that, the selected vendor shall discuss the progress on the project with the Department weekly, and a draft report shall be delivered to the Department at least one week before the final report is issued.

- e. Technical Approach – This section shall include, in narrative, outline, and/or graph form the offeror's approach to accomplishing the tasks outlined in the Scope of Work section of this RFP. A description of each task and deliverable and the schedule for accomplishing each shall be included, as well as a description of the sources of, or methods for collecting, the information that will form the basis of the Offeror's conclusions
- f. Recommendations – Identify any analyses not specified in the Scope of Work section of this RFP that Offeror believes should be included and that would add value to the final report
- g. Outsourcing – The offeror must detail the manner in which it intends to utilize resources or workers located outside of the United States, and the State of North Carolina will evaluate the additional risks, costs and other factors associated with such utilization to make the award for this proposal as deemed by the awarding authority to be in the best interest of the State.

For any proposed or actual utilization or contract performance outside of the United States, the offeror's proposal must include:

- i. The location of work performed under a state contract by the vendor, any subcontractors, employees, or other persons performing the contract.
- ii. The corporate structure and location of corporate employees and activities of the vendors, its affiliates or any subcontractors.

The State may initiate proceedings to debar a vendor from participation in the bid process and from contract award as authorized by North Carolina law, if it is determined that the vendor has refused to disclose or has falsified any information provided herein.

In accordance with NC General Statute 143-59.4 (Session Law 2005-169), Attachment C to this RFP is to be completed and submitted with the offeror's proposal.

- h. Availability – An explanation of the ability of the Offeror to travel and meet with the Department officials, Legislative officials, or other groups as required by the Department to discuss the study and present the findings.

2. **Cost Proposal Content**

- a. The Cost Proposal shall be submitted and contain the completed and signed Cost Proposals/Execution of Proposal form included in this RFP **as Attachment B. Unsigned proposals will not be considered.**
- b. The cost proposal package must contain a signed letter indicating the total cost offered and detailing the following:
 - i. Personnel costs (identify staff level and hourly rates for each level; identify anticipated staff level participation for typical work).
 - ii. Travel and subsistence expenses (out-of-pocket expense).
 - iii. Subcontractor costs (if any).
 - iv. Any other costs (e.g., office expenses).
 - v. Total cost (a total not to exceed cost representing the maximum amount for all work to be preformed must be clearly indicated under this heading).
- c. Please note that the desired time frame for work to begin as soon as possible after the effective date of the new contract which is December 21, 2010, with the goal of finalizing a report by February 14, 2011. In no event shall the report be issued later than February 21, 2011.
- d. This contract will be funded entirely by a federal grant received by the Department to study the establishment of an Exchange. The Department has allocated up to \$300,000 for the portion of the study that will be performed pursuant to a contract issued as a result of this RFP. However, payment to the Offeror shall be made in accordance with the fees specified in the Offeror's proposal.

B. GENERAL INFORMATION ON SUBMITTING PROPOSALS

1. **EXCEPTIONS:** All proposals are subject to the terms and conditions outlined herein. All responses shall be controlled by such terms and conditions and the submission of other terms and conditions, price lists, catalogs, and/or other documents as part of an offeror's response will be waived and have no effect either on this Request for Proposals or on any contract that may be awarded resulting from this solicitation. Offeror specifically agrees to the conditions set forth in the above paragraph by signature to the proposal.
2. **CERTIFICATION:** By executing the proposal, the signer certifies that this proposal is submitted competitively and without collusion (G.S. 143-54), that none of our officers, directors, or owners of an unincorporated business entity has been convicted of any violations of Chapter 78A of the General Statutes, the Securities Act of 1933, or the Securities Exchange Act of 1934 (G.S. 143-59.2), and that we are not an ineligible vendor as set forth in G.S. 143-59.1. False certification is a Class I felony.
3. **ORAL EXPLANATIONS:** The State shall not be bound by oral explanations or instructions given at any time during the competitive process or after award.
4. **REFERENCE TO OTHER DATA:** Only information which is received in response to this RFP will be evaluated; reference to information previously submitted shall not be evaluated.

5. **ELABORATE PROPOSALS:** Elaborate proposals in the form of brochures or other presentations beyond that necessary to present a complete and effective proposal are not desired.

In an effort to support the sustainability efforts of the State of North Carolina we solicit your cooperation in this effort.

It is desirable that all responses meet the following requirements:

- All copies are printed **double sided**.
 - All submittals and copies are printed on **recycled paper with a minimum post-consumer content of 30%** and indicate this information accordingly on the response.
 - Unless absolutely necessary, all proposals and copies should **minimize or eliminate use of non-recyclable or non re-usable materials** such as plastic report covers, plastic dividers, vinyl sleeves, and GBC binding. Three-ringed binders, glued materials, paper clips, and staples are acceptable.
 - Materials should be submitted in a format which allows for **easy removal and recycling** of paper materials.
6. **COST FOR PROPOSAL PREPARATION:** Any costs incurred by offerors in preparing or submitting offers are the offerors' sole responsibility; the State of North Carolina will not reimburse any offeror for any costs incurred prior to award.
 7. **TIME FOR ACCEPTANCE:** Each proposal shall state that it is a firm offer which may be accepted within a period of 60 days. Although the contract is expected to be awarded prior to that time, the 60 day period is requested to allow for unforeseen delays.
 8. **TITLES:** Titles and headings in this RFP and any subsequent contract are for convenience only and shall have no binding force or effect.
 9. **CONFIDENTIALITY OF PROPOSALS:** In submitting its proposal the offeror agrees not to discuss or otherwise reveal the contents of the proposal to any source outside of the using or issuing agency, government or private, until after the award of the contract. Only those communications with the using agency or issuing agency authorized by this RFP are permitted. All offerors are advised that they are not to have any communications with the using or issuing agency during the evaluation of the proposals (i.e., after the public opening of the proposals and before the award of the contract), unless the State's purchaser contacts the offeror(s) for purposes of seeking clarification. An offeror shall not: transmit to the issuing and/or using agency any information commenting on the ability or qualifications of other offerors to perform the advertised contract and/or the other offerors' proposals and/or prices at any time during the procurement process; or engage in any other communication or conduct attempting to influence the evaluation and/or award of the contract that is the subject of this RFP. Offerors not in compliance with this provision may be disqualified, at the option of the State, from contract award. Only discussions authorized by the issuing agency are exempt from this provision.
 10. **RIGHT TO SUBMITTED MATERIAL:** All responses, inquiries, or correspondence relating to or in reference to the RFP, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by the offerors shall become the property of the State when received.
 11. **OFFEROR'S REPRESENTATIVE:** Each offeror shall submit with its proposal the name, address, and telephone number of the person(s) with authority to bind the firm and answer questions or provide clarification concerning the firm's proposal.
 12. **SUBCONTRACTING:** Offerors may propose to subcontract portions of the work provided that their proposals clearly indicate what work they plan to subcontract and to whom and that all information required about the prime contractor is also included for each proposed subcontractor.
 13. **PROPRIETARY INFORMATION:** Trade secrets or similar proprietary data which the offeror does not wish disclosed to other than personnel involved in the evaluation or contract administration will be kept confidential to the extent permitted by NCAC T01:05B.1501 and G.S. 132-1.3 if identified as follows: Each page shall be identified in boldface at the top and bottom as "CONFIDENTIAL". Any section of the proposal which is to remain confidential shall also be so marked in boldface on the title page of that section. Cost information may not be deemed confidential. In spite of what is labeled as confidential, the determination as to whether or not it is shall be determined by North Carolina law.

14. **HISTORICALLY UNDERUTILIZED BUSINESSES:** Pursuant to General Statute 143-48 and Executive Order #150, the State invites and encourages participation in this procurement process by businesses owned by minorities, women, disabled, disabled business enterprises and non-profit work centers for the blind and severely disabled.
15. **PROTEST PROCEDURES:** When an offeror wants to protest a contract awarded by the Secretary of Administration or by an agency over \$25,000 resulting from this solicitation, they must submit a written request to the State Purchasing Officer at Purchase and Contract, 1305 Mail Service Center, Raleigh, NC 27699-1305. This request must be received in the Division of Purchase and Contract within thirty (30) consecutive calendar days from the date of the contract award. When an offeror wants to protest a contract awarded by an agency or university resulting from this solicitation that is over \$10,000 but less than \$25,000 for any agency, or any contract awarded by a university, they must submit a written request to the issuing procurement officer at the address of the issuing agency. This request must be received in that office within thirty (30) consecutive calendar days from the date of the contract award. Protest letters must contain specific reasons and any supporting documentation for the protest. Note: Contract award notices are sent only to those actually awarded contracts, and not to every person or firm responding to this solicitation. Contract status and Award notices are posted on the Internet at <http://www.pandc.nc.gov/>. All protests will be handled pursuant to the North Carolina Administrative Code, Title 1, Department of Administration, Chapter 5, Purchase and Contract, Section 5B.1519. (See Protest Information at <http://www.pandc.nc.gov/protests.pdf> for more information.)
16. **TABULATIONS:** The Division has implemented an Interactive Purchasing System (IPS) that allows the public to retrieve bid tabulations electronically from our Internet web site: <http://www.pandc.nc.gov/>. Click on the IPS BIDS icon, click on Search for Bid, enter the RFP number, and then search. Tabulations will normally be available at this web site not later than one working day after opening. Lengthy tabulations may not be available on the Internet, and requests for these verbally or in writing cannot be honored.
17. **VENDOR REGISTRATION AND SOLICITATION NOTIFICATION SYSTEM:** Vendor Link NC allows vendors to electronically register free with the State to receive electronic notification of current procurement opportunities for goods and services available on the Interactive Purchasing System. Online registration and other purchasing information are available on our Internet web site: <http://www.pandc.nc.gov/>.
18. **RECIPROCAL PREFERENCE:** G.S. 143-59 establishes a reciprocal preference law to discourage other states from applying in-state preferences against North Carolina's resident offerors. The "Principal Place of Business" is defined as the principal place from which the trade or business of the offeror is directed or managed.

C. NORTH CAROLINA GENERAL CONTRACT TERMS AND CONDITIONS

1. **GOVERNING LAW:** This contract is made under and shall be governed and construed in accordance with the laws of the State of North Carolina.
2. **SITUS:** The place of this contract, its situs and forum, shall be North Carolina, where all matters, whether sounding in contract or tort, relating to its validity, construction, interpretation and enforcement shall be determined
3. **INDEPENDENT CONTRACTOR:** The Contractor shall be considered to be an independent contractor and as such shall be wholly responsible for the work to be performed and for the supervision of its employees. The Contractor represents that it has, or will secure at its own expense, all personnel required in performing the services under this agreement. Such employees shall not be employees of, or have any individual contractual relationship with the Agency.
4. **KEY PERSONNEL:** The Contractor shall not substitute key personnel assigned to the performance of this contract without prior written approval by the Agency's Contract Administrator. The individuals designated as key personnel for purposes of this contract are those specified in the Contractor's proposal.
5. **SUBCONTRACTING:** Work proposed to be performed under this contract by the Contractor or its employees shall not be subcontracted without prior written approval of the Agency's Contract Administrator. Acceptance of an offeror's proposal shall include any subcontractor(s) specified therein.

6. **PERFORMANCE AND DEFAULT:** If, through any cause, the Contractor shall fail to fulfill in timely and proper manner the obligations under this agreement, the Agency shall thereupon have the right to terminate this contract by giving written notice to the Contractor and specifying the effective date thereof. In that event, all finished or unfinished deliverable items under this contract prepared by the Contractor shall, at the option of the Agency, become its property, and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such materials. Notwithstanding, the Contractor shall not be relieved of liability to the Agency for damages sustained by the Agency by virtue of any breach of this agreement, and the Agency may withhold any payment due the Contractor for the purpose of setoff until such time as the exact amount of damages due the Agency from such breach can be determined.

In case of default by the Contractor, the State may procure the services from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The State reserves the right to require a performance bond or other acceptable alternative performance guarantees from successful offeror without expense to the State.

In addition, in the event of default by the Contractor under this contract, the State may immediately cease doing business with the Contractor, immediately terminate for cause all existing contracts the State has with the Contractor, and de-bar the Contractor from doing future business with the State

Upon the Contractor filing a petition for bankruptcy or the entering of a judgment of bankruptcy by or against the Contractor, the State may immediately terminate, for cause, this contract and all other existing contracts the Contractor has with the State, and de-bar the Contractor from doing future business

Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or other catastrophic natural event or act of God.

7. **TERMINATION:** The Agency may terminate this agreement at any time by 30 days notice in writing from the Agency to the Contractor. In that event, all finished or unfinished deliverable items prepared by the Contractor under this contract shall, at the option of the Agency, become its property. If the contract is terminated by the Agency as provided herein, the Contractor shall be paid for services satisfactorily completed, less payment or compensation previously made.
8. **PAYMENT TERMS:** Payment terms are Net not later than 30 days after receipt of correct invoice(s) or acceptance of services, whichever is later, or in accordance with any special payment schedule identified in this RFP. The using agency is responsible for all payments to the contractor under the contract. Payment by some agencies may be made by procurement card and it shall be accepted by the contractor for payment if the contractor accepts that card (Visa, Mastercard, etc.) from other customers. If payment is made by procurement card, then payment may be processed immediately by the contractor.
9. **AVAILABILITY OF FUNDS:** Any and all payments to the Contractor are dependent upon and subject to the availability of funds to the Agency for the purpose set forth in this agreement.
10. **CONFIDENTIALITY:** Any information, data, instruments, documents, studies or reports given to or prepared or assembled by the Contractor under this agreement shall be kept as confidential and not divulged or made available to any individual or organization without the prior written approval of the Agency.
11. **CARE OF PROPERTY:** The Contractor agrees that it shall be responsible for the proper custody and care of any property furnished it for use in connection with the performance of this contract or purchased by it for this contract and will reimburse the State for loss of damage of such property.
12. **COPYRIGHT:** No deliverable items produced in whole or in part under this agreement shall be the subject of an application for copyright by or on behalf of the Contractor.
13. **ACCESS TO PERSONS AND RECORDS:** The State Auditor shall have access to persons and records as a result of all contracts or grants entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7.
The Contractor shall retain all records for a period of three years following completion of the contract.

14. **ASSIGNMENT:** No assignment of the Contractor's obligations nor the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may:

- a. Forward the contractor's payment check(s) directly to any person or entity designated by the Contractor, or
- b. Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s).

In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.

15. **COMPLIANCE WITH LAWS:** The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

16. **AFFIRMATIVE ACTION:** The Contractor shall take affirmative action in complying with all Federal and State requirements concerning fair employment and employment of people with disabilities, and concerning the treatment of all employees without regard to discrimination by reason of race, color, religion, sex, national origin, or disability.

17. **INSURANCE:** During the term of the contract, the contractor at its sole cost and expense shall provide commercial insurance of such type and with such terms and limits as may be reasonably associated with the contract. As a minimum, the contractor shall provide and maintain the following coverage and limits:

- a. **Worker's Compensation -** The contractor shall provide and maintain Worker's Compensation Insurance, as required by the laws of North Carolina, as well as employer's liability coverage with minimum limits of \$150,000.00, covering all of Contractor's employees who are engaged in any work under the contract. If any work is subcontracted, the contractor shall require the subcontractor to provide the same coverage for any of its employees engaged in any work under the contract.

- b. **Commercial General Liability -** General Liability Coverage on a Comprehensive Broad Form on an occurrence basis in the minimum amount of \$500,000.00 Combined Single Limit. (Defense cost shall be in excess of the limit of liability).

- c. **Automobile -** Automobile Liability Insurance, to include liability coverage, covering all owned, hired and non-owned vehicles, used in connection with the contract. The minimum combined single limit shall be \$150,000.00 bodily injury and property damage; \$150,000.00 uninsured/under insured motorist; and \$1,000.00 medical payment.

Providing and maintaining adequate insurance coverage is a material obligation of the contractor and is of the essence of this contract. All such insurance shall meet all laws of the State of North Carolina. Such insurance coverage shall be obtained from companies that are authorized to provide such coverage and that are authorized by the Commissioner of Insurance to do business in North Carolina. The contractor shall at all times comply with the terms of such insurance policies, and all requirements of the insurer under any such insurance policies, except as they may conflict with existing North Carolina laws or this contract. The limits of coverage under each insurance policy maintained by the contractor shall not be interpreted as limiting the contractor's liability and obligations under the contract.

18. **ADVERTISING:** The offeror shall not use the award of a contract as part of any news release or commercial advertising.

19. **ENTIRE AGREEMENT:** This contract and any documents incorporated specifically by reference represent the entire agreement between the parties and supersede all prior oral or written statements or agreements. This Request for Proposals, any addenda thereto, and the offeror's proposal are incorporated herein by reference as though set forth verbatim.

All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.

20. **AMENDMENTS:** This contract may be amended only by written amendments duly executed by the Agency and the Contractor. The NC Division of Purchase and Contract shall give prior approval to any amendment to a contract awarded through that office.
21. **TAXES:** G.S. 143-59.1 bars the Secretary of Administration from entering into contracts with vendors if the vendor or its affiliates meet one of the conditions of G. S. 105-164.8(b) and refuse to collect use tax on sales of tangible personal property to purchasers in North Carolina. Conditions under G. S. 105-164.8(b) include: (1) Maintenance of a retail establishment or office, (2) Presence of representatives in the State that solicit sales or transact business on behalf of the vendor and (3) Systematic exploitation of the market by media-assisted, media-facilitated, or media-solicited means. By execution of the proposal document the vendor certifies that it and all of its affiliates, (if it has affiliates), collect(s) the appropriate taxes.
22. **YEAR 2000 COMPLIANCE/WARRANTY:** Vendor shall ensure the product(s) and service(s) furnished pursuant to this agreement ("product" shall include, without limitation, any piece of equipment, hardware, firmware, middleware, custom or commercial software, or internal components, subroutines, and interfaces therein) which perform any date and/or time data recognition function, calculation, or sequencing, will support a four digit year format, and will provide accurate date/time data and leap year calculations on and after December 31, 1999, at the same level of functionality for which originally acquired without additional cost to the user. This warranty shall survive termination or expiration of the agreement.
23. **GENERAL INDEMNITY:** The contractor shall hold and save the State, its officers, agents, and employees, harmless from liability of any kind, including all claims and losses accruing or resulting to any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation that may be injured or damaged by the contractor in the performance of this contract and that are attributable to the negligence or intentionally tortious acts of the contractor provided that the contractor is notified in writing within 30 days that the State has knowledge of such claims. The contractor represents and warrants that it shall make no claim of any kind or nature against the State's agents who are involved in the delivery or processing of contractor goods to the State. The representation and warranty in the preceding sentence shall survive the termination or expiration of this contract.
24. **OUTSOURCING:** Any vendor or subcontractor providing call or contact center services to the State of North Carolina shall disclose to inbound callers the location from which the call or contact center services are being provided.

If, after award of a contract, the contractor wishes to outsource any portion of the work to a location outside the United States, prior written approval must be obtained from the State agency responsible for the contract.

Vendor must give notice to the using agency of any relocation of the vendor, employees of the vendor, subcontractors of the vendor, or other persons performing services under a state contract outside of the United States.

25. **By EXECUTIVE ORDER 24**, issued by Governor Perdue, and N.C. G.S. § 133-32, it is unlawful for any vendor or contractor (i.e. architect, bidder, contractor, construction manager, design professional, engineer, landlord, offeror, seller, subcontractor, supplier, or vendor), to make gifts or to give favors to any State employee of the Governor's Cabinet Agencies (i.e., Administration, Commerce, Correction, Crime Control and Public Safety, Cultural Resources, Environment and Natural Resources, Health and Human Services, Juvenile Justice and Delinquency Prevention, Revenue, Transportation, and the Office of the Governor). This prohibition covers those vendors and contractors who:
- (1) have a contract with a governmental agency; or
 - (2) have performed under such a contract within the past year; or
 - (3) anticipate bidding on such a contract in the future.

For additional information regarding the specific requirements and exemptions, vendors and contractors are encouraged to review Executive Order 24 and G.S. Sec. 133-32.

Executive Order 24 also encouraged and invited other State Agencies to implement the requirements and prohibitions of the Executive Order to their agencies. Vendors and contractors should contact other State Agencies to determine if those agencies have adopted Executive Order 24."

07/12/2010

IV. Other Considerations

Unless otherwise stated in the individual proposal, the situations described below will be followed.

- A. The Offeror will be responsible to its employees for salaries, all taxes, all benefits and any expenses incurred in the performance of the job. The Department has no financial liability, implied or otherwise, to the offeror's employees.
- B. The Offeror will be responsible for ensuring its employees are adequately trained. When requested by the Department, the Offeror, at its own expense, will provide its employees with the training required to properly perform their duties.
- C. In consideration of the decision to acquire personnel under these contracts, the needs of the Department are foremost. The Department reserves the right to contract for personnel services from other sources, if the skills required exceed those specified in the RFP, or if the project definition incorporates specific skill requirements and time constraints which cannot be met by Offerors under this contract.
- D. Offerors must comply with all Department, National Association of Insurance Commissioners, other applicable policy standards and procedures, and North Carolina laws and regulations governing assigned projects.
- E. For the project arranged under this contract, a specific letter of agreement listing work, dates and requirements will be issued. This project agreement or letter will include the provisions of this convenience contract, as well as any additional terms and conditions deemed necessary for this project.
- F. The Department will develop and implement internal procedures to administer this contract.

ATTACHMENT A – REFERENCES

Prospective contractors must supply at least three (3) references of governmental agencies and/or private firms for which they have done similar or related work during the past five (5) years.

1. Agency or Firm Name _____
Business Address _____
Contact Person _____
Telephone Number _____

2. Agency or Firm Name _____
Business Address _____
Contact Person _____
Telephone Number _____

3. Agency or Firm Name _____
Business Address _____
Contact Person _____
Telephone Number _____

*****THIS PAGE MUST BE INCLUDED IN YOUR PROPOSAL*****

ATTACHMENT B – COST PROPOSAL/EXECUTION OF PROPOSAL

By submitting this proposal, the potential contractor certifies the following:

- This proposal is signed by an authorized representative of the firm.
- It can obtain insurance certificates as required within 10 calendar days after notice of award.
- The cost and availability of all equipment, materials, and supplies associated with performing the services described herein have been determined and included in the proposed cost.
- All labor costs, direct and indirect, have been determined and included in the proposed cost.
- The potential contractor has read and understands the conditions set forth in this RFP and agrees to them with no exceptions.
- The offeror is registered in NC E-Procurement @ Your Service or agrees to register within two days after notification of contract award.

Therefore, in compliance with this Request for Proposals, and subject to all conditions herein, the undersigned offers and agrees, if this proposal is accepted within 60 days from the date of the opening, to furnish the subject services for a cost not to exceed:

\$ _____

OFFEROR: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____ FAX: _____

E-MAIL: _____

Principal Place of Business if different from above (See General Information on Submitting Proposals, Item 18.):

Will any of the work under this contract be performed outside the United States? Yes No
(If yes, describe in technical proposal.)

N.C.G.S. § 133-32 and Executive Order 24 prohibit the offer to, or acceptance by, any State Employee of any gift from anyone with a contract with the State, or from any person seeking to do business with the State. By execution of any response in this procurement, you attest, for your entire organization and its employees or agents, that you are not aware that any such gift has been offered, accepted, or promised by any employees of your organization.

BY: _____ TITLE: _____ DATE: _____
(Signature)

(Typed or printed name)

ACCEPTANCE OF PROPOSAL

North Carolina Department of Insurance

BY: _____ TITLE: _____ DATE: _____

THIS PAGE MUST BE SIGNED AND INCLUDED IN YOUR PROPOSAL.

Unsigned proposals will not be considered.

ATTACHMENT C

Where Service Contracts Will Be Performed

In accordance with NC General Statute 143-59.4 (Session Law 2005-169), this form is to be completed and submitted with the offeror's proposal.

.....
Issuing Agency: NC Department of Insurance **RFP #12-001065**
Department Contact Person: Lorraine Richardson, Purchasing Officer, at 919-733-3355

Solicitation Title / Type of Services: Professional Technical Contract for a NC Health Benefit Exchange Study

Offeror: _____

City & State: _____

Location(s) from which services will be performed by the contractor:

Service	City/Providence/State	Country
_____	_____	_____
_____	_____	_____
_____	_____	_____

Location(s) from which services are anticipated to be performed outside the U.S. by the contractor:

_____	_____	_____
_____	_____	_____

Location(s) from which services will be performed by subcontractor(s):

Service	Subcontractor	City/Providence/State	Country
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Location(s) from which services are anticipated to be performed outside the U.S. by the subcontractor(s):

_____	_____	_____	_____
_____	_____	_____	_____

(Attach additional pages if necessary.)

APPENDIX A – REFERENCE MATERIAL

1. The terms and conditions of Federal Grant No. 1 HBEIE100042-01-00;
2. Affordable Care Act Sections 1311 - 1313 (collectively “Consumer Choices and Insurance Competition Through Health Benefit Exchanges”) and Sections 1321-1324 (collectively “State Flexibility Relating to Exchanges”)

1. Terms and Conditions of Federal Grant No. 1 HBEIE100042-01-00

Office of Consumer Information and Insurance Oversight

**State Planning and Establishment Grants for the
Affordable Care Act's Exchanges**

**Standard Terms & Conditions
Attachment A**

1. The HHS/Office of Consumer Information and Insurance Oversight (OCIO) Program Official. The Program Official assigned with responsibility for technical and programmatic questions from the Grantee is Susan Lumsden (Susan.Lumsden@hhs.gov).

2. The HHS/OCIO Grants Management Specialist. The Grants Management Specialist assigned with the responsibility for the financial and administrative aspects (nonprogrammatic areas) of grants administration questions from the Grantee is Michelle Feagins in the Division of Grants Management (Michelle.Feagins@hhs.gov).

3. The HHS Grants Policy Statement (HHS GPS). This grant is subject to the requirements of the HHS GPS that are applicable to the Grantee based on your recipient type and the purpose of this award. This includes any requirements in Part I and II (available at <http://www.hhs.gov/grantsnetadminis/gpd/index.htm>) of the HHS GPS that apply to an award.

Although consistent with the HHS GPS, any applicable statutory or regulatory requirements, including 45 CFR 92 directly applies to this award apart from any coverage in the HHS GPS.

4. Cost Principles for State, Local and Indian Tribal Governments (OMB Circular A-87). This grant is subject to the requirements as set forth in Title 2 Part 225, State, Local, and Indian Tribal Governments (previously A-87).

Office of Consumer Information and Insurance Oversight

**State Planning and Establishment Grants for the
Affordable Care Act's Exchanges**

Special Terms & Conditions

Attachment B

1. Budget and Project Period: The project and budget period for State Planning and Establishment Grants for the Affordable Care Act's Exchanges is from September 30, 2010 through September 29, 2011. The start date for the grants is on or after September 30, 2010. No grant funds can be used for expenses incurred prior to September 30, 2010.

2. Collaborative Responsibilities: At the request of OCIO, Grantees may be required to participate in scheduled activities and communications to identify and share "best practices" for Exchanges, including discussion of State proposals and sharing of information via public websites. OCIO will post general summaries of the State proposals on the OCIO website. The Grantee is required to participate in all required communications (e.g., monitoring calls, guidance calls) as requested by OCIO.

3. Personnel Changes: The Grantee is required to notify the OCIO Project Officer and the OCIO Grants Management Officer within thirty (30) days of any personnel changes affecting the grant's Project Director, Assistant Project Director, or the Financial Officer.

4. Funding Specifications: All funds provided under this grant will be used by the Grantee exclusively for the State Planning and Establishment Grants for the Affordable Care Act's Exchanges as defined in Section 1311 of the Affordable Care Act and as described in the funding opportunity announcement. If the Grantee uses these funds for any purpose other than those awarded through this program (or those modifications that have the prior written approval of the OCIO Project Officer) then all funds provided under this grant may be required to be returned to the United States Treasury.

a. Consumer Assistance. States can use Exchange grant funds to conduct activities that can be funded under the Consumer Assistance Program Grants and only to the extent that there will be no duplicative Federal funding for such activities and that the activities funded meet the terms and conditions for all of grants.

b. Medicaid/CHIP. Exchange grant funds cannot be used exclusively for the modification of systems or processes solely related to Medicaid/CHIP eligibility.

c. Information Technology (IT) Systems. The funding for Exchange IT systems should come from the Exchange grant funds. The Exchange grant funds awarded under this Notice of Grant Award are intended for planning activities only and any procurement activities should not be pursued without prior approval from OCIO.

d. Medical Loss Ratio (MLR). Exchange grant funds cannot be used for the implementation of the MLR requirements of the Affordable Care Act. States can use Exchange grant funds for MLR activities only to the extent that such activities are related to the planning and implementation of Exchanges.

5. Required Grant Reporting: The templates for the Required Grant Reporting will be forthcoming.

a. Quarterly Project Report. The Grantee is required to submit four (4) Quarterly Progress Reports to the OCIO Grants Management Specialist and to the OCIO Project Officer. Quarterly Progress Reports are due within 30 days after the end of the quarter (no later than January 31, April 30, July 31, and October 31, 2011).

b. Final Project Report. The Grantee is required to submit a Final Project Report to the OCIO Grants Management Specialist, with a copy to the OCIO Project Officer, within 90 days after the project period ending date (no later than December 31, 2011).

c. Public Report. The Grantee is required to prominently post specific information about the Exchange grants on their respective Internet websites to ensure that the public has information on the use of funds.

6. Required Financial Reports: A Financial Status Report (FSR) (SF 269A - Short Form) is required from the recipient within 90 days after the end of the project period. Records of expenditures and any program income generated must be maintained in accordance with the provisions of 45 CFR 74.53 or 92.42. The Grantee will submit the FSR to the OCIO Grants Management Specialist listed on this Notice of Grant Award with a copy to the OCIO Project Officer. (The SF-269A may be accessed at the following site: www.whitehouse.gov/omb/grants/sf269a).

Effective January 1, 2010, Grantees are to report cash transaction data via the Payment Management System (PMS) using the Federal Financial Report (FFR or Standard Form 425) cash transaction data elements. The FFR must be filed within 30 days of the end of the quarter (instead of the 45 days allowed for filing the PSC 272). Reporting cash transaction data using the FFR replaces the use of the Federal Cash Transaction Report (SF-272/SF272A). Additional information and training are available on the Division of Payment Management website (www.dpm.psc.gov).

A Quick Reference Guide for completing the FFR in the PMS is at www.dpm.psc.gov/grantRecipient/guides_forms/ffr_quick_reference.

2. Affordable Care Act Sections 1311 - 1313 (collectively “Consumer Choices and Insurance Competition Through Health Benefit Exchanges”) and Sections 1321-1324 (collectively “State Flexibility Relating to Exchanges”)

PART II--CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) Assistance to States to Establish American Health Benefit Exchanges-

(1) PLANNING AND ESTABLISHMENT GRANTS- There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED- For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

(3) USE OF FUNDS- A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(4) RENEWABILITY OF GRANT-

(A) IN GENERAL- Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant--

(i) is making progress, as determined by the Secretary, toward--

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

(B) LIMITATION- No grant shall be awarded under this subsection after January 1, 2015.

(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES- The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

(b) American Health Benefit Exchanges-

(1) IN GENERAL- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an `Exchange') for the State that--

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a `SHOP Exchange') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES- A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) Responsibilities of the Secretary-

(1) IN GENERAL- The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum--

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1);

(F) utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account criteria that the National Association of Insurance Commissioners develops and submits to the Secretary;

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance endorsed under section 399JJ of the Public Health Service Act, as applicable.

(2) **RULE OF CONSTRUCTION-** Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provider refuses to accept the generally applicable payment rates of such plan.

(3) **RATING SYSTEM-** The Secretary shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to individuals and employers through the Internet portal established under paragraph (4).

(4) **ENROLLEE SATISFACTION SYSTEM-** The Secretary shall develop an enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with qualified health plans offered through an Exchange, for each such qualified health plan that had more than 500 enrollees in the previous year. The Exchange shall include enrollee satisfaction information in the information provided to individuals and employers through the Internet portal established under paragraph (5) in a manner that allows individuals to easily compare enrollee satisfaction levels between comparable plans.

(5) **INTERNET PORTALS-** The Secretary shall--

(A) continue to operate, maintain, and update the Internet portal developed under section 1103(a) and to assist States in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model template for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health insurance choices.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 2716 of the Public Health Service Act and to a copy of the plan's written policy.

(6) **ENROLLMENT PERIODS-** The Secretary shall require an Exchange to provide for--

(A) an initial open enrollment, as determined by the Secretary (such determination to be made not later than July 1, 2012);

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(d) **Requirements-**

(1) **IN GENERAL-** An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(2) **OFFERING OF COVERAGE-**

(A) **IN GENERAL-** An Exchange shall make available qualified health plans to qualified individuals and qualified employers.

(B) **LIMITATION-**

(i) **IN GENERAL-** An Exchange may not make available any health plan that is not a qualified health plan.

(ii) **OFFERING OF STAND-ALONE DENTAL BENEFITS-** Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).

(3) **RULES RELATING TO ADDITIONAL REQUIRED BENEFITS-**

(A) *IN GENERAL*- Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) *STATES MAY REQUIRE ADDITIONAL BENEFITS*-

(i) *IN GENERAL*- Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).

(ii) *STATE MUST ASSUME COST*- A State shall make payments--

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

~~to defray the cost of any additional benefits described in clause (i). (ii) *STATE MUST ASSUME COST* A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 36B(b)(3)(D) of such Code and section 1402(c)(4).~~

(4) *FUNCTIONS*- An Exchange shall, at a minimum--

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

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

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize 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 Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) 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;

(H) subject to section 1411, 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 such section because--

(i) there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(I) transfer to the Secretary of the Treasury--

(i) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(ii) 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--

(I) the employer did not provide minimum essential coverage; or

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) 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 such cessation);

(J) provide to each employer the name of each employee of the employer described in subparagraph

(I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) *FUNDING LIMITATIONS*-

(A) **NO FEDERAL FUNDS FOR CONTINUED OPERATIONS-** In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.

(B) **PROHIBITING WASTEFUL USE OF FUNDS-** In carrying out activities under this subsection, an 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 and regulatory modifications.

(6) **CONSULTATION-** An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including--

(A) educated health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) **PUBLICATION OF COSTS-** An Exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) **Certification-**

(1) **IN GENERAL-** An Exchange may certify a health plan as a qualified health plan if--

(A) such health plan meets the requirements for certification as promulgated by the Secretary under subsection (c)(1); and

(B) the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan--

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(2) **PREMIUM CONSIDERATIONS-** The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange ~~shall~~ take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(3) TRANSPARENCY IN COVERAGE-

(A) IN GENERAL- The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, 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 this title.

(ix) Other information as determined appropriate by the Secretary.

(B) USE OF PLAIN LANGUAGE- The information required to be submitted under subparagraph (A) shall be provided in plain language. The term 'plain language' means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(C) COST SHARING TRANSPARENCY- The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (including 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 in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet.

(D) GROUP HEALTH PLANS- The Secretary of Labor shall update and harmonize the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary under subparagraph (A).

(f) Flexibility-

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES- An Exchange may operate in more than one State if--
(A) each State in which such Exchange operates permits such operation; and
(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES- A State may establish one or more subsidiary Exchanges if--
(A) each such Exchange serves a geographically distinct area; and
(B) the area served by each such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT-

(A) IN GENERAL- A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY- In this paragraph, the term 'eligible entity' means--

(i) a person--

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medicaid agency under title XIX of the Social Security Act.

(g) Rewarding Quality Through Market-Based Incentives-

(1) STRATEGY DESCRIBED- A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for--

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; ~~and~~

(D) the implementation of wellness and health promotion activities; and

(E) the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) GUIDELINES- The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS- The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) Quality Improvement-

(1) ENHANCING PATIENT SAFETY- Beginning on January 1, 2015, a qualified health plan may contract with--

(A) a hospital with greater than 50 beds only if such hospital--

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) EXCEPTIONS- The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) ADJUSTMENT- The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

(i) Navigators-

(1) *IN GENERAL*- An Exchange shall establish a program under which it awards grants to entities described in paragraph (2) to carry out the duties described in paragraph (3).

(2) *ELIGIBILITY*-

(A) *IN GENERAL*- To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan.

(B) *TYPES*- Entities described in subparagraph (A) may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration~~small business development centers~~, other licensed insurance agents and brokers, and other entities that--

(i) are capable of carrying out the duties described in paragraph (3);

(ii) meet the standards described in paragraph (4); and

(iii) provide information consistent with the standards developed under paragraph (5).

(3) *DUTIES*- An entity that serves as a navigator under a grant under this subsection shall--

(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;

(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 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 such plan or coverage; and

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(4) *STANDARDS*-

(A) *IN GENERAL*- The Secretary shall establish standards for navigators under this subsection, including provisions to ensure that any private or public entity that is selected as a navigator is qualified, and licensed if appropriate, to engage in the navigator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not--

(i) be a health insurance issuer; or

(ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

(5) *FAIR AND IMPARTIAL INFORMATION AND SERVICES*- The Secretary, in collaboration with States, shall develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

(6) *FUNDING*- Grants under this subsection shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

(j) *Applicability of Mental Health Parity*- Section 2726 of the Public Health Service Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.

(k) *Conflict*- An Exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.

(a) *Choice*-

(1) *QUALIFIED INDIVIDUALS*- A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) *QUALIFIED EMPLOYERS*-

(A) *EMPLOYER MAY SPECIFY LEVEL*- A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) *EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL*- Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) *Payment of Premiums by Qualified Individuals*- A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) *Single Risk Pool*-

(1) **INDIVIDUAL MARKET**- A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(2) **SMALL GROUP MARKET**- A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) **MERGER OF MARKETS**- A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) **STATE LAW**- A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) **Empowering Consumer Choice-**

(1) **CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES**- Nothing in this title shall be construed to prohibit--

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) **CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS**- Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) **VOLUNTARY NATURE OF AN EXCHANGE-**

(A) **CHOICE TO ENROLL OR NOT TO ENROLL**- Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) **PROHIBITION AGAINST COMPELLED ENROLLMENT**- Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) **INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN**- A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) **MEMBERS OF CONGRESS IN THE EXCHANGE-**

(i) **REQUIREMENT**- Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are--

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) **DEFINITIONS**- In this section:

(I) **MEMBER OF CONGRESS**- The term `Member of Congress' means any member of the House of Representatives or the Senate.

(II) **CONGRESSIONAL STAFF**- The term `congressional staff' means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) **NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE**- An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) **Enrollment Through Agents or Brokers**- The Secretary shall establish procedures under which a State may allow agents or brokers--

(1) to enroll individuals and employers in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

~~Such procedures may include the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.~~

(f) **Qualified Individuals and Employers; Access Limited to Citizens and Lawful Residents-**

(1) **QUALIFIED INDIVIDUALS**- In this title:

(A) **IN GENERAL**- The term `qualified individual' means, with respect to an Exchange, an individual who--

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange ~~(except with respect to territorial agreements under section 1312(f)).~~

(B) **INCARCERATED INDIVIDUALS EXCLUDED-** An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) **QUALIFIED EMPLOYER-** In this title:

(A) **IN GENERAL-** The term 'qualified employer' means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) **EXTENSION TO LARGE GROUPS-**

(i) **IN GENERAL-** Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) **LARGE EMPLOYERS ELIGIBLE-** If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term 'qualified employer' shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) **ACCESS LIMITED TO LAWFUL RESIDENTS-** If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

SEC. 1313. FINANCIAL INTEGRITY.

(a) **Accounting for Expenditures-**

(1) **IN GENERAL-** An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.

(2) **INVESTIGATIONS-** The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, may examine the properties and records of an Exchange, and may require periodic reports in relation to activities undertaken by an Exchange. An Exchange shall fully cooperate in any investigation conducted under this paragraph.

(3) **AUDITS-** An Exchange shall be subject to annual audits by the Secretary.

(4) **PATTERN OF ABUSE-** If the Secretary determines that an Exchange or a State has engaged in serious misconduct with respect to compliance with the requirements of, or carrying out of activities required under, this title, the Secretary may rescind from payments otherwise due to such State involved under this or any other Act administered by the Secretary an amount not to exceed 1 percent of such payments per year until corrective actions are taken by the State that are determined to be adequate by the Secretary.

(5) **PROTECTIONS AGAINST FRAUD AND ABUSE-** With respect to activities carried out under this title, the Secretary shall provide for the efficient and non-discriminatory administration of Exchange activities and implement any measure or procedure that--

(A) the Secretary determines is appropriate to reduce fraud and abuse in the administration of this title; and

(B) the Secretary has authority to implement under this title or any other Act.

(6) **APPLICATION OF THE FALSE CLAIMS ACT-**

(A) **IN GENERAL-** Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

[DEEMED NULL, VOID AND OF NO EFFECT] (B) **DAMAGES-** Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) **GAO Oversight-** Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review--

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including data on enrollees in Exchanges and

individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to qualified health plans, complaints data relating to such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of Exchanges; ~~and~~

(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and

(45) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs, and the adequacy of provider networks of Federal Government health care programs.

PART III--STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. STATE FLEXIBILITY IN OPERATION AND ENFORCEMENT OF EXCHANGES AND RELATED REQUIREMENTS.

(a) Establishment of Standards-

(1) IN GENERAL- The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to--

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part V; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) CONSULTATION- In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) State Action- Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect--

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) Failure To Establish Exchange or Implement Requirements-

(1) IN GENERAL- If--

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State--

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement--

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) ENFORCEMENT AUTHORITY- The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) No Interference With State Regulatory Authority- Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) Presumption for Certain State-Operated Exchanges-

(1) IN GENERAL- In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) *PROCESS*- The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) *Establishment of Program*-

(1) *IN GENERAL*- The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) *PURPOSE*- It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) *Loans and Grants Under the CO-OP Program*-

(1) *IN GENERAL*- The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of--

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) *REQUIREMENTS FOR AWARDING LOANS AND GRANTS*-

(A) *IN GENERAL*- In awarding loans and grants under the CO-OP program, the Secretary shall--

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) *STATES WITHOUT ISSUERS IN PROGRAM*- If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) *AGREEMENT*-

(i) *IN GENERAL*- The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)--

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) *RESTRICTIONS ON USE OF FEDERAL FUNDS*- The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used--

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) *FAILURE TO MEET REQUIREMENTS*- If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of--

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

(D) *TIME FOR AWARDING LOANS AND GRANTS-* The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) *REPAYMENT OF LOANS AND GRANTS-* Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.

~~(34)~~ *ADVISORY BOARD-*

(A) *IN GENERAL-* The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) *RULES RELATING TO APPOINTMENTS-*

(i) *STANDARDS-* Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) *ORIGINAL APPOINTMENTS-* The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) *VACANCY-* Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) *PAY AND REIMBURSEMENT-*

(i) *NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD-* Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) *TRAVEL EXPENSES-* Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) *APPLICATION OF FACA-* The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) *TERMINATION-* The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(c) *Qualified Nonprofit Health Insurance Issuer-* For purposes of this section--

(1) *IN GENERAL-* The term 'qualified nonprofit health insurance issuer' means a health insurance issuer that is an organization--

(A) that is organized under State law as a nonprofit, member corporation;

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) *CERTAIN ORGANIZATIONS PROHIBITED-* An organization shall not be treated as a qualified nonprofit health insurance issuer if--

(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

(3) *GOVERNANCE REQUIREMENTS-* An organization shall not be treated as a qualified nonprofit health insurance issuer unless--

(A) the governance of the organization is subject to a majority vote of its members;

(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(4) *PROFITS INURE TO BENEFIT OF MEMBERS-* An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

(5) *COMPLIANCE WITH STATE INSURANCE LAWS-* An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State law described in section 1324(b).

(6) **COORDINATION WITH STATE INSURANCE REFORMS-** An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).

(d) **Establishment of Private Purchasing Council-**

(1) **IN GENERAL-** Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

(2) **COUNCIL MAY NOT SET PAYMENT RATES-** The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) **CONTINUED APPLICATION OF ANTITRUST LAWS-**

(A) **IN GENERAL-** Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) **ANTITRUST LAWS-** For purposes of this subparagraph, the term 'antitrust laws' has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(e) **Limitation on Participation-** No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(f) **Limitations on Secretary-**

(1) **IN GENERAL-** The Secretary shall not--

(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) **COMPETITION-** Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(g) **Appropriations-** There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, \$6,000,000,000 to carry out this section.

(h) **Tax Exemption for Qualified Nonprofit Health Insurance Issuer-**

(1) **IN GENERAL-** Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

“(29) **CO-OP HEALTH INSURANCE ISSUERS-**

“(A) **IN GENERAL-** A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

“(B) **CONDITIONS FOR EXEMPTION-** Subparagraph (A) shall apply to an organization only if--

“(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

“(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

“(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

“(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.’.

(2) **ADDITIONAL REPORTING REQUIREMENT-** Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

“(m) **Additional Information Required From CO-OP Insurers-** An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

“(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

“(2) The amount of reserves on hand.’.

(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS- Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking `paragraph (3) or (4)' and inserting `paragraph (3), (4), or (29)'.

(i) GAO Study and Report-

(1) STUDY- The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT- The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

SEC. 1323. COMMUNITY HEALTH INSURANCE OPTION.

~~(a) Voluntary Nature-~~

~~(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE- Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non participation.~~

~~(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN- Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non participation.~~

~~(3) STATE OPT OUT-~~

~~(A) IN GENERAL- A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.~~

~~(B) TERMINATION OF OPT OUT- A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.~~

~~(b) Establishment of Community Health Insurance Option-~~

~~(1) ESTABLISHMENT- The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title (other than Exchanges in States that elect to opt out as provided for in subsection (a)(3)), health care coverage that provides value, choice, competition, and stability of affordable, high quality coverage throughout the United States.~~

~~(2) COMMUNITY HEALTH INSURANCE OPTION- In this section, the term `community health insurance option' means health insurance coverage that-~~

~~(A) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;~~

~~(B) provides high value for the premium charged;~~

~~(C) reduces administrative costs and promotes administrative simplification for beneficiaries;~~

~~(D) promotes high quality clinical care;~~

~~(E) provides high quality customer service to beneficiaries;~~

~~(F) offers a sufficient choice of providers; and~~

~~(G) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b).~~

~~(3) ESSENTIAL HEALTH BENEFITS-~~

~~(A) GENERAL RULE- Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage only for the essential health benefits described in section 1302(b).~~

~~(B) STATES MAY OFFER ADDITIONAL BENEFITS- Nothing in this section shall preclude a State from requiring that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option offered in such State.~~

~~(C) CREDITS-~~

~~(i) IN GENERAL- An individual enrolled in a community health insurance option under this section shall be eligible for credits under section 36B of the Internal Revenue Code of 1986 in the same manner as an individual who is enrolled in a qualified health plan.~~

~~(ii) NO ADDITIONAL FEDERAL COST- A requirement by a State under subparagraph (B) that benefits in addition to the essential health benefits required under subparagraph (A) be provided to enrollees of a community health insurance option shall not affect the amount of a premium tax credit provided under section 36B of the Internal Revenue Code of 1986 with respect to such plan.~~

~~(D) STATE MUST ASSUME COST- A State shall make payments to or on behalf of an eligible individual to defray the cost of any additional benefits described in subparagraph (B).~~

~~(E) ENSURING ACCESS TO ALL SERVICES- Nothing in this Act shall prohibit an individual enrolled in a community health insurance option from paying out of pocket the full cost of any item or service not included as an essential health benefit or otherwise covered as a benefit by a health plan. Nothing in~~

~~subparagraph (B) shall prohibit any type of medical provider from accepting an out-of-pocket payment from an individual enrolled in a community health insurance option for a service otherwise not included as an essential health benefit.~~

~~(F) PROTECTING ACCESS TO END-OF-LIFE CARE—A community health insurance option offered under this section shall be prohibited from limiting access to end-of-life care.~~

~~(4) COST SHARING—A community health insurance option shall offer coverage at each of the levels of coverage described in section 1302(d).~~

~~(5) PREMIUMS—~~

~~(A) PREMIUMS SUFFICIENT TO COVER COSTS—The Secretary shall establish geographically adjusted premium rates in an amount sufficient to cover expected costs (including claims and administrative costs) using methods in general use by qualified health plans.~~

~~(B) APPLICABLE RULES—The provisions of title XXVII of the Public Health Service Act relating to premiums shall apply to community health insurance options under this section, including modified community rating provisions under section 2701 of such Act.~~

~~(C) COLLECTION OF DATA—The Secretary shall collect data as necessary to set premium rates under subparagraph (A).~~

~~(D) NATIONAL POOLING—Notwithstanding any other provision of law, the Secretary may treat all enrollees in community health insurance options as members of a single pool.~~

~~(E) CONTINGENCY MARGIN—In establishing premium rates under subparagraph (A), the Secretary shall include an appropriate amount for a contingency margin.~~

~~(6) REIMBURSEMENT RATES—~~

~~(A) NEGOTIATED RATES—The Secretary shall negotiate rates for the reimbursement of health care providers for benefits covered under a community health insurance option.~~

~~(B) LIMITATION—The rates described in subparagraph (A) shall not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Exchange.~~

~~(C) INNOVATION—Subject to the limits contained in subparagraph (A), a State Advisory Council established or designated under subsection (d) may develop or encourage the use of innovative payment policies that promote quality, efficiency and savings to consumers.~~

~~(7) SOLVENCY AND CONSUMER PROTECTION—~~

~~(A) SOLVENCY—The Secretary shall establish a Federal solvency standard to be applied with respect to a community health insurance option. A community health insurance option shall also be subject to the solvency standard of each State in which such community health insurance option is offered.~~

~~(B) MINIMUM REQUIRED—In establishing the standard described under subparagraph (A), the Secretary shall require a reserve fund that shall be equal to at least the dollar value of the incurred but not reported claims of a community health insurance option.~~

~~(C) CONSUMER PROTECTIONS—The consumer protection laws of a State shall apply to a community health insurance option.~~

~~(8) REQUIREMENTS ESTABLISHED IN PARTNERSHIP WITH INSURANCE COMMISSIONERS—~~

~~(A) IN GENERAL—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as the ‘NAIC’), may promulgate regulations to establish additional requirements for a community health insurance option.~~

~~(B) APPLICABILITY—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.~~

~~(e) Start up Fund—~~

~~(1) ESTABLISHMENT OF FUND—~~

~~(A) IN GENERAL—There is established in the Treasury of the United States a trust fund to be known as the ‘Health Benefit Plan Start Up Fund’ (referred to in this section as the ‘Start Up Fund’), that shall consist of such amounts as may be appropriated or credited to the Start Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option. Such amounts shall remain available until expended.~~

~~(B) FUNDING—There is hereby appropriated to the Start Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—~~

~~(i) pay the start up costs associated with the initial operations of a community health insurance option; and~~

~~(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days from the date on which such option is offered.~~

~~(2) USE OF START UP FUND—The Secretary shall use amounts contained in the Start Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).~~

~~(3) PASS THROUGH OF REBATES—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.~~

~~(4) REPAYMENT—~~

~~(A) IN GENERAL—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary may require) for any payments made under paragraph (1)(B) by the date that is not later than 9 years after the date on which the payment is made. The Secretary may require the payment of interest with respect to such repayments at rates that do not exceed the market interest rate (as determined by the Secretary).~~

~~(B) SANCTIONS IN CASE OF FOR PROFIT CONVERSION—In any case in which the Secretary enters into a contract with a qualified entity for the offering of a community health insurance option and such entity is determined to be a for-profit entity by the Secretary, such entity shall be—~~

~~(i) immediately liable to the Secretary for any payments received by such entity from the Start-Up Fund; and~~

~~(ii) permanently ineligible to offer a qualified health plan.~~

~~(d) State Advisory Council—~~

~~(1) ESTABLISHMENT—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:~~

~~(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;~~

~~(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and~~

~~(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.~~

~~(2) MEMBERS—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.~~

~~(3) APPLICABILITY OF RECOMMENDATIONS—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.~~

~~(e) Authority To Contract; Terms of Contract—~~

~~(1) AUTHORITY—~~

~~(A) IN GENERAL—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including functions described in subsection (a)(4) of section 1874A of the Social Security Act) with respect to a community health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.~~

~~(B) REQUIREMENTS APPLY—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract such entity—~~

~~(i) shall meet the criteria established under paragraph (2); and~~

~~(ii) shall receive an administrative fee under paragraph (7).~~

~~(C) LIMITATION—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.~~

~~(D) REFERENCE—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a "contracting administrator".~~

~~(2) QUALIFIED ENTITY—To be qualified to be selected by the Secretary to offer a community health insurance option, an entity shall—~~

~~(A) meet the criteria established under section 1874A(a)(2) of the Social Security Act;~~

~~(B) be a nonprofit entity for purposes of offering such option;~~

~~(C) meet the solvency standards applicable under subsection (b)(7);~~

~~(D) be eligible to offer health insurance or health benefits coverage;~~

~~(E) meet quality standards specified by the Secretary;~~

~~(F) have in place effective procedures to control fraud, abuse, and waste; and~~

~~(G) meet such other requirements as the Secretary may impose.~~

~~Procedures described under subparagraph (F) shall include the implementation of procedures to use beneficiary identifiers to identify individuals entitled to benefits so that such an individual's social security account number is not used, and shall also include procedures for the use of technology (including front end, prepayment intelligent data matching technology similar to that used by hedge funds, investment funds, and banks) to provide real time data analysis of claims for payment under this title to identify and investigate unusual billing or order practices under this title that could indicate fraud or abuse.~~

~~(3) TERM—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph.~~

~~(4) LIMITATION—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met performance requirements established by the Secretary in the areas described in paragraph (7)(B).~~

~~(5) AUDITS—The Inspector General shall conduct periodic audits with respect to contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.~~

~~(6) REVOCATION—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that such administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement. An entity that has had a contract revoked under this paragraph shall not be qualified to enter into a subsequent contract under this subsection.~~

~~(7) FEE FOR ADMINISTRATION—~~

~~(A) IN GENERAL—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.~~

~~(B) REQUIREMENT FOR HIGH QUALITY ADMINISTRATION—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 50 percent, based on the extent to which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:~~

~~(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1302.~~

~~(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.~~

~~(iii) Promoting high quality clinical care.~~

~~(iv) Providing high quality customer service to beneficiaries.~~

~~(C) NON RENEWAL—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subparagraph (B) during the contract period.~~

~~(8) LIMITATION—Notwithstanding the terms of a contract under this subsection, the Secretary shall negotiate the reimbursement rates for purposes of subsection (b)(6).~~

~~(f) Report by HHS and Insolvency Warnings—~~

~~(1) IN GENERAL—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.~~

~~(2) RESULT—If, in any year, the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option solvency warning.~~

~~(3) SUBMISSION OF PLAN AND PROCEDURE—~~

~~(A) IN GENERAL—If there is a community health insurance option solvency warning under paragraph (2) made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.~~

~~(B) PROCEDURE—In the case of a legislative proposal submitted by the President pursuant to subparagraph (A), such proposal shall be considered by Congress using the same procedures described under sections 803 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a medicare funding warning.~~

~~(g) Marketing Parity—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials related to a community health insurance option are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.~~

~~(h) Authorization of Appropriations—There is authorized to be appropriated such sums as may be necessary to carry out this section.~~

SEC. 1324. LEVEL PLAYING FIELD.

~~(a) In General—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334 a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law.~~

(b) Laws Described- The Federal and State laws described in this subsection are those Federal and State laws relating to-

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- (1) guaranteed renewal;*
- (2) rating;*
- (3) preexisting conditions;*
- (4) non-discrimination;*
- (5) quality improvement and reporting;*
- (6) fraud and abuse;*
- (7) solvency and financial requirements;*
- (8) market conduct;*
- (9) prompt payment;*
- (10) appeals and grievances;*
- (11) privacy and confidentiality;*
- (12) licensure; and*
- (13) benefit plan material or information.*

Mandated Benefits

Statute/Reg Number	Short Description	Longer Description
58-3-121	TMJ Joint Dysfunction Coverage	Requires coverage for diagnostic, therapeutic, or surgical procedures involving any bone or joint of the jaw, face, or head, so long as the plan provides such services for any other bone or joint, the procedure is medically necessary to treat a condition which prevents normal functioning of the particular bone or joint involved, and the condition is caused by congenital deformity, disease, or traumatic injury.
58-3-122	Anesthesia and hospital charges for dental procedures for certain individuals	Requires payment for anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for qualified individuals.
58-3-168	Coverage for postmastectomy inpatient care.	The decision whether to discharge a patient following mastectomy shall be made by the physician and the patient and based upon the individual situation presented.
58-3-169 + federal mandate	Minimum inpatient stays following delivery of a baby	Requires that when a plan provides maternity coverage is provided with respect to a mother and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.
58-3-170	Treat maternity as any other illness	Requires that when a plan provides maternity coverage that the benefits for the necessary care and treatment of maternity are no less favorable than physical illness in general.
58-3-174	Coverage for bone mass measurement	Requires coverage for qualified for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass.
58-3-178	Coverage for prescription drug contraceptives or devices	Requires coverage for prescription contraceptive drugs or devices when a plan provides prescription drug coverage.
58-3-179	Coverage for colorectal cancer screening	Requires coverage for colorectal cancer examinations and laboratory tests for cancer in accordance with the most recently published American Cancer Society guidelines.
58-3-190	Coverage for emergency care	Requires coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person. This includes requiring treating emergency care provided at an out-of-network provider as an in-network benefit.
58-3-200(d)	Coverage for services provided outside provider networks	Prohibits penalizing an insured or subjecting the insured to the out-of-network benefit levels offered under the insured's plan unless contracting health care providers able to meet the health needs of the insured are reasonably available to the insured without unreasonable delay.

58-3-220	Mental Illness Minimum Coverage Requirements (Applicable only to group policies)	Mandates equitable coverage for mental illness benefits in group health benefit plans providing that the plan shall provide benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally, including the application of the same limits which include the deductible, co-payments, lifetime and annual dollar limits, maximum out-of-pocket limits, and any other dollar limits or fees for covered services. Permits for most mental illness conditions a 30-day inpatient/outpatient limit of visits per year and a 30 office visits per year. For certain specified conditions, the durational limits must be the same as for general physical illness.
58-3-220(i) + federal mandate	Equity in benefits for Mental Health in employer group health benefit plans covering 51 or more employees.	Requires when a plan that provides both surgical and medical benefits AND mental health benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenci Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees.
58-3-221	Access to nonformulary drugs	Requires when an insurer who maintains one or more closed drug formularies, to establish and maintain a process that allows an enrollee to obtain, without penalty or additional cost-sharing, specific nonformulary drugs or devices determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer.
58-3-228	Coverage for prescription drugs during an emergency or disaster	Provides that all health benefit plans must develop and implement a procedure to waive time restrictions on filling or refilling prescriptions for medication if request by the covered person or subscriber when there is an emergency or disaster declared. The procedure must permit for the waiver or override of "refill too soon" edits to pharmacies, and the procedure must include a provision for payment to the pharmacy for any prescription dispensed under the statute.
58-3-255	Coverage for certain clinical trials	Requires coverage for participation in phase II, phase III, and phase IV covered clinical trials for qualified individuals.
58-3-260	Coverage for newborn hearing screening	Requires coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125
58-3-270	Coverage for ovarian cancer surveillance tests	Requires coverage for surveillance tests for women age 25 and older at risk for ovarian cancer.
58-3-280	Coverage for the diagnosis and treatment of lymphadema	Requires coverage for the diagnosis, evaluation, and treatment of lymphadema, including benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education if the treatment is determined to be medically necessary.
58-3-285	Coverage for hearing aids	Requires coverage for one hearing aid per hearing-impaired ear up to \$2500 dollars per hearing aid every 36 months for covered individuals under the age of 22 years of age.
58-51-5(a)(8)	Limits on exclusion of claims that are subject to Workers' Compensation Act	Prohibits an exclusion of claims that are subject to the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes unless the exclusion extends to only specific medical charges for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under that Article or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.

58-51-16	Coverage for Intoxicants and narcotics	Prohibits an exclusion in medical expense policies for claims related to or resulting from being intoxicated or under the influence of any narcotic.
58-51-30	Coverage coverage for congenital defects and anomalies	Requires coverage for benefits for any sickness, illness, or disability shall be provided with the moment of the child's birth or placement in the home as a foster child. Benefits in such plans shall be the same for congenital defects or anomalies as are provided for most sicknesses or illnesses suffered by minor children that are covered by the plans. Benefits for congenital defects or anomalies shall specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.
58-51-37	Pharmacy of Choice	Provides "any-willing-provider" type requirements for pharmacies.
58-51-50	Minimum benefit offering for Alcoholism/Drug Abuse Treatment (Applicable only to group and blanket policies)	Provides for a minimum benefit offering for chemical dependency treatment for a group or blanket accident and health insurance policy.
58-51-50(f) + federal mandate	Equity in benefits for Chemical Dependency/Addiction in employer group health benefit plans covering 51 or more employees.	Requires when a plan that provides both surgical and medical benefits AND chemical dependency/addiction benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenci Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees.
58-51-57	Coverage for mammograms and cervical cancer screening	Requires coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography.
58-51-58	Coverage for prostate cancer screening	Requires coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer
58-51-59	Coverage for certain off-label drug use for the treatment of cancer	Prohibits the exclusion of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug does have to be approved by the FDA and the efficacy must have been proven and accepted for treatment in an established compendium.
58-51-61	Coverage for certain treatment of diabetes	Requires coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes.
58-51-62 + federal mandate	Coverage for reconstructive breast surgery following a mastectomy	Requires coverage for reconstructive breast surgery following a mastectomy if the plan provides coverage for the mastectomy.
T11 12.0323	Coverage for complications of pregnancy	Requires that a complication of pregnancy may not be treated any differently from any other illness or sickness under the contract. Specifically includes a non-electing cesarean section as a complication.
T11 12.0324	Coverage to treat HIV/AIDS	HIV infection and AIDS must be treated as any other illness or sickness under the contract.