

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Drafting Note: States expanding the definition of “qualified employer” to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the references to “small” employers and the “small” group market.

Section 3. Definitions

For purposes of this Act:

- A. “Commissioner” means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- B. “Educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.
- C. “Exchange” means the [insert name of State Exchange] established pursuant to section 4 of this Act.

- D. “Federal Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.
- E. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms “health plan” and “health insurance coverage.” “Health benefit plan,” as defined above, is intended to be consistent with the definition of “health insurance coverage” contained in Title XXVII of the Public Health Service Act, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

- (2) “Health benefit plan” does not include:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; or
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.
- (3) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

- (4) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- F. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- G. “Qualified dental plan” means a limited scope dental plan that has been certified in accordance with section 7E of this Act.
- H. “Qualified employer” means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:
 - (1) Has its principal place of business in this state and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
 - (2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this state.

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection H accordingly.

- I. “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

- J. “Qualified individual” means an individual, including a minor, who:
- (1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;
 - (2) Resides in this state;
 - (3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and
 - (4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.
- K. “Secretary” means the Secretary of the federal Department of Health and Human Services.
- L. “SHOP Exchange” means the Small Business Health Options Program established under section 6 of this Act.
- M. (1) “Small employer” means an employer that employed an average of not more than 100 employees during the preceding calendar year.

Drafting Note: The Federal Act permits States to define “small employers” as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

- (2) For purposes of this subsection:
- (a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;
 - (b) An employer and any predecessor employer shall be treated as a single employer;
 - (c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

Drafting Note: This issue is discussed in HHS Bulletin 99-03 (Group Size Issues Under Title XXVII of the Public Health Service Act). States with different legal standards for counting employer size should review their definitions for consistency with federal law and substitute their existing definitions when appropriate. States should also consider the adverse selection issues that arise if different definitions of “small employer” are used within the Exchange and outside the Exchange.

- (d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

- (e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

- A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be established as an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act relating to governance and operations, including sections that set out:

- The appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act;
- Authority and procedures for hiring staff and procurement resources; and
- Responsibilities of State agencies coordinating activities with the Exchange.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such a license.

- B. The Exchange shall:
- (1) Facilitate the purchase and sale of qualified health plans;
 - (2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and
 - (3) Meet the requirements of this Act and any regulations implemented under this Act.
- C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

Drafting Note: States should be aware that the Federal Act does not refer to “affiliate” as referenced in subsection C above. Section 1311(f)(3)(B) of the Federal Act, as related to a health insurance issuer, defines “eligible entity” as a person: 1) incorporated under, and subject to the laws of, one or more States; 2) has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and 3) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer.

- D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

- A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.
- B.
- (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.
 - (2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.
- C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual’s employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. The NAIC, through the Exchanges (B) Subgroup, intends to develop an issues paper on the topic to assist States in evaluating options in this area.

The Exchange shall:

- A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;
- B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;
- C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;
- D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;
- E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;
- F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;
- G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;
- H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;
- I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for individual coverage, but only if the Exchange has adequate resources to assist these individuals and employers. States that do so will need to reconcile the eligibility rules for participation, which are currently based on residence for individual coverage and based on employment for coverage through the SHOP Exchange.

- J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:
- (1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
 - (2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
- K. Transfer to the federal Secretary of the Treasury the following:
- (1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;
 - (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:
 - (a) The employer did not provide minimum essential coverage; or
 - (b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
 - (3) The name and taxpayer identification number of:
 - (a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
 - (b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;
- L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
- M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;
- N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:
- (1) Conduct public education activities to raise awareness of the availability of qualified health plans;

- (2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;
 - (3) Facilitate enrollment in qualified health plans;
 - (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and
 - (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;
- O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;
- P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;
- Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:
 - (1) Educated health care consumers who are enrollees in qualified health plans;
 - (2) Individuals and entities with experience in facilitating enrollment in qualified health plans;
 - (3) Representatives of small businesses and self-employed individuals;
 - (4) The [insert name of State Medicaid office]; and
 - (5) Advocates for enrolling hard to reach populations; and
- R. Meet the following financial integrity requirements:
 - (1) Keep an accurate accounting of all activities, receipts and expenditures and annually submits to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;
 - (2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:
 - (a) Investigate the affairs of the Exchange;
 - (b) Examine the properties and records of the Exchange; and

- (c) Require periodic reports in relation to the activities undertaken by the Exchange; and
- (3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.

Drafting Note: States should consider revising the language above to ensure that the commissioner, consistent with the provisions of the State insurance code and regulations, is given specific authority to investigate the affairs of the Exchange, examine the properties and records of the Exchange and require the Exchange to provide periodic reporting to the commissioner in relation to the activities undertaken by the Exchange under this Act, as may be appropriate given the structure and governance of the Exchange.

Section 7. Health Benefit Plan Certification

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

- (1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E, if:
 - (a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and
 - (b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;
- (2) The premium rates and contract language have been approved by the commissioner;

Drafting Note: States should modify the language in paragraph (2) above for consistency with their State law and regulations governing rate and form review and approval.

- (3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;
- (4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;
- (5) The health carrier offering the plan:
 - (a) Is licensed and in good standing to offer health insurance coverage in this state;

- (b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where “component” refers to the SHOP Exchange and the Exchange for individual coverage;
- (c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

Drafting Note: States whose licensing laws do not use the term “producer” should substitute the appropriate terminology.

- (d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and
 - (e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;
- (6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

Drafting Note: As states consider certification standards, they should consider factors such as consumer choice and additional costs, in light of the value to enrollees provided by the proposed standards, when evaluating whether or not to include requirements above the minimum standards under section 1311(c)(1).

- (7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this state.

Drafting Note: States should consider whether the Exchange should delegate all or part of plan certification function to the commissioner pursuant to the commissioner’s rate and form review responsibilities.

B. The Exchange shall not exclude a health benefit plan:

- (1) On the basis that the plan is a fee-for-service plan;
- (2) Through the imposition of premium price controls by the Exchange; or
- (3) On the basis that the health benefit plan provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

- (1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

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

- (2)
 - (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:
 - (i) Claims payment policies and practices;
 - (ii) Periodic financial disclosures;
 - (iii) Data on enrollment;
 - (iv) Data on disenrollment;
 - (v) Data on the number of claims that are denied;
 - (vi) Data on rating practices;
 - (vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
 - (viii) Information on enrollee and participant rights under title I of the Federal Act; and
 - (ix) Other information as determined appropriate by the Secretary; and
 - (b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and
 - (3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.
- D. The Exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.

- E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;
- (2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

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

- (3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation; and
- (4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Section 8. Funding; Publication of Costs

- A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

Drafting Note: As provided in section 1311(d)(5)(A) of the Federal Act, in establishing an Exchange under this Act, the State must ensure that the Exchange is self-sustaining by January 1, 2015.

- B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Relation to Other Laws

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

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

Section 11. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

2010 Proc. 3rd Quarter, Vol. I, 130-132, 605-606, 727-739 (adopted).