Senate File 391 - Introduced

SENATE FILE 391
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO SF 235)

A BILL FOR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Workers' compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinics.

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

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

(1) Limited scope dental or vision benefits.

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

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

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

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

(2) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

eligible employers wherever employed.

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

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

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

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

b. Is a resident of this state.

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

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

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

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

b. For the purposes of this subsection:

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

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

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

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

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

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

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

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

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

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

4. An exchange shall do all of the following:

a. Facilitate the purchase and sale of qualified health

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

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

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

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

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

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

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

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

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

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

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

4. An exchange or a health carrier offering qualified health benefit plans through an exchange shall not 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 the federal Act, to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

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

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

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

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

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

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

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

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

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

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

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

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

10. Subject to section 1411 of the federal Act and applicable state law, grant a certification attesting that, for purposes of the individual responsibility penalty under the standards of the federal Act, to be codified at 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 any of the following:

a. There is no affordable qualified health benefit 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.

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

a. A list of the individuals who are issued a certification under subsection 10, paragraph "*a*", 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 the standards of the federal Act to be codified at section 36B(c)(2)(C) of the Internal Revenue Code of 1986, because of either of the following:

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

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

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

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

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

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

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

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

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

16. Meet all of the following financial integrity requirements:

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

b. Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the federal Act, and allow the secretary, in coordination with the inspector general of the United States 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.

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

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

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

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

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

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

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

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

insurance producer to assist in such facilitation.

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

Sec. 8. NEW SECTION. **514M.8 Health benefit plan certification.**

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

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

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

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

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

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

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

e. The plan offers wellness programs.

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

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

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

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

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

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

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

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

on quality measures for health benefit plan performance.

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

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

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

b. Through the imposition of premium price controls.

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

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

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

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

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

health benefits.

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

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

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

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

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

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

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

the federal Act.

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

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

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

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

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

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

EXPLANATION

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

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

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

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

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

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

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

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

An exchange or a health carrier offering qualified health benefit plans through the exchange cannot 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 is newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable.

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

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

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

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

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

The bill takes effect six months prior to the date upon

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