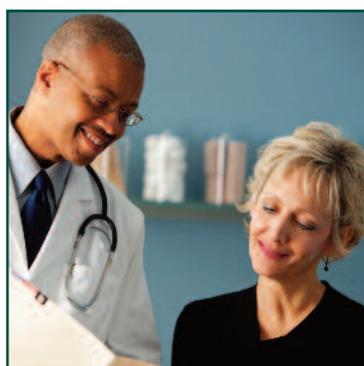


Report from the Study Panel on Health
Insurance Exchanges created under the
Patient Protection and Affordable Care Act



Designing an Exchange:

A Toolkit
for State
Policymakers



January 2011



Robert Wood Johnson
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Background

The Patient Protection and Affordable Care Act (P.L. 111-148) was designed to expand coverage and create a more organized and competitive health insurance market.¹ How state health insurance Exchanges are designed and implemented will be important to achieving the ACA's coverage, quality, and efficiency aims.² Beginning in 2014, these new entities will offer consumers a choice of plans, establish common rules regarding the offering and pricing of certified health benefit plans, and provide information to help consumers better understand the coverage options available to them.³ While federal regulations will define key elements of the ACA, each state will be able to design critical aspects of the operation and financing of its Exchange and will continue to make decisions about the regulation of its insurance markets.

To assist states with implementation of the ACA, the National Association of Insurance Commissioners (NAIC) has developed legislative language that describes the elements of a state Exchange required by federal law.⁴ NAIC's legislative language offers a useful blueprint for state authorizing legislation that would comply with the minimum requirements of the ACA.

This project builds on the NAIC model act with the purpose of providing technical assistance to state policymakers interested in a broader range of policy options for designing an insurance Exchange. Sponsored by the National Academy of Social Insurance (NASI) and funded by the Robert Wood Johnson Foundation, this project offers policymakers a toolkit that includes legislative language with alternatives and additions to the NAIC model act, as well as a narrative explaining key issues and concerns that motivated the NASI model act. The narrative also addresses longer-term

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- 1 The Patient Protection and Affordable Care Act was amended by the Health Care Reconciliation Act of 2010 (P.L. 111-152). The two are often combined and referred to as the Affordable Care Act (ACA).
 - 2 The ACA specifies two health insurance Exchanges, the individual Exchange and the Small Business Health Options Program (SHOP) Exchange. Unless otherwise noted, references to an exchange are to the individual Exchange.
 - 3 See The Henry J. Kaiser Health Reform Source, available online at <http://healthreform.kff.org/Faq/What-is-a-health-insurance-exchange.aspx>.
 - 4 The NAIC document is called the American Health Benefits Exchange Model Act and was formally adopted by the full NAIC executive committee on December 16, 2010. The model law can be found at http://www.naic.org/documents/committees_b_Exchanges_adopted_health_benefit_Exchanges.pdf.

policy issues that state lawmakers may reasonably defer to a later time or delegate to the Exchange. In addition, the project will include a series of issue briefs that explore critical policy issues in state implementation of the ACA; the first of these focuses on the issue of Exchange governance.⁵

This project is the work of a blue-ribbon panel composed of twenty-one national experts from academia, public interest organizations, and industry representing diverse disciplines and philosophical perspectives. It represents a collaboration of panel members with divergent perspectives on the ACA. The panel worked within the framework of the ACA to provide a range of options for state policymakers, who are in the best position to understand the health care delivery systems, insurance markets, and population needs that set the context of health insurance Exchanges.

5 See Paul N. Van de Water and Richard P. Nathan, *Governance Issues for Health Insurance Exchanges*, National Academy of Social Insurance, January 2011, <http://www.nasi.org/sites/default/files/research/Health%20Policy%20Brief%20No%201.pdf>.

How To Use This Toolkit

This toolkit has two major components: (1) a document entitled *Additional Legislative Options to the NAIC American Health Benefit Exchange Model Act* that adds legislative language to the NAIC model act, accompanied by a section-by-section analysis showing how the NASI legislative language modifies the NAIC model act; and (2) this narrative, which provides an overview of key issues facing state policymakers.

The NASI model act offers both additions and alternatives to the NAIC model act. Any NASI changes to the NAIC model act are shown in italics. Where the NAIC model act does not offer specific language on an issue, as in the section on governance, the NASI language stands on its own.⁶ In many instances, the NASI language offers several alternatives that may differ only in the amount of discretion granted to the Exchange. While such alternatives are listed as Alternative 1, Alternative 2, or Alternative 3, no hierarchy is intended, and the NAIC model act language should always be considered an equally viable alternative. The legislative language occasionally includes drafting notes that explain NASI's added language.

The alternatives offered in the NASI model act may be useful at various stages of the state policymaking process. States may find this toolkit useful in drafting legislation, developing regulations or guidelines by operational Exchanges, and in guiding the policy development activities of related agencies such as a state Medicaid agency or a Department of Insurance, whose policies and operations will need to be coordinated with those of the Exchanges.

6 Throughout the document, the NAIC language is kept intact, including the numbering of the sections. While full NAIC drafting notes have been omitted, their placement has been noted and their content has been summarized.

Discussion of Key Issues

This section offers a discussion of the key issues that the panel considered in developing additional legislative language embodied in the NASI model act. The discussion is a result of many hours of in-depth deliberation among panel members, who formed workgroups to consider issues in four categories: (1) governance; (2) Exchange functions; (3) the relationship of the Exchange to the health insurance market; and (4) the relationship of the Exchange to Medicaid. The organization of this section roughly follows this same structure.

ESTABLISHMENT OF EXCHANGES AND GOVERNANCE

Under section 1311(d) of the ACA, an Exchange may be created within an existing state agency, as an independent executive branch agency, or as a new nonprofit entity.⁷ There is no single correct approach and section 4(A) of the NASI model act offers all three options.

The first option would establish the Exchange within an existing executive branch agency, either as part of the Governor's cabinet or subordinate to a cabinet-level agency. Locating the Exchange in such an agency might facilitate use of current staff with relevant skills, as well as use of established administrative systems and procedures. Thus, it might promote inter-agency coordination and offer savings from shared infrastructure. However, this approach could also overwhelm an existing agency and create intra-agency friction over resources. In addition, it could foster a too-narrow focus for the Exchange, oriented to the host agency's original jurisdiction and the concerns of its existing stakeholders.

While NASI Drafting Note 7 identifies several agencies as potential locations for an Exchange, in fact none might fit with the role of an Exchange.⁸ Housing the Exchange within the Department of Insurance raises particular concerns about the careful balance that must be struck between an Exchange and the state's insurance department, which is responsible for ensuring that insurers are financially solvent, able to meet regulatory requirements, and are otherwise legally qualified to sell insurance in the state. In contrast, in some states, an Exchange's job might be to help develop a more competitive insurance market that works better for consumers. A single agency

7 ACA, section 1311(d)(1).

8 Timothy S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, The Commonwealth Fund, September 2010, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>.

would find it challenging to reconcile these two substantially different roles and thus, locating an Exchange within the Department of Insurance could prove particularly problematic.⁹

Alternatively, a state might create an Exchange as an independent executive branch agency with its own governing board, as was done in Massachusetts and more recently in California. This approach in alternative 2 could offer the Exchange a significant amount of political independence, operational flexibility and public accountability. California created an Exchange in which the Governor and state legislators each make appointments to the Exchange Board. The constitution of some states may preclude this arrangement, but having the two branches of government share in the appointment of the board is not crucial to creating an Exchange as an independent executive branch agency.

Yet another option might be to establish an Exchange as a nonprofit entity, separate from state government. This option, alternative 3 in the NASI legislative language, could offer a greater degree of independence and flexibility in operational matters, but also raises important legal questions.¹⁰ For example, certain Exchange functions such as levying taxes, certifying that a health plan is “in the interest of qualified individuals and qualified employers,” or taking “unreasonable” premium increases “into account” in determining whether to allow a health plan into the Exchange might be inherently governmental duties that are not delegable to a private sector entity.

The Exchange will be starting from a largely blank legal slate under alternative 2 or 3. A state’s authorizing legislation will specify the Exchange’s legal responsibilities and its relationship to current laws — including whether current personnel laws, procurement laws, and administrative laws of the state apply. Many of these laws are vital to ensuring accountability, and transparent and clean government (for example, open meetings laws, open records laws and statutes barring state employees from engaging in political activity on the job). Others, however, may prevent an Exchange from hiring staff with sufficient experience or from purchasing capital goods in a timely manner. Without a clear indication of legislative intent, it may be unclear whether these laws apply to an independent agency or a nonprofit entity. Such ambiguity would cause obvious problems for an Exchange (see NASI Drafting Notes 10 and 13).

9 Van de Water and Nathan, *Governance Issues*.

10 Jost, *Eight Difficult Issues*, p. 3. Van de Water, *Governance Issues*.

SHOP EXCHANGES

Section 1311 of the ACA requires a state to establish an Exchange that in turn would establish a Small Business Health Options Program (called a SHOP Exchange).¹¹ The NASI legislative language addresses the governance of a SHOP Exchange separately from issues of structure, e.g. whether it is established as part of a larger Exchange with dual responsibilities, or established as an independently operated and governed Exchange. A state may want to achieve the maximum integration of individual and SHOP Exchange functions, as required under law. Combining functions such as certification and rating of qualified health plans could be cost-effective and could produce economies of scale and ease the transition of individuals who move between individual and employer-sponsored coverage as their employment circumstances change. However, there are practical limits on how much a state may want to merge the two sets of Exchange functions. Some operations, such as billing and enrollment processes, are different for employer groups; separate administration of such functions might be the most efficient. The same is true for managing employee and employer contributions to premiums in the SHOP Exchange, versus managing eligibility for premium and cost-sharing subsidies in the Exchange.

The ACA is unclear about the extent to which the SHOP Exchange might limit employees to health plans selected by their employers (employer choice) or allow employees to choose more broadly from among a range of qualified health plan products (employee choice). The NAIC model law assumes employer choice; that is, employers purchasing in the SHOP Exchange would choose one or more health plans for their employees, as is typical currently. When promulgated, federal standards may resolve this issue. Regardless, the NASI language suggests that the state could take steps to structure the SHOP Exchange in a way that is useful for participating employers—for example, aggregating employee premiums to minimize the administrative burden on employers whose employees may enroll.

CERTIFICATION OF QUALIFIED HEALTH PLANS

An Exchange must certify plans based on a determination of what “is in the interests of qualified individuals and qualified employers” in the state.¹² The ACA requires that health plans sold in the Exchange meet certain criteria, including marketing, network adequacy, accreditation, and quality improvement requirements.¹³ However, the ACA does not preclude a state from adopting additional standards for qualified health

11 ACA, section 1311(b)(1).

12 ACA, section 1311(e)(1).

13 ACA, section 1311(c)(1).

plans. Such additional standards might include transparency and information disclosure, service area designation, achievement of benchmarks for health outcomes, among other considerations.

For states that wish to have the Exchange play a more active role in certifying qualified health plans, the alternative offered in section 7(A)(6) of the NASI legislative language would allow plans to selectively contract among qualified health plans and further standardize both essential and optional benefits as well as cost-sharing within benefit tiers. A state might want an Exchange to consider this as a measure to reduce a potentially confusing array of benefit and cost-sharing options.¹⁴ Even within the benefit tiers that the ACA specifies, wide variation in benefits and cost-sharing can have significant implications for a consumer's out-of-pocket costs.¹⁵

DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE

The ACA is unclear about the eligibility determination and enrollment functions of the Exchange. Section 1411(c)(4) states that the Exchange will collect information from applicants and send it to the Department of Health and Human Services (HHS) for verification, implying that HHS will make the initial eligibility determinations for advance premium tax credits and handle any appeals of unfavorable decisions. Similarly, section 1311(d)(4) of the ACA directs Exchanges to enroll individuals in Medicaid or the Children's Health Insurance Program (CHIP) if eligible, but contains conflicting language about which entity makes the actual eligibility determination. Section 1413(d) gives Exchanges the authority to contract out the eligibility determination process to the state Medicaid agency, thereby implying that Exchanges are to engage in initial screening, with eligibility determination and enrollment carried out by state Medicaid and CHIP agencies under an agreement.¹⁶ Yet another provision of the ACA, section 1311(f), directs the Internal Revenue Service (IRS) to carry out recoupment activities in the event that an overpayment of advance premium tax credits occurs. However, the ACA does not address how individuals will be counseled regarding this potential recoupment process or assisted in reporting

14 The ACA requires the federal government to define a set of "essential" benefits that all qualified health plans must offer, although they may offer additional benefits as well. ACA section 1302 requires that the actuarial value of the benefits offered by qualified health plans fit into one of four tiers. The four tiers are platinum (the actuarial equivalent to 90% of the full actuarial value of the benefits provided under the plan), gold (80%), silver (70%) and bronze (60%).

15 Jost, *Eight Difficult Issues*, p. 29-30.

16 See also section 1413, which states that individuals applying to an Exchange shall be screened for Medicaid or CHIP eligibility and enrolled if found to be eligible.

income changes that might affect the level of tax credits. Nor does the act specify which entity is responsible for periodic redetermination of Medicaid or CHIP eligibility or eligibility for advance premium tax credit payments.

In advance of federal regulations that are expected to explain and reconcile these provisions, a state might consider legislative language that gives the Exchange authority broad enough to accommodate federal requirements when they are promulgated. Sections 6(G), 6(R4) and 6(R5) of the NASI legislative language would authorize the Exchange to take administrative steps (including creation of data sharing agreements and databases with enrollee information) to facilitate determinations of eligibility for advance premium tax credits or Medicaid or CHIP, as well as eligibility redetermination and re-enrollment procedures and procedures for assuring that individuals get the benefit of any “safe harbor” provisions that may be created as part of the federal recoupment process. Given the significant penalty for overpayment of advance premium tax credits,¹⁷ a state might want to ensure that the Exchange and other relevant state agencies are empowered to provide the necessary support and assistance to individuals and families participating in an Exchange.

BROKERS AND AGENTS

Establishment of an Exchange under the ACA raises questions about how the role of brokers and agents in the small group and individual market might evolve. Currently, brokers and agents play at least two roles: First, they help prospective consumers cut through a difficult tangle of choices by presenting a clear set of options. Second, they advise consumers on their insurance decisions, sometimes even assisting employees with denied claims or service issues after enrollment. When insurance companies embed brokers’ commissions into the premiums of health plans, the direct cost of these services is invisible to the consumer. Credible estimates suggest that sales commissions add 4 to 10 percent to the cost of insurance products on average.¹⁸ Therefore, a state may wish to consider policies to ensure that the commissions paid for plans sold in the outside market do not cause brokers and agents to steer consumers away from the Exchange.

17 The penalty for overpayment of advance premium tax credits was increased in December 2010. Section 208 of the Medicare and Medicaid Extenders Act, signed into law on December 15, 2010, raised the limit on the amount that can be recovered in reconciliation of the health insurance tax credit and the advance of that credit. See <http://www.gpo.gov/fdsys/pkg/BILLS-111hr4994enr/pdf/BILLS-111hr4994enr.pdf>.

18 Leslie Jackson Conwell, *The Role of Health Insurance Brokers: Providing Small Employers with a Helping Hand*, The Center for Health Studying Health System Change, 2002, p. 1, <http://www.hschange.com/CONTENT/480/480.pdf>.

ROLE OF NAVIGATORS

Under section 1311(i) of the ACA, an Exchange is required to establish a Navigator program, awarding grants to eligible entities to carry out education, enrollment and information dissemination activities. Although the Navigator program will be administered by the Exchange, HHS will establish national standards for Navigators, including provisions to ensure that entities selected are qualified, and licensed if appropriate.

The ACA's Navigator program addresses at least two problems. First, beginning in 2014, a new group of consumers will require assistance in understanding their health care options. In the past, many of these consumers have received coverage through either their employer or a public program; most have never purchased health insurance on their own and some may face language barriers in doing so.¹⁹ Second, to be sustainable, an Exchange must generate sufficient enrollment, which in many states may require aggressive efforts at outreach and consumer education.²⁰

Under the NASI alternative language, Exchanges would have a duty to ensure that a sufficient number of Navigators are available to assist disadvantaged, hard-to-reach and/or culturally isolated populations as referenced in the ACA. Navigators would also be expected to counsel Exchange-eligible individuals about their options, including those related to potential transitions between Medicaid or CHIP and the Exchange. Continuity of coverage and care might be improved if people whose income changes during the year are advised about which certified health plans also participate in Medicaid and CHIP.

For states concerned whether Navigators will have the expertise necessary to help individuals and small businesses select plans, the NASI alternative language offered in section 6(N) raises the issue of certification. To the extent permissible under forthcoming HHS standards, a state might require that the Exchange review qualifications of entities selected as Navigators, particularly with respect to transitioning between the Exchange and Medicaid or CHIP.²¹

19 Robert Carey, *Health Insurance Exchanges: Key Issues for State Implementation*, AcademyHealth: State Coverage Initiatives, September 2010, p. 14, <http://www.rwjf.org/files/research/70388.pdf>.

20 Carey, *Key Issues for State Implementation*, p. 14.

21 While not contained in that legislative language, a state might consider also imposing the same requirements related to transitions between the Exchange and Medicaid in licensing agents and brokers.

States may have a significant timing issue with respect to funding for a Navigator program. States may not use federal start-up funds to support their Navigator programs.²² However, a state that will fund the Exchange through fees levied on insurance premiums may not have the revenues to support Navigator activities before January 1, 2014. Therefore, a state might need to identify a separate funding source for the enrollment and outreach activities of its Navigator program prior to this date.

The other issue with regard to funding is that there may be entities qualified to provide Navigator activities that would do so regardless of government funding. For example, associations, unions and other organizations regularly communicate with their members about benefits, including health care coverage. NASI offers alternative language that would allow the Exchange to designate these entities as Navigators if they are able to meet the standards established by the Secretary and by the Exchange, regardless of funding.

While the functional need for the activities Navigators will perform is unquestioned, their prospective role is viewed by some as potentially duplicating that of brokers and agents.²³ Although brokers and agents may serve as Navigators under the federal law, to do so would entail an important change for brokers and agents relative to the way they are now compensated; specifically, a Navigator cannot receive payment from an insurer or for their clients' specific purchase decisions.²⁴ Exchanges will have to decide how to best match the roles of Navigators with the expertise and trust that brokers and agents have earned over the years.

ADVERSE SELECTION

Adverse selection occurs when a health plan product or group of products enrolls a greater proportion of individuals with higher-than-average expected health costs than are either eligible to seek coverage or actually covered in the market. Adverse selection occurs in part because people who anticipate using health care are more likely than others to seek coverage, and more likely to seek relatively comprehensive coverage.

22 ACA, section 1311(i)(6).

23 See *The Role of Health Insurance Agents, Brokers and Consultants in Any Health Insurance "Exchange"*, National Association of Health Underwriters, http://www.nahu.org/legislative/connector/agents_and_brokers_Exchange.pdf.

24 Mark Newsom, *Health Insurance Agents and Brokers in the Reformed Health Insurance Market*, Congressional Research Service, October 2010, p. 4, http://www.achp.org/themes/ACPH_Main/files/CBO_Report_on_brokers_and_navigators.pdf.

The ACA includes a number of provisions — including temporary federal reinsurance and risk corridor programs, market-wide risk pooling, and market-wide state risk adjustment — intended to address the potential for adverse selection disrupting health insurance markets, including Exchanges. Nevertheless, in developing an Exchange, state policymakers may want to give considerable attention to the potential for adverse selection to destabilize the Exchange, the outside market, or both.

There are at least four situations where adverse selection might occur. First, the ACA’s guaranteed offer of coverage, elimination of health-based underwriting and rating, and restrictions on other rating factors mean that less healthy people will be able to buy affordable coverage. If less healthy people enroll in greater numbers compared to healthier people, then it is likely that premiums will rise.

Second, some products might attract less healthy people in greater numbers, causing premiums for those products to rise. This could occur if some products simply are more attractive to less healthy people (for example, because they offer more comprehensive benefits or provider networks more skilled in the management of certain conditions) or if carriers use marketing or customer service to alter their mix of enrollees. If products offered outside the Exchange attract healthier enrollees than similar products offered in the Exchange (thereby causing adverse selection in the Exchange), Exchange premiums will exceed those for similar products outside. This can trigger a “death spiral” for products in the Exchange, causing the Exchange to fail.

Third, while all insurers (whether offering products inside or outside the Exchange) are required to accept all applicants for coverage, some states may allow insurers that offer products outside the Exchange broader latitude to use marketing or enrollment practices that attract relatively healthy people or, conversely, discourage less healthy people from enrolling. In contrast, products offered in the Exchange are likely to be widely publicized and easily available to everyone. Also, insurers offering outside an Exchange might offer only lower-cost, higher-deductible bronze plans that may attract healthier people. In contrast, insurers in the Exchange must offer more comprehensive silver and gold plans on a subsidized basis for individuals who qualify for advance premium tax credits. These plans could attract people with greater health care needs who are both willing to pay for more comprehensive coverage and subsidized to do so.

Fourth, the ACA applies new standards to qualified health plans certified by the Exchange. For example, their networks must include essential community providers in accordance with federal standards, and they must be accredited for meeting local performance standards. The ACA does not require that these standards apply to products offered outside the Exchange, which need not be qualified health plans. Thus, products offered outside an Exchange could be less expensive than similar

products offered in the Exchange. If relatively healthy people are more interested in lower premiums and less interested in the additional standards because they do not anticipate needing care, adverse selection against the Exchange could result.

States concerned about adverse selection, despite the market-wide risk adjustment that the ACA requires, might consider additional strategies to help address the concern that products offered in the Exchange could attract a less healthy mix of enrollees than those offered outside. However, because these strategies would entail regulation of the market outside the Exchange, they are beyond the scope of the NASI model act, which focuses more narrowly on alternative provisions for establishing an Exchange.²⁵

COORDINATION WITH STATE INSURANCE REGULATORS

The ACA links Exchanges with state insurance regulators by requiring that products offered in the Exchange be licensed in the state.²⁶ Since Exchanges will operate within health insurance markets, effective coordination between the Exchange and state insurance regulators will be essential to help manage the potential for adverse selection and to ensure the stability of the Exchange.

NASI offers legislative language in Section 7(E2) for three alternative ways to coordinate the roles of the Exchange and the health insurance regulator, varying the responsibilities and resource cost allocation to each. Alternative 1 would rely on insurance regulators to ensure that a plan seeking certification meets all licensure and solvency requirements, as well as all requirements for a qualified health plan. Placing all of the responsibilities with the Commissioner for oversight of qualified health plans could minimize the additional resources needed to operate the Exchange. Alternative 2 would have insurance regulators determine whether a plan meets some aspects of ACA and/or other state requirements for a qualified health plan (as well as state licensure and solvency requirements), and the Exchange would determine whether a plan meets all other requirements for a qualified plan. Under alternative 2, a state

25 For example, making some or all of the additional requirements for Exchange certification a condition of licensure could enhance competition among plans and reduce the potential for adverse selection between Exchange and non-Exchange plans. However, in determining whether to apply an ACA standard to all plans, states may want to balance these considerations against the additional burden placed on plans outside the Exchange. A forthcoming issue brief from NASI's Health Reform project will address adverse selection and the ACA's related provisions and options for states.

26 The ACA also links the two in a number of more subtle ways, including the requirement that nongroup and small-group health plans offer the essential benefits package, the requirement that carriers poll risk across nongroup and small group markets, the creation of a CO-OP program and the ability to merge the individual and SHOP Exchange.

would decide which responsibilities are more efficiently allocated to insurance regulators, and which are more efficient to allocate to the Exchange. Alternative 3 would have insurance regulators ensure that plans meet licensure and solvency requirements (as they do now), but the Exchange would determine whether a plan meets all other ACA and Exchange requirements. Alternative 3 would require the Exchange to employ the most resources and directly finance the greatest cost. Conversely, it might require insurance regulators to take on fewer new responsibilities associated with the operation of an Exchange.

MEDICAID AND THE EXCHANGE

Neither Medicaid nor the ACA's provision for advance premium tax credits guarantees eligibility for assistance for a full enrollment year. Changes in modified adjusted gross income (MAGI), including actual changes in income as well as changes in family circumstances affecting income, can be expected to result in movement between Medicaid and Exchange coverage (as well as changes in the amount of advance premium tax credits received by individuals and families enrolled in qualified health plans).

To address these issues, NASI offers legislative language related to the coordination between the Exchange and Medicaid or CHIP. The language offered in section 6(R3) and section 6(R4) would explicitly authorize or require the Exchange to collaborate with the state Medicaid and CHIP agencies on various strategies aimed at promoting continuity of coverage and care. In addition to coordination of eligibility determination and enrollment activities as required under section 1413 of the ACA, these provisions include use (where possible) of common health plan certification standards on matters such as provider networks, coverage terms, and quality performance standards in order to promote health plan participation in both the Medicaid and Exchange markets. They also include the development of policies governing health plan operations in the case of individuals and families undergoing a transition between the Medicaid and Exchange health plan markets. In addition, section 6(R4) of the NASI model act offers language that would authorize the Exchange and the Medicaid agency (and where applicable the state CHIP agency) to coordinate health plan payment procedures in order to better align enrollment and health plan payments.

Finally, because recoupment of advance premium tax credits is anticipated in cases in which families undergo a change in income that affects the size of the credit to which they are entitled, the NASI options include provisions for the Exchange to assist consumers in reporting income changes that might affect the amount of subsidy, as well as in qualifying for any "safe harbor" against federal recoupment that might ultimately be recognized in federal rules.

Additional Legislative Options to the NAIC American Health Benefit Exchange Model Act

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SECTION 1. TITLE

This Act shall be known and may be cited as *Additional Legislative Options to the NAIC American Health Benefit Exchange Model Act*.

NASI Drafting Note 1: Replacing NAIC language to reflect a new title that distinguishes this NASI document from the model act formally adopted by the NAIC on December 16, 2010.

SECTION 2. PURPOSE AND INTENT

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

[**NAIC Drafting Note Omitted:** Explains that states that elect to expand the Exchange market to larger groups will need to revise the small group reference in the model.]

NASI Drafting Note 2: A state may have additional objectives for its Exchange, including but not limited to, increased competition, reduced health care costs, portability and simplicity.

SECTION 3. DEFINITIONS

For purposes of this Act:

AA. “Catastrophic plan” means

(1) *In General.* — a health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of section 1302(d) of the ACA with respect to any plan year if —

(a) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(b) the plan provides —

(i) except as provided in clause (ii), the essential health benefits determined under section 1302(b) of the ACA, except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under section 1302 (c)(1) of the ACA for the plan year (except as provided for in section 2713 of the Public Health Services Act); and

(ii) coverage for at least three primary care visits.

(2) *Individuals Eligible for Enrollment.* — An individual is described in this paragraph for any plan year if the individual—

(a) has not attained the age of 30 before the beginning of the plan year; or

(b) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of —

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) *Restrictions to Individual Market.* — If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

NASI Drafting Note 3: Defines a catastrophic plan, as specified in section 1302(e) of the Patient Protection and Affordable Care Act (ACA).

A. “Commissioner” means the Commissioner of Insurance.

[NAIC Drafting Note Omitted: Related to terminology for chief insurance regulatory official.]

B. “Educated health care consumer” means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. “Exchange” means the [insert name of State Exchange] established pursuant to section 4 of this Act.

- D. “Federal Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.
- E. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

[NAIC Drafting Note Omitted: Explains the meaning of “health benefit plan.”]

- (2) “Health benefit plan” does not include:
- (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; or
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.
- (3) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (4) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (5) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.

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

NASI Drafting Note 4: *The ACA uses the term “health insurance issuer,” as defined in section 2791(b) of the Public Health Service Act (PHSA). The NAIC draft and many state insurance laws use the term “carrier.” PHSA section 2791(b) defines “health insurance issuer” as “an insurance company, insurance service, or insurance organization (including a health maintenance organization...which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance.... Such term does not include a group health plan.”*

- G. “Qualified dental plan” means a limited scope dental plan that has been certified in accordance with section 7E of this Act.
- H. “Qualified employer” means a small employer that elects to make *all* of its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:
- (1) Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
 - (2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

NASI Drafting Note 5: *Inserts language in subsection H to maintain consistency with section 1312(f)(2) of the ACA.*

[**NAIC Drafting Note Omitted:** Explains a state’s option to expand Exchange eligibility beyond small employers beginning in 2017.]

- I. “Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.
- J. “Qualified individual” means an individual, including a minor, who:
- (1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;
 - (2) Resides in this State;
 - (3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and
 - (4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

- K. “Secretary” means the Secretary of the federal Department of Health and Human Services.
- L. “SHOP Exchange” means the Small Business Health Options Program established under section 6 of this Act.
- M. (1) “Small employer” means an employer that employed an average of not more than 100 employees during the preceding calendar year.

[*NAIC Drafting Note Omitted*: Explains a state’s option to define small employers as employers with one to 50 employees only for plan years beginning before Jan. 1, 2016.]

- (2) For purposes of this subsection:
 - (a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;
 - (b) An employer and any predecessor employer shall be treated as a single employer;
 - (c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

[*NAIC Drafting Note Omitted*: Refers to HHS’ guidelines on defining group size and the potential for risk selection if different definitions are used inside and outside the Exchange.]

 - (d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and
 - (e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

SECTION 4. ESTABLISHMENT OF EXCHANGE

- A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

[*NAIC Drafting Note Omitted*: Explains different governance policy approaches and additional legislative drafting considerations, depending on whether the Exchange is established as an existing state agency, an independent public or quasi-governmental agency or a nonprofit entity. Advises states they will have to include additional sections related to governance and operations, including responsibilities of the Board, procedures for hiring staff and responsibilities of state agencies coordinating with the Exchange. Also recognizes that states are permitted to establish regional or interstate Exchanges, and should modify their legisla-

tion accordingly if they choose to establish such an Exchange. Lastly, counsels states to review their producer and licensing laws to determine whether the Exchange should be exempt from such laws.]

NASI Drafting Note 6: ACA section 1311 requires the Exchange to provide for the establishment of a SHOP Exchange, and the NAIC model act assumes that the Exchange will do so. That said, nothing in the ACA appears to prohibit a SHOP Exchange from operating under different standards and governance. Therefore, a state may wish to establish the Exchange and SHOP Exchange independently, specifying a governance structure and powers for each. Alternatively, a state might establish a single Exchange authority with two divisions, each authorized to perform separate duties and functions.

Alternative 1: Creates the Exchange as an executive branch office subordinate to the Governor.

(1) The [insert official title of the Exchange] is hereby established within [insert existing executive branch office].

NASI Drafting Note 7: Authorizing legislation would place the Exchange in a cabinet or sub-cabinet level agency (e.g., the Department of Insurance, agency administering the state's Medicaid program, the Department of Finance and Administration or other agency responsible for coordination/management of state government, the Labor Department or an agency administering health benefits for state employees) or in the Executive Office of the Governor.

Alternative 2: Creates the Exchange as an independent executive branch agency.

(1) There shall be a public instrumentality to be known as the [insert official title of the Exchange], which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the State except as specifically provided in this Act. The [insert official title of Exchange] shall be governed by an Executive Board consisting of ___ individuals. The [insert title of Secretary of Health or equivalent], [insert title of Commissioner of Insurance], and [insert title of state's Medicaid Director] or their designees shall serve as ex-officio members of the Board.

(2) Members of the Board, other than ex-officio members, shall be appointed for a term of ___ years, except that the initial appointments by [insert title of relevant appointing authority] shall be for a term of ___ years and the initial appointments by [insert title of relevant appointing authority] shall be for a term of ___ years.

NASI Drafting Note 8: A state may wish to stagger the terms of members of the Board of Directors so that only a portion of the Board is stepping down in any given year. Further, a state may want to make terms relatively short and bar members from serving more than two consecutive terms.

- (3) (a) *Each person appointed to the Board shall have demonstrated and acknowledged expertise in at least one of the following areas:*
 - (i) *Individual health care coverage.*
 - (ii) *Small employer health care coverage.*
 - (iii) *Health benefits plan administration.*
 - (iv) *Health care finance and economics.*
 - (v) *Actuarial science.*
 - (vi) *Administering public or private health care services delivery.*
 - (vii) *Purchasing health plan coverage.*
- (b) *The membership of the Board shall include, but not be limited to, individuals who represent the interests of:*
 - (i) *Health care consumers.*
 - (ii) *Small business owners.*
 - (iii) *Other organizations eligible to purchase in the Exchange.*
- (c) *Appointing authorities shall consider the range of experience and expertise of the other members of the Board and attempt to make appointments so that the Board's composition reflects the range of experience and expertise required in subsections (a) and (b).*
- (d) *No appointee may be employed by, a consultant to, a member of the Board of Directors of, or otherwise a representative of or a lobbyist for an entity in the business of, or potentially in the business of, selling items or services of significant value to the [insert name of state Exchange]. Such entities would include, but not be limited to, carriers or insurers that provide coverage of health benefits, producers, vendors, and health care providers selling services directly to the [insert name of state Exchange].*

NASI Drafting Note 9: *HHS' January 19, 2011 Funding Opportunity Announcement requires a state establishing its own Exchange to develop standards for preventing conflicts of interest in the governance of the Exchange. While such a standard could simply be the disclosure of any conflicts by Board members, a stronger standard may be necessary to ensure that the Exchange can fairly and impartially execute its responsibilities under the law to foster a more competitive insurance marketplace. A simpler standard might exclude from the Board anyone with a direct financial interest in Board decisions, with the exception that consumers and employers whose only interest is to purchase insurance products would not be excluded from the Board. Subsection d, or any alternative provision, would apply regardless of whether the Exchange is a government agency or an independent nonprofit entity.*

- (4) *The Board shall appoint an Executive Director of the [insert official title of the Exchange], who shall appoint other staff as necessary.*
- (5) *In order to ensure efficient operation of the [insert official title of the Exchange], the Executive Director may seek assistance and support as may be required in the performance of its duties from appropriate state departments, agencies and offices.*
- (6) *The Board shall appoint an advisory committee to allow for the involvement of the health care industry and other stakeholders in the operation of the [insert official title of the Exchange]. Such advisory committee shall provide expertise and recommendations to the Board, but shall have no authority to promulgate rules or regulations or enter into contracts on behalf of the [insert official title of the Exchange].*
- (7) *The Board shall be subject to [insert cross-references to state's open meeting laws, freedom of information provisions as well as any of the state's relevant administrative or ethics laws].*

NASI Drafting Note 10: This language provides legislative direction regarding the establishment of the Exchange as an independent executive branch agency. A state wanting to pursue this approach may want to consider examining public benefit corporations used to maintain state infrastructure. In many states, these are considered part of state government.

Whether the Exchange director is legislatively confirmed will depend on state law and practice for the appointment of high-level officials.

Other provisions of state law may need to be amended to require relevant state agencies to provide assistance as needed.

Finally, a state may want to decide whether existing procurement or personnel rules should apply to the Exchange, and to clarify that bids to offer coverage through the Exchange are not subject to state procurement or competitive bidding laws.

Alternative 3: Establishes the Exchange as a new private nonprofit organization, chartered under state law as a board-only organization.

- (1) The [insert official title of the Exchange] is hereby established as an independent nonprofit entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the State except as specifically provided in this Act. [Insert cross-references to state procurement and personnel rules] shall not apply to the [insert official title of the Exchange]. The [insert official title of the Exchange] shall be governed by an executive Board consisting of ___ individuals. The [insert title of Secretary of Health or equivalent], [insert title of Commissioner of Insurance], and [insert title of state's Medicaid Director] or their designees shall serve as ex-officio members of the Board.
- (2) Members of the Board, other than ex-officio members, shall be appointed for a term of ___ years, except that the initial appointments by [insert title of relevant officeholder] shall be for a term of ___ years and the initial appointments by [insert title of relevant officeholder] shall be for a term of ___ years.

NASI Drafting Note 11: As with an independent executive branch agency, a state may wish to stagger the terms of members of the Board of Directors so that only a portion of the Board is stepping down in any given year. Further, a state may want to make terms relatively short and bar members from serving more than two consecutive terms.

- (3) (a) Each person appointed to the Board shall have demonstrated and acknowledged expertise in at least one of the following areas:
 - (i) Individual health care coverage.
 - (ii) Small employer health care coverage.
 - (iii) Health benefits plan administration.
 - (iv) Health care finance and economics.
 - (v) Actuarial science.

- (vi) Administering a public or private health care delivery system.
- (vii) Purchasing health plan coverage.
- (b) The membership of the Board shall include, but not be limited to, individuals who represent the interests of:
 - (i) Health care consumers.
 - (ii) Small business owners.
 - (iii) Other organizations eligible to purchase in the Exchange.
- (c) Appointing authorities shall consider the range of experience and expertise of the other members of the Board and attempt to make appointments so that the Board's composition reflects the experience and expertise required in subsections (a) and (b).
- (d) No appointee may be employed by, a consultant to, a member of the Board of Directors of, or otherwise a representative of or a lobbyist for an entity in the business of, or potentially in the business of, selling items or services of significant value to the [insert name of state Exchange]. Such entities would include, but not be limited to, carriers or insurers that provide coverage of health benefits, producers, vendors, and health care providers selling services directly to the [insert name of state Exchange].

NASI Drafting Note 12: HHS' January 19, 2011 Funding Opportunity Announcement encourages states to enact authorizing language with conflict of interest language, regardless of the form of governance. Language applicable to a private nonprofit entity is likely to be similar to that needed for an independent executive branch agency. A fuller discussion of this topic is included in **NASI Drafting Note 9**.

- (4) The Board shall be subject to [insert cross-references to a state's open meeting laws, freedom of information provisions as well as any of the state's relevant administrative or ethics laws].
- (5) The Board shall appoint an Executive Director of the [insert official title of the Exchange], who shall appoint other staff as necessary.
- (6) The Board shall establish a governance committee to be comprised of independent members. It shall be the responsibility of the governance committee to:
 - (a) Keep the Board informed of current best governance practices;
 - (b) Identify potential and observed problems of governance;
 - (c) Review corporate governance trends;
 - (d) Update the [insert official title of Exchange]'s corporate governance principles;
 - (e) Advise appointing authorities on the skills and experiences required of potential Board members; and
 - (f) Report periodically to the [insert relevant legislative committee(s)] on trends in nonprofit governance and recommend any necessary changes in the [insert official title of Exchange]'s governance practices.
- (7) The Board shall establish an audit committee to be comprised of independent members. It shall be the responsibility of the audit committee to recommend to the Board the hiring of a certified independent accounting firm for [insert official title of the Exchange], establish the compensation to be paid to the accounting firm and provide direct oversight of the performance of the independent audit performed by the accounting firm hired for such purposes. The audit committee shall

provide a report to the [insert relevant legislative committee(s)] on any financial expenditures of the Exchange over [insert dollar amount] per annum and estimates of the Exchange's financial operations over [insert appropriate number of years].

- (8) *The Board shall appoint an advisory committee to allow for the views of the health care industry and other stakeholders to be heard in the operation of the [insert official title of the Exchange]. Such advisory committee shall provide expertise and recommendations to the Board, but shall have no authority to promulgate rules or regulations or enter into contracts on behalf of the [insert official title of the Exchange].*

NASI Drafting Note 13: *A state's choice of governance structure for the Exchange may have consequences for the Exchange's rulemaking authority. Depending on a state's constitution, certain tasks that are inherently governmental may not be delegated to an independent private nonprofit. Such an Exchange may need to rely on an Executive branch agency to carry out necessary rulemaking.*

Depending upon how the Exchange is structured, a state may need to consider whether existing procurement rules for state agencies and personnel rules for state employees are applicable to the Exchange. A state also may need to clarify that bids to offer coverage through the Exchange are not subject to the state procurement laws or competitive bidding laws applicable to executive branch agencies.

B. The Exchange shall:

- (1) Facilitate the purchase and sale of qualified health plans;
- (2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans;
- (3) Meet the requirements of this Act and any regulations implemented under this Act; and
- (4) *Coordinate the policy and operations of the Exchange with those of other state agencies whose policies and operations relate to those of the Exchange, including but not limited to the state agency that administers title XIX of the Social Security Act, the state agency that administers title XXI of the Social Security Act, and other [insert names of other relevant agencies].*

NASI Drafting Note 14: *Due to changes in income, many individuals might move between the Exchange and Medicaid or CHIP eligibility. Thus, the Exchange will need to coordinate policy and administrative responsibilities with the state's Medicaid and CHIP agencies, as well as other relevant agencies. Aside from the insurance department, other relevant agencies could include (but might not be limited to) the department of corrections to address the issues that arise in aligning Exchange enrollment with incarceration or release from incarceration.*

- C. The Exchange may contract with or enter into a memorandum of understanding with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of state Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

[*NAIC Drafting Note Omitted*: Describes affiliation options available to states under the terms of the ACA and defines “eligible entities.”]

NASI Drafting Note 15: The Exchange will need to enter into memoranda of understanding with other state entities, such as the state Medicaid, CHIP, and public health agencies in order to effectively perform its duties.

- D. The Exchange *shall* enter into information-sharing agreements with federal and State agencies and other State Exchanges *as needed* to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

NASI Drafting Note 16: Revises “may” in section D to “shall” in order to clarify an NAIC provision that Exchanges enter into information-sharing responsibilities “as needed.”

SECTION 5. GENERAL REQUIREMENTS

- A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.
- B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.
- (2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.
- C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual’s employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

SECTION 6. DUTIES OF EXCHANGE

[*NAIC Drafting Note Omitted*: Explains that the NAIC language meets the minimum requirements of the Federal Act, which are not necessarily appropriate to any one state’s market conditions and policy goals.]

The Exchange shall:

- A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

- B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance, *utilizing staff that is trained to provide assistance in a culturally and linguistically appropriate manner.*

NASI Drafting Note 17: *A state could consider requiring the Exchange to provide more effective consumer assistance by ensuring the appropriate training of hotline staff.*

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

NASI Drafting Note 18: *Federal law requires that applicants for health insurance in the nongroup market be provided an annual open enrollment period. To the extent permissible under forthcoming federal regulations (and following an initial open enrollment period starting January 1, 2014, which presumably would be the same for everyone), a state may want to provide for annual open enrollment periods at different times during the year for different potential enrollees (for example, based on date of birth). This would spread the administrative burden on Exchanges and carriers more evenly over the year. A state may also want to consider permitting carriers to reprice their products only at enrollment or renewal (thus guaranteeing every enrollee that his premium would not change during the plan year), consistent with the carrier's best estimates of future costs. Currently, carriers in many states may change premiums during an enrollee's plan year.*

- D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

NASI Drafting Note 19: *Section 1311(c) of the ACA requires the Exchange website to provide important and useful information to consumers on issues such as enrollee satisfaction and plan ratings. In addition, the Exchange could list additional information such as the portion of the monthly premium that each qualified health plan pays to agents and brokers.*

The Exchange website might also serve as a vehicle for ongoing communication with health plan enrollees on a broad range of health issues. For example, enrollees might sign up for periodic alerts containing seasonal or age-related health advice or other information, allowing the Exchange to develop an ongoing relationship with them between open enrollment periods. However, this additional duty might add cost to the operation of the Exchange.

- E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;
- F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;
- G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable

State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

Alternative: *In accordance with section 1413 of the Federal Act, and any federal regulations promulgated thereunder, 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. In addition, consistent with section 1413 of the Federal Act, the Exchange shall:*

- (1) In accordance with section 4(D), enter into data sharing agreements with relevant state and federal agencies to facilitate eligibility determinations and enrollment;*
- (2) Provide enrollment information and other relevant data, consistent with federal and state privacy rules, to the qualified health plan in which a qualified individual or qualified small employer is enrolled;*
- (3) Conduct redeterminations of eligibility for subsidies and assist in re-enrollment as necessary, if an individual experiences changes in income or circumstances; and*
- (4) Inform individuals of the potential for overpayments of advance premium tax credits and of procedures by which individuals can report a change of income that may affect the subsequent level of premium tax credits, including the availability of any safe harbor from recoupment of any overpayment, to the extent permissible under the Federal Act or any federal regulations promulgated thereunder.*

NASI Drafting Note 20: *A state may wish to be more specific about the Exchange’s responsibilities related to enrolling eligible individuals in Medicaid and CHIP. Such responsibilities might include inter-agency sharing of data, providing enrollment information to plans when appropriate under federal and state law, informing individuals about the importance of reporting changes in income that might affect eligibility for the level of subsidy, redetermining eligibility for Medicaid or advance tax credits as circumstances and enrollment change, and providing information to individuals about the potential for recoupment of advance tax credits by the IRS. An alternative to this option would be to empower but not require the Exchange to undertake these activities.*

- H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act. *Such calculator shall also be designed to provide consumers with information on out-of-pocket costs for in-network and, if feasible, out-of-network services, taking into account any cost-sharing reductions.*

NASI Drafting Note 21: *A state may wish to consider expanding on the requirements in the ACA by requiring the Exchange to provide additional tools for consumers to calculate out-of-pocket costs of coverage.*

- I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

NASI Drafting Note 22: *As noted in NASI Drafting Note 6, a state might authorize a SHOP Exchange that is independent of the individual Exchange. Regardless of whether the SHOP Exchange is independent, section 6(l) of the NAIC model act describes certain duties that a SHOP Exchange must carry out.*

Alternative: *Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall (a) 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; or (b) provide a specific amount or other payment formulated in accordance with the ACA to be used as part of an employee choice plan. The SHOP Exchange shall provide, as appropriate, premium aggregation and other related services to minimize administrative burdens for qualified employers.*

[**NAIC Drafting Notes Omitted:** Describes a state’s option to establish a separate SHOP Exchange under certain conditions. Also addresses the impact of a merged versus separate individual and group market on premium rates for individual and small groups.]

NASI Drafting Note 23: *Section 1312(a) of the Federal Act requires SHOP Exchanges to enable qualified employers to choose the tier (Bronze, Silver, Gold, or Platinum) of coverage, and for employees to choose health plans within the selected tier. However, nothing in the ACA apparently would constrain a SHOP Exchange from offering greater employee choice. While the NAIC model act assumes that employers would select health plans for their employees, the NASI alternative language would allow for a greater degree of employee choice among health plans in the SHOP Exchange, within or across tiers. The NASI alternative language also would require the SHOP Exchange to manage premium payments across health plans and provide other administrative services as necessary to manage employee choice among plans.*

- J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:
 - (1) There is no affordable qualified health plan available through the Exchange, or the individual’s employer, covering the individual; or
 - (2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;
- K. Transfer to the federal Secretary of the Treasury the following:
 - (1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;
 - (2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the pre-

mium tax credit under section 36B of the Internal Revenue Code of 1986 because:

- (a) The employer did not provide minimum essential coverage; or
 - (b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
- (3) The name and taxpayer identification number of:
- (a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
 - (b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;
- L. Provide to each employer the name of each employee of the employer described in subsection (K)(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;
- M. 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;
- N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:
- (1) Conduct public education activities to raise awareness of the availability of qualified health plans;
 - (2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;
 - (3) Facilitate enrollment in qualified health plans;
 - (4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and
 - (5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

Alternative: *Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, standards developed by the Secretary and the selection criteria in subparagraph (1).*

- (1) *Award grants to enable Navigators to:*
 - (a) *Conduct public education activities to raise awareness of the availability of qualified health plans;*
 - (b) *Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;*
 - (c) *Facilitate enrollment in qualified health plans;*
 - (d) *Provide referrals to any applicable office of health insurance consumer*

assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage;

- (e) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange; and
 - (f) Counsel Exchange participants about the Exchange, Medicaid and CHIP markets, including selection of plans and transition procedures for transitioning among Medicaid, CHIP, Exchange plans and other coverage.
- (2) Ability to serve certain populations. —The Exchange shall ensure that there are a sufficient number of Navigators that possess the experience and capacity to serve disadvantaged, hard-to-reach, and culturally or linguistically isolated populations.
- (3) Qualifications. —A state may require that any individuals or individuals affiliated with any entity selected to be a Navigator must be certified as able to carry out the duties required by Federal law under section 1311(i)(3).

NASI Drafting Note 24: This section offers language that adds to the scope of Navigator duties, specifically, to counsel individuals on enrollment choices in a manner that is culturally and linguistically appropriate. This counseling activity may be particularly important for individuals with limited experience in selecting among health plans, as well as for individuals who experience income-related changes that affect either the amount of advance premium tax credit they are eligible to receive or necessitate their moving between Medicaid and Exchange coverage. Counseling implies a more significant duty than simply providing information, and a higher standard of performance could present liability issues. A state might address this by establishing certification standards for Navigators. To the extent that Navigators are required to be certified, a state may also want to review its producer laws (governing oversight of agents and brokers) to ensure that appropriate producer standards are applied to the Navigator certification program and, conversely, that producers acting as Navigators meet the appropriate requirements.

- O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;
- P. 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;
- Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:
 - (1) Educated health care consumers who are enrollees in qualified health plans;
 - (2) Individuals and entities with experience in facilitating enrollment in qualified health plans;
 - (3) Representatives of small businesses and self-employed individuals;
 - (4) The [insert name of State Medicaid office]; and
 - (5) Advocates for enrolling hard to reach populations; and

- R. Meet the following financial integrity requirements:
- (1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;
 - (2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:
 - (a) Investigate the affairs of the Exchange;
 - (b) Examine the properties and records of the Exchange; and
 - (c) Require periodic reports in relation to the activities undertaken by the Exchange; and
 - (3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.

[**NAIC Drafting Note Omitted:** Related to the question of authorizing the Commissioner to conduct investigations of Exchange operations and finances.]

- R2.** *Enrollee transitions between sources of coverage and subsidies. The Exchange shall work jointly with the state Medicaid and CHIP agencies to develop and administer transition procedures that:*
- (1) *Address the needs of individuals and families who experience a change in income that results in a change in the source of coverage, with a particular emphasis on children and adults with special health care needs, chronic illnesses, conditions, and disabilities, as well as individuals who are also enrolled in Medicare; and*
 - (2) *To the extent possible under the Federal Act, provide for the coordination of payments to Medicaid managed care organizations and Exchange-participating qualified health plans that experience changes in enrollment resulting from changes in eligibility for Medicaid during an enrollment period.*

NASI Drafting Note 25: *Adds as a possible Exchange duty the obligation to coordinate with state Medicaid and CHIP agencies to develop specific transition procedures, particularly for enrollee populations with significant health care needs. Also adds as a possible Exchange duty the obligation to develop procedures for coordinating plan payments in the event that changes in individual or family income result in a change in eligibility for Medicaid during an enrollment period.*

- R3.** *Joint development of policies to promote cross-market health plans. The Exchange and state Medicaid and CHIP agencies, in consultation with the Commissioner, shall jointly develop policies to encourage the development of and participation by health plans capable of serving Medicaid, CHIP, and Exchange enrollees, in order to promote continuity of enrollment and coverage when an individual's coverage source changes as a result of changes in family income or family circumstances that affect the calculation of family income in relation to the federal poverty level.*

NASI Drafting Note 26: A state may wish the Exchange to work with the state Medicaid and CHIP agencies, in consultation with the Insurance Commissioner, to jointly develop policies that promote the development of certified health plans that meet the requirements of Medicaid, CHIP, and the Exchange. Such plans could provide continuous coverage and care to individuals who gain or lose eligibility for Medicaid or CHIP due to a change in family income or family circumstances. By enrolling in such plans, families and individuals who might otherwise experience a change in coverage and care could remain continuously enrolled in a plan (and stay in the same provider network), regardless of changes in their source of subsidy.

R4. Additional coordination responsibilities with state Medicaid and CHIP agencies. The Exchange and state Medicaid and CHIP agencies shall provide for the additional coordination responsibilities:

- (1) *Single application form.* —The Exchange [or other relevant state agency] shall use a single application for enrollment in Medicaid, CHIP, and health plans offered in the Exchange, including establishing eligibility for premium tax credits cost-sharing reductions. The Exchange may use the single application form developed by the Secretary under section 1413(b) of the Federal Act, or may work with [reference to agencies responsible for Medicaid and CHIP] to develop an application form for this purpose.
- (2) *Eligibility determination and redetermination.* —The Exchange shall coordinate with the state Medicaid and CHIP agencies to ensure:
 - (a) Consistent methods and standards (including formulas and verification methods) for prompt calculation of income based on individuals' modified adjusted gross incomes (MAGI) in order to guard against lapses in coverage and inconsistent eligibility determinations and procedures;
 - (b) Maximum access to federal data sources for the purpose of verifying income eligibility for Medicaid, CHIP, and premium tax credits, and cost sharing reductions;
 - (c) The prompt processing of applications and enrollment in the correct state subsidy program, regardless of whether the program is Medicaid, CHIP, or premium tax credits or cost sharing reductions;
 - (d) Procedures for transitioning individuals between Medicaid and tax-credit based subsidies that protect individuals against delays in eligibility and plan enrollment;
 - (e) Rapid resolution of inconsistent information affecting eligibility as well as clear and understandable information to applicants regarding the resolution process and interim assistance that may be available while resolution is pending and procedures to assure that individuals are meaningfully informed of:
 - (i) The potential existence of overpayments of advance tax credits;
 - (ii) Procedures for reconciling enrollee liability for repayment in the event that an advance tax credit is subsequently proved to be an overpayment;
 - (iii) Procedures by which individuals can report a change in income that may affect the subsequent level of advance tax payment or the availability of a safe harbor; and
 - (iv) Information regarding safe harbors against overpayment liability or recoupment that may exist under federal or state law.
- (3) *Cross-market participation.* —The Exchange may [or shall] work jointly with the state Medicaid and CHIP agencies to:
 - (a) Encourage the development of common provider networks, network performance standards for plans that participate in the Exchange and

- Medicaid and CHIP, develop coverage terms, and quality standards in order to ensure maximum continuity and quality of care;
- (b) Promote participation by plans that satisfy both qualified health plan and Medicaid managed care plan criteria, in order to minimize disruption in care as a result of enrollment shifts between subsidy sources;
 - (c) Develop incentives, including quality ratings, default enrollment preferences, and other approaches, to encourage health plans to participate in both Medicaid and the Exchange; and
 - (d) Coordinate health plan payments and timely adjustments in all markets that may result from enrollment changes.

NASI Drafting Note 27: This alternative offers additional detail regarding the Exchange’s responsibilities to coordinate with the state Medicaid and CHIP agencies. Such responsibilities would require coordination in the areas of enrollment, eligibility determination and redetermination, and the development of cross-market plan participation.

A state using a single application will need to ensure that appropriate administrative procedures are in place to account for the fact that income is determined differently for the purposes of Medicaid and CHIP and the advance tax credits.

R5. Data Sharing. —The Exchange, Medicaid and CHIP agencies, and other state health care benefit programs may [shall] exchange data on health plan performance.

NASI Drafting Note 28: This language adds a specific option related to data sharing.

SECTION 7. HEALTH BENEFIT PLAN CERTIFICATION AND CERTIFIED HEALTH PLAN OVERSIGHT

- A. The Exchange may certify a health benefit plan as a qualified health plan if:
- (1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E, if:
 - (a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan’s coverage; and
 - (b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;
 - (2) The premium rates and contract language have been approved by the commissioner;

[NAIC Drafting Note Omitted: Related to modifications that may be needed to conform to state law.]

- (3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;
- (4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;
- (5) The health carrier offering the plan:
 - (a) Is licensed and in good standing to offer health insurance coverage in this State;
 - (b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;
 - (c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

[*NAIC Drafting Note Omitted:* Addresses the issue of terminology in states that not use the term "producer."]

- (d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and
- (e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;
- (6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

[*NAIC Drafting Note Omitted:* Discusses the factors that states should consider in adding certification requirements.]

Alternative: *The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act. Such plans include, but are not limited to:*

- (a) *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.*
- (b) *selectively contracting for health coverage offered to qualified individuals and qualified small employers; and*

- (c) *the development of standardized essential and optional benefits and cost-sharing within benefit tiers.*

NASI Drafters Note 29: NAIC subsection 6 authorizes broad action by Exchanges pursuant to Federal law and their own rulemaking powers. However, a state may want to empower the Exchange more specifically with respect to transparency, service area designation and achievement of health outcomes. A state may further wish to explicitly authorize the Exchange to standardize benefits and cost-sharing and selectively admit qualified health plans as a means of encouraging competition.

- (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.

[**NAIC Drafting Note Omitted:** Addresses the question of whether plan certification functions should be delegated to the Commissioner.]

B. The Exchange shall not exclude a health benefit plan:

- (1) On the basis that the plan is a fee-for-service plan;
- (2) Through the imposition of premium price controls by the Exchange; or
- (3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

- (1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

[**NAIC Drafting Note Omitted:** Addresses legislative conformance review needs in states with additional rate filing requirements.]

- (2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:
 - (i) Claims payment policies and practices;
 - (ii) Periodic financial disclosures;
 - (iii) Data on enrollment;
 - (iv) Data on disenrollment;
 - (v) Data on the number of claims that are denied;
 - (vi) Data on rating practices;
 - (vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
 - (viii) Information on enrollee and participant rights under title I of the Federal Act; and
 - (ix) Other information as determined appropriate by the Secretary; and

- (b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and
- (3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet;
- (4) Promptly notify affected individuals of price and benefit changes, or other changes in circumstance that could materially impact enrollment or coverage; and
- (5) Provide, via a publicly accessible Internet website, timely updates regarding the plan's provider network, including the addition of new providers or the withdrawal of an existing provider.

NASI Drafting Note 30: Adds notification requirements as a standard for certification of a qualified health plan.

- D. The Exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.
- E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;
- (2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

[**NAIC Drafting Note Omitted:** Refers to the need to review above language in states that do not provide for a limited scope license.]

- (3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation; and
- (4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

E2. *Certified Health Plan Oversight:*

Alternative 1: *The [Commissioner] of Insurance shall determine that a plan seeking certification or recertification as a qualified health plan, meets all requirements related to licensure and solvency, as well as all requirements of the ACA and the Exchange.*

- Alternative 2:** *The [Commissioner] of Insurance shall determine that a health plan seeking certification or recertification as a qualified health plan meets all requirements related to licensure and solvency, as well as all requirements of the ACA as they relate to [insert the ACA and Exchange requirements under Commissioner oversight]. The Exchange shall determine whether such a health plan meets other requirements of the ACA and the Exchange, including but not limited to [insert the ACA and Exchange requirements under Exchange oversight].*
- Alternative 3:** *The [Commissioner] of Insurance shall determine that a health plan seeking certification or recertification as a qualified health plan meets all the requirements related to licensure and solvency. The Exchange shall determine whether such a health plan meets all other requirements of a qualified health plan.*

NASI Drafting Note 31: *A state may find it efficient to place some responsibilities related to health plan certification and recertification and oversight with the Commissioner of Insurance. This allocation may facilitate efficient coordination between the Exchange and the Commissioner, and also minimize the additional resources needed to operate the Exchange. The alternatives vary the responsibility and resource cost allocated to the Commissioner and to the Exchange. Responsibilities allocated to the Commissioner imply resource costs that may be, but are not necessarily, financed in the Commissioner's budget; responsibilities allocated to the Exchange imply resource costs that the Exchange must finance directly. Alternative 1 has the most significant implications for the Commissioner of Insurance and represents the lowest direct resource cost for the Exchange; Alternative 3 has the least implication for the Commissioner of Insurance and represents the greatest direct resource cost for the Exchange.*

SECTION 8. FUNDING; PUBLICATION OF COSTS

- A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

[NAIC Drafting Note Omitted: Refers to the self-sustaining requirements of the ACA.]

NASI Drafting Note 32: *A state may finance the Exchange in several ways, including but not limited, to state appropriations or a surcharge on health benefit plans and insurers.*

- B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Alternative: *The [insert official title of the Exchange] shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and any financial expenditures of the Exchange above [insert dollar amount]. This information shall include information on monies lost to waste, fraud and abuse. The Exchange shall further report on any cash reserves at the end of the fiscal year and estimates of its financial operations over [insert appropriate time horizon here].*

NAI Drafting Note 33: *The alternative to subsection B specifies greater transparency on Exchange expenditures and reserves. Regardless of how the Exchange is structured, a state may want to require the Exchange to provide a report to the legislature that is sufficient to allow the legislature to evaluate the Exchange's financial operations.*

SECTION 9. REGULATIONS

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

[NAIC Drafting Note Omitted: Addresses the need to specify an executive branch agency that will engage in necessary rulemaking if the Exchange is created as a nonprofit entity.]

SECTION 10. RELATION TO OTHER LAWS

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

[NAIC Drafting Note Omitted: Describes state options and obligations in situations in which states requires qualified health plans to offer additional benefits.]

SECTION 11. EFFECTIVE DATE

This Act shall be effective [insert date].

Section-by-Section Analysis of NASI's Additional Legislative Options to the NAIC American Health Benefit Exchange Model Act

SECTION 1

- Replaces NAIC language to reflect title of the document.

SECTION 2

- No change.

SECTION 3

- (AA) Inserts definition for “Catastrophic plan” as specified under ACA section 1302(e).
- (H) Inserts language in the definition of “Qualified employer” in subsection H to maintain consistency with section 1312(f)(2) of the ACA.

SECTION 4

- (A) Adds three governance alternatives for establishing an Exchange.
 - Alternative 1 establishes the Exchange either within an existing executive branch agency or as part of the Executive Office of the Governor.
 - Alternative 2 establishes the Exchange as an independent executive branch agency, with specific legislative direction on board appointments, stakeholder input, conflict of interest and relationship to state laws.
 - Alternative 3 establishes the Exchange as a newly created independent nonprofit with legislative direction on board appointments, stakeholder input, conflict of interest and relationship to state laws.
- (B)(4) Adds language that requires the Exchange to coordinate its policy and operations with relevant state agencies.
- (C) Inserts language giving the Exchange the option of entering into a memorandum of understanding with other state entities to effectively perform its duties.
- (D) Revises “may” with “shall” to require Exchanges to enter into information-sharing agreements with state and federal agencies “as needed.”

SECTION 5

- No change.

SECTION 6

- (B) Adds language requiring that hotline staff are trained to provide assistance in a culturally and linguistically appropriate manner.
- (G) Adds an alternative that specifies the Exchange’s responsibilities in enrolling eligible individuals in Medicaid and CHIP. Such activities include inter-agency data sharing, providing enrollment information to plans, redetermining eligibility for Medicaid or advance tax credits, and providing information to individuals about the potential for recoupment of advance tax credits by the IRS.
- (H) Adds language requiring Exchanges to include a calculator that estimates out-of-pocket costs for consumers.
- (I) Adds language that allows for both employer and employee choice in the SHOP Exchange. Additional language is included that would require the Exchange to the extent possible to aggregate employee premiums to minimize administrative burdens for qualified employers.
- (N) Adds an alternative that augments the scope of Navigator duties, ensures that there are sufficient Navigators to reach certain populations and provides for Navigator certification.
- (R2) Creates a provision related to enrollee transitions between sources of coverage and subsidies that provides for coordination among the Exchange, Medicaid and CHIP agencies.
- (R3) Creates a provision related to the joint development of policies to promote cross-market health plans. Such plans would meet the requirements of Medicaid, CHIP and the Exchange to provide continuity of enrollment and coverage to individuals experiencing market shifts.
- (R4) Creates a provision requiring additional coordination responsibilities for Exchange, state Medicaid and CHIP agencies. Provision requires a single application form for all coverage programs and coordination of eligibility determination and redetermination, and the development of cross-market plans.
- (R5) Creates a provision related to data sharing on health plan performance across the Exchange, Medicaid and CHIP programs.

SECTION 7

- Inserts “Certified Health Plan Oversight” into the title of the Section.
- (A)(6) Adds an alternative that empowers the Exchange to selectively contract and develop standardized benefits.
- (C)(4) Adds language requiring that health plans seeking certification notify affected individuals when premium, cost-sharing or benefits change significantly.
- (C)(5) Adds language requiring that health plans seeking certification provide updates to the Exchange Internet website regarding the plan’s provider networks.

- (E2) Creates three alternatives for certified health plan oversight. These alternatives vary the responsibility and resource cost allocated to the Exchange and the Commissioner of Insurance with respect to health plan certification.

SECTION 8

- (B) Adds an alternative to the publication of costs provision that specifies greater transparency on Exchange expenditures, reserves and financial operations.

SECTION 9

- No change.

SECTION 10

- No change.

SECTION 11

- No change.

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