HOUSE BILL 126

Short Title:	North Carolina Health Benefit Exchange Act.	(Public)
Sponsors:	Representatives Insko, Hall, and Fisher (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services, if favorable, Appropriations.	

February 21, 2011

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE NORTH CAROLINA HEALTH BENEFIT EXCHANGE.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known and may be cited as the "North Carolina Health Benefit Exchange Act."

SECTION 2. The purpose of this act is to provide for the establishment of the North Carolina Health Benefit Exchange (Exchange). The Exchange shall assist both qualified individuals and the employees of qualified employers in learning about and enrolling in qualified health plans offered through the Exchange. The Exchange shall facilitate the purchase and sale of qualified health plans in the individual market and shall assist qualified employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the Exchange. The intent of the Exchange is to reduce the number of uninsured individuals and to promote both improved competition in the health care marketplace and consumer engagement in care and coverage choices. In carrying out its duties, the Board of Directors of the North Carolina Health Benefit Exchange shall help promote meaningful choice; increase competition based on comparative cost, value, quality of care, and customer service; reduce competition based on risk avoidance, risk selection, and market segmentation; provide a transparent marketplace; increase consumer education and consumer protections; and assist individuals and employers in accessing health coverage, premium tax credits, and cost-sharing reductions. The Board of Directors shall also seek to encourage greater emphasis on health promotion and illness prevention, improved care and chronic condition management, self-management, and more active engagement of patients in their own health care management and coverage decisions.

SECTION 3. 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 in 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) Agent. – As defined in G.S. 58-33-10.

(3) Board or Board of Directors. – The Board of Directors of the North Carolina Health Benefit Exchange.
(4) Broker. – As defined in G.S. 58-33-10.
(5) Commissioner. – The Commissioner of Insurance of North Carolina or the Commissioner's authorized designee.
(6) 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.
(7) Essential community provider. – A provider that serves predominantly low-income, medically underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of P.L. 111-8.
(8) Essential health benefits. – As defined in section 1302(b) of the Affordable Care Act.
(9) Exchange. – The North Carolina Health Benefit Exchange established under this Part, including both the individual and the SHOP Exchanges unless otherwise specified.
(10) Executive Director. – The individual selected by a majority vote of the Board members and hired to serve as the Executive Director of the Exchange.
(11) Grandfathered health plan coverage or grandfathered health plan. – As defined in 45 CFR part 147.140(a).
(12) Health benefit plan. – As defined in G.S. 58-3-167(a).
(13) Health care provider. – As defined in G.S. 58-50-270.
(14) Individual Exchange. – The Exchange through which qualified individuals may purchase coverage established under this Part.
(15) Individual market. – As defined in G.S. 58-68-25(a).
(16) Insurer. – As defined in G.S. 58-3-167(a), but also includes (i) qualified nonprofit health insurance issuers (CO-OP Insurers) as provided in section 1322 of the Affordable Care Act and (ii) multistate qualified health plans as provided in section 1334 of the Affordable Care Act.
(17) Navigator. – An individual who provides fair, accurate, and impartial information about qualified health plans to individuals and employers, and who has been trained and certified by the North Carolina Department of Insurance Consumer Assistance Program in accordance with the standards set forth by the Secretary, as provided in section 1311(i) of the Affordable Care Act and in G.S. 58-50-320(6).
(18) PHSA. – The federal Public Health Service Act, Title 42 of the United States Code.
(19) Plan of Operation. – Includes the articles, bylaws, and operating rules and procedures adopted by the Board in accordance with G.S. 58-50-322.
(20) Principal place of business. – The location where (i) an employer has its headquarters or significant place of business and (ii) the persons with direction and control authority over the business are employed.
(21) Qualified dental plan. – A limited scope dental plan that has been certified in accordance with G.S. 58-50-325.
(22) Qualified employer. – An employer that does all of the following:
a. 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.

b. Has its principal place of business in this State.
c. Elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed.
d. Employs no more than the maximum number of employees allowable, as determined by the Board and consistent with the provisions of this Part and the Affordable Care Act.

(23) 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 Affordable Care Act and G.S. 58-50-325 and any additional requirements adopted by the Board pursuant to this Part.

(24) Qualified individual. – An individual, including a minor, who is all of the following:
a. Seeking to enroll in a qualified health plan offered to individuals through the Exchange.
b. Legally domiciled in the State on the date of enrollment for coverage.
c. Not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges.
d. A citizen or national of the United States or an alien lawfully present in the United States and who is also reasonably expected to be for the entire period for which enrollment is sought.

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

(26) SHOP Exchange. – The Small Business Health Options Program established under G.S. 58-50-320(15).

(27) Small employer. – As defined in G.S. 58-50-110, subject to the requirements of the Affordable Care Act.

(28) Small group market. – As defined in G.S. 58-68-25(a).

"**§ 58-50-301. Establishment of Exchange.**

The North Carolina Health Benefit Exchange is hereby established as a nonprofit entity which shall operate under the supervision and control of the Board of Directors of the Exchange. Although the Exchange may be supported in whole or in part from federal or State funds, the Exchange is not an instrumentality of the State.

"**§ 58-50-302. General requirements of Exchange.**

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

(1) The Exchange shall not make available any health benefit plan that is not a qualified health plan, unless it is a limited scope dental benefit under subdivision (2) of this subsection.

(2) The Exchange shall allow properly authorized insurers to offer 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 Affordable Care Act.

(b) Except to the extent that the Board has determined it is not in the public interest in accordance with G.S. 58-50-325(a)(7), nothing in this section shall preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits, including a wellness program.

(c) As required by section 1311(d)(B)(II) of the Affordable Care Act, to the extent that State law or regulation requires that qualified health plans offer benefits in addition to the essential health benefits, the State shall make payments to defray the costs of the additional

benefits directly to the individual enrolled in a qualified health plan in the Exchange or on behalf of an individual directly to the qualified health plan in the Exchange in which the individual is enrolled. To the extent that funding to defray the costs of the additional benefits is not provided by the State, the qualified health plan shall not be required to provide the additional benefits.

(d) Neither the Exchange nor an insurer 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.

"**§ 58-50-310. Composition of Board of Directors; appointments, terms, and vacancies.**

(a) The Board shall consist of the Commissioner, who shall serve as an ex officio nonvoting member of the Board, and the Director of the Division of Medical Assistance or the Director's authorized designee, who shall serve as an ex officio voting member of the Board, and eight members appointed as follows:

(1) Two members appointed by the Governor, who represent employers of the following sizes:

a. One member representing an employer with no more than 50 employees.

b. One member representing an employer with more than 50 employees.

(2) Two members of the general public who can reasonably be expected to enroll in a qualified health plan offered through the Exchange. 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 of the general public, upon recommendation of the President Pro Tempore of the Senate.

b. One member of the general public, upon recommendation of the Speaker of the House of Representatives.

(3) Four members appointed by the Commissioner, who have demonstrated and acknowledged expertise and experience in one or more of the following subject area groupings:

a. 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.

b. Health economics or health care finance.

c. Actuarial science or risk management.

d. Health policy analysis or health law.

In making appointments to the Board under this subdivision, the Commissioner shall ensure that each of the subject area groupings listed in this subdivision is represented by at least one member with expertise in that area and shall consider the expertise of the other members of the Board and attempt to make appointments so that the Board's composition reflects a diversity of expertise.

(b) The length of the initial appointments made pursuant to subsection (a) of this section shall be as follows

(1) Two years. – Appointees under sub-subdivisions (1)a. and (2)a. of subsection (a) of this section.

(2) Three years. – Appointees under sub-subdivisions (1)b. and (2)b. of subsection (a) of this section and sub-subdivision (3)c of subsection (a) of this section.

(3) Four years. – Appointees under sub-subdivisions (3)a., (3)b., and (3)d. of subsection (a) of this section.

All succeeding appointments shall be for terms of three years.

(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) Members shall not serve for more than two successive terms.

"**§ 58-50-311. Board meetings, chair, and travel reimbursement.**

(a) The Board shall meet at least quarterly. A majority of the total voting membership of the Board shall constitute a quorum.

(b) The Commissioner shall appoint a chair to serve for the initial two years of Board operations, beginning with the first convening of the Board. Subsequent chairs shall be elected by a majority vote of the Board members and shall serve for two-year terms.

(c) Board members shall receive travel reimbursement under G.S. 138-5 when traveling to and from meetings of the Board or for official business of the Exchange but shall not receive any per diem.

"**§ 58-50-312. Individual duties of Board members.**

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

"**§ 58-50-313. Personal liability of Board members and Exchange employees.**

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, 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.

"**§ 58-50-314. Ethics provisions for Board and Exchange.**

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

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

(c) A member of the Board or of the executive management staff of the Exchange or their immediate family member shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, an insurer, an agent, or a broker while serving on the board or on the staff of the Exchange. A member of the Board or of the staff of the Exchange shall not be a member, a board member, or an employee of a trade association of insurers while serving on the Board or on the staff of the Exchange.

(d) 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 a reasonably foreseeable material effect on any business entity in which the member or his or her immediate family is a director, officer, partner, trustee, employee, or holds any position of management.

"**§ 58-50-315. Board subject to open meetings law.**

The Board shall be considered a public body under G.S. 143-318.10(b) and shall be subject to the provisions of Article 33C of Chapter 143 of the General Statutes.

"**§ 58-50-320. Duties and powers of Exchange.**

(a) The Exchange shall do all of 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 in facilitating the enrollment of their employees in qualified health plans.

(4) Maintain an accessible Internet Web site through which enrollees and prospective enrollees of qualified health plans, Medicaid, or North Carolina Health Choice may do the following:

a. Obtain standardized comparative information on the aforementioned plans and programs, as appropriate.

b. Enter and submit information sufficient for facilitating eligibility determinations for Medicaid and North Carolina Health Choice and premium tax credit and cost-sharing reduction determinations.

c. Enter and submit information sufficient for facilitating enrollment of individuals in the plans or programs appropriate to their particular circumstances or selections.

(5) 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.

(6) Award grants to Navigators, trained and certified by the North Carolina Department of Insurance Consumer Assistance Program, 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 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 accessible, as well as culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(7) 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 culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(8) Ensure that all Exchange employees interacting with the general public be trained and certified as Navigators.

(9) Allow properly licensed agents and brokers to do the following:
a. Enroll individuals and employers in any qualified health plan in the individual or small group market as soon as the plan is offered through the Exchange.
b. Assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through the Exchange.
(10) Provide for enrollment periods, as provided under section 1311(c)(6) of the Affordable Care Act.
(11) 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.
(12) Implement procedures for the certification, recertification, and decertification of health benefit plans as qualified health plans, consistent with guidelines developed by the Secretary under section 1311(c) of the Affordable Care Act and G.S. 58-50-325.
(13) 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.
(14) 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 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.
(15) Establish an Individual Exchange through which qualified individuals may enroll in any qualified health plan for which they are eligible.
(16) 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.
(17) 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.
(18) 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 (17) 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 to be either 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.

(19) Provide to each employer the name of each employee of the employer described in sub-subdivision (17)b. of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

(20) 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.

(21) Develop proposals on how best to reduce unnecessary premium growth and any adverse selection in the individual, small group, and large group markets, and, if needed to address factors outside the Exchange, submit recommendations to the Department of Insurance along with identification of any additional departmental authority necessary to implement the recommendations.

(22) 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, collect the amount credited from the offering employer, and remit the amount of the free choice voucher to the appropriate insurer.

(23) 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.

(24) Meet the requirements of this Part and the Affordable Care Act and any rules adopted pursuant to this Part.

(25) Consider the impact that standardization of benefit designs would have on facilitating comparisons between benefit plans offered through the Exchange, facilitating meaningful choice, reducing risk segmentation and risk selection, and facilitating the success of the Exchange, and if appropriate, prescribe a variety of standardized, defined benefit plans to be offered through the Exchange.

(26) Provide for a comprehensive publicity and outreach campaign to raise awareness of the existence of the Exchange 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.

(27) Establish an advisory committee to provide technical assistance concerning the operation of the Exchange, the formulation and implementation of Exchange policies or procedures, and any other function the Board deems relevant to the operations of the Exchange. The advisory committee shall consist of at least one representative of each of the following stakeholder groups:

a. Insurers who sell individual health insurance policies.
b. Insurers who sell small group health insurance policies.
c. Agents or brokers who sell health insurance policies.
d. Organizations that represent consumer interests.
e. Educated health care consumers who are enrollees in qualified health plans, once these plans are available.
f. Individuals and entities with experience in facilitating enrollment in qualified health plans, once these plans are available.
g. Qualified employers, including small employers and self-employed individuals.
h. Advocates for enrolling hard to reach populations.
i. Health care professionals and provider groups.
j. Essential community providers.
k. Any other representatives necessary to ensure that the Exchange receives appropriate advice and technical assistance.

(b) The Exchange may do any of the following:

(1) Contract with an eligible entity for any of its functions described in this Part. For the purposes of this subdivision, the term "eligible entity" includes, but is not limited to, the Division of Medical Assistance, the Department of Insurance, the North Carolina Consumer Assistance Program, 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. For purposes of this subdivision, the term "eligible entity" does not include an insurer or an affiliate of an insurer.

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

"**§ 58-50-321. Duties of Board.**

The Board shall do the following:

(1) Employ and fix compensation of the Executive Director and other employees of the Exchange.

(2) Consult with stakeholders relevant to carrying out the activities required under this Part, 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 qualified employers, including small employers and self-employed individuals.
  d. The Division of Medical Assistance.
  e. Advocates for enrolling hard to reach populations.
  f. Health care professionals and provider groups, including essential community providers.

(3) Establish a process to appoint individuals with appropriate expertise, to serve on legal, actuarial, or other committees as appropriate or necessary to provide technical assistance in the operation of the Exchange, the formulation and implementation of Exchange policies or procedures, and any other function the Board deems relevant to the operations of the Exchange. These appointees may include representatives of stakeholder groups.

(4) Take legal action as necessary and appropriate to do any of the following:
  a. Recover any amounts erroneously or improperly paid by the Exchange.
  b. Recover any amounts paid by the Exchange as a result of mistake of fact or law.
  c. Recover other amounts due the Exchange.

(5) Adopt bylaws, policies, and procedures as may be necessary or appropriate for the implementation of this Part, the Affordable Care Act, or the operation of the Exchange.

(6) Deliver a report on February 1 of 2012, 2013, 2014, 2015, and biennially thereafter to all of the following:
  a. Speaker of the House of Representatives.
  b. President Pro Tempore of the Senate.
  c. Commissioner.
  d. The following legislative oversight and appropriations committees:
    1. Joint Legislative Commission on Governmental Operations.
    2. House Appropriations Subcommittee on Health and Human Services.
    3. House Appropriations Subcommittee on General Government.
    4. Senate Appropriations on Education/Higher Education.
    5. Senate Appropriations on General Government and Information Technology.

The report shall also be prominently posted on the Exchange Web site. The report shall summarize the activities of the Exchange since the last report, including the enrollment of individuals in health benefit plans offered through the Exchange, the movement of individuals into and out of health benefit plans offered through the Exchange, the cost of operating the Exchange, a comparison of premiums in and outside the Exchange, and any other matters relating to the operation of the Exchange, as determined by the Board.

"**§ 58-50-322. Plan of Operation.**

(a) The Board shall develop a Plan of Operation, in consultation with the advisory committee, and submit it to the Commissioner in accordance with the requirements of this subsection. The Board shall make the Plan of Operation open to public inspection and provide an opportunity for public input prior to submitting the Plan of Operation to the Commissioner.

(b) The Board shall submit to the Commissioner a Plan of Operation for the Exchange and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Plan of Operation. The Commissioner shall review and approve or disapprove the Plan of Operation within 90 days after its submission or resubmission. The Commissioner may disapprove the Plan of Operation only if the Commissioner determines that it does not comply with the requirements of this Part, the Affordable Care Act, or Chapter 58 of the General Statutes. If the Commissioner disapproves the Plan of Operation, the Commissioner shall identify the specific provision or provisions upon which the disapproval is based and shall provide the Board an opportunity to revise and resubmit the Plan of Operation. 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 needed amendments as required by State or federal law 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.

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

(1) Establish procedures and policies for operation of the Exchange, covering at least the following:

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

b. Process for determining qualified health plan participation in the Exchange, consistent with the requirements of G.S. 58-50-325.

c. Process for determining the role of the Exchange in collecting and distributing premiums for qualified employers. In making this determination, the Exchange shall consult with small employers and consider the added value, costs, and operational requirements for the Exchange to accomplish this.

d. The role and compensation of insurance agents and brokers in assisting qualified individuals and employers with plan selection, enrollment, and other relevant activities through the Exchange consistent with the requirements of G.S. 58-50-320 and the regulations adopted by the Secretary pursuant to section 1312(e) of the Affordable Care Act. In considering and developing the role and compensation, the Board shall consult with the Department of Insurance and shall consider the impact on insurance coverage and premium rates inside and outside the Exchange.

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

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

g. Statement acknowledging the fiduciary duty owed by the Exchange to persons receiving health benefit plan coverage through the Exchange.

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

i. 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.

(2) Establish a process for review of all of the following:

a. Individual appeals of Exchange premium tax credit and cost-sharing reductions and mandate exemption determinations. To the extent possible, this appeals process shall be established in collaboration with Medicaid eligibility determinations.

b. Employer appeals of employer-sponsored plan availability or affordability determinations.

c. Decisions made by the Exchange that may appeal adverse decisions affecting insurers.

(3) 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 and Medicaid.

(4) Provide an approach to encourage broad participation from interested insurers to offer qualified health plans through the Exchange.

(5) Develop policies by which the Board may place parameters on the plan designs offered in order to promote competition, ensure meaningful choice for individuals and employers, encourage positive innovations, and prevent risk segmentation.

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

"**§ 58-50-325. 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 insurer 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, and the level of coverage, as specified in section 1302(d)(1) of the Affordable Care Act, has been actuarially certified and calculated pursuant to regulations issued by the Secretary under section 1302(d)(2)(A) of the Affordable Care Act.

(3) The plan provides at least a bronze level of coverage, as specified in section 1302(d)(1)(a) of the Affordable Care Act and determined pursuant to regulations issued by the Secretary under section 1302(d)(2)(A) of the

Affordable Care Act, 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 to small employers, 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 insurer or through an agent or broker.

d. Does not charge any cancellation fees or penalties in violation of G.S. 58-50-302.

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 rules pursuant to G.S. 58-50-341 and by regulations developed by the Secretary under section 1311(c) of the Affordable Care Act.

(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, after considering the purposes of this Part, G.S. 58-50-322(c)(5), and G.S. 58-50-320(24).

(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, 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 shall not exempt any 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 insurers 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 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.

(f) In accordance with section 1312(b) of the Affordable Care Act, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by the individual to the insurer issuing the qualified health plan.

"**§ 58-50-330. Consumer choice.**

(a) Nothing in this Part or the Affordable Care Act shall be construed to prohibit any of the following:

(1) A properly authorized insurer from offering outside of the Exchange a health benefit plan to a qualified individual or qualified employer.

(2) A qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health benefit plan offered outside of the Exchange.

(b) Nothing in this Part or the Affordable Care 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.

(c) Nothing in this Part or the Affordable Care Act shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health benefit plan or to participate in the Exchange.

(d) Nothing in this Part shall be construed to compel an individual to enroll in a qualified health plan or to participate in the Exchange.

(e) 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 Affordable Care 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 Affordable Care Act.

"**§ 58-50-335. Risk pooling.**

(a) An insurer who delivers or issues for delivery any health benefit plan in this State shall consider all enrollees in all health benefit plans other than grandfathered health plans offered by the insurer in the individual market, including those enrollees who do not enroll in individual plans offered through the Exchange, to be members of a single risk pool.

(b) An insurer who delivers or issues for delivery any health benefit plan in this State shall consider all enrollees in all health benefit plans other than grandfathered health plans offered by the insurer in the small group market, including those enrollees who do not enroll in small group plans offered through the Exchange, to be members of a single risk pool.

(c) The Commissioner may require the individual and small group insurance markets within the State to be merged or separated, if the Commissioner and the Board determine that merger or separation of these markets is appropriate.

(d) The Commissioner shall have the power and authority to enforce the provisions of this section and any rules adopted to implement the provisions of this section.

"**§ 58-50-340. Funding, publication of costs, audit, and taxation.**

(a) Beginning in 2014, the funding stream that supports the North Carolina Health Insurance Risk Pool shall be made available to the Exchange to support the operations of the Exchange in 2015 and subsequent years. The Exchange shall examine its operational costs and propose to the Department of Insurance any additional changes to the funding stream necessary to ensure its solvency.

(1) The Exchange, in consultation with the Department of Insurance, may charge assessments or user fees on insurers, individuals, and employers participating in the Exchange to support its operations.

(2) The Department of Insurance, in consultation with the Exchange, may charge assessments or user fees to insurers necessary to support the reasonable operations of the Exchange provided under this Part. In establishing charges or assessments, the Department of Insurance may consider any other user fees or assessments established in subdivision (1) of this subsection.

(3) Any assessment or user fee shall be limited to the amount that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange, less funding from other sources. This assessment or user fee shall not affect the requirement under section 1301 of the Affordable Care Act that insurers charge the same premium rate for each qualified health plan whether offered inside or outside the Exchange.

(b) The Exchange shall publish the average costs of taxes, assessments, licensing, regulatory fees, and any other payments required to finance 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.

(c) An audit of the Exchange shall be conducted annually under the oversight of the State Auditor.

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

(e) Taxes, fees, or assessments required to be paid by a health carrier 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 as defined in Section 2794 of the PHSA.

"**§ 58-50-341. Rules.**

The Board and the Commissioner may adopt rules pursuant to Chapter 150B of the General Statutes, including temporary rules, to implement the provisions of this Part. Rules adopted by the Board under this section shall not conflict with or prevent the application of rules adopted by the Commissioner under this Part or under Chapter 58 of the General Statutes.

"**§ 58-50-342. Exchange subject to public records law.**

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, made or received in connection with the operations of the Exchange are public records under G.S. 132-1(a) and 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.

"**§ 58-50-343. Relation to other laws.**

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

"**§§ 58-50-344 through 58-50-349: Reserved for future codification purposes.**"

SECTION 4. Studies and Recommendations. – The Exchange shall do all of the following:

(1) Study and make recommendations to the 2013 Regular Session of the General Assembly regarding the Board operation of a fund for administrative expenses. The study shall address potential operations costs and related issues.

(2) Study and make recommendations to the Department of Insurance as to whether large employers should be offered coverage through the Exchange in or after 2017. For the purposes of this section, the term "large employer" means an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

(3) Collaborate with the Department of Insurance to study costs associated with the provision of mandated coverage, following publication of the contents of the essential health benefits package by the Secretary. The Exchange shall report the results of the study and any recommendations to the General Assembly prior to the convening of the 2012 Regular Session of the 2011 General Assembly.

SECTION 5. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-3-300. Reinsurance and risk adjustment for qualified health plans.**

(a) Definitions. – The following definitions apply in this section:

(1) Affordable Care Act. – The federal Patient and Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and as further amended.

(2) Individual market. – As defined in G.S. 58-68-25(a).

(b) Transitional Reinsurance Program. – No later than January 1, 2014, the Commissioner shall establish, and continue to maintain, a program of reinsurance as specified in section 1341 of the Affordable Care Act for the individual market. The program of reinsurance established pursuant to this subsection may be based upon the model regulation developed by the Secretary of the United States Department of Health and Human Services.

(c) Risk Adjustment. – Using the criteria and methods developed under section 1343(b) of the Affordable Care Act, the Commissioner shall assess a charge on health plans and health insurers or make a payment to health plans and health insurers depending upon whether the actuarial risk of the enrollees of the plans or coverage for a year is more or less than the average actuarial risk of all enrollees in all plans or covered in the State for that year that are not self-insured group health plans and which are subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as amended. The risk adjustment methodology may be based upon the model developed by the Secretary of the United States Department of Health and Human Services.

(d) Rules. – The Commissioner may adopt rules as necessary or appropriate to implement the provisions of this section.

"**§ 58-3-305. Transparency in health insurance coverage.**

(a) Definitions. – The following definitions apply in this section:

(1) Affordable Care Act. – As defined in G.S. 58-3-300.

(2) Group market. – As defined in G.S. 58-62-25(a).

(3) Health Benefit Exchange. – The Health Benefit Exchange established under Part 8 of Article 50 of this Chapter.

(4) Health benefit plan. – As defined in G.S. 58-3-167.

(3) Health Benefit Exchange. – The Health Benefit Exchange established under Part 8 of Article 50 of this Chapter.

(5) Individual market. – As defined in G.S. 58-62-25(a).

(6) Insurer. – As defined in G.S. 58-50-300.

(b) Transparency Required. – Insurers providing coverage under a health benefit plan in the individual or group markets shall comply with the provisions of section 1311(e)(3) of the Affordable Care Act, except that a plan or coverage that is not offered through the Health Benefit Exchange shall only be required to (i) submit the information required to the Secretary of the United States Department of Health and Human Services and the Commissioner and (ii) make that information public."

SECTION 6. This act is effective when it becomes law.