GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H **D**

HOUSE DRH80028-ME-17 (02/08)

Short Title:	North Carolina Health Benefit Exchange Act.	(Public)
Sponsors:	Representatives Dockham, Brubaker, Wray, and Murry (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 8. North Carolina Health Benefit Exchange Act.

"**§ 58-50-300. Definitions.**

The following definitions apply to this Part:

(1) Affordable Care Act. – The federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and as further amended, as well as any regulations or guidance issued under those acts.

(2) Board or Board of Directors. – The Board of Directors of the North Carolina Health Benefit Exchange.

(3) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.

(4) Educated health care consumer. – An individual who (i) is knowledgeable about the health care system and (ii) has background or experience in making informed decisions regarding health, medical, and scientific matters.

(5) Exchange. – The North Carolina Health Benefit Exchange established pursuant to G.S. 58-50-305.

(6) Health benefit plan. – 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. The term does not include any of the following:

a. Any of the following insurance products:

1. Coverage only for accident or disability income insurance, including any combination of the two.
2. Coverage issued as a supplement to liability insurance.
3. Liability insurance, including general liability insurance and automobile liability insurance.
4. Workers' compensation or similar insurance.
5. Automobile medical payment insurance.
6. Credit-only insurance.

7. Coverage for on-site medical clinics.
8. Other similar insurance coverage, specified in federal regulations issued pursuant to HIPAA, under which benefits for health care services are secondary or incidental to other insurance benefits.

b. Any of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:
1. Limited scope dental or vision benefits.
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits.
3. Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

c. Any of the following benefits, if (i) the benefits are provided under a separate policy, certificate, or contract of insurance, (ii) 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 (iii) 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:
1. Coverage only for a specified disease or illness.
2. Hospital indemnity or other fixed indemnity insurance.

d. Any of the following, if offered as a separate policy, certificate, or contract of insurance:
1. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act.
2. 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)).
3. Similar supplemental coverage provided to coverage under a group health plan.

(7) Health carrier or carrier. – 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, an 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.

(8) HIPAA. – The federal Health Insurance Portability and Accountability Act of 1996, P. L. 104-191, as amended.

(9) Reserved for future codification purposes.

(10) PHSA. – The federal Public Health Service Act, Title 42 of the United States Code.

(11) Qualified dental plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-340.

(12) Qualified employer. – A small employer that elects to make (i) its full-time employees eligible for one or more qualified health plans offered through the

SHOP Exchange and (ii) at the option of the employer, some or all of its part-time employees eligible.

(13) Qualified health plan. – 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 G.S. 58-50-340.

(14) Qualified individual. – An individual, including a minor, who meets all of the following requirements:

a. Is seeking to enroll in a qualified health plan offered to individuals through the Exchange.

b. Resides in this State.

c. Is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges.

d. 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.

(15) Secretary. – The Secretary of the federal Department of Health and Human Services.

(16) SHOP Exchange. – The Small Business Health Options Program established pursuant to G.S. 58-50-325(10).

(17) Small employer. – An employer that employed an average of no more than 50 employees during the preceding calendar year. For purposes of this definition, the following apply:

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 should be counted, including part-time employees and employees who are not eligible for coverage through the employer.

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.

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 Part as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

"**§ 58-50-305. North Carolina Health Benefit Exchange established.**

There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange. Notwithstanding that the Exchange may be supported in whole or in part from State funds, the Exchange is not an instrumentality of the State. The Exchange shall operate under the supervision and control of the Board of Directors.

"**§ 58-50-310. General requirements of the Exchange.**

(a) The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on January 1, 2014.

(b) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(c) 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, as long as the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Affordable Care Act.

(d) 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.

"**§ 58-50-315. Board of Directors; composition, terms, meetings, travel, liability, ethics.**

(a) The Board of the North Carolina Health Insurance Exchange shall consist of the Commissioner, who shall serve as an ex officio nonvoting member of the Board, and 11 members appointed as follows:

(1) One member who represents a health carrier, as appointed by the Governor.

(2) Two members of the general public who (i) are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider and (ii) can reasonably be expected to qualify for coverage in the Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member. The two members of the general public shall be appointed by the General Assembly in accordance with G.S. 120-121, as follows:

a. One member upon the recommendation of the President Pro Tempore of the Senate.

b. One member upon the recommendation of the Speaker of the House of Representatives.

(3) Eight members appointed by the Commissioner, as follows:

a. One health carrier who sells individual health insurance policies.

b. One who represents the insurance industry, as recommended by the health carrier who covers the largest number of persons in the State.

c. One who is licensed to sell health insurance in this State.

d. Two who represent the medical provider community, (i) one as recommended by the North Carolina Medical Society and (ii) one as recommended by the North Carolina Hospital Association.

e. One who represents business, as recommended by the North Carolina Chamber.

f. One who represents small business, as recommended by the National Federation of Independent Business.

g. One who is either a health policy researcher or a health economist with experience relating to the operation of health insurance.

(b) The initial appointments by the Governor and the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall serve a term of three years. The initial appointments by the Commissioner under sub-subdivisions a., b., and d. of subdivision (a)(3) of this section shall be for a term of two years. The initial appointments by the Commissioner under sub-subdivisions c., e., f., and g. of subdivision (a)(3) of this section shall be for a term of one year. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms.

(c) A Board member's term shall continue until the member's successor is appointed by the original appointing authority. Vacancies shall be filled by the appointing authority for the

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

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

(e) The Commissioner shall appoint a chair to serve for the initial two years of the Exchange's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms.

(f) Board members shall receive travel allowances under G.S. 138-6 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under G.S. 138-5.

(g) Neither the Board nor the employees of the Exchange are liable for any obligations of the Exchange. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange or its agents or employees, the Board, the Executive Director, the Commissioner, or the Commissioner's representatives for any action taken by them in good faith in the performance of their powers and duties under this Part.

(h) The members of the Board are public servants as defined in G.S. 138A-3 and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-320. Powers and authority of the Exchange.**

The Exchange shall have the general powers and authority to do all of the following:

(1) Enter into contracts as are necessary or proper to carry out the provisions of this Part, including, but not limited to, contracts with the following:
   a. The Division of Medical Assistance.
   b. 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.

   The Exchange does not have the power to enter into a contract with a health carrier or an affiliate of a health carrier.

(2) Sue or be sued.

(3) Take legal action as necessary.

(4) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Exchange, policy, and other contract design, and any other function within the Exchange's authority.

(5) Employ and fix the compensation of the Executive Director and employees.

(6) Adopt bylaws, policies, and procedures as may be necessary or convenient for the implementation of this Part and the operation of the Exchange.

(7) Enter into information-sharing agreements with federal and State agencies and other state exchanges to carry out its responsibilities under this Part, 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.

"**§ 58-50-325. Duties and operational requirements of the Exchange.**

The Exchange shall do all of the following:

(1) Facilitate the purchase and sale of qualified health plans.

(2) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Affordable Care Act and G.S. 58-50-340, of health benefit plans as qualified health plans.

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

(4) Provide for enrollment periods, as provided under section 1311(c)(6) of the Affordable Care Act.

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

(6) 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 Affordable Care 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 Affordable Care Act.

(7) 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.

(8) In accordance with section 1413 of the Affordable Care 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. If, through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, then the Exchange shall enroll that individual in that program.

(9) 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 Affordable Care Act.

(10) Establish a SHOP Exchange (i) through which qualified employers may access coverage for their employees and (ii) 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.

(11) Subject to section 1411 of the Affordable Care 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 of either of the following:

a. There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual.

b. The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

(12) Transfer to the federal Secretary of the Treasury all of the following:

a. A list of the individuals who are issued an exemption certification under subdivision (11) of this section, including the name and taxpayer identification number of each individual.

b. 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 of either of the following:

1. The employer did not provide minimum essential coverage.

2. The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code either to be unaffordable to the employee or not to provide the required minimum actuarial value.

c. The name and taxpayer identification number of both of the following:
1. Each individual who notifies the Exchange under section 1411(b)(4) of the Affordable Care Act that he or she has changed employers.
2. Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(13) Provide to each employer the name of each employee of the employer described in sub-subdivision (12)b. of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

(14) 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.

(15) Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Affordable Care Act and standards developed by the Secretary, and also award grants to enable Navigators to do the following:
a. Conduct public education activities to raise awareness of the availability of qualified health plans.
b. Distribute fair and impartial information concerning enrollment in qualified health plans, 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 Affordable Care Act.
c. Facilitate enrollment in qualified health plans.
d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the 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.
e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(16) 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.

(17) 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 Affordable Care Act, and collect the amount credited from the offering employer.

(18) Consult with stakeholders relevant to carrying out the activities required under this Part, including, but not limited to, the following stakeholders:
a. Educated health care consumers who are enrollees in qualified health plans.
b. Individuals and entities with experience in facilitating enrollment in qualified health plans.
c. Representatives of small businesses and self-employed individuals.
d. The Division of Medical Assistance.
e. Advocates for enrolling hard to reach populations.

(19) Meet the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commissioner, and the General Assembly a report on the past year's activities, receipts, and expenditures.

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Affordable Care Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to do all of the following:

1. Investigate the affairs of the Exchange.
2. Examine the properties and records of the Exchange.
3. Require periodic reports in relation to the activities undertaken by the Exchange.

c. In carrying out its activities under this Part, 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.

(20) Meet all of the requirements of this Part and any regulations implemented under this Part.

"**§ 58-50-330. Duties of the Executive Director.**

(a) The Executive Director, with the approval of the Board, shall operate the Exchange in a manner so that the estimated cost of operating the Exchange during any calendar year is not anticipated to exceed the total receipts of the Exchange.

(b) The Executive Director shall make an annual report to the Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner. The report shall summarize the activities of the Exchange in the preceding calendar year, including the net written and earned premiums, benefit plan enrollment, the expense of administration, and the paid and incurred losses. This report is in addition to the report required under G.S. 58-50-325(19)a.

"**§ 58-50-335. Plan of Operation required from Board of Directors.**

(a) The Board shall submit to the Commissioner a Plan of Operation for the Exchange and shall make any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Part must be made available. If the Board fails to submit a suitable Plan of Operation within 180 days after the appointment of the Board, or at any time thereafter fails to submit suitable amendments to the Plan of Operation, the Commissioner shall adopt temporary rules necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the Commissioner or superseded by a Plan of Operation submitted by the Board and approved by the Commissioner.

(b) The Plan of Operation shall do all of the following:

(1) Establish procedures for the operation of the Exchange.

(2) Develop a program to (i) publicize the existence of the Exchange, the eligibility requirements, the procedures for enrollment, and the availability of premium subsidies and (ii) maintain public awareness of the Exchange.

(3) Establish procedures under which applicants and participants may appeal decisions by the Exchange.

(4) Provide for other matters as may be necessary and proper for the execution of the Exchange's powers, duties, and obligations under this Part.

"**§ 58-50-340. Health benefit plan certification.**

(a) The Exchange shall certify a health benefit plan as a qualified health plan if the plan meets all of the following conditions:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Affordable Care Act. The plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, however, as provided in subsection (e) of this section, if both of the following are true:

a. The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage.

b. The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that (i) the plan does not provide the full range of essential pediatric benefits and (ii) 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.

(3) The plan provides at least a bronze level of coverage, as determined pursuant to G.S. 58-50-325(6), unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Affordable Care 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 Affordable Care 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 Affordable Care Act.

(5) The health carrier offering the plan meets all of the following:

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 either the SHOP Exchange or 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.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-310.

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Affordable Care Act and other requirements established by the Exchange.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to Section 58-50-340 of this Part and by the Secretary under section 1311(c) of the Affordable Care 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.

(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.

(b) The Exchange shall not exclude a health benefit plan through the imposition of premium price controls by the Exchange. Additionally, the Exchange shall not exclude a health benefit plan solely for any of the following reasons:

(1) The plan is a fee-for-service plan.

(2) 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 do all of the following:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet Web site. 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.

(2) Make available to the public and submit to the Exchange, the Secretary, and the Commissioner, accurate and timely disclosure of all of the following:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

g. Information on cost-sharing and payments with respect to any out-of-network coverage.

h. Information on enrollee and participant rights under Title I of the Affordable Care Act.

i. Other information as determined appropriate by the Secretary.

The information required in this subdivision shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Affordable Care Act.

(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 Web site 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) The provisions of this Part that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans, subject to regulations adopted by the Exchange and are subject to all of the following:

(1) The carrier shall be licensed to offer dental coverage but need not be licensed to offer other health benefits.

(2) 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 Affordable Care Act and such other dental benefits as the Exchange or the Secretary may specify by regulation.

(3) 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.

"**§§ 58-50-341 through 58-50-349: Reserved for future codification purposes.**"

SECTION 2. Funding. – Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange. 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 Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

SECTION 3. No Conflict Intended. – Nothing in this act, and no action taken by the Exchange pursuant to this act, shall be construed to conflict with, 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.

SECTION 4. Severability. – If any provision of this act or its application is held invalid, the invalidity does not affect other provisions or applications of this act that can be given effect without the invalid provisions or application, and to this end the provisions of this act are severable. If the federal Patient Protection and Affordable Care Act, P.L. 111-148, is repealed in whole or in part as it relates to exchanges or is not fully funded as to exchanges pursuant to the Federal Act, then this Part shall be invalid and have no effect.

SECTION 5. This act is effective when it becomes law.