HOUSE BILL 115
Committee Substitute Favorable 3/30/11

Short Title: North Carolina Health Benefit Exchange. (Public)

Sponsors:

Referred to:

February 17, 2011

A BILL TO BE ENTITLED

AN ACT TO PRESERVE STATE-BASED AUTHORITY TO REGULATE THE NORTH CAROLINA HEALTH INSURANCE MARKET AND TO PREVENT FEDERAL ENCROACHMENT ON STATE AUTHORITY BY ESTABLISHING THE NORTH CAROLINA BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. The purpose of this act is to provide for the establishment of the North Carolina Health Benefits Exchange Authority (Exchange Authority). The purpose of the Exchange Authority is to facilitate the purchase and role of qualified health plans in the individual and small employer market by providing education, outreach, and technical assistance. The General Assembly believes it is in the best interest of the State, and thus the purpose of the Exchange Authority, to promote competition and choice in the health care marketplace and to facilitate innovation by offering products with variation in price and design. The Exchange Authority shall accomplish its purpose through a robust portal that provides meaningful guidance to health benefit plans that meet the needs of the health care marketplace of this State and not through the limitations of health benefit plan options to qualified individuals or qualified employers or by excluding health benefit plans who meet the premium and solvency requirements approved by the North Carolina Department of Insurance. In establishing the Exchange Authority, it is the intent of the General Assembly to reduce the number of uninsured individuals in this State, promote improved competition in the health care marketplace, reduce health care costs by, among other things, improving reimbursements to health care providers for uncompensated care, increasing consumer education, increasing transparency, and assisting individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions.

SECTION 2. 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) Agent. – Defined in G.S. 58-33-10(1).

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

(3) Broker. – Defined in G.S. 58-33-10(3).

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

(5) Educated Health Care Consumer. – 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.

(6) Essential Health Benefits. – Defined under section 1302(b) of the Federal Act.

(7) Exchange Authority. – The North Carolina Health Benefit Exchange Authority established pursuant to G.S. 58-50-310 and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

(8) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange Authority.

(9) Federal Act. – 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 as further amended, as well as any regulations or guidance issued under those acts.

(10) Grandfathered Health Plan Coverage or Grandfathered Health Plan. – Defined in 45 C.F.R. Part 147.140(a).

(11) Health Benefit Plan. – Defined in G.S. 58-3-167(a)(1).

(12) Health Care Provider. – Defined in G.S. 58-50-270(3a).

(13) Health Insurer or Insurer. – Defined in G.S. 58-68-25(a)(6) and, for the purposes of this act, the terms also include qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Federal Act, and multistate Qualified Health Plans as provided in section 1334 of the Federal Act.

(14) Individual Exchange. – The Exchange through which Qualified Individuals may purchase coverage established pursuant to this Part.

(15) Plan of Operation. – The articles, bylaws, and operating rules and procedures adopted by the Board in accordance with this Part.

(16) Qualified Dental Plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-350.

(17) Qualified Employer. – 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.

(18) 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. 58-50-350.

(19) 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 Individual Exchange.

b. Resides in this State pursuant to G.S. 58-50-175(18).

c. At the time of enrollment, is not incarcerated, 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.

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

(21) SHOP Exchange. – The Small Business Health Options Program established in G.S. 58-50-340(a)(13) that is designed to assist Qualified Employers in

the State who are Small Employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the small group market in the State.

(22) Small Employer. – An employer as such term is defined in G.S. 58-50-110(22), subject to the requirements of the Federal Act and the Public Health Service Act (PHSA).

"**§ 58-50-310. Exchange established; Board of Directors; Plan of Operation.**

(a) There is hereby created a nonprofit entity to be known as the North Carolina Health Benefit Exchange Authority, which is subject to the supervision of the Commissioner. Notwithstanding that the Exchange Authority may be supported in whole or in part from State or federal funds, the Exchange Authority is not an instrumentality of the State or federal government and shall be operated by the Board. The purpose of the Exchange Authority is to do the following:

(1) Create and administer an Individual Exchange and a SHOP Exchange which shall be operated as two separate health benefit exchanges and shall not be operated as one health benefit exchange.

(2) Facilitate the purchase and sale of Qualified Health Plans to Qualified Individuals and Qualified Employers.

(3) Assist Qualified Individuals in enrollment in Qualified Health Plans and assist Qualified Employers in facilitating the enrollment of their employees in Qualified Health Plans.

(b) There is established the North Carolina Health Benefit Exchange Authority Board. The Board shall have the duties and powers as established by this section.

(1) The North Carolina Health Benefit Exchange Authority Board shall consist of the Commissioner of Insurance, the Director of the Division of Medical Assistance, who shall both serve as ex officio nonvoting members of the Board, and 11 additional members appointed as follows:

a. Four members appointed by the President Pro Tempore of the Senate as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Medical Society.

2. One member who represents an insurer, as recommended by the North Carolina Association of Health Plans.

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

4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

b. Four members appointed by the Speaker of the House of Representatives as follows:

1. One member who represents the medical provider community, as recommended by the North Carolina Hospital Association.

2. One member who represents the insurance industry.

3. One member who represents small business, as recommended by the National Federation of Independent Business.
4. One member who represents the general public who is not employed by or affiliated with an insurance company or plan, group hospital, or other Health Care Provider and shall reasonably be expected to qualify for coverage in the Individual Exchange or SHOP Exchange. Members of the general public include individuals whose only affiliation with health insurance or health care coverage is as a covered member.

c. Three members appointed by the Governor who do not represent the categories listed in sub-subdivision a. and sub-subdivision b. of this subdivision and have expertise and experience in one or more of the subject area groupings: development and operation of State-scale information technology systems capable of conducting electronic funds transfers, secure data transfers, and other electronic functions relating to the creation and ongoing operations of the Exchange Authority; health economics or health care finance; actuarial science or risk management; health policy analysis or health law; or as a health insurance agent.

(2) The initial appointments by the General Assembly upon the recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate shall be made no later than 30 days after enactment of this Part and shall serve a term of three years. The initial appointments by the Governor shall be made no later than 30 days after enactment of this Part and shall be for a term of two years. All succeeding appointments shall be for terms of three years. Members shall not serve for more than two successive terms. 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 or by the Commissioner for cause. 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. The Commissioner shall appoint a chair to serve for the initial two years of the Exchange Authority's operation. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms. Board members shall receive travel allowances under G.S. 138-5 when traveling to and from meetings of the Board but shall not receive any subsistence allowance or per diem under subdivision (a)(1) of that section.

(3) The Board shall employ or fix compensation of the Executive Director.

(4) The Board shall appoint appropriate legal, actuarial, and other persons, entities, or committees as necessary to provide technical assistance in the operation, policy, contractual design, and other functions of the Exchange Authority.

(5) The Board shall adopt bylaws, policies, and procedures as may be necessary or convenient.

(6) Each member of the Board shall comply with the conflict of interest rules and recusal procedures set forth in the Plan of Operation.

(7) No member of the Board or staff shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any

decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or which will have reasonable foreseeable material effect on any business entity in which the member or his or her immediate family is director, officer, partner, trustee, employee, or holds any position of management.

(8) Each member of the Board shall have the responsibility and duty to meet the requirements of this Part, the Federal Act, and all applicable State and federal laws, rules, and regulations to serve the public interest of the individuals and employers seeking health care coverage through the Exchange Authority, and to ensure the operational well-being and fiscal solvency of the Exchange Authority.

(c) The Board shall submit to the Commissioner a Plan of Operation for the Exchange Authority and any amendments.

(1) The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. If the Commissioner fails to act within 90 days of submission, the Plan of Operation shall be deemed approved. If the Commissioner disapproves any part of the Plan of Operation, the Commissioner shall provide specific reasons for the disapproval and provide the Board an opportunity to revise and resubmit the Plan of Operation. The Plan of Operation shall become effective upon approval in writing by the Commissioner. If the Board fails to submit a Plan of Operation within 180 days after the appointment of the Board that is approved by the Commissioner, or at any time thereafter fails to submit amendments as required by statute or federal law to the Plan of Operation, the Commissioner shall adopt temporary rules necessary 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.

(2) The Plan of Operation shall establish policies and procedures for operation of the Exchange Authority, including, but not limited to, the following:

a. Process by which the Board sets policies and conducts business, including bylaws.

b. Process for certifying Qualified Health Plans.

c. Plans for determining the need for and selection of eligible entities with whom to contract for performance of Exchange Authority functions or operations.

d. Fiscal operations of the Exchange Authority, addressing the collection, handling, disbursing, accounting, and auditing of assets and monies of the Exchange Authority and any eligible entity with whom the Exchange Authority contracts.

e. Statement acknowledging the fiduciary duty owed by the Exchange Authority to persons receiving Qualified Health Plan coverage through the Exchange Authority.

f. Process for evaluating the effectiveness of the Executive Director and the overall operations of the Exchange Authority.

g. Provide for conflict of interest rules and recusal procedures that require a Board member to recuse himself or herself from an official matter, whenever the Board member or his or her immediate family has any financial involvement or interest in that matter.

h. Identify an approach for coordinating efforts with the Department of Health and Human Services to fairly allocate administrative costs for eligibility determinations in the Exchange Authority and Medicaid.

i. Provide for other matters as may be necessary or proper for the execution of the Executive Director's powers, duties, and obligations under this act.

j. Appeals processes authorized by this Part, including appeals of tax credit eligibility, cost-sharing subsidy, mandate waiver determination, affordability determinations pursuant to G.S. 58-50-340 and appeals of Insurer noncertification or decertification pursuant to G.S. 58-50-350.

"**§ 58-50-320. Exchange Authority general powers.**

(a) The Exchange Authority shall have the general powers and authority granted under the laws of this State and the specific authority to do all of the following:

(1) Contract with an eligible entity for any of its functions described in this act. For the purposes of this act, an eligible entity has the same meaning as section 1311(f)(3)(B) of the Federal Act.

(2) Take legal action as necessary.

(3) 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.

"**§ 58-50-330. General requirements.**

(a) The Exchange Authority shall make Qualified Health Plans available to Qualified Individuals and Qualified Employers beginning with effective dates on or after January 1, 2014.

(b) The Exchange Authority shall not make available any Health Benefit Plan that is not a Qualified Health Plan. The Exchange Authority shall allow a Health Insurer 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 Authority, 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 Authority nor an Insurer offering Qualified Health Plans through the Exchange Authority 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.

(d) The Exchange Authority may make a Qualified Health Plan available notwithstanding any provision of law that may require benefits other than the Essential Health Benefits specified under section 1302(b) of the Federal Act.

(1) Nothing in this section shall preclude a Qualified Health Plan from including benefits in addition to Essential Health Benefits, including wellness programs.

(2) To the extent that State law or regulation requires that a Qualified Health Plan include benefits in addition to the Essential Health Benefits, the State shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a Qualified Health Plan or on behalf of an individual directly to the Health Insurer in whose Qualified Health Plan such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, notwithstanding any requirements in Chapter 58 of the General Statutes, a Health Insurer is not required to include such additional benefits in a Qualified Health Plan, may discontinue such benefits at the time such funding is no longer available, and shall provide written or electronic notice of discontinuation of such benefits to insureds and contracted Health Care Providers as soon as is reasonably practicable. The Exchange Authority shall not require that a Qualified Health Plan provide such additional benefits when funding to defray the cost for such additional benefits is not provided.

(e) Nothing in this Part, and no action taken by the Exchange Authority pursuant to the Part, shall be construed to conflict with, preempt, limit, or supersede any applicable health insurance laws of this State or regulations adopted and orders issued by the Commissioner. Nothing in this Part shall be construed to conflict with, limit, or supersede the statutory or regulatory authority vested with the North Carolina Department of Insurance. Except as expressly provided to the contrary by federal law, Insurers and any other entities or persons participating in the Exchange Authority in this State shall comply fully with all applicable provisions of Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner. Participation in the Exchange Authority in any way, including payment or receipt of payment in relation to a Qualified Health Benefits Plan, does not exempt any Insurer, entity, or person from complying fully with Chapter 58 of the General Statutes and all related regulations adopted and orders issued by the Commissioner.

(f) The Executive Director shall make an annual report to the Governor, Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Commissioner by March 1 of each year. The report shall summarize the activities of the Exchange Authority in the preceding calendar year, including information about the number and types of plans offered; number of Insurers; summary information about premiums, enrollment levels and enrollment/disenrollment activity, duration of coverage; and cost of operating the Exchange Authority.

(g) Neither the Board nor the employees of the Exchange Authority are liable for any obligations of the Exchange Authority. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Exchange Authority or its agents or employees, the Board, the Executive Director, or 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 Exchange Authority, including the Board and its employees, is subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

(i) The Executive Director, with the approval of the Board, shall operate the Exchange Authority in a manner so that the estimated cost of operating the Exchange Authority during any calendar year is not anticipated to exceed the total income the Exchange Authority expects to receive from any revenue available to the Exchange Authority.

(j) The Board shall provide for other matters as may be necessary and proper for the execution of the Executive Director's powers, duties, and obligations under this Part.

(k) All documents, papers, letters, maps, books, photographs, films, sound recordings, magnetic or other tapes, electronic data-processing records, artifacts, or other documentary material, regardless of physical form or characteristics within the possession of the Exchange Authority, including its employees and the Board, are subject to the provisions of Chapter 132 of the General Statutes except to the extent that these public records are protected under State or federal law, or are confidential or proprietary property of a person as defined in G.S. 66-152.

(l) The members of the Board and the Executive Director are public servants under G.S. 138A-3(30) and are subject to the provisions of Chapter 138A of the General Statutes.

"**§ 58-50-340. General duties.**

(a) The Exchange Authority shall do the following:

(1) Facilitate the purchase and sale of Qualified Health Plans.

(2) Assist qualified individuals in this State with enrollment in Qualified Health Plans.

(3) Assist qualified employers in this State with enrollment of their employees in Qualified Health Plans.

(4) Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and this Part, of health benefit plans as Qualified Health Plans.

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance in a manner that is accessible to individuals with different communication needs and that effectively communicates information in a manner that is appropriate to the needs of the population being served by the Exchange Authority.

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

(7) Maintain an Internet Web site through which enrollees and prospective enrollees of Qualified Health Plans and individuals eligible for Medicaid or North Carolina Health Choice may obtain standardized comparative information on such plans.

(8) Assign a rating to each Qualified Health Plan offered through the Exchange Authority 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.

(9) Use a standardized format for presenting health benefit options in the Exchange Authority, including the use of the uniform outline of coverage established under section 2715 of the PHSA that supports consumer choice by making comprehensive information about health plans available in an objective, easy-to-understand format.

(10) 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 Authority, the Exchange Authority determines that any individual is eligible for any such program, enroll that individual in that program.

(11) 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.

(12) Establish an Individual Exchange, through which Qualified Individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

(13) Establish a SHOP Exchange through which Qualified Employers may make its employees eligible for one or more Qualified Health Plans offered through the SHOP Exchange or through which Qualified Employers may 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.

(14) 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 of either of the following:
  a. There is no affordable Qualified Health Plan available through the Exchange Authority, 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.

(15) Transfer to the federal Secretary of the Treasury the following:
  a. A list of the individuals who are issued a certification under subdivision (14) of this subsection, 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 of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.
  c. The name and taxpayer identification number of the following:
    1. Each individual who notifies the Exchange Authority under section 1411(b)(4) of the Federal 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.

(16) Provide to each employer the name of each employee of the employer described in sub-sub-subdivision b.2. of subdivision (15) of this subsection who ceases coverage under a Qualified Health Plan during a plan year and the effective date of the cessation.

(17) Perform duties required of the Exchange Authority 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.

(18) 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 who are certified and trained by the North Carolina Department of Insurance 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, 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.
  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 Authority.

(19) Take into account any excess of premium growth outside of the Exchange Authority as compared to the rate of such growth inside the Exchange Authority when determining under section 1302(f)(2)(B) of the Federal Act whether to recommend to the General Assembly that Qualified Health Plans be offered in the large group market through the SHOP Exchange.

(20) 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 and remit the amount of the free choice voucher to the appropriate health carrier.

(21) Consult with stakeholders relevant to carrying out the activities required under this act, including, but not limited to, the following:

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. Representatives of Health Insurers that offer Qualified Health Plans through the Exchange Authority.

e. Representatives of Health Insurers that are not offering qualified plans through the Exchange Authority.

f. Representatives of Health Care Providers.

g. The Division of Medical Assistance.

h. The North Carolina Department of Insurance.

i. Advocates for enrolling hard to reach populations.

(22) Meet all of 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 concerning such accountings.

b. 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 do all of the following:

1. Investigate the affairs of the Exchange Authority.

2. Examine the properties and records of the Exchange Authority.

3. Require periodic reports in relation to the activities undertaken by the Exchange Authority.

c. In carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the Exchange

Authority for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or State legislative and regulatory modifications.

(23) Meet the following fiduciary duties and liability:

a. Any person who acts on behalf of an Exchange Authority shall act as a fiduciary. Such person shall ensure that the Exchange Authority is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange Authority and (ii) for the exclusive purpose of facilitating the purchase of Qualified Health Plans.

b. Any person who acts as a fiduciary on behalf of the Exchange Authority who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange Authority, the Qualified Health Plans offered through the Exchange Authority, or participants of Qualified Health Plans offered through the Exchange Authority any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

(24) With respect to eligibility determinations, provide for (i) review of enrollee appeals of Exchange Authority premium tax credit and cost-sharing reductions and mandate exemption determinations and establish procedures for identifying and confirming income levels of applicants for Exchange Authority coverage and eligibility for receipt of premiums and tax credits and (ii) employer appeals of employer-sponsored plan availability or affordability determinations.

(25) Conduct a review of the costs and benefits of collecting and distributing premiums for small businesses. No later than January 1, 2015, the Exchange Authority shall report the results of the review, including analysis of the financial impact of such collection and distribution, and its recommendations to the North Carolina General Assembly. The Exchange Authority may implement and carry out a process for collecting and distributing premiums if it has sufficient funding to implement the initiative and upon approval by vote by both chambers of the North Carolina General Assembly.

(26) Study the feasibility of offering a Basic Health Plan pursuant to section 1331 of the Federal Act and make a recommendation to the 2013 Regular Session of the 2013 General Assembly.

(27) Provide for publicity and outreach campaigns to raise awareness of the existence of the Exchange Authority and disseminate information regarding eligibility criteria, enrollment procedures, availability of premium tax credits and cost-sharing reductions, small employer tax credits, and other relevant information.

"**§ 58-50-350. Health Benefit Plan certification.**

(a) The Exchange Authority shall certify a Health Benefit Plan as a Qualified Health Plan if the Department of Insurance determines that it satisfies the requirements set forth in subdivisions (1) through (6) of this subsection unless the Exchange Authority determines that making the plan available through the Exchange Authority is not in the interest of Qualified Individuals and Qualified Employers in this State.

(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) of this section, if both of the following occur:

a. The Exchange Authority has determined that at least one Qualified Dental Plan is available to supplement the plan's coverage.

b. The Insurer makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange Authority, 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 Authority.

(2) The premium rates and contract language have been approved by the Commissioner.

(3) The plan provides at least a bronze level of coverage, 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 Insurer offering the plan meets the following requirements:

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 Authority in which the Insurer participates, where "component" refers to the SHOP Exchange and the Individual Exchange.

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange Authority and without regard to whether the plan is offered directly from the Insurer or through an insurance producer.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-330(c).

e. Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange Authority may establish.

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to this section and by the Secretary under section 1311(c) of the Federal Act.

(b) The Exchange Authority shall not exclude a health plan through the imposition of premium price controls nor shall it exclude a health plan based on the following:

(1) That the plan is a fee-for-service plan.

(2) That the Health Benefit Plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange Authority determines are inappropriate or too costly.

(c) The Exchange Authority shall require each Health Insurer seeking certification of a plan as a Qualified Health Plan to do the following:

(1) Submit a justification for any premium increase before implementation of that increase. The Insurer shall prominently post such information on its Internet Web site. The Exchange Authority shall take this information, along

with the information and the recommendations provided to the Exchange Authority by the Commissioner under section 2794(b) of the PHSA, relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to continue to allow the Insurer to make plans available through the Exchange Authority. In no case shall an Exchange Authority impose any premium price controls or restrict premiums that otherwise meet the requirements of State law.

(2) Make available to the public and submit to the Exchange Authority, the Secretary, and the Commissioner, accurate and timely disclosure 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 Federal Act.
i. Other information as determined appropriate by the Secretary.

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

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, 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 Authority shall establish and publish a transparent, objective process for denying certification or decertifying Qualified Health Plans.

(1) The Exchange Authority shall give each Health Insurer the opportunity to appeal a decertification decision or the denial of certification as a Qualified Health Plan.

(2) The Exchange Authority shall give each Health Insurer that appeals a decertification decision or the denial of certification the opportunity for the following:

a. The submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue.
b. A hearing and a decision on the record, to the extent that the Exchange Authority and the Health Insurer are unable to reach agreement following the submission of the information in sub-subdivision a. of this subdivision.

(3) Any hearing held pursuant to subdivision (2) of this subsection shall be conducted by an impartial party agreed to by the Exchange Authority and the Health Insurer. If the Exchange Authority and the Health Insurer cannot agree on an impartial party, then the hearing must be held by an administrative law judge.

(4) The hearing decision may be appealed to the North Carolina Court of Appeals by the aggrieved party.

(e) The Exchange Authority shall not exempt any Health Insurer seeking certification of a Qualified Health Plan, regardless of the type or size of the Insurer, 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 Insurers participating in the Exchange Authority.

(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 subdivisions (2), (3), and (4) of this subsection or by regulations adopted by the Commissioner.

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

(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 Authority or the Secretary may specify by regulation.

(4) Insurers may jointly offer a comprehensive plan through the Exchange Authority in which the dental benefits are provided by an Insurer through a Qualified Dental Plan and the other benefits are provided by an Insurer through a Qualified Health Plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

"**§ 58-50-360. Choice.**

(a) In accordance with section 1312(f)(2)(A) of the Federal Act, a Qualified Employer may either designate one or more Qualified Health Plans from which its employees may choose or designate any level of coverage to be made available to employees through the SHOP Exchange.

(b) In accordance with section 1312(b) of the Federal Act, a Qualified Individual enrolled in any Qualified Health Plan may pay any applicable premium owed by such individual to the Health Insurer issuing such Qualified Health Plan.

(c) In accordance with section 1312(c) of the Federal Act, the following risk pools are established:

(1) Individual Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, to be members of a single risk pool.

(2) SHOP Exchange. – A Health Insurer shall consider all enrollees in all health plans other than Grandfathered Health Plans offered by such Insurer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

(d) In accordance with section 1312(d) of the Federal Act, this section shall not prohibit either of the following:

(1) A Health Insurer from offering outside of the Individual Exchange or the SHOP Exchange a health plan to a Qualified Individual or a Qualified Employer.

(2) A Qualified Individual from enrolling in, or a Qualified Employer from selecting for its employees, a health plan offered outside of the Exchange Authority.

(e) This section shall not limit the operation of any requirement under State law or regulation with respect to any policy or plan that is offered outside of the Exchange Authority with respect to any requirement to offer benefits.

(f) Nothing in this section shall restrict the choice of a Qualified Individual to enroll or not to enroll in a Qualified Health Plan or to participate in the Individual Exchange.

(g) Nothing in this section shall compel an individual to enroll in a Qualified Health Plan or to participate in the Exchange Authority.

(h) A Qualified Individual may enroll in any Qualified Health Plan, except that in the case of a catastrophic plan described in section 1302(e) of the Federal Act, a Qualified Individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1312(e)(2) of the Federal Act.

(i) Nothing in this act or the Federal Act shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any Health Benefit Plan that is offered outside of the Exchange Authority.

(j) In accordance with section 1312(e) of the Federal Act, the Exchange Authority shall allow Agents or Brokers to do the following:

(1) To enroll Qualified Individuals and Qualified Employers in any Qualified Health Plan offered through the Exchange Authority for which the individual or employer is eligible.

(2) To assist Qualified Individuals in applying for premium tax credits and cost-sharing reductions for any Qualified Health Plan purchased through the Individual Exchange.

(k) Any compensation to Agents and Brokers paid under this Part shall be determined by the insurer.

"**§ 58-50-370. Funding; publication of costs.**

(a) 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 Authority. Beginning in 2015, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be utilized to support the operations of the Exchange Authority that serve those individuals with incomes less than or equal to four hundred percent (400%) of the federal poverty level and Qualified Employers receiving a tax credit for the purchase of insurance pursuant to the Federal Act. The proportional cost associated with serving individuals with incomes over four hundred percent (400%) of the federal poverty level and the Qualified Employers not receiving a tax credit pursuant to the Federal Act shall be funded by an annual user fee paid by the individual or the employer to the Exchange Authority. The user fee assessed by the Exchange Authority shall be no greater than the anticipated expenses for serving this market for the applicable fiscal year and must be approved by the Commissioner. Additionally, the Exchange Authority is authorized to utilize grant funding for operations, including, but not limited to, grant funding from the Department of Health and Human Services. The Exchange Authority is also authorized to collect and use advertising fees to help support operations of the Exchange Authority.

(b) Prior to the commencement of the 2013 Regular Session of the 2013 General Assembly, the Exchange Authority shall examine its potential operational costs and propose to the General Assembly any additional changes to the funding stream necessary to ensure its solvency.

(c) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange Authority shall be self-sustaining by January 1, 2015. A budget for the Exchange Authority shall be prepared by the Exchange Authority and submitted to the Commissioner annually for approval.

(d) Services performed by the Exchange Authority on behalf of other State or federal programs shall be paid for by those State or federal programs.

(e) Any unspent funding by the Exchange Authority shall be used for future operation of the Exchange Authority or reducing future user fees.

(f) The Exchange Authority shall publish the average costs of licensing, regulatory fees, and any other payments required by the Exchange Authority, and the administrative costs

of the Exchange Authority, on an Internet Web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(g) The Exchange Authority is exempt from any and all State taxes.

"**§ 58-50-380. Regulations.**

The Commissioner shall promulgate regulations pursuant to Chapter 150B of the General Statutes, including temporary rules, to implement the provisions of this Part.

"**§ 58-50-390. Audit.**

An audit of the Exchange Authority shall be conducted annually under the oversight of the State Auditor. The cost of the audit shall be reimbursed to the State Auditor from Exchange Authority funds.

SECTION 3. Nothing in this Act shall be construed to interfere with payments to federally qualified health centers. If any item or service covered by a qualified health plan is provided by a federally qualified health center, as defined in section 1905(1)(2)(B) under the Social Security Act 42 U.S.C. 1396d(1)(2)(B), to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or services an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service.

SECTION 4. Severability. – If any provision of this act is held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If section 1311 of the federal Patient Protection and Affordable Care Act or the federal Patient Protection and Affordable Care Act in its entirety is repealed or held invalid by a court of competent jurisdiction, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, is repealed. If funding is not provided as set forth in the federal Patient Protection and Affordable Care Act, then Part 8 of Article 50 of Chapter 58 of the General Statutes, as established by this act, shall not be enforceable.

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