

Health Benefit Exchange

This Act establishes the governance, structure, and funding of the Health Benefit Exchange, a public corporation and independent unit of government created to (1) reduce the number of uninsured; (2) facilitate the purchase and sale of qualified health plans (QHPs) in the individual market; (3) assist qualified employers facilitating the enrollment of their employees in QHPs in the small group market and in accessing small business tax credits; (4) assist individuals in accessing public programs, premium tax credits, and cost-sharing reductions; and (5) supplement the individual and small group insurance markets outside of the exchange. The exchange will be governed by a Board of Trustees and funded through specified fees or assessments. The bill also establishes a Health Benefit Exchange Fund. Appointed members serve four-year terms and may not serve more than two consecutive terms. Board members are entitled to reimbursement for expenses. Members of the board must disclose certain relationships and adhere strictly to conflict of interest provisions. The exchange must study and report on specified functions and is prohibited from implementing those functions until the Governor and General Assembly enact additional legislation.

The primary function of the exchange will be to certify and make available QHPs to individuals and small businesses and to serve as a gateway to an expanded Medicaid program.

To offer a QHP, a carrier must be licensed and in good standing to offer health insurance; offer at least one QHP at both silver and gold levels outside the exchange if participating in the individual exchange; offer at least one QHP at both silver and gold levels in the small group market outside the exchange if participating in the SHOP exchange; and charge the same premiums for plans offered inside and outside the exchange. The exchange must certify health benefit plans as QHPs. To be certified, a plan must provide the essential benefits package required under ACA; obtain prior approval of premium rates and contract language from the Insurance Commissioner; provide at least a bronze level of coverage; and ensure that cost-sharing requirements do not exceed the limits established under ACA. A QHP is required to provide at least a bronze level of coverage if the QHP is certified as a qualified catastrophic plan.

A QDP must meet all QHP requirements except that dental plan carriers need not be licensed to offer other health benefits. Plans must be limited to dental/oral health benefits and include essential pediatric dental benefits and other dental benefits required by the Secretary of Health and Human Services or the exchange. Carriers may offer health and dental plans jointly under certain circumstances.

Submitted as:

Maryland

[Chapter 2 of 2011](#)

Status: Enacted into law in 2011.

Suggested State Legislation

(Title, enacting clause, etc.)

- 1 Section 1. [*Short Title.*] This Act shall be cited as “The Health Benefit Exchange Act.”
- 2
- 3 Section 2. [*Findings.*]
- 4
- 5 Section 3. [Health benefit exchange definitions.]
- 6 (a) in this title the following words have the meanings indicated.

1 (b) “affordable care act” means the federal patient protection and affordable care act, as
2 amended by the federal health care and education reconciliation act of 2010, and any regulations
3 adopted or guidance issued under the acts.

4 (c) “board” means the board of trustees of the exchange.

5 (d) “carrier” means:

6 (1) an insurer authorized to sell health insurance;

7 (2) a nonprofit health service plan;

8 (3) a health maintenance organization; or

9 (4) a dental plan organization; or

10 (5) any other entity providing a plan of health insurance, health benefits, or health
11 services authorized under this article or the Affordable Care Act.

12 (e) “exchange” means the health benefit exchange established as a public corporation under
13 [insert citation] of this title.

14 (f) “fund” means the health benefit exchange fund established under [insert citation] of this
15 subtitle.

16 (g) (1) “health benefit plan” means a policy, contract, certificate, or agreement offered,
17 issued, or delivered by a carrier to an individual or small employer in the state to provide, deliver,
18 arrange for, pay for, or reimburse any of the costs of health care services.

19 (2) “health benefit plan” does not include:

20 (i) coverage only for accident or disability insurance or any combination of
21 accident and disability insurance;

22 (ii) coverage issued as a supplement to liability insurance;

23 (iii) liability insurance, including general liability insurance and automobile
24 liability insurance;

25 (iv) workers’ compensation or similar insurance;

26 (v) automobile medical payment insurance;

27 (vi) credit-only insurance;

28 (vii) coverage for on-site medical clinics; or

29 (viii) other similar insurance coverage, specified in federal regulations issued
30 pursuant to [insert citation] the federal health insurance portability and accountability act, under
31 which benefits for health care services are secondary or incidental to other insurance benefits.

32 (3) “health benefit plan” does not include the following benefits if they are provided
33 under a separate policy, Certificate, or contract of insurance, or are otherwise not an integral part of
34 the plan:

35 (i) limited scope dental or vision benefits;

36 (ii) benefits for long-term care, nursing home care, home health care,
37 community-based care, or any combination of these benefits; or

38 (iii) such other similar limited benefits as are specified in federal regulations
39 issued pursuant to P.L. 104-191 the federal Health Insurance Portability and Accountability Act.

40 (4) “health benefit plan” does not include the following benefits if the benefits are
41 provided under a separate policy, certificate, or contract of insurance, there is no coordination
42 between the provision of the benefits and any exclusion of benefits under any group health plan
43 maintained by the same plan sponsor, and the benefits are paid with respect to an event without
44 regard to whether the benefits are provided under any group health plan maintained by the same plan
45 sponsor:

46 (i) coverage only for a specified disease or illness; or

47 (ii) hospital indemnity or other fixed indemnity insurance.

1 (5) “health benefit plan” does not include the following if offered as a separate policy,
2 certificate, or contract of insurance:

3 (i) Medicare supplemental insurance (as defined under § 1882(g)(1) of the
4 Social Security Act);

5 (ii) coverage supplemental to the coverage provided under chapter 55 of title
6 10, United States Code (Civilian Health and Medical Program of the Uniformed Services
7 (CHAMPUS)); or

8 (iii) similar supplemental coverage provided to coverage under a group health
9 plan.

10 (h) “managed care organization” has the meaning stated in [insert citation] of the health –
11 general article.

12 (i) “qualified dental plan” means a plan certified by the exchange that provides limited scope
13 dental benefits, as described in [insert citation] of this title.

14 (j) “qualified employer” means a small employer that elects to make its full–time employees
15 eligible for one or more qualified health plans offered through the shop exchange and, at the option
16 of the employer, some or all of its part–time employees, provided that the employer:

17 (1) has its principal place of business in the state and elects to provide coverage
18 through the shop exchange to all of its eligible employees, wherever employed; or

19 (2) elects to provide coverage through the shop exchange to all of its eligible
20 employees who are principally employed in the state.

21 (k) “qualified health plan” means a health benefit plan that has been certified by the
22 exchange to meet the criteria for certification described in § 1311(c) of the Affordable Care Act and
23 [insert citation] of this title.

24 (l) “qualified individual” means an individual, including a minor, who at the time of
25 enrollment:

26 (1) is seeking to enroll in a qualified health plan offered to individuals through the
27 exchange;

28 (2) resides in the state;

29 (3) is not incarcerated, other than incarceration pending disposition of charges; and

30 (4) is, and reasonably is expected to be for the entire period for which enrollment is
31 sought, a citizen or national of the United States or an alien lawfully present in the United States.

32 (m) “secretary” means the secretary of the federal department of health and human services.

33 (n) “shop exchange” means the small business health options program authorized under
34 [insert citation] of this title.

35 (o) (1) “small employer” means an employer that, during the preceding calendar year,
36 employed an average of not more than:

37 (i) 50 employees if the preceding calendar year ended on or before [insert
38 date]; and

39 (ii) 100 employees if the preceding calendar year ended after [insert date].

40 (2) for purposes of this subsection:

41 (i) all persons treated as a single employer under § 414(b), (c), (m), or (o) of
42 the Internal Revenue Code shall be treated as a single employer;

43 (ii) an employer and any predecessor employer shall be treated as a single employer;

44 (iii) all employees shall be counted, including part–time employees and
45 employees who are not eligible for coverage through the employer;

46 (iv) if an employer was not in existence throughout the preceding calendar
47 year, the determination of whether the employer is a small employer shall be based on the average
48 number of employees that the employer is reasonably expected to employ on business days in the
49 current calendar year; and

1 (v) an employer that makes enrollment in qualified health plans available to its
2 employees through the shop exchange, and would cease to be a small employer by reason of an
3 increase in the number of its employees, shall continue to be treated as a small employer for
4 purposes of this title as long as it continuously makes enrollment through the shop exchange
5 available to its employees.

6
7 Section 4. [*Authorization of the health benefit exchange.*]

8 (A) there is a [insert state] health benefit exchange.

9 (B) (1) the exchange is a body politic and corporate and is an instrumentality of the state.

10 (2) the exchange is a public corporation and a unit of state government.

11 (3) the exercise by the exchange of its authority under this title is an essential
12 governmental function.

13 (C) the purposes of the exchange are to:

14 (1) reduce the number of uninsured in the state;

15 (2) facilitate the purchase and sale of qualified health plans in the individual market in
16 the state by providing a transparent marketplace;

17 (3) assist qualified employers in the state in facilitating the enrollment of their
18 employees in qualified health plans in the small group market in the state and in accessing small
19 business tax credits; and

20 (4) assist individuals in accessing public programs, premium tax credits, and cost-
21 sharing reductions; and

22 (5) supplement the individual and small group insurance markets outside of the
23 exchange.

24 (D) nothing in this title, and no regulation adopted or other action taken by the exchange
25 under this title, may be construed to:

26 (1) preempt or supersede:

27 (i) the authority of the commissioner to regulate insurance business in the
28 state; or

29 (ii) the requirements of the Affordable Care Act; or

30 (2) authorize the exchange to carry out any function not authorized by the Affordable
31 Care Act.

32
33 Section 5. [*Health benefit exchange board of trustees.*]

34 (A) there is a board of trustees of the exchange.

35 (B) the board consists of the following members:

36 (1) the secretary of [state health agency];

37 (2) the commissioner;

38 (3) the executive director of the [insert state] health care commission; and

39 (4) the following members appointed by the governor, with the advice and consent of
40 the senate:

41 (i) three members who:

42 1. Represent the interests of employers and individual consumers of
43 products offered by the exchange; and

44 2. May have public health research expertise; and

45 (ii) three members who have demonstrated knowledge and expertise in at least
46 two of the following areas:

47 1. Individual health care coverage;

48 2. Small employer-sponsored health care coverage;

- 3. Health benefit plan administration;
- 4. Health care finance;
- 5. Administration of public or private health care delivery systems;

and

6. Purchasing and facilitating enrollment in health plan coverage, including demonstrated knowledge and expertise about the role of licensed health insurance producers and third-party administrators in connecting employers and individual consumers to health plan coverage; and

7. Public health and public health research, including knowledge about the health needs and health disparities among the state's diverse communities.

(C) in making appointments of members under subsection (b)(4) of this section, the governor shall assure that:

(1) the board's composition reflects a diversity of expertise;

(2) the board's composition reflects the gender, racial, and ethnic diversity of the state; and

(3) the geographic areas of the state are represented.

(D) (1) for purposes of this subsection, "affiliation" means:

(i) a financial interest, as defined in [insert citation];

(ii) a position of governance, including membership on a board of directors, regardless of compensation;

(iii) a relationship through which compensation, as defined in [insert citation], is received; or

(iv) a relationship for the provision of services as a regulated lobbyist, as defined in [insert citation].

(2) a member of the board or of the staff of the exchange, while serving on the board or the staff, may not have an affiliation with:

(i) a carrier, an insurance producer, a third-party administrator, a managed care organization, or any other person doing business contracting directly with the exchange; or

(ii) a trade association of carriers, insurance producers, third-party administrators, or managed care organizations; or

(iii) any other association of entities doing business in a position to contract directly with the exchange.

(E) (1) the term of a member appointed by the governor is 4 years.

(2) the terms of members appointed by the governor are staggered as required by the terms provided for members of the board on [insert date].

(3) at the end of a term, a member continues to serve until a successor is appointed and qualifies.

(4) a member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies.

(F) an appointed member of the board may not serve more than two consecutive full terms.

(G) the governor shall designate a chair of the board.

(H) (1) the board shall determine the times, places, and frequency of its meetings.

(2) five members of the board constitute a quorum.

(3) action by the board requires the affirmative vote of at least five members.

(I) a member of the board is entitled to reimbursement for expenses under the standard state travel regulations, as provided in the state budget.

(J) a member shall:

(1) meet the requirements of this title, the affordable care act, and all applicable state and federal laws and regulations;

1 (2) serve the public interest of the individuals and qualified employers seeking health
2 care coverage through the exchange; and

3 (3) ensure the sound operation and fiscal solvency of the exchange.

4 (K) a member of the board shall perform the member's duties:

5 (1) in good faith;

6 (2) in the manner the member reasonably believes to be in the best interests of the
7 exchange; and

8 (3) without intentional or reckless disregard of the care an ordinarily prudent person
9 in a like position would use under similar circumstances.

10 (L) a member of the board who performs the member's duties in accordance with the
11 standard provided in subsection (K) of this section may not be liable personally for actions taken as a
12 member.

13 (M) a member of the board may be removed for incompetence, misconduct, or failure to perform the
14 duties of the position.

15 (N) (1) (i) a member of the board shall be subject to the state ethics law, [insert citation].

16 (ii) in addition to the disclosure required under [insert citation], a member of the board shall disclose
17 to the board and to the public any relationship not addressed in the required financial disclosure that
18 the member has with a carrier, insurance producer, third-party administrator, managed care
19 organization, or other entity in an industry involved in matters likely to come before the board.

20 (2) on all matters that come before the board, the member shall:

21 (i) adhere strictly to the conflict of interest provisions under title 15, subtitle 5
22 of the state government article relating to restrictions on participation, employment, and financial
23 interests; and

24 (ii) provide full disclosure to the board and the public on:

25 1. Any matter that gives rise to a potential conflict of interest; and

26 2. The manner in which the member will comply with the provisions
27 of [insert citation] to avoid any conflict of interest or appearance of a conflict of interest.

28
29 Section 6. [*Executive director of the health benefits exchange.*]

30 (A) (1) with the approval of the governor, the board shall appoint an executive director of the
31 exchange.

32 (2) subject to the approval of the governor, the the executive director shall serve at the
33 pleasure of the board.

34 (3) the board shall determine the appropriate compensation for the executive director.

35 (B) under the direction of the board, the executive director shall:

36 (1) be the chief administrative officer of the exchange;

37 (2) direct, administer, and manage the operations of the exchange; and

38 (3) perform all duties necessary to comply with and carry out the provisions of this
39 title, other state law and regulations, and the Affordable Care Act.

40 (C) (1) the executive director may employ and retain a staff for the exchange.

41 (2) except as provided in paragraphs (3) and (4) of this subsection, or otherwise by
42 law, the executive director's appointment, retention, and removal of staff of the exchange are not
43 subject to [insert citation] of the state personnel and pensions article.

44 (3) in hiring staff for functions that must be performed by state personnel under the
45 affordable care act or other applicable federal or state laws, the executive director's appointment,
46 retention, and removal of such staff shall be in accordance with [insert citation] of the state
47 personnel and pensions article.

48 (4) to the extent practicable, in in hiring staff for functions that have been and
49 currently are performed by state personnel, the executive director's appointment, retention, and

1 removal of such staff shall be in accordance with [insert citation] of the state personnel and pensions
2 article.

3 (5) in hiring except as provided in paragraph (6) of this subsection, staff for all other
4 positions necessary to carry out the purposes of this title, the executive director, with the approval of
5 the board, may:

6 (i) designate positions as technical or professional to be shall be positions in
7 the executive service or management service, or special appointments of the skilled service or the
8 professional service in the state personnel management system; and

9 (ii) retain as independent contractors or employees, and set compensation for,
10 attorneys, financial consultants, and any other professionals or consultants necessary to carry out the
11 planning, development, and operations of the exchange and the provisions of this title.

12 (6) the executive director may retain as independent contractors or employees, and set
13 compensation for, attorneys, financial consultants, and any other professionals or consultants
14 necessary to carry out the planning, development, and operations of the exchange and the provisions
15 of this title.

16 (D) the executive director shall determine the classification, grade, and compensation of staff
17 of the exchange hired or designated under subsection (C)(3), (4), and (5)(i) of this section:

18 (1) in consultation with the secretary of [insert appropriate state budget agency];

19 (2) with the approval of the board; and

20 (3) when possible, in accordance with the state pay plan.

21 (E) (1) with respect to staff of the exchange hired or designated under subsection (C)(3), (4),
22 and (5)(i) of this section, the executive director shall submit to the secretary of [insert appropriate
23 state budget agency], at least 45 days before the effective date of the change, each change to the
24 exchange's salary plans that involves increases or decreases in salary ranges other than those
25 associated with routine reclassifications and promotions or general salary increases approved by the
26 general assembly.

27 (2) reportable changes include:

28 (i) the creation or abolition of classes;

29 (ii) the re-grading of classes from one established range to another; and

30 (iii) the creation of new pay schedules or ranges.

31 (3) the secretary of [insert state budget agency] shall:

32 (i) review the proposed change; and

33 (ii) at least 15 days before the effective date of the proposed change:

34 1. Advise the executive director whether the change would have an
35 adverse effect on comparable state jobs; and

36 2. If there would be an adverse effect, recommend an alternative
37 change that would not have an adverse effect on comparable state jobs.

38 (4) failure of the secretary of [insert appropriate budget agency] to respond in a timely
39 manner is deemed to be agreement with the change as submitted.

40 (F) except as otherwise provided in this title, an employee or independent contractor of the
41 exchange is not subject to any law, regulation, or executive order governing state compensation,
42 including furloughs, pay cuts, or any other general fund cost savings measure.

43
44 Section 7. *[Powers of the board.]*

45 (A) subject to any limitations under this title or other applicable law, the board shall have all
46 powers necessary or convenient to further carry out the functions authorized by the Affordable Care
47 Act and consistent with the purposes of the exchange.

48 (B) the enumeration of specific powers in this title is not intended to restrict the board's
49 power to take any lawful action that the board determines is necessary or convenient to further carry

1 out the functions authorized by the Affordable Care Act and consistent with the purposes of the
2 exchange.

3 (C) in addition to the powers set forth elsewhere in this title, the board may:

4 (1) adopt and alter an official seal;

5 (2) sue, be sued, plead, and be impleaded;

6 (3) adopt bylaws, rules, and policies;

7 (4) adopt regulations to carry out this title:

8 (i) in accordance with title 10, subtitle 1 of the state government article; and

9 (ii) without conflicting with or preventing application of regulations adopted
10 by the secretary under Title 1, Subtitle d of the Affordable Care Act;

11 (5) maintain an office at the place designated by the board;

12 (6) appoint advisory committees composed of experts and individuals knowledgeable
13 about individual and employer-sponsored health care coverage, health benefit plan administration,
14 health care finance, administration of public and private health care delivery systems, purchasing
15 and facilitating enrollment in health plan coverage, health care delivery models and payment
16 reforms, and other experts and individuals as appropriate;

17 (7) enter into any agreements or contracts and execute the instruments necessary or
18 convenient to manage its own affairs and carry out the purposes of this title;

19 (8) apply for and receive grants, contracts, or other public or private funding; and

20 (9) do all things necessary or convenient to carry out the powers granted by this title.

21 (D) (1) to carry out the purposes of this title or perform any of its functions under this title,
22 the board may contract or enter into memoranda of understanding with eligible entities, including:

23 (i) the [insert state] medical assistance program;

24 (ii) the family investment unit of the department of human resources;

25 (iii) insurance producers and third party administrators registered in the state
26 that are not affiliated with a carrier; and

27 (IV) any other entities not affiliated with a carrier that have experience in
28 individual and small group public and private health insurance plans and or facilitating enrollment in
29 those plans.

30 (2) the operations of the exchange are subject to the provisions of this title whether
31 the operations are performed directly by the exchange or through an entity under a contract with the
32 exchange.

33 (3) the board shall ensure that any entity under a contract with the exchange complies
34 with the provisions of this

35 (E) (1) the board may enter into information-sharing agreements with federal and state
36 agencies, and other state health insurance exchanges, to carry out the provisions of this title.

37 (2) an information-sharing agreement entered into under paragraph (1) of this
38 subsection shall:

39 (i) include adequate protections with respect to the confidentiality of
40 information; and

41 (ii) comply with all state and federal laws and regulations.

42 (F) (1) the board, in accordance with [insert citation], shall adopt written policies and
43 procedures governing all procurements of the exchange.

44 (2) to the fullest extent practicable, and in a manner that does not impair the
45 exchange's ability to carry out the purposes of this title, the board's procurement policies and
46 procedures shall establish an open and transparent process that:

47 (i) promotes public confidence in the procurements of the exchange;

- (ii) ensures fair and equitable treatment of all persons and entities that participate in the procurement system of the exchange;
- (iii) fosters appropriate competition and provides safeguards for maintaining a procurement system of quality and integrity;
- (iv) promotes increased economic efficiency and responsibility on the part of the exchange;
- (v) achieves the maximum benefit from the purchasing power of the exchange; and
- (vi) provides clarity and simplicity in the rules and procedures governing the procurements of the exchange.

(G) to carry out the purposes of this title, the board shall:

- (1) create and consult with advisory committees; and
- (2) appoint to the advisory committees representatives of:
 - (i) insurers or health maintenance organizations offering health benefit plans in the state;
 - (ii) nonprofit health service plans offering health benefit plans in the state;
 - (iii) licensed health insurance producers and advisers;
 - (iv) third-party administrators;
 - (v) health care providers, including:
 - 1. hospitals;
 - 2. long-term care facilities;
 - 3. mental health providers;
 - 4. developmental disability providers;
 - 5. substance abuse treatment providers;
 - 6. federally qualified health centers;
 - 7. physicians;
 - 8. nurses;
 - 9. experts in services and care coordination for criminal and juvenile justice populations;
 - 10. licensed hospice providers; and
 - 11. other health care professionals;
 - (vi) managed care organizations;
 - (vii) employers, including large, small, and minority-owned employers;
 - (viii) public employee unions, including public employee union members who are caseworkers in local departments of social services with direct knowledge of information technology systems used for Medicaid eligibility determination;
 - (ix) consumers, including individuals who:
 - 1. Reside in lower-income and racial or ethnic minority communities;
 - 2. Have chronic diseases or disabilities; or
 - 3. Belong to other hard-to-reach or special populations;
 - (x) individuals with knowledge and expertise in advocacy for consumers described in item (ix) of this item;
 - (xi) public health researchers and other academic experts with knowledge and background relevant to the functions and goals of the exchange, including knowledge of the health needs and health disparities among the state's diverse communities; and
 - (xii) any other stakeholders identified by the exchange as having knowledge or representing interests relevant to the functions and duties of the exchange.

Section 8. [Health benefit exchange fund.]

(A) in this section, "fund" means the [insert state] health benefit exchange fund.

1 (B) there is a [insert state] health benefit exchange fund.

2 (C) the purpose of the fund is to provide funding for the operation and administration of the
3 exchange in carrying out the purposes of the exchange under this title.

4 (D) the exchange shall administer the fund.

5 (E) (1) the fund is a special, non-lapsing fund that is not subject [insert citation] of the state
6 finance and procurement article.

7 (2) the state treasurer shall hold the fund separately, and the comptroller shall account
8 for the fund.

9 (F) the fund consists of:

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

11 (2) income from investments made on behalf of the fund;

12 (3) interest on deposits or investments of money in the fund;

13 (4) money collected by the board as a result of legal or other actions taken by the
14 board on behalf of the exchange or the fund;

15 (5) money donated to the fund;

16 (6) money awarded to the fund through grants; and

17 (7) any other money from any other source accepted for the benefit of the fund.

18 (G) the fund may be used only to provide funding for the operation and administration of the
19 exchange in carrying out the purposes authorized under this title.

20 (H)(1) the state treasurer shall invest the money of the fund in the same manner as other state
21 money may be invested.

22 (2) any investment earnings of the fund shall be credited to the fund.

23 (3) no part of the fund may revert or be credited to the general fund or any special
24 fund of the state.

25 (I) a debt or an obligation of the fund is not a debt of the state or a pledge of credit of the
26

27 Section 8. [*Functions and operations of the exchange.*]

28 (A) on or before [insert date], the functions and operations of the exchange shall include at a
29 minimum all functions required by § 1311(d)(4) of the Affordable Care Act.

30 (B) on or before January 1, 2014, in compliance with § 1311(D)(4) of the Affordable Care
31 Act, the exchange shall:

32 (1) make qualified health plans available to qualified individuals and qualified
33 employers;

34 (2) allow a carrier to offer a qualified health dental plan through the exchange that
35 provides limited scope dental benefits under that meet the requirements of § 9832(C)(2)(A) of the
36 Internal Revenue Code, either separately or in conjunction with a qualified health plan, provided that
37 the qualified health plan provides pediatric dental benefits that meet the requirements of §
38 1302(B)(1)(J) of the Affordable Care Act;

39 (3) implement procedures for the certification, recertification, and decertification of
40 health benefit plans as qualified health plans, consistent with guidelines developed by the secretary
41 under § 1311(C) of the Affordable Care Act;

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

44 (5) provide for initial, annual, and special enrollment periods, in accordance with
45 guidelines adopted by the secretary under § 1311(C)(6) of the Affordable Care Act;

46 (6) maintain a web site through which enrollees and prospective enrollees of qualified
47 health plans may obtain standardized comparative information on qualified health plans and
48 qualified dental plans;

1 (7) with respect to each qualified health plan offered through the exchange:
2 (i) assign a rating for each qualified health plan in accordance with the criteria
3 developed by the secretary under § 1311(C)(3) of the Affordable Care Act and any additional criteria
4 that may be applicable under the laws of the state and regulations adopted by the exchange under
5 this title; and
6 (ii) determine each qualified health plan's level of coverage in accordance
7 with regulations adopted by the secretary under § 1302(D)(2)(A) of the Affordable Care Act and any
8 additional regulations adopted by the exchange under this title;
9 (8) present qualified health plan options offered by the exchange in a standardized
10 format, including the use of the uniform outline of coverage established under § 2715 of the Federal
11 Public Health Service Act;
12 (9) in accordance with § 1413 of the Affordable Care Act, provide information and
13 make determinations regarding eligibility for the following programs:
14 (i) the [insert state] medical assistance program under title XIX of the Social
15 Security Act;
16 (ii) the [insert state] children's health insurance program under title XXI OF
17 the Social Security Act; and
18 (iii) any applicable state or local public health insurance program;
19 (10) facilitate the enrollment of any individual who the exchange determines is
20 eligible for a program described in item (9) of this subsection;
21 (11) establish and make available by electronic means a calculator to determine the
22 actual cost of coverage of a qualified health plan and a qualified dental plan offered by the exchange
23 after application of any premium tax credit under § 36B of the Internal Revenue Code and any cost-
24 sharing reduction under § 1402 of the Affordable Care Act;
25 (12) establish a shop exchange through which qualified employers may access
26 coverage for their employees at specified levels of coverage and meet standards for the federal
27 qualified employer tax credit;
28 (13) implement a certification process for individuals exempt from the individual
29 responsibility requirement and penalty under § 5000A of the Internal Revenue Code on the grounds
30 that:
31 (i) no affordable qualified health plan that covers the individual is available
32 through the exchange or the individual's employer; or
33 (ii) the individual meets other requirements under the affordable care act that
34 make the individual eligible for the exemption;
35 (14) implement a process for transfer to the United States Secretary of the Treasury
36 the name and taxpayer identification number of each individual who:
37 (i) is certified as exempt from the individual responsibility requirement;
38 (ii) is employed but determined eligible for the premium tax credit on the
39 grounds that:
40 1. The individual's employer does not provide minimum essential
41 coverage; or
42 2. The employer's coverage is determined to be unaffordable for the
43 individual or does not provide the requisite minimum actuarial value;
44 (iii) notifies the exchange under § 1411(B)(4) of the Affordable Care Act that
45 the individual has changed employers; and
46 (iv) ceases coverage under a qualified health plan during the plan year,
47 together with the date coverage ceased;
48 (15) provide notice to employers of employees who cease coverage under a qualified
49 health plan during a plan year, together with the date coverage ceased;

1 (16) conduct processes required by the secretary and the United States Secretary of
2 the Treasury to determine eligibility for premium tax credits, reduced cost-sharing, and individual
3 responsibility requirement exemptions;

4 (17) establish a navigator program in accordance with § 1311(i) of the Affordable
5 Care Act and any requirements established under this title;

6 (18) (i) establish a process, in accordance with § 10108 of the Affordable Care Act,
7 for crediting the amount of free choice vouchers to premiums of qualified health plans and qualified
8 dental plans in which qualified employees are enrolled; and

9 (ii) collect the amount credited from the employer offering the qualified health
10 plan;

11 (19) carry out a plan to provide appropriate assistance for consumers seeking to
12 purchase products through the exchange, including the implementation of the navigator program and
13 toll-free hotline required under item (4) of this subsection; and

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

15 (C) if the individual enrolls in another type of minimum essential coverage neither the
16 exchange nor a carrier offering qualified health plans through the exchange may charge an individual
17 a fee or penalty for termination of coverage on the grounds that:

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

19 (2) the individual's employer-sponsored coverage has become affordable under the
20 standards of § 36B(C)(2)(C) of the Internal Revenue Code.

21 (D) in carrying out its duties under this title, the exchange, through the advisory committees
22 established under [insert citation] of this title or through other means, shall consult with
23 stakeholders, including:

24 (1) individual health care consumers;

25 (2) small and large employers;

26 (3) individuals and entities with experience in facilitating enrollment in qualified
27 health plans;

28 (4) advocates for special and hard-to-reach populations;

29 (5) representatives of health care providers, carriers, and plan administrators;

30 (6) experts in the administration of public and private health care delivery systems
31 and health care finance; and

32 (7) any other appropriate stakeholders identified by the exchange.

33 (E) the exchange, through the advisory committees established under § 31-106(g) of this title
34 or through other means, shall consult with and consider the recommendations of the stakeholders
35 represented on the advisory committees in the exercise of its duties under this title.

36 (F) the exchange may not make available:

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

38 (2) any dental plan that is not a qualified dental plan.

39
40 Section 9. [*Certification of health benefit plans by the exchange.*]

41 (A) the exchange shall certify health benefit plans as qualified health plans.

42 (B) to be certified as a qualified health plan, a health benefit plan shall:

43 (1) except as provided in subsection (c) of this section, provide the essential benefits
44 package required under § 1302(a) of the Affordable Care Act;

45 (2) obtain prior approval of premium rates and contract language from the
46 commissioner;

1 (3) except as provided in subsection (d) of this section, provide at least a bronze level
2 of coverage, as defined in the affordable care act and determined by the exchange under § 31–
3 108(b)(7)(ii) of this title;

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

6 (ii) if the health benefit plan is offered through the shop exchange, ensure that
7 the health benefit plan’s deductible does not exceed the limits established under § 1302(c)(2) of the
8 Affordable Care Act;

9 (5) be offered by a carrier that:

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

12 (ii) if the carrier participates in the exchange’s individual market, offers at
13 least one qualified health plan at the silver level and one at the gold level in the individual market
14 outside the exchange;

15 (iii) if the carrier participates in the shop exchange, offers at least one
16 qualified health plan at the silver level and one at the gold level in the small group market outside
17 the shop exchange;

18 (iv) charges the same premium rate for each qualified health plan regardless of
19 whether the qualified health plan is offered through the exchange, through an insurance producer
20 outside the exchange, or directly from a carrier;

21 (V) does not charge any cancellation fees or penalties in violation of [insert
22 citation] of this title; and

23 (VI) complies with the regulations adopted by the secretary under § 1311(d)
24 of the Affordable Care Act and by the exchange under § 31–106(c)(4) of this title;

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

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

31 (ii) the exchange under [insert citation] of this title;

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

34 (8) provide any other benefits as may be required by the commissioner under any
35 applicable state law or regulation; and

36 (9) meet any other requirements established by the exchange under this title.

37 (C) a qualified health plan is not required to provide essential benefits that duplicate the minimum
38 benefits of qualified dental plans, as provided in subsection (G) of this section, if:

39 (1) the exchange has determined that an adequate choice of at least one qualified
40 dental plans plan is available to supplement the qualified health plan’s coverage; and

41 (2) at the time the carrier offers the qualified health plan, the carrier discloses in a
42 form approved by the exchange that:

43 (I) the plan does not provide the full range of essential pediatric benefits; and

44 (ii) qualified dental plans providing these and other dental benefits also not
45 provided by the qualified health plan are offered through the exchange.

46 (D) a qualified health plan is not required to provide at least a bronze level of coverage under
47 subsection (B)(3) of this section if the qualified health plan:

48 (1) meets the requirements and is certified as a qualified catastrophic plan as provided
49 under the affordable care act; and

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

2 (E) a health benefit plan may not be denied certification:

3 (1) solely on the grounds that the health benefit plan is a fee-for-service plan;

4 (2) through the imposition of premium price controls by the exchange; or

5 (3) solely on the grounds that the health benefit plan provides treatments necessary to
6 prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

7 (F) in addition to other rate filing requirements that may be applicable under this article, each
8 carrier seeking certification of a health benefit plan shall:

9 (1) (i) submit to the exchange a justification for any premium increase before
10 implementation of the increase; and

11 (ii) post the increase on the carrier's web site;

12 (2) submit to the exchange, the secretary, and the commissioner, and make available
13 to the public, in plain language as required under § 1311(E)(3)(B) of the Affordable Care Act,
14 accurate and timely disclosure of:

15 (i) claims payment policies and practices;

16 (ii) financial disclosures;

17 (iii) data on enrollment, disenrollment, number of claims denied, and rating
18 practices;

19 (iv) information on cost-sharing and payments with respect to out-of-
20 network coverage;

21 (v) Information on enrollee and participant rights under title I of the
22 Affordable Care Act; and

23 (vi) any other information as determined appropriate by the secretary and the
24 exchange; and

25 (3) make available information about costs an individual would incur under the
26 individual's health benefit plan for services provided by a participating health care provider,
27 including cost-sharing requirements such as deductibles, co-payments, and coinsurance, in a manner
28 determined by the exchange.

29 (G) (1) except as provided in paragraphs (2), (3), and (4) of this subsection, the requirements
30 applicable to qualified health plans under this title also shall apply to qualified dental plans.

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

33 (3) a qualified dental plan shall:

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

36 (ii) include at a minimum:

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

39 2. Other dental benefits required by the secretary or the exchange.

40 (iii) include any other benefits as may be required by the secretary or the
41 exchange.

42 (4) carriers jointly may offer a comprehensive plan through the exchange in which
43 dental benefits are provided by a carrier through a qualified dental plan and other benefits are
44 provided by a carrier through a qualified health plan, provided that the plans are priced separately
45 and made available for purchase separately at the same price as when offered jointly.

46 Section 10. [*Exchange fees.*]

1 (A) subject beginning [insert date], subject to subsection (B) subsections (B) and (C) of this
2 section, the exchange may:

3 (1) impose user fees, licensing or other regulatory fees, or other assessments on
4 persons that benefit from the exchange that do not exceed reasonable projections regarding the
5 amount necessary to support the operations of the exchange under this title; or

6 (2) otherwise generate funding necessary to support its operations under this title.

7 (B) any fees, assessments, or other funding mechanisms shall be imposed or implemented, to
8 the maximum extent possible, in a manner that is transparent and broad-based.

9 (C) before imposing or altering any fee or assessment established by law, the exchange shall
10 adopt regulations that specify:

11 (1) the persons subject to the fee or assessment;

12 (2) the amount of the fee or assessment; and

13 (3) the manner in which the fee or assessment will be collected.

14 (D) funds collected through any fees, assessments, or other funding mechanisms:

15 (1) shall be deposited in the [insert state] health benefit exchange fund;

16 (2) shall be used only for the purposes authorized under this title; and

17 (3) may not be used for staff retreats, promotional giveaways, excessive executive
18 compensation, or promotion of federal or state legislative and regulatory actions.

19 (E) the exchange may not impose fees or assessments authorized under this section in a
20 manner that would provide a competitive disadvantage to health benefit plans operating outside of
21 the exchange.

22 (F) the exchange shall maintain a web site on which it shall publish:

23 (1) the average amounts of any fees, assessments, or other payments required by the
24 exchange;

25 (2) the administrative costs of the exchange; and

26 (3) the amount of funds known to be lost through waste, fraud, and abuse.

27
28 Section 11. *[Administration of the exchange.]*

29 (A) the exchange shall be administered in a manner designed to:

30 (1) prevent discrimination;

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

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

34 (4) promote financial integrity.

35 (B) the exchange shall keep an accurate accounting of all its activities, expenditures, and
36 receipts.

37 (C) (1) on or before [insert month] of each year, the board shall forward to the secretary, the
38 governor, and, in accordance with [insert citation].

39 (2) the report shall:

40 (i) be in the standardized format required by the secretary;

41 (ii) include data regarding coverage, price, quality, benefits, consumer choice,
42 and other metrics to evaluate exchange performance, assure transparency, and facilitate research and
43 analysis:

44 1. Health plan participation, ratings, coverage, price, quality
45 improvement measures, and benefits;

46 2. Consumer choice, participation, and satisfaction information to the
47 extent the information is available;

48 3. Financial integrity, fee assessments, and status of the fund; and

1 4. Any other appropriate metrics related to the operation of the
2 exchange that may be used to evaluate exchange performance, assure transparency, and facilitate
3 research and analysis; and

4 (iii) include data to identify disparities related to gender, race, ethnicity,
5 geographic location, language, disability, or other attributes of special populations.

6 (D) the board shall cooperate fully with any investigation into the affairs of the exchange,
7 including making available for examination the records of the exchange, conducted by:

8 (1) the secretary under the secretary’s authority under the Affordable Care Act; and

9 (2) the commissioner under the commissioner’s authority to regulate the sale and
10 purchase of insurance in the state.

11
12 Section 11. [*Study and recommendations.*]

13 (A) Be it enacted, that, with respect to the functions of the [insert state] health benefit
14 exchange established under Section 1 of this Act, and the requirements for health benefit plan
15 certification mandated by the federal Patient Protection and Affordable Care Act and as
16 implemented by [insert citation], as enacted by section 1 of this Act, that require further study and
17 recommendations under section 13 of this Act before full implementation is possible, including
18 recommendations for further legislative or regulatory action, the exchange of trustees of the [insert
19 state] Health Benefit Exchange established under section 1 of this Act, may not implement those
20 functions or impose those requirements until:

21 (1) the Exchange conducts the studies and reports its findings and recommendations
22 to the Governor and the General Assembly as required under section 5 of this Act; and

23 (2) the findings and recommendations for further legislative or regulatory action are
24 acted upon by the governor and the general assembly. the [insert state] health benefit exchange
25 established under Section 1 of this Act may not exercise any powers, duties, or functions under the
26 provisions of [insert citation], as enacted by section 1 of this Act, until:

27 (i) the exchange has reported its findings and recommendations, including
28 recommendations for legislation necessary or desirable to carry out its purposes and functions, to the
29 governor and the general assembly, in accordance with Section 5 of this Act; and

30 (ii) the governor and the general assembly authorize the exercise of the
31 powers, duties, and functions through enactment of additional legislation in the [insert year]
32 legislative session.

33
34 Section 12. [*Appointment clarification to board of trustees.*]

35 Be it enacted, that, with respect to the governor’s appointment to the board of trustees of the
36 [insert state] health benefit exchange established under Section 1 of this Act, of those members
37 representing the interests of employers and consumers, it is the intent of the general assembly that
38 the governor seek to appoint, where practicable and particularly in the initial appointments, members
39 whose particular knowledge and understanding include the interests of minority-owned employers
40 and individual consumers who come from lower-income and minority communities, have chronic
41 diseases or disabilities, or belong to other hard-to-reach or special populations.

42
43 Section 13. [*Health benefit exchange advisory committee.*]

44 (A) Be it enacted that the [insert state] health benefit exchange established under section 1 of
45 this Act:

46 (1) in consultation with the advisory committees established under [insert citation], as
47 enacted by section 1 of this Act, and with other stakeholders, shall study and make recommendations
48 regarding:

- 1 (i) the feasibility and desirability of the exchange engaging in:
- 2 1. selective contracting, either through competitive bidding or a
- 3 negotiation process similar to that used by large employers, to reduce health care costs and improve
- 4 quality of care by certifying only those health benefit plans that meet certain requirements such as
- 5 promoting patient-centered medical homes, adopting electronic health records, meeting minimum
- 6 outcome standards, implementing payment reforms to reduce medical errors and preventable
- 7 hospitalizations, reducing disparities, ensuring adequate reimbursements, enrolling low-risk
- 8 members and underserved populations, managing chronic conditions and promoting healthy
- 9 consumer lifestyles, value-based insurance design, and adhering to transparency guidelines and
- 10 uniform price and quality reporting; and
- 11 2. multistate or regional contracting within the State;
- 12 (ii) the rules under which health benefit plans should be offered inside and
- 13 outside the Exchange in order to mitigate adverse selection and encourage enrollment in the
- 14 Exchange, including:
- 15 1. whether any benefits should be required of qualified health plans
- 16 beyond those mandated by the federal Patient Protection and Affordable Care Act (Affordable Care
- 17 Act), and whether any such additional benefits should be required of health benefit plans offered
- 18 outside the exchange;
- 19 2. whether carriers offering health benefit plans outside the exchange
- 20 should be required to offer either all the same health benefit plans inside the exchange, or
- 21 alternatively, at least one health benefit plan inside the exchange; and
- 22 3. whether managed care organizations with health choice contracts
- 23 should be required to offer products inside the exchange, and whether carriers offering health benefit
- 24 plans inside the exchange should be required to also participate in the [insert state] medical
- 25 assistance program which provisions applicable to qualified health plans should be made applicable
- 26 to qualified dental plans;
- 27 (iii) the design and operation of the exchange's navigator program and any
- 28 other appropriate consumer assistance mechanisms, including:
- 29 1. how the navigator program could utilize, interact with, or
- 30 complement private sector resources, including insurance producers the infrastructure of the existing
- 31 private sector health insurance distribution system in the state to determine whether private sector
- 32 resources may be available and suitable for use by the exchange;
- 33 2. the effect the exchange may have on private sector employment in
- 34 the health insurance distribution system in the state;
- 35 3. what functions, in addition to those required by the Affordable Care
- 36 Act, should be performed by navigators;
- 37 4. what training and expertise should be required of navigators, and
- 38 whether different markets and populations require navigators with different qualifications;
- 39 5. how navigators should be retained and compensated, and how
- 40 disparities between navigator compensation and the compensation of insurance producers outside the
- 41 exchange can be minimized or avoided; and
- 42 6. how to ensure that navigators provide information in a manner
- 43 culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served by
- 44 the exchange, and that navigators have the capacity to meet these needs; and
- 45 7. what other means of consumer assistance may be appropriate and
- 46 feasible, and how they should be designed and implemented;
- 47 (iv) the design and function of the SHOP exchange beyond the requirements
- 48 of the Affordable Care Act, to promote quality, affordability, and portability, including:

1. whether it should be a defined contribution/employee choice model or whether employers should choose the qualified health plan to offer their employees;
 2. whether the current individual and small group markets should be merged; and
 3. whether the SHOP exchange should be made available to employers with 50 to 100 employees prior to [insert year], as authorized by the Affordable Care Act; and
- (v) how the exchange can be self-sustaining by [insert year] in compliance with the Affordable Care Act, including:
1. a recommended plan for the budget of the exchange;
 2. the user fees, licensing fees, or other assessments that should be imposed by the exchange to fund its operations, including what type of user fee cap or other methodology would be appropriate to ensure that the income of the exchange comports with the expenditures of the exchange; and
 3. a recommended plan for how to prevent fraud, waste, and abuse;
- and
- (vi) how the exchange should conduct its public relations and advertising campaign, including what type of solicitation, if any, of individual consumers or employers, would be desirable and appropriate; and
- (2) on or before [insert date], shall report its interim findings and recommendations, including initial recommendations for further legislative or regulatory action, to the governor and, in accordance with [insert citation], the general assembly; and
- (3) on or before [insert date], shall report its final findings and recommendations, including final recommendations for further legislative or regulatory action, to the governor and, in accordance with [insert date] of the state government article, the general assembly.

Section 14. *[Report by the advisory committee.]*

Be it enacted that on or before [insert date], the [insert state] health benefit exchange established under section 1 of this Act, in consultation with the advisory committees established under section 13, as enacted by section 1 of this Act, and with other stakeholders, shall conduct a study and report its findings and recommendations to the governor and, in accordance with [insert citation] of the state government article, the general assembly, on whether the exchange should remain an independent public body or should become a nongovernmental, nonprofit entity.

Section 15. *[Potentiality for the exchange to become a nongovernmental entity.]*

It is the intent of the general assembly that the [insert state] health benefits exchange established under section 1 of this Act should not take any action that would inhibit the potential transformation of the exchange into a nongovernmental, nonprofit entity or a quasi-governmental entity.

Section 16. *[Severability.]* Insert severability clause.

Section 17. *[Repealer.]* Insert repealer clause.

Section 18. *[Effective Date.]* Insert effective date.