

Health Benefit Exchange

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

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

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

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

Submitted as:

California

[Chapter 655 of 2010](#)

Status: Enacted into law in 2010.

California

[Chapter 659 of 2010](#)

Status: Enacted into law in 2010.

Suggested State Legislation

(Title, enacting clause, etc.)

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

3
4 Section 2. [*Definitions.*] As used in this Act:

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

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

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

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

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

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

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

20 (8) “SHOP Program” means the [Small Business Health Options Program] established by
21 [insert citation].

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

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

26
27 Section 3. *[Health Benefit Exchange and Governing Executive Board.]*

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

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

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

44 (a) Individual health care coverage.

45 (b) Small employer health care coverage.

46 (c) Health benefits plan administration.

47 (d) Health care finance.

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

49 (f) Purchasing health plan coverage.

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

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

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

60 composition reflects the communities of [this state].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

137 (I) Claims payment policies and practices.
138 (II) Periodic financial disclosures.
139 (III) Data on enrollment.
140 (IV) Data on disenrollment.
141 (V) Data on the number of claims that are denied.
142 (VI) Data on rating practices.
143 (VII) Information on cost sharing and payments with respect to any
144 out-of-network coverage.
145 (VIII) Information on enrollee and participant rights under Title I
146 of the federal Act.
147 (IX) Other information as determined appropriate by the United
148 States Secretary of Health and Human Services.

149 (b) The information required under subparagraph (a) shall be provided in
150 plain language, as defined in subparagraph (B) of paragraph (3) of subdivision (e) of Section
151 1311 of the federal Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

207 exemptions.

208 (14) Establish the navigator program in accordance with subdivision (i) of Section
209 1311 of the federal Act. Any entity chosen by the Exchange as a navigator shall do all of the
210 following:

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

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

217 (c) Facilitate enrollment in qualified health plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

286 (13) Employ necessary staff.

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

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

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

300 (ii) Other relevant labor pools.

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

304 (III) The state [department of personnel administration]

305 shall review the methodology used in the surveys conducted pursuant to subparagraph (I).
306 (c) The positions described in paragraph (b)(I) and subdivision (I) of this
307 Section shall not be subject to otherwise applicable provisions of [insert citation] and, for those
308 purposes, the Exchange shall not be considered a state agency or public entity.

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

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

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

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

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

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

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

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

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

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

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

347 (d) The state [Medicaid Director].

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

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

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

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

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

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

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

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

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

374 (2) Enter into contracts.

375 (3) Sue and be sued.

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

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

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

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

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

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

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

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

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

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

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

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

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

433

434 Section 4. *[Health Benefit Exchange Not Subject to Certain Licensing and Regulations.]*
435 (A) Notwithstanding any other provision of law, the Exchange shall not be subject to
436 licensure or regulation by the state [department of insurance] or the state [department of
437 managed health care].

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

440

441 Section 5. *[Health Benefit Exchange Records: Disclosure Exemptions.]*
442 (A) Records of the Exchange that reveal any of the following shall be exempt from
443 disclosure under the state [Public Records Act] as defined under [insert citation]:

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

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

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

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

457

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

514
515 Section 7. [*Requirements for Health Care Service Plans to Participate in the Health*
516 *Benefit Exchange.*]

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

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

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

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

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

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

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

550 Section 1302 of the federal Act.

551

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

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

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

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

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

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

570 (C) Commencing [January 1, 2014], a health insurer, with respect to policies that cover
571 hospital, medical, or surgical benefits, may only sell the five levels of coverage contained in
572 subdivisions (d) and (e) of Section 1302 of the federal Act, except that a health insurer that does
573 not participate in the Exchange may, with respect to policies that cover hospital, medical, or
574 surgical benefits only sell the four levels of coverage contained in subdivision (d) of Section
575 1302 of the federal Act.

576 (D) Commencing January 1, 2014, a health insurer that does not participate in the
577 Exchange shall, with respect to policies that cover hospital, medical, or surgical expenses, offer
578 at least one standardized product that has been designated by the Exchange in each of the four
579 levels of coverage contained in subdivision (d) of Section 1302 of the federal Act. This
580 subdivision shall only apply if the [board] of the Exchange exercises its authority under Section
581 3 (P) of this Act. Nothing in this subdivision shall require an insurer that does not participate in
582 the Exchange to offer standardized products in the small employer market if the insurer only
583 sells products in the individual market. Nothing in this subdivision shall require an insurer that
584 does not participate in the Exchange to offer standardized products in the individual market if the
585 insurer only sells products in the small employer market. This subdivision shall not be construed
586 to prohibit the insurer from offering other products provided that it complies with subdivision (d)
587 of Section 1302 of the federal Act.

588

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

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

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

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

604 (C) The Exchange shall repay a loan made under this Section no later than [June 30,
605 2016], and shall pay interest at the rate paid on moneys in the [Pooled Money Investment
606 Account] established under [insert citation].

607
608 Section 10. [*Review of Federal Internet Portal and Health Benefit Exchange.*] The state
609 [director of the department of managed health care] shall, in coordination with the state
610 [insurance commissioner], review the Internet portal developed by the United States Secretary of
611 Health and Human Services under subdivision (a) of Section 1103 of the federal Patient
612 Protection and Affordable Care Act (Public Law 111-148) and paragraph (5) of subdivision (c)
613 of Section 1311 of that Act, and any enhancements to that portal expected to be implemented by
614 the secretary on or before [January 1, 2015]. The review shall examine whether the Internet
615 portal provides sufficient information regarding all health benefit products offered by health care
616 service plans and health insurers in the individual and small employer markets in [this state] to
617 facilitate fair and affirmative marketing of all individual and small employer products,
618 particularly outside the Health Benefit Exchange. If the [director of the department of managed
619 health care] and the state [insurance commissioner] jointly determine that the Internet portal does
620 not adequately achieve those purposes, they shall jointly develop and maintain an electronic
621 clearinghouse to achieve those purposes. In performing this function, the [director of the
622 department of managed health care] and the [insurance commissioner] shall routinely monitor
623 individual and small employer benefit filings with, and complaints submitted by individuals and
624 small employers to, their respective [departments], and shall use any other available means to
625 maintain the clearinghouse.

626
627 Section 11. [*Severability.*] [Insert severability clause.]

628
629 Section 12. [*Repealer.*] [Insert repealer clause.]

630
631 Section 13. [*Effective Date.*] [Insert effective date.]