

House File 559 - Introduced

HOUSE FILE 559
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO HSB 159)

A BILL FOR

1 An Act authorizing the establishment of health insurance
2 exchanges in the state and including effective date
3 provisions.

4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. NEW SECTION. 514M.1 Title.

2 This Act shall be known and may be cited as the "*Iowa Health*
3 *Insurance Exchange Act*".

4 Sec. 2. NEW SECTION. 514M.2 Purpose and intent.

5 The purpose of this Act is to provide for the establishment
6 of health insurance exchanges in this state to facilitate
7 the sale and purchase of qualified health benefit plans in
8 the individual market in this state and to assist qualified
9 small employers in the state in facilitating the availability
10 of qualified health benefit plans offered in the small group
11 market. The intent of authorizing the establishment of health
12 insurance exchanges in the state is to reduce the number of
13 uninsured, provide a transparent marketplace and consumer
14 education, and assist individuals with access to programs,
15 premium assistance tax credits, and cost-sharing reductions.

16 Sec. 3. NEW SECTION. 514M.3 Definitions.

17 As used in this chapter, unless the context otherwise
18 requires:

19 1. "*Commissioner*" means the commissioner of insurance.

20 2. "*Exchange*" means a health insurance exchange established
21 or approved pursuant to section 514M.4.

22 3. "*Federal Act*" means the federal Patient Protection and
23 Affordable Care Act, Pub. L. No. 111-148, as amended by the
24 federal Health Care and Education Reconciliation Act of 2010,
25 Pub. L. No. 111-152, and any amendments thereto, or regulations
26 or guidance issued under, those Acts.

27 4. a. "*Health benefit plan*" means a policy, contract,
28 certificate, or agreement offered or issued by a health carrier
29 to provide, deliver, arrange for, pay for, or reimburse any of
30 the costs of health care services.

31 b. "*Health benefit plan*" does not include any of the
32 following:

33 (1) Coverage only for accident, or disability income
34 insurance, or any combination thereof.

35 (2) Coverage issued as a supplement to liability insurance.

1 (3) Liability insurance, including general liability
2 insurance and automobile liability insurance.

3 (4) Workers' compensation or similar insurance.

4 (5) Automobile medical payment insurance.

5 (6) Credit-only insurance.

6 (7) Coverage for on-site medical clinics.

7 (8) Other similar insurance coverage, specified in federal
8 regulations issued pursuant to Tit. XXVII of the federal Public
9 Health Service Act, as enacted by the federal Health Insurance
10 Portability and Accountability Act of 1996, Pub. L. No.
11 104-191, and amended by the federal Act, under which benefits
12 for health care services are secondary or incidental to other
13 insurance benefits.

14 c. *"Health benefit plan"* does not include any of the
15 following benefits if they are provided under a separate
16 policy, certificate, or contract of insurance or are otherwise
17 not an integral part of the plan:

18 (1) Limited scope dental or vision benefits.

19 (2) Benefits for long-term care, nursing home care, home
20 health care, community-based care, or any combination thereof.

21 (3) Other similar, limited benefits specified in federal
22 regulations issued pursuant to the federal Health Insurance
23 Portability and Accountability Act of 1996, Pub. L. No.
24 104-191.

25 d. *"Health benefit plan"* does not include any of the
26 following benefits if the benefits are provided under a
27 separate policy, certificate, or contract of insurance, there
28 is no coordination between the provision of the benefits
29 and any exclusion of benefits under any group health plan
30 maintained by the same plan sponsor, and the benefits are paid
31 with respect to an event without regard to whether benefits are
32 provided with respect to such an event under any group health
33 plan maintained by the same plan sponsor:

34 (1) Coverage only for a specified disease or illness.

35 (2) Hospital indemnity or other fixed indemnity insurance.

1 *e.* "*Health benefit plan*" does not include any of the
2 following if offered as a separate policy, certificate, or
3 contract of insurance:

4 (1) Medicare supplemental health insurance as defined under
5 section 1882(g)(1) of the federal Social Security Act.

6 (2) Coverage supplemental to the coverage provided under 10
7 U.S.C. ch. 55, by the civilian health and medical program of
8 the uniformed services.

9 (3) Supplemental coverage similar to that provided under a
10 group health plan.

11 5. "*Health carrier*" means an entity subject to the insurance
12 laws and rules of this state, or subject to the jurisdiction
13 of the commissioner, that contracts or offers to contract to
14 provide, deliver, arrange for, pay for, or reimburse any of
15 the costs of health care services, including an insurance
16 company offering sickness and accident plans, a health
17 maintenance organization, a nonprofit hospital or health
18 service corporation, or any other entity providing a plan of
19 health insurance, health benefits, or health services.

20 6. "*Insurance producer*" means a person required to be
21 licensed under chapter 522B.

22 7. "*Mandate-free health benefit plan*" means a health
23 benefit plan that is exempt from some or all special health and
24 accident insurance coverages required pursuant to the federal
25 Act or chapter 514C.

26 8. "*Qualified dental plan*" means a limited scope dental plan
27 that has been certified in accordance with section 514M.8.

28 9. "*Qualified employer*" means a small employer that elects
29 to make its full-time employees eligible for one or more
30 qualified health benefit plans offered through the exchange,
31 and at the option of the employer, some or all of its part-time
32 employees, provided that the employer does either of the
33 following:

34 *a.* Has its principal place of business in this state and
35 elects to provide coverage through the exchange to all of its

1 eligible employers wherever employed.

2 *b.* Elects to provide coverage through the exchange to all
3 of its eligible employees who are principally employed in this
4 state.

5 10. "*Qualified health benefit plan*" means a health benefit
6 plan that has in effect a certification as described in section
7 1311(c) of the federal Act and section 514M.8.

8 11. "*Qualified individual*" means an individual, including a
9 minor, who is all of the following:

10 *a.* Is seeking to enroll in a qualified health plan offered
11 to individuals through the exchange.

12 *b.* Is a resident of this state.

13 *c.* At the time of enrollment, is not incarcerated, other
14 than incarceration pending the disposition of charges.

15 *d.* Is, and is reasonably expected to be, for the entire
16 period for which enrollment is sought, a citizen or national of
17 the United States or an alien lawfully present in the United
18 States.

19 12. "*Secretary*" means the secretary of the United States
20 department of health and human services.

21 13. *a.* "*Small employer*" means an employer that employed an
22 average of one to fifty employees during the preceding calendar
23 year.

24 *b.* For the purposes of this subsection:

25 (1) All persons treated as a single employer under
26 subsection (b), (c), (m), or (o) of section 414 of the Internal
27 Revenue Code of 1986 shall be treated as a single employer.

28 (2) An employer and any predecessor employer shall be
29 treated as a single employer.

30 (3) All employees shall be counted, including part-time
31 employees and employees who are not eligible for coverage
32 through the employer.

33 (4) If an employer was not in existence throughout the
34 preceding calendar year, the determination of whether that
35 employer is a small employer shall be based on the average

1 number of employees that is reasonably expected that employer
2 will employ on business days in the current calendar year.

3 (5) An employer that makes enrollment in qualified health
4 plans available to its employees through the small business
5 health options program exchange, and would cease to be a
6 small employer by reason of an increase in the number of its
7 employees, shall continue to be treated as a small employer
8 for purposes of this chapter as long as it continuously makes
9 enrollment through the small business health options program
10 exchange available to its employees.

11 **Sec. 4. NEW SECTION. 514M.4 Establishment of Iowa health**
12 **insurance exchange — additional exchanges authorized.**

13 1. A health insurance exchange shall be established in
14 this state, and subject to the discretion of the commissioner,
15 may be operated by the insurance division of the department
16 of commerce under the supervision of the commissioner or as
17 a nonprofit corporation approved by the commissioner. The
18 commissioner shall approve the establishment of one or more
19 exchanges in the state that meet the requirements of this
20 chapter. An exchange or components of an exchange established
21 or approved pursuant to this subsection may be operated on a
22 statewide or regional basis, or on a multistate basis, subject
23 to the approval of the commissioner. An exchange established
24 or approved pursuant to this subsection shall be operated
25 pursuant to a plan of operation approved by the commissioner.

26 2. The commissioner shall establish a provider
27 reimbursement system for health benefit plans issued in this
28 state that all health carriers and health providers may join to
29 facilitate fair and reasonable payments for the cost of health
30 care services provided pursuant to a health benefit plan.

31 3. The commissioner shall create a value or outcome-based
32 reimbursement system for health benefit plans issued in this
33 state to which all health carriers may subscribe.

34 4. An exchange shall do all of the following:

35 a. Facilitate the purchase and sale of qualified health

1 benefit plans to qualified individuals and qualified employers
2 as described in this chapter and in the federal Act.

3 *b.* Meet the requirements of this chapter and any rules
4 adopted pursuant to this chapter.

5 5. All persons who enroll in a qualified health benefit plan
6 offered through an exchange shall be enrolled by an insurance
7 producer. The health carrier that issues the qualified health
8 benefit plan selected shall pay the producer a commission of
9 at least five percent of the premium paid by the enrollee.
10 If a health carrier offers health benefit plans outside the
11 exchange, the health carrier shall pay an insurance producer
12 that enrolls a person in that health benefit plan a commission
13 of at least five percent of the premium paid by the enrollee.

14 6. An exchange may employ staff to carry out the functions
15 of the exchange, but no public employee shall sell, solicit,
16 negotiate, advise, or counsel consumers on health insurance or
17 otherwise offer services for which a license as an insurance
18 producer is required pursuant to chapter 522B.

19 7. An exchange may contract with an eligible entity to
20 fulfill any of its responsibilities as described in this
21 chapter. An eligible entity includes but is not limited to an
22 entity that has experience in individual and small group health
23 benefit plans, benefit administration, or other experience
24 relevant to the responsibilities to be assumed by the entity.
25 However, a health carrier or an affiliate of a health carrier
26 is not an eligible entity for the purposes of this subsection.

27 8. An exchange may enter into information-sharing
28 agreements with federal and state agencies and other state
29 exchanges to carry out its responsibilities under this chapter
30 provided such agreements include adequate protections with
31 respect to the confidentiality of the information to be shared
32 and comply with all state and federal laws and regulations.

33 Sec. 5. NEW SECTION. **514M.5 General requirements.**

34 1. An exchange or exchanges established or approved
35 pursuant to section 514M.4 shall make qualified health

1 benefit plans that are effective on or before January 1, 2014,
2 available to qualified individuals and qualified employers in
3 the state.

4 2. The exchange or exchanges that are established or
5 approved shall request a five-year waiver from the secretary
6 from the certification requirements for health benefit plans of
7 the federal Act to enable the exchange to offer mandate-free
8 health benefit plans in addition to offering qualified health
9 benefit plans through the exchange.

10 3. The exchange or exchanges shall allow a health carrier
11 to offer a plan that provides limited scope dental benefits
12 meeting the requirements of section 9832(c)(2)(A) of the
13 Internal Revenue Code of 1986 through the exchange, either
14 separately or in conjunction with a qualified health benefit
15 plan, if the plan provides pediatric dental benefits meeting
16 the requirements of section 1302(b)(1)(J) of the federal Act.

17 4. An exchange or a health carrier offering qualified
18 health benefit plans through an exchange shall not charge an
19 individual a fee or penalty for termination of coverage if
20 the individual enrolls in another type of minimum essential
21 coverage because the individual has become newly eligible for
22 that coverage or because the individual's employer-sponsored
23 coverage has become affordable under the standards of the
24 federal Act, to be codified at section 36B(c)(2)(C) of the
25 Internal Revenue Code of 1986.

26 **Sec. 6. NEW SECTION. 514M.6 Duties of an exchange.**

27 An exchange established or approved pursuant to section
28 514M.4 shall do all of the following:

29 1. Implement procedures for the certification,
30 recertification, and decertification of health benefit plans
31 as qualified health benefit plans, consistent with guidelines
32 developed by the secretary under section 1311(c) of the federal
33 Act and applicable state law.

34 2. Provide for the operation of a toll-free telephone
35 hotline to respond to requests for assistance.

1 3. Provide for enrollment periods, as determined by the
2 secretary under section 1311(c)(6) of the federal Act and
3 applicable state law.

4 4. Maintain an internet site through which enrollees and
5 prospective enrollees of qualified health benefit plans may
6 obtain standardized comparative information on such plans.

7 5. Assign a rating to each qualified health benefit plan
8 offered through the exchange in accordance with criteria
9 developed by the secretary under section 1311(c)(3) of the
10 federal Act, and determine the level of coverage of each
11 qualified health benefit plan in accordance with regulations
12 issued by the secretary under section 1302(d)(2)(A) of the
13 federal Act and applicable state law.

14 6. Utilize a standardized format for presenting health
15 benefit plan options in the exchange, including the use of the
16 uniform outline of coverage established under section 2715 of
17 the Public Health Service Act and applicable state law.

18 7. In accordance with section 1413 of the federal Act
19 and applicable state law, inform individuals of eligibility
20 requirements for the Medicaid program under Tit. XIX of the
21 federal Social Security Act, the children's health insurance
22 program under Tit. XXI of the federal Social Security Act, or
23 any applicable state or local public program and, if through
24 screening of an application by the exchange, the exchange
25 determines that any individual is eligible for any such
26 program, enroll that individual in that program.

27 8. Establish and make available by electronic means a
28 calculator to determine the actual cost of coverage after
29 application of any premium tax credit under the standards of
30 the federal Act to be codified at section 36B(c)(2)(C) of the
31 Internal Revenue Code of 1986 and any cost-sharing reductions
32 under section 1402 of the federal Act.

33 9. Establish a component of the exchange through which
34 qualified employers may access coverage for their eligible
35 employees and the employees can enroll in any qualified health

1 benefit plan offered through the exchange at the level of
2 coverage specified by the employer.

3 10. Subject to section 1411 of the federal Act and
4 applicable state law, grant a certification attesting that,
5 for purposes of the individual responsibility penalty under
6 the standards of the federal Act, to be codified at section
7 5000A of the Internal Revenue Code of 1986, an individual is
8 exempt from the individual responsibility requirement or from
9 the penalty imposed by that section because of any of the
10 following:

11 a. There is no affordable qualified health benefit plan
12 available through the exchange, or the individual's employer,
13 covering the individual.

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

17 11. Transfer to the United States secretary of the treasury
18 all of the following:

19 a. A list of the individuals who are issued a certification
20 under subsection 10, paragraph "a", including the name and
21 taxpayer identification number of each individual.

22 b. The name and taxpayer identification number of each
23 individual who was an employee of an employer but who was
24 determined to be eligible for the premium tax credit under
25 the standards of the federal Act to be codified at section
26 36B(c)(2)(C) of the Internal Revenue Code of 1986, because of
27 either of the following:

28 (1) The employer did not provide minimum essential health
29 benefits coverage.

30 (2) The employer provided the minimum essential health
31 benefits coverage, but it was determined under the standards
32 of the federal Act, to be codified at section 36B(c)(2)(C) of
33 the Internal Revenue Code of 1986, to either be unaffordable to
34 the employee or not to provide the required minimum actuarial
35 value.

1 c. The name and taxpayer identification number of all of the
2 following:

3 (1) Each individual who notifies the exchange under section
4 1411(b)(4) of the federal Act that the individual has changed
5 employers.

6 (2) Each individual who ceases coverage under a qualified
7 health benefit plan during a plan year and the effective date
8 of that cessation.

9 12. Provide to each employer the name of each employee of
10 the employer described in subsection 11, paragraph "b", who
11 ceases coverage under a qualified health benefit plan during a
12 plan year and the effective date of the cessation.

13 13. Perform duties required of, or delegated to, the
14 exchange by the secretary, the United States secretary of
15 the treasury, or the commissioner related to determining
16 eligibility for premium tax credits, reduced cost-sharing, or
17 individual responsibility requirement exemptions.

18 14. Review the rate of premium growth within the exchange
19 and outside the exchange, and consider the information obtained
20 in developing recommendations on whether to continue limiting
21 qualified employer status to small employers.

22 15. Credit the amount of any free choice voucher to the
23 monthly premium of the plan in which a qualified employee is
24 enrolled, in accordance with section 10108 of the federal Act,
25 and collect the amount credited from the offering employer.

26 16. Meet all of the following financial integrity
27 requirements:

28 a. Keep an accurate accounting of all activities, receipts,
29 and expenditures of the exchange and annually submit to the
30 commissioner a report concerning such accountings.

31 b. Fully cooperate with any investigation conducted by
32 the secretary pursuant to the secretary's authority under the
33 federal Act, and allow the secretary, in coordination with the
34 inspector general of the United States department of health and
35 human services, to do all of the following:

- 1 (1) Investigate the affairs of the exchange.
- 2 (2) Examine the properties and records of the exchange.
- 3 (3) Require periodic reports in relation to the activities
- 4 undertaken by the exchange.

5 Sec. 7. NEW SECTION. 514M.7 Navigators.

6 1. An exchange may select entities qualified to serve as
7 navigators in accordance with section 1311(i) of the federal
8 Act, standards developed by the secretary, and applicable state
9 law, and award grants to enable navigators to do all of the
10 following:

11 a. Conduct public education activities to raise awareness
12 of the availability of qualified health benefit plans through
13 an exchange.

14 b. Distribute fair and impartial information concerning
15 enrollment in qualified health benefit plans, and the
16 availability of premium tax credits under the standards of the
17 federal Act, to be codified at section 36B(c)(2)(C) of the
18 Internal Revenue Code of 1986, and any cost-sharing reductions
19 under section 1402 of the federal Act.

20 c. Facilitate enrollment through an insurance producer in
21 qualified health benefit plans through an exchange or in health
22 benefit plans outside an exchange.

23 d. Provide referrals to the office of health insurance
24 consumer assistance established under the federal Act pursuant
25 to section 2793 of the federal Public Health Service Act
26 and the office of the commissioner or any other appropriate
27 state agency, for any enrollee with a grievance, complaint,
28 or question regarding the enrollee's health benefit plan,
29 coverage, or a determination under that plan or coverage.

30 e. Provide information in a manner that is culturally and
31 linguistically appropriate to the needs of the population being
32 served by an exchange.

33 2. All entities qualified as navigators that facilitate
34 enrollment in health benefit plans shall be licensed as
35 insurance producers or shall utilize the services of an

1 insurance producer to assist in such facilitation.

2 3. All entities that provide facilitation for a navigator
3 shall be licensed as insurance producers.

4 Sec. 8. NEW SECTION. 514M.8 Health benefit plan
5 certification.

6 1. An exchange may certify a health benefit plan as a
7 qualified health benefit plan if the plan meets all of the
8 following criteria:

9 a. The plan provides the essential health benefit package
10 described in section 1302(a) of the federal Act, except that
11 the plan is not required to provide essential benefits that
12 duplicate the minimum benefits of qualified dental plans, as
13 provided in subsection 5, if all of the following occur:

14 (1) The exchange determines that at least one qualified
15 dental plan is available to supplement the plan's coverage.

16 (2) The health carrier makes a prominent disclosure at the
17 time it offers the plan, in a form approved by the exchange,
18 that the plan does not provide the full range of essential
19 pediatric benefits and that qualified dental plans providing
20 those benefits and other dental benefits not covered by the
21 plan are offered through the exchange.

22 b. The premium rates and contract language have been
23 approved by the commissioner.

24 c. The plan provides at least a bronze level of coverage,
25 as that level is defined by the federal Act, unless the plan
26 is certified as a qualified catastrophic plan, meets the
27 requirements of the federal Act for catastrophic plans, and
28 will only be offered to individuals eligible for catastrophic
29 coverage.

30 d. The plan's cost-sharing requirements do not exceed the
31 limits established under section 1302(c)(1) of the federal
32 Act, and if the plan is offered through the component of the
33 exchange that offers plans to small employers, the plan's
34 deductible does not exceed the limits established under section
35 1302(c)(2) of the federal Act.

1 e. The plan offers wellness programs.

2 f. The health carrier offering the plan provides greater
3 transparency and disclosure of information about the plan
4 benefits, provider networks, claim payment practices, and
5 solvency ratings, and establishes a process for consumers to
6 compare features of health benefit plans offered through an
7 exchange or exchanges that have been established or approved
8 pursuant to section 514M.4.

9 g. The health carrier offering the plan meets all of the
10 following criteria:

11 (1) Is licensed and in good standing to offer health
12 insurance coverage in this state.

13 (2) Offers at least one qualified health benefit plan in
14 the silver level and at least one qualified health benefit plan
15 in the gold level, as those levels are defined in the federal
16 Act, through each component of the exchange in which the health
17 carrier participates, where component refers to the components
18 of the exchange which offer individual coverage and coverage
19 for small employers.

20 (3) Charges the same premium rate for each qualified health
21 benefit plan without regard to whether the plan is offered
22 through the exchange.

23 (4) Does not charge any termination of coverage fees or
24 penalties in violation of section 514M.5.

25 (5) Complies with the regulations developed by the
26 secretary under section 1311(d) of the federal Act, applicable
27 state laws, and such other requirements as the exchange may
28 establish.

29 h. The plan meets the requirements of certification as
30 adopted by rule pursuant to this section and by the secretary
31 under section 1311(c) of the federal Act, which include but
32 are not limited to minimum standards in the areas of marketing
33 practices, network adequacy, essential community providers in
34 underserved areas, accreditation, quality improvement, uniform
35 enrollment forms and descriptions of coverage, and information

1 on quality measures for health benefit plan performance.

2 *i.* The exchange determines that making the health benefit
3 plan available through the exchange is in the interest of
4 qualified individuals and qualified employers in the state.

5 2. An exchange shall not exclude a health benefit plan from
6 certification for any of the following reasons:

7 *a.* On the basis that the plan is a fee-for-service plan.

8 *b.* Through the imposition of premium price controls.

9 *c.* On the basis that the health benefit plan provides
10 treatments necessary to prevent patients' deaths in
11 circumstances the exchange determines are inappropriate or too
12 costly.

13 3. An exchange shall permit individuals to learn, in a
14 timely manner upon the request of an individual, the amount
15 of cost-sharing, including deductibles, copayments, and
16 coinsurance, under the individual's plan or coverage that the
17 individual would be responsible for paying with respect to the
18 furnishing of a specific item or service by a participating
19 provider. At a minimum, this information shall be made
20 available to the individual through an internet site and
21 through other means for individuals without access to the
22 internet.

23 4. An exchange shall not exempt any health carrier seeking
24 certification of a health benefit plan, regardless of the type
25 or size of the health carrier, from applicable state licensure
26 or solvency requirements and shall apply the criteria of this
27 section in a manner that assures a level playing field between
28 or among health carriers participating in the exchange.

29 5. *a.* The provisions of this chapter that are applicable
30 to qualified health benefit plans shall also apply to the
31 extent relevant to qualified dental plans except as modified in
32 accordance with the provisions of paragraphs "b", "c", and "d"
33 or by rules adopted by an exchange.

34 *b.* A health carrier shall be licensed to offer dental
35 coverage, but is not required to be licensed to offer other

1 health benefits.

2 *c.* A qualified dental plan shall be limited to dental and
3 oral health benefits, without substantially duplicating the
4 benefits typically offered by health benefit plans without
5 dental coverage and shall include, at a minimum, the essential
6 pediatric dental benefits prescribed by the secretary pursuant
7 to section 1302(b)(1)(J) of the federal Act, and such other
8 dental benefits as an exchange or the secretary may specify by
9 regulation or rule.

10 *d.* Health carriers may jointly offer a comprehensive plan
11 through an exchange in which the dental benefits are provided
12 by a health carrier through a qualified dental plan and the
13 other benefits are provided by a health carrier through a
14 qualified health benefit plan, provided that the plans are
15 priced separately and are also made available for purchase
16 separately at the same price.

17 Sec. 9. NEW SECTION. 514M.9 Funding — publication of
18 costs.

19 1. An exchange may charge assessments or user fees to health
20 carriers that offer health benefit plans through the exchange
21 or may otherwise generate the funding necessary to support the
22 operation of the exchange, as provided pursuant to the plan of
23 operation of the exchange.

24 2. An exchange shall publish the average costs of licensing,
25 regulatory fees, and any other payments required by the
26 exchange, and the administrative costs of the exchange, on an
27 internet site for the purpose of educating consumers about the
28 costs of operating the exchange. The information provided
29 shall include information on moneys lost due to waste, fraud,
30 and abuse of the health care system.

31 Sec. 10. NEW SECTION. 514M.10 Rules.

32 The commissioner shall adopt rules pursuant to chapter 17A
33 to administer the provisions of this chapter. Rules adopted
34 under this section shall not conflict with or prevent the
35 application of regulations promulgated by the secretary under

1 the federal Act.

2 Sec. 11. NEW SECTION. 514M.11 **Advisory committee — risk**
3 **adjustment.**

4 The commissioner shall establish an advisory committee
5 within the division of insurance of the department of commerce
6 to develop a risk adjustment mechanism that will apportion
7 risk among the health carriers providing defined contribution
8 health benefit plans, to protect those health carriers from
9 the risks of adverse selection. The commissioner may delegate
10 the responsibility for development of this mechanism to an
11 exchange.

12 Sec. 12. NEW SECTION. 514M.12 **Relation to other laws.**

13 This chapter, and action taken by an exchange pursuant to
14 this chapter, shall not be construed to preempt or supersede
15 the authority of the commissioner to regulate the business
16 of insurance in this state. Except as expressly provided to
17 the contrary in this chapter, all health carriers offering
18 qualified health benefit plans in this state shall comply fully
19 with all applicable health insurance laws of this state and
20 rules adopted and orders issued by the commissioner.

21 Sec. 13. **FUTURE REPEAL.** If the federal Act is repealed
22 by federal legislation or is ruled invalid by a federal court
23 decision, chapter 514M is repealed effective twelve months
24 after the effective date of such federal legislation or after
25 the date of the federal court decision.

26 Sec. 14. **CONTINGENT EFFECTIVE DATE.** This Act takes effect
27 six months prior to the date upon which an exchange is required
28 by federal law to be operational.

29 **EXPLANATION**

30 This bill authorizes the establishment of health insurance
31 exchanges in the state.

32 The bill creates new Code chapter 514M, which authorizes the
33 establishment of health insurance exchanges in the state to
34 facilitate the purchase and sale of qualified health benefit
35 plans in the individual market in this state and to assist

1 qualified small employers in facilitating the availability
2 of qualified health benefit plans offered in the small group
3 market. The intent of establishing of such exchanges is
4 to reduce the number of uninsured, provide a transparent
5 marketplace and consumer education, and assist individuals
6 with access to programs, premium assistance tax credits, and
7 cost-sharing reductions.

8 A health insurance exchange shall be established in the
9 state, and subject to the discretion of the commissioner of
10 insurance, may be operated by the insurance division of the
11 department of commerce or as a nonprofit corporation approved
12 by the commissioner. The commissioner is required to approve
13 the establishment of one or more exchanges in the state that
14 meet the requirements of new Code chapter 514M. An exchange
15 or components of an exchange may be operated on a statewide
16 or regional basis, or on a multistate basis, subject to the
17 approval of the commissioner. Such an exchange shall be
18 operated pursuant to a plan of operation approved by the
19 commissioner.

20 All persons who enroll in a qualified health benefit plan
21 offered through an exchange must be enrolled by an insurance
22 producer who is licensed as provided in Code chapter 522B. The
23 health carrier that issues the qualified health benefit plan
24 selected must pay the insurance producer a commission of at
25 least 5 percent of the premium paid by the enrollee. If a
26 health carrier offers health benefit plans outside an exchange,
27 the health carrier must also pay the producer involved in the
28 sale a commission of at least 5 percent of the premium paid by
29 the enrollee.

30 An exchange may contract with an eligible entity to
31 fulfill any of its responsibilities as described in new Code
32 chapter 514M. An eligible entity includes an entity with
33 experience in individual and small group health benefit plans,
34 benefit administration, or other experience relevant to the
35 responsibilities to be assumed by the entity, but does not

1 include a health carrier or its affiliate. An exchange may
2 also enter into information-sharing agreements with federal
3 and state agencies and other state exchanges if there are
4 adequate protections with respect to the confidentiality of the
5 information to be shared.

6 An exchange established or approved pursuant to Code section
7 514M.4 is required to make qualified health benefit plans
8 that are effective on or before January 1, 2014, available
9 to qualified individuals and qualified employers. Such an
10 exchange is also required to request a five-year waiver from
11 the secretary of the United States department of health and
12 human services of the certification requirements for health
13 benefit plans of the federal Patient Protection and Affordable
14 Care Act (PPACA), to enable the exchange to offer mandate-free
15 health benefit plans that are exempt from some or all of
16 the special health and accident insurance coverages required
17 pursuant to the federal Act or Code chapter 514C.

18 An exchange or a health carrier offering qualified health
19 benefit plans through the exchange cannot charge an individual
20 a fee or penalty for termination of coverage if the individual
21 enrolls in another type of minimum essential coverage because
22 the individual is newly eligible for that coverage or because
23 the individual's employer-sponsored coverage has become
24 affordable.

25 The bill specifies the duties of an exchange to carry out
26 the intent of the Code chapter consistent with the PPACA and
27 state law. The bill authorizes an exchange to select entities
28 to serve as navigators and to award grants to enable navigators
29 to conduct public education activities; distribute fair and
30 impartial information concerning enrollment in qualified health
31 benefit plans including the availability of premium tax credits
32 and cost-sharing reductions; facilitate enrollment through an
33 insurance producer in health benefit plans through or outside
34 the exchange; provide referrals to the federal office of health
35 insurance consumer assistance; and provide information that is

1 culturally and linguistically appropriate to the needs of the
2 population being served by the exchange. Entities qualified as
3 navigators that facilitate enrollment in health benefit plans
4 must be licensed as insurance producers or utilize the services
5 of an insurance producer to assist in such facilitation. All
6 entities that provide facilitation for a navigator shall be
7 licensed as insurance producers.

8 An exchange is given parameters for certifying health
9 benefit plans as qualified health benefit plans. Under the
10 PPACA, only qualified health benefit plans can be sold through
11 an exchange and a health benefit plan must be certified as
12 meeting certain minimum standards specified in the PPACA
13 and in new Code chapter 514M to be certified as a qualified
14 health benefit plan. Also, a health carrier must meet certain
15 standards in order to have its plans certified so that the
16 plans can be offered through an exchange.

17 An exchange is authorized to charge assessments or user fees
18 to health carriers that offer health benefit plans through
19 the exchange, or to otherwise generate the funding necessary
20 to support the operation of the exchange, as provided in the
21 plan of operation of the exchange. An exchange is required
22 to publish the average costs of licensing, regulatory fees,
23 and any other payments required by the exchange and the
24 administrative costs of the exchange on an internet site, to
25 educate consumers about the costs of operating the exchange.
26 The commissioner of insurance is required to adopt rules
27 pursuant to Code chapter 17A to administer the provisions of
28 the new Code chapter.

29 The commissioner is required to establish an advisory
30 committee or delegate the responsibility to an exchange, to
31 develop a risk adjustment mechanism that will apportion risk
32 among the health carriers providing defined contribution health
33 benefit plans, to protect those health carriers from the risks
34 of adverse selection.

35 The bill takes effect six months prior to the date upon

1 which an exchange is required by federal law to be operational.
2 If the PPACA is repealed by federal legislation or is ruled
3 invalid by a federal court decision, new Code chapter 514M is
4 repealed effective 12 months after the effective date of such
5 federal legislation or after the date of the federal court
6 decision.