~~AMERICAN~~ HEALTH BENEFIT EXCHANGE ~~MODEL~~ ACT OF NORTH DAKOTA

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Section 1. Title

This Act shall be known and may be cited as the ~~American~~ Health Benefit Exchange Act of North Dakota.

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.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

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. "Essential health benefits" has the meaning provided under section 1302(b) of the Federal Act.

D~~C~~. "Exchange" means the ~~[insert name of~~North Dakota State Exchange~~]~~ established pursuant to section 4 of this Act and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

E~~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.

F. "Individual Exchange" means the Exchange through which qualified individuals may purchase coverage established under Section 6 of this Act.

G~~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.

(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.

H~~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.

I~~G~~. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7G~~E~~ of this Act.

JH. "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~~ 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.

K. "Principal place of business" is defined as the location in a state where an employer has its headquarters or significant place of business and where the person with direction and control authority over the business are employed.

LI. "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.

MJ. "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.

NK. "Secretary" means the Secretary of the federal Department of Health and Human Services.

OL. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

PM.

(1) "Small employer" means an employer that employed an average of 2 to not more than 50~~100~~ employees during the preceding calendar year unless and until such time as Federal law or regulations may require.

(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 e~~Employees shall be counted in accordance with state law~~, 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; 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]~~Health Benefit Exchange of North Dakota is hereby established by the State as a ~~[insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity]~~nonprofit entity.

A. -Board of Directors: The nonprofit entity shall be governed by a board, with duties and powers as established by this section. The Board shall consist of 8 members; 5 voting members appointed by the Governor who are not public employees and 3 non-voting, ex officio members.

(1) The term for the voting members of the Board shall be a three year term, except that a person appointed to fill a vacancy shall serve only for the unexpired term.

(2) Of the voting members first appointed, in order to ensure staggered terms, two of the Governor's appointees shall serve for a term of two years and the remaining Governor's appointees shall serve for a term of three years.

(3) The Board's ex officio members shall include the Lieutenant Governor, the State director of Medicaid and the Commissioner of the Department of Insurance or their respective designees.

(4) The Governor shall appoint one voting member in good standing of the American Academy of Actuaries, two voting members from the consumer community who are familiar with the purchase of individual or group insurance, and two voting members from leading North Dakota health insurance carriers.

(5) The Governor shall designate one voting member of the Board to serve as chairperson.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans to qualified individuals and qualified employers;

(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 a qualified health plan or qualified health plans; and

(3) Meet the requirements of the Federal Act, this Act and any regulations implemented under this Act~~.~~; and

(4) Select an Executive Director to lead operations and hire necessary staff; and

(5) Consult with an appointed member of the Attorney General's office regarding legal interpretation and advice.

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.~~

(1) An eligible entity is not a health carrier and is defined as:

a. A person –

i. Incorporated under, and subject to the laws, of 1 or more states;

ii. That has demonstrated experience on a state or regional basis in the individual or small group health insurance markets, or in benefits coverage.

(2) Any eligible entity that enters into an agreement to carry out 1 or more responsibilities of the Exchange shall have the same fiduciary duties and liability as provided for in Section 6.R. of this Act.

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~~as established by Federal law or regulation.

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.

D. The Exchange may make a qualified health plan available notwithstanding any provision of state law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act.

(1) Additional Benefits-

(a) Nothing in this section shall preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits, including wellness programs.

(b) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that state law or regulation requires that a qualified health plan offer 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 qualified health plan in which such individual is enrolled.

(c) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that funding to defray the cost for such additional benefits is not provided, the qualified health plan shall not be required to provide such additional benefits.

Section 6. Duties of Exchange

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 an Individual Exchange, through which qualified individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

J~~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;

K~~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;

L~~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;

ML. 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;

NM. 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;

ON. 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;

PO. Review Consider 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;

QP. 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;

RQ. ~~Consult with~~Establish an advisory panel of 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) Representatives of health carriers that offer qualified health plans through the Exchange;

(5) Representatives of health carriers that are not offering qualified plans through the Exchange;

(6) The Department of Insurance;

(47) The ~~[insert name of State Medicaid office]~~Department of Human Services;

(8) The Information Technology Department

(9) Representatives of health care providers; and

(~~5~~10) Advocates for enrolling hard to reach populations~~; and~~.

SR. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit, 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.

(4) Fiduciary Duties and Liability -

(a) Any person who acts on behalf of an Exchange shall act as a fiduciary. Such person shall ensure that the Exchange is operated (i) solely in the interests of qualified individuals and qualified employers participating in qualified health plans offered through the Exchange, 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 who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange, the qualified health plans offered through the Exchange, or participants of qualified health plans offered through the Exchange, 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

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~~G, 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 ~~c~~Commissioner;

(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;

(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~~ unless

(7) The Exchange determines that making the plan available through the Exchange is not in the interest of qualified individuals and qualified employers in this State, in accordance with section 7.C of this Act.

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. Presumption of Best Interest:

(1) In order to foster a competitive Exchange marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the Exchange to certify all health plans meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange.

(2) The Exchange shall certify all health plans meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange. The Exchange shall establish and publish a transparent, objective process for decertifying qualified health plans that are determined to be not in the public interest to be offered through the Exchange.

D~~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 continue to allow the carrier to make plans available through the Exchange~~;~~. In no case shall an Exchange impose any premium price controls or restrict premium that otherwise meets the requirements of 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.

E. Appeal of Decertification or Denial of Certification:

(1) The Exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan.

(2) The Exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

(a) the submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue; and

(b) a hearing and a decision on the record, to the extent that the Exchange and the health carrier are unable to reach agreement following the submission of the information in subparagraph (a).

(3) Any hearing held pursuant to paragraph (2) of this subsection shall be conducted by an [impartial party or an administrative law judge with appropriate legal training] and in accordance with [state administrative hearing requirements or APA hearing requirements (5 U.S.C. § 556)].

F~~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.

G~~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;

(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. Choice

A. 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 carrier issuing such qualified health plan.

B. Risk Pooling - In accordance with section 1312(c) of the Federal Act

(1) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, members of a single risk pool.

(2) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer 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.

C. Empowering Consumer Choice - In accordance with section 1312(d) of the Federal Act

(1) This section shall not prohibit --

(a) a health carrier from offering outside of an Exchange a health plan to a qualified individual or qualified employer; or

(b) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) 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 with respect to any requirement to offer benefits.

(3) Voluntary Nature of an Exchange-

(a) 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 an Exchange.

(b) Nothing in this section shall compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(c) 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 1302(e)(2) of the Federal Act.

D. Enrollment through Agents or Brokers - In accordance with section 1312(e) of the Federal Act, the Exchange may allow agents or brokers

(1) to enroll qualified individuals and qualified employers in any qualified health plan offered through the Exchange for which the individual or employer is eligible; and

(2) to assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the Exchange.

Section 9. Funding; Publication of Costs

A. Funding -

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

(2) The Exchange may charge assessments or user fees to health carriers or otherwise may ~~generate~~ receive funding necessary to support its operations provided under this Act, such as from the State's general fund revenue, tobacco taxes, premium taxes and from grants.

(3) Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding.

(4) Services performed by the Exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers.

(5) Any unspent funding by an Exchange shall be used for future state operation of its Exchange or returned to health carriers as a credit if a state charges fees to carriers.

B. Disclosure - Taxes, fees or assessments used to finance the Exchange must be clearly disclosed by the Exchange as such, including publishing the average cost 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.

C. Treatment of Taxes or Fees for Medical Loss Ratio Purposes - Taxes, fees or assessment used to finance the Exchange shall be considered a state tax or assessment as defined in section 2718(a) of the PHSA and its implementing regulations, and must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

D. Publication - ~~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~~10. Regulations

The Exchange may promulgate ~~regulations~~ rules to implement the provisions of this Act. ~~Regulations~~ Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act or exceed the rules enforced by the Department of Insurance.

~~**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.~~

Section 11. Effective Date

This Act shall be effective [insert date].