

1 Amendment in the Nature of a Substitute

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7 A BILL

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9 19-0002

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12 IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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19 To establish the Health Benefit Exchange Authority and its functions and duties, to provide for
20 the appointment of executive and advisory boards to the Health Benefit Exchange
21 Authority, to establish the powers and duties of the executive board, to include conflict of
22 interest provisions for and limit the liability of the executive and advisory boards, to
23 establish the minimum criteria for the certification of health benefit plans as qualified
24 health plans, to require the executive board to report to the Council, Mayor, and public
25 regarding the operation of the Health Benefit Exchange Authority, and to require the
26 Health Benefit Exchange Authority to submit rules for Council review.

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28 BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA,

29 That this act may be cited as the “Health Benefit Exchange Authority Establishment Act
30 of 2011”.

31 Sec. 2. Definitions.

32 For purposes of this act, the term:

33 (1) “American Health Benefit Exchange” means an entity established pursuant to
34 § 1311(b) of the Federal Act.

35 (2) “Commissioner” means the Commissioner of the Department of Insurance,
36 Securities and Banking, as established by section 3 of the Department of Insurance and

1 Securities, Regulation Establishment Act of 1996, effective May 21, 1997 (D.C. Law 11-268;
2 D.C. Official Code § 31-102).

3 (3) “Federal Act” means the Patient Protection and Affordable Care Act approved March
4 23, 2010 (124 Stat. 111; 42 U.S.C. 18001, note), as amended by the Health Care and Education
5 Reconciliation Act of 2010 approved March 30, 2010 (124 Stat. 1029; 42 U.S.C. 1305, note), and any
6 amendments, regulations, or guidance issued pursuant to the Federal Act.

7 (4)(A) “Health benefit plan” means a policy, contract, certificate, or agreement
8 offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of
9 the costs of health care services.

10 (B) “Health benefit plan” does not include:

11 (i) Coverage only for accident, or disability income insurance, or
12 any combination thereof;

13 (ii) Liability insurance, including general liability insurance and
14 automobile liability insurance;

15 (iii) Coverage issued as a supplement to liability insurance;

16 (iv) Workers’ compensation or similar insurance;

17 (v) Automobile medical payment insurance;

18 (vi) Credit-only insurance;

19 (vii) Coverage for on-site medical clinics; or

20 (viii) Other similar insurance coverage, specified in federal

21 regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996,

22 approved August 21, 1996 (110 Stat. 1936; 42 U.S.C. 201, note) (“HIPAA”), under which

23 benefits for health care services are secondary or incidental to other insurance benefits.

1 (C) “Health benefit plan” does not include the following benefits if they
2 are provided under a separate policy, certificate of insurance, or contract of insurance, or are
3 otherwise not an integral part of the plan:

- 4 (i) Limited scope dental or vision benefits;
- 5 (ii) Benefits for long-term care, nursing home care, home health
6 care, community-based care, or any combination thereof; or
- 7 (iii) Other similar, limited benefits specified in federal regulations
8 issued pursuant to HIPAA.

9 (D) “Health benefit plan” does not include the following benefits if the
10 benefits are provided under a separate policy, certificate of insurance, or contract of insurance,
11 there is no coordination between the provision of the benefits and any exclusion of benefits
12 under any group health plan maintained by the same plan sponsor, and the benefits are paid with
13 respect to an event without regard to whether benefits are provided with respect to such an event
14 under any group health plan maintained by the same plan sponsor:

- 15 (i) Coverage only for a specified disease or illness; or
- 16 (ii) Hospital indemnity or other fixed indemnity insurance.

17 (E) “Health benefit plan” does not include the following if offered as a
18 separate policy, certificate of insurance, or contract of insurance:

- 19 (i) A Medicare supplemental policy as defined under 42 U.S.C. §
20 1395ss(g)(1);
- 21 (ii) Coverage supplemental to the coverage provided under 10
22 U.S.C. 1071 *et seq.*; or

1 (iii) Similar supplemental coverage provided to coverage under a
2 group health plan.

3 (5) "Health carrier" means an entity subject to the insurance laws and regulations
4 of the District that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or
5 reimburse any of the costs of health care services, including:

- 6 (A) An accident and sickness insurance company;
- 7 (B) A health maintenance organization;
- 8 (C) A hospital and medical services corporation; or
- 9 (D) Any other entity providing a health benefit plan.

10 (6) "Health professional" shall have the same meaning as it does in section 101(8)
11 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986
12 (D.C. Law 6-99; D.C. Official Code § 3-1201.01(8)).

13 (7) "Qualified dental plan" means a limited-scope dental plan that has been
14 certified in accordance with section 10 .

15 (8) "Qualified employer" means a small employer that elects to make its full-time
16 employees eligible for one or more qualified health plans offered through the Small Business
17 Health Options Program Exchange ("SHOP Exchange"), and, at the option of the employer,
18 some or all of its part-time employees; provided, that the employer:

- 19 (A) Has its principal place of business in the District and elects to provide
20 coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or
- 21 (B) Elects to provide coverage through the SHOP Exchange to all of its
22 eligible employees who are principally employed in the District.

1 (9) “Qualified health plan” means a health benefit plan that has a certification
2 validating that the plan meets the criteria for certification described in section 1311(c) of the
3 Federal Act and section 10.

4 (10) “Qualified individual” means an individual, including a minor, who:

5 (A) Is seeking to enroll in a qualified health plan offered to individuals
6 through the Authority;

7 (B) Resides in the District;

8 (C) At the time of enrollment, is not incarcerated, other than incarceration
9 pending the disposition of charges; and

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

13 (11) “Secretary” means the Secretary of the federal United States Department of
14 Health and Human Services.

15 (12) “SHOP Exchange” means a Small Business Health Options Program
16 established pursuant to section 5 and section 1311(b) of the Federal Act.

17 (13)(A) “Small employer” means a single employer that employed an average of
18 not more than 50 employees during the preceding calendar year.

19 (B) For purposes of this paragraph:

20 (i) All persons treated as a single employer under 26 U.S.C.
21 414(b), (c), (m) or (o) shall be treated as a single employer.

22 (ii) An employer and any predecessor employer shall be treated as
23 a single employer.

1 (iii) All employees shall be counted, including part-time
2 employees and employees who are not eligible for health benefit coverage through the employer.

3 (iv) If an employer was not in existence throughout the preceding
4 calendar year, the determination of whether that employer is a small employer shall be based on
5 the average number of employees that employer is reasonably expected to employ in the current
6 calendar year.

7 (v) An employer that makes enrollment in qualified health plans
8 available to its employees through the SHOP Exchange, and would cease to be a small employer
9 by reason of an increase in the number of its employees, shall continue to be treated as a small
10 employer for purposes of this act as long as it continuously makes enrollment through the SHOP
11 exchange available to its employees.

12 Sec. 3. Establishment and purpose.

13 (a) There is established, as an independent authority of the District government, the
14 District of Columbia Health Benefit Exchange Authority (“Authority”). The Authority shall be
15 an instrumentality, created to effectuate the purposes stated in this act, that shall have a legal
16 existence separate from the District government.

17 (b) The purposes of the Authority shall be to:

18 (1) Enable individuals and small employers to find more affordable and easier-to-
19 understand health insurance;

20 (2) Facilitate the purchase and sale of qualified health plans;

21 (3) Assist small employers in facilitating the enrollment of their employees in
22 qualified health plans;

23 (4) Reduce the number of uninsured;

- 1 (5) Provide a transparent marketplace for health benefit plans;
- 2 (6) Educate consumers; and
- 3 (7) Assist individuals and groups to access programs, premium assistance tax
- 4 credits and cost-sharing reductions.

5 Sec. 4. District of Columbia Health Benefit Exchange Authority Fund.

6 (a) There is established, as a nonlapsing fund, the District of Columbia Health Benefit
7 Exchange Authority Fund (“Fund”), which shall be administered by the Authority in accordance
8 with generally accepted accounting principles and which shall be used solely for the purposes set
9 forth in this act and the costs of administering the act.

10 (b) The Fund shall consist of:

- 11 (1) Any user fees, licensing fees, or other assessments collected by the Authority;
- 12 (2) Income from investments made on behalf of the Fund;
- 13 (3) Interest on money in the Fund;
- 14 (4) Money collected by the executive board as a result of legal or other action;
- 15 (5) Donations;
- 16 (6) Grants;
- 17 (7) All general revenue funds appropriated by a line item in the budget submitted
18 pursuant to section 446 of the District of Columbia Home Rule Act, approved December 24,
19 1973 (87 Stat. 801; D.C. Official Code §1-204.46, and authorized by Congress for the purposes
20 of the Authority; and
- 21 (8) Any other money from any other source accepted for the benefit of the Fund.

22 (c) All revenues, income from investments, proceeds, and other monies, from whatever
23 source derived, that are collected or received by the Authority shall be deposited into the Fund.

1 All funds deposited into the Fund, and any interest earned on those funds, shall not revert to the
2 unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal
3 year, or at any other time, but shall be continually available for the uses and purposes set forth in
4 this act without regard to fiscal year limitation.

5 (d) The Chief Financial Officer shall invest the money of the Fund in the same manner as
6 other District money may be invested.

7 (e)(1) The Authority is authorized to charge, through rulemaking:

8 (A) User fees;

9 (B) Licensing fees; and

10 (C) Other assessments on health carriers selling qualified dental plans or
11 qualified health plans in the District, including qualified health plans and qualified dental plans
12 sold outside the exchanges.

13 (2) User fees, licensing fees, or other assessments authorized shall not exceed
14 reasonable projections regarding the amount necessary to support the operations of the
15 Authority.

16 Sec. 5. Authority duties and powers.

17 (a) The Authority shall:

18 (1) Establish the American Health Benefit Exchange to assist qualified individuals
19 in the District with enrollment in qualified health plans;

20 (2) Establish a SHOP Exchange through which qualified employers may access
21 coverage for their employees and shall enable any qualified employer to specify a level of
22 coverage so that any of its employees may enroll in any qualified health plan offered through the
23 SHOP Exchange at the specified level of coverage;

1 (3) Certify plans as qualified health plans as set forth in section 10 of this act and
2 make such plans available to qualified individuals and qualified employers as required by the
3 Federal Act with effective dates on January 1, 2014; provided that, the Authority shall not make
4 available any health benefit plan that is not a qualified health plan.

5 (4) Have independent personnel authority to hire, retain, and terminate personnel
6 as appropriate to perform the functions of the Authority consistent with the District of Columbia
7 Comprehensive Merit Personnel Act of 1978, effective March 3, 1979 (D.C. Law 2-139; D.C.
8 Official Code § 5 1-601.01 *et seq.*), including establishing compensation and reimbursement
9 consistent with the District’s wage grade and non-wage grade schedules;

10 (5) Have procurement authority independent of the Office of Contracting and
11 Procurement, consistent with the Procurement Practices Reform Act of 2010, effective April 8,
12 2011 (D.C. Law 18-371; D.C. Official Code § 2-352.01 *et seq.*) (“PPRA”); except, that section
13 202(a), (b), (c), and (e) of the PPRA shall apply.

14 (6) Publish the average costs of licensing, regulatory fees and any other payments
15 required by the Authority, and the administrative costs of the Authority, on a website that is
16 publically accessible, to educate consumers on such costs. This information shall include
17 information on monies lost to waste, fraud and abuse;

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

21 (8) Provide for the operation of a toll-free telephone hotline to respond to requests
22 for assistance, utilizing staff that is trained to provide assistance in a culturally and linguistically
23 appropriate manner;

1 (9) Provide for enrollment periods, as provided under section 1311(c)(6) of the
2 Federal Act;

3 (10) Maintain a publically accessible website, through which enrollees and
4 prospective enrollees of qualified health plans and dental plans may obtain standardized
5 comparative information, including health plan quality and performance, for such plans;

6 (11) Assign a rating to each qualified health plan offered through the exchanges in
7 accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal
8 Act, and determine each qualified health plan’s level of coverage in accordance with regulations
9 issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

10 (12) Use a standardized format for presenting health benefit options in the
11 exchanges, including the use of the uniform outline of coverage established under section 2715
12 of the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; 42 U.S.C. 201 *et seq.*)
13 (“PHSA”);

14 (13) ~~Inform individuals, Conduct eligibility determinations, in accordance with~~
15 ~~section 1413 of the Federal Act, of eligibility requirements for the Medicaid program under title~~
16 ~~XIX of the Social Security Act, the Children’s Health Insurance Program under title XXI of the~~
17 ~~Social Security Act or any other applicable District program pursuant to the policies and~~
18 ~~procedures established by the Department of Health Care Finance and if through screening of the~~
19 ~~application by the Authority, the Authority determines that any individual is eligible for any such~~
20 ~~program, enroll that individual in that program;~~

21 (14) Establish and make available, through a website that is publicly available, a
22 calculator to determine the actual cost of coverage after application of any premium tax credit
23 under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under

1 section 1402 of the Federal Act, and, if feasible, the calculator shall be designed to provide
2 consumers with information on out of pocket costs for in-network and out-of-network services,
3 taking into account any cost sharing reductions;

4 (15) Grant a certification, subject to section 1411 of the Federal Act, attesting
5 that, for purposes of the individual responsibility penalty under section 5000A of the Internal
6 Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or
7 from the penalty imposed by that section because:

8 (A) There is no affordable qualified health plan available through the
9 exchanges, or the individual's employer, covering the individual; or

10 (B) The individual meets the requirements for any other such exemption
11 from the individual responsibility requirement or penalty;

12 (16) Transfer to the Secretary of the United States Department of the Treasury the
13 following:

14 (A) A list of the individuals who are issued a certification under paragraph
15 (15) of this subsection, including the name and taxpayer identification number of each
16 individual;

17 (B) The name and taxpayer identification number of each individual who
18 was an employee of an employer but who was determined to be eligible for the premium tax
19 credit under section 36B of the Internal Revenue Code of 1986 because the employer:

20 (i) Did not provide minimum essential coverage; or

21 (ii) Provided the minimum essential coverage, but it was
22 determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 to either be
23 unaffordable to the employee or did not provide the required minimum actuarial value; and

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(C) The name and taxpayer identification number of:

(i) Each individual who notifies the Authority under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

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

(17) Provide to each employer the name of each employee of the employer described in paragraph (16)(B) of this subsection who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(18) Perform the duties required of the Authority by the Secretary, or the Secretary of the United States Department of the Treasury, related to determining eligibility for:

- (A) Premium tax credits;
- (B) Reduced cost-sharing; or
- (C) Individual responsibility requirement exemptions;

(19) 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:

- (A) Conduct public education activities to raise awareness of the availability of qualified health plans and qualified dental plans;
- (B) Distribute fair and impartial information concerning enrollment in qualified health plans and qualified dental 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;

1 (C) Facilitate enrollment in qualified health plans and qualified dental
2 plans;

3 (D) Provide referrals to an office of health insurance consumer assistance
4 or health insurance ombudsman, including the Office of Health Care Ombudsman and Bill of
5 Rights, or any other appropriate District agency, for any enrollee with a grievance, or question
6 regarding his or her health benefit plan, coverage or a determination under that plan or coverage;
7 and

8 (E) Provide information in a manner that is culturally and linguistically
9 appropriate to the needs of the population being served by the exchanges;

10 (20) Review the rate of premium growth within and outside the exchanges and
11 consider the information in developing recommendations on whether to continue limiting
12 qualified employer status to small employers;

13 (21) Consult with stakeholders relevant to carrying out the activities required
14 under this act, including:

15 (A) Educated health care consumers who are enrollees in qualified health
16 plans or qualified dental plans;

17 (B) Individuals and entities with experience in facilitating enrollment in
18 qualified health plans or dental plans;

19 (C) Representatives of small businesses and self-employed individuals;

20 (D) The Department of Health Care Finance;

21 (E) Individuals who have experience enrolling difficult to reach
22 populations in public insurance programs;

23 (F) Public health experts;

1 (G) Health care providers; and

2 (H) Office of Health Care Ombudsman and Bill of Rights;

3 (22) Meet the following financial integrity requirements:

4 (A) Keep an accurate accounting of all activities, receipts and
5 expenditures and annually submit to the Secretary, Mayor, Council and the Commissioner a
6 report of the accountings;

7 (B) Fully cooperate with any investigation conducted by the Secretary
8 pursuant to the Secretary's authority under the Federal Act;

9 (C) Allow the Secretary, in coordination with the Inspector General of the
10 United States Department of Health and Human Services, to:

11 (i) Investigate the affairs of the Authority;

12 (ii) Examine the properties and records of the Authority; and

13 (iii) Require periodic reports in relation to the activities undertaken
14 by the Authority; and

15 (D) In carrying out its activities under this act, not use any funds intended
16 for the administrative and operational expenses of the Authority for:

17 (i) Staff retreats;

18 (ii) Promotional giveaways;

19 (iii) Excessive executive compensation; or

20 (iv) Promotion of federal or District legislative and regulatory
21 modifications not contemplated under the Federal Act.

22 (b) In addition to certifying qualified health plans the Authority shall allow a health
23 carrier to offer a plan that provides limited scope dental benefits meeting the requirements of

1 section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchanges, either
2 separately or in conjunction with a qualified health plan, if the plan provides pediatric dental
3 benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

4 (c) Neither the Authority nor a health carrier offering qualified health plans through the
5 exchanges may charge an individual a fee or penalty for termination of coverage if the individual
6 enrolls in another type of minimum essential coverage because the individual has become newly
7 eligible for that coverage or because the individual's employer-sponsored coverage has become
8 unaffordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

9 (d) The operations of the Authority are subject to the provisions of this act whether the
10 operations are performed directly by the Authority or through an entity under a contract with the
11 Authority.

12 ~~(e) Functions of the exchanges or Authority requiring additional guidance from the~~
13 ~~Secretary shall be implemented upon receiving such guidance.~~

14 Sec 6. Executive board establishment and membership.

15 (a) There is established an executive board to govern the Authority consisting of:

16 (1) 7 voting members who are residents of the District of Columbia and appointed
17 by the Mayor, with the advice and consent of the Council pursuant to section 2(f) of the
18 Confirmation Act of 1978, effective March 3, 1979 (D.C. Law 2-142; D.C. Official Code § 1-
19 523.01(f)).

20 (2) 4 non-voting ex-officio members, or their designees, who shall be the:

21 (A) Director of the Department of Health Care Finance;

22 (B) Commissioner of the Department of Insurance, Securities and
23 Banking;

1 (C) Director of the Department of Health; and

2 (D) Director of the Department of Human Services.

3 (b)(1) Members of the executive board, other than an ex-officio member, shall be
4 appointed for a term of 4 years, except that:

5 (A) 2 of the initial appointments shall be for a term of 2 years;

6 (B) 1 of the initial appointments shall be for a term of 3 years;

7 (C) 2 of the initial appointments shall be for a term of 4 years; and

8 (D) 2 of the initial appointments shall be for a term of 5 years.

9 ~~(2)(A) The nomination of a voting executive board member by the Mayor shall be~~
10 ~~transmitted to the Council, for a 90-day period of review, excluding days of Council recess. If~~
11 ~~the Council does not approve by resolution within the 90-day period a nomination to the~~
12 ~~executive board the nomination shall be deemed disapproved.~~

13 ~~(BA)~~ A member of the executive board may continue to serve until
14 appointment by the Mayor and confirmation by the Council of his or her successor.

15 ~~(CB)~~ Vacancies shall be filled by Mayoral appointment for the unexpired
16 term in the same manner of the original appointment.

17 ~~(DC)~~ A member of the executive board, upon findings by the Mayor, may
18 be removed for incompetence, misconduct, or failure to perform the duties of the position.

19 (c)(1) Each person appointed to the executive board as a voting member shall have
20 demonstrated and acknowledged expertise in at least 2 of the following areas:

21 (A) Individual or small employer health care coverage;

22 (B) Health benefits plan administration;

23 (C) Health care finance;

1 (D) Administering a public or private health care delivery system;

2 (E) Purchasing health plan coverage;

3 (F) Prior experience in commercial insurance management;

4 (G) Actuarial analysis;

5 (H) Health care economics;

6 (I) Human services administration; ~~or~~

7 (J) Health care consumer interest advocacy;

8 (K) Public health programs; or

9 (L) Enrolling individuals into health benefit plans.

10 (2) The Mayor shall consider the expertise of the other members of the executive
11 board and attempt to make appointments so that the executive board's composition reflects a
12 diversity of expertise.

13 (3) At least 1 voting member of the executive board shall demonstrate knowledge
14 in health care consumer interest advocacy.

15 (d) Each member of the executive board shall have the responsibility and duty to meet the
16 requirements of this act, the Federal Act, and all applicable District and federal laws and
17 regulations, to serve the public interest of the individuals and small businesses seeking health
18 care coverage through the exchanges, and to ensure the operational well-being and fiscal
19 solvency of the Authority.

20 (e) The executive board shall elect a chairperson on an annual basis.

21 (f) Executive board members shall receive no compensation for their services but shall
22 receive actual and necessary expenses incurred in the performance of their official duties.

1 (g) The Mayor shall nominate a majority of the executive board members within 90 days
2 of the effective date of this act.

3 Sec. 7. Powers and duties of executive board

4 (a) Subject to any limitations under this act, or other applicable law, the executive board
5 shall have all powers necessary to carry out the functions authorized by the Federal Act and
6 consistent with the purposes of the Authority.

7 (b) The enumeration of specific powers in this act is not intended to restrict the executive
8 board's power to take any lawful action that it determines is necessary to carry out the functions
9 authorized by the Federal Act and consistent with the purposes of the Authority.

10 (c) In addition to the powers set forth elsewhere in this act, the executive board may:

11 (1) Adopt and alter an official seal;

12 (2) Sue, be sued, plead, and be impleaded;

13 (3) Adopt bylaws, rules, and policies;

14 (4) Maintain an office in the District at the place designated by the executive
15 board;

16 (5) Enter into any agreements or contracts and execute the instruments necessary
17 to manage its affairs and to carry out the purposes of this act;

18 (6) Apply for and receive grants, contracts, or other public or private funding; and

19 (7) Do all things necessary in conformity with the law to exercise the powers
20 granted by this act.

21 (d)(1) To carry out the purposes of this act or perform any of its functions under this act,
22 the executive board may contract or enter into memoranda of understanding with eligible
23 entities, including the:

- 1 (A) Department of Health Care Finance;
- 2 (B) Department of Human Services;
- 3 (C) Department of Insurance, Securities and Banking;
- 4 (D) Insurance producers and third party administrators registered in the

5 District; and

- 6 (E) Any other entities that have experience in individual and small group
- 7 public and private health insurance plans or facilitating enrollment in those plans.

8 (2) The executive board shall ensure that any entity under a contract with the
9 Authority complies with the provisions of this act when performing services on behalf of the
10 Authority that are subject to this act.

11 (e)(1) The executive board may enter into information-sharing agreements with federal
12 agencies, District agencies, agencies of one or more states, and other state health insurance
13 exchanges, to carry out the provisions of this act.

14 (2) An information-sharing agreement entered into under paragraph (1) of this
15 subsection shall:

16 (A) Include adequate protections with respect to the confidentiality of
17 information; and

18 (B) Comply with all District and federal laws and regulations.

19 (f) The executive board shall adopt written policies and procedures governing all
20 procurements of the Authority.

21 ~~(g) The executive board shall be responsible for using the funds awarded by the Secretary~~
22 ~~for the planning and establishment of the Authority, consistent with of section 1311(b) of the~~
23 ~~Federal Act.~~

1 (hg) The executive board may limit the number of plans offered in the exchanges using
2 selective criteria or contracting, provided individuals and employers have an adequate number
3 and selection of choices.

4 (hh) The executive board may merge the exchange for individual coverage within the
5 American Health Benefits Exchange and the SHOP Exchange if a merger is considered, by the
6 Authority, to be in the best interest of the District.

7 Sec. 8. Advisory board.

8 (a) In addition to the executive board, there shall be a standing advisory board consisting
9 of 9 members who are residents of the District.

10 (b) The executive board may create additional advisory boards as it deems appropriate.

11 (c) The executive board shall solicit the recommendations of, and consult with, the
12 advisory boards on:

13 (1) Insurance standards;

14 (2) Covered benefits;

15 (3) Premiums;

16 (4) Plan certification;

17 (5) Internet technology system development; and

18 (6) Any other policy or operational issues, within the executive board's discretion.

19 (d) The executive board shall select the members of the advisory boards, establish the
20 terms of their appointment, determine the residency requirement of any additional advisory
21 board created, appoint the chair of the standing advisory board, and appoint the chair of any
22 additional advisory boards established, and ensure that at least 1 member of the standing
23 advisory board demonstrates expertise as a health insurance broker or agent.

1 (e)(1) An advisory board member may continue to serve until the appointment and
2 qualification of his or her successor.

3 (2) Vacancies shall be filled by appointment by the executive board for the
4 unexpired term.

5 (f) Each person appointed to an advisory board shall have demonstrated and
6 acknowledged expertise on issues related to one of the following groups:

7 (1) Health professionals;

8 (2) Health insurance consumers;

9 (3) Disease and demographic-specific advocacy groups;

10 (4) Commercial and public sector health plans;

11 (5) Public sector health plans;

12 (6) Health insurance brokers;

13 (7) Health care consumer interest advocacy;

14 (8) Health care foundations;

15 (9) Exchange consumers; or

16 (10) Such other interests deemed necessary.

17 Sec. 9. Executive director and Authority staff.

18 (a) The executive board shall hire an executive director, within 60 days of a majority of
19 executive board members being confirmed, to organize, administer, and manage the operations
20 of the Authority.

21 (1) The executive director shall not be an employee in the career service and shall
22 serve at the pleasure of the executive board.

1 (2) The executive director of the Authority shall become a resident of the District
2 within 180 days of such hire.

3 (b)The executive board shall determine the appropriate compensation for the executive
4 director; provided, that the executive director’s compensation shall not exceed the maximum
5 allowable salary contained within the District of Columbia Excepted Service Salary Schedule.

6 (c) Under the direction of the executive board, the executive director shall;

7 (1) Be the chief administrative officer of the Authority;

8 (2) Direct, administer, and manage the operations of the Authority; and

9 (3) Perform all duties necessary to comply with and carry out the provisions of
10 this act, other District laws and regulations, and the Federal Act.

11 (d)(1) The executive director may employ and retain staff for the Authority.

12 (2) The executive director may retain as independent contractors or employees,
13 and set compensation for:

14 (A) Attorneys;

15 (B) Financial consultants; and

16 (C) Other professionals or consultants necessary to carry out the planning,
17 development, and operations of the Authority and the provisions of this act.

18 (3) Employee compensation shall not exceed the maximum allowable salary
19 contained within the District of Columbia Excepted Service Salary Schedule.

20 (e) Except as otherwise provided in this act, an employee or independent contractor of the
21 Authority, is not subject to any law, regulation or Mayor’s Order governing District government
22 compensation, including furloughs, pay cuts, or any other general fund cost saving measure.

23 Sec. 10. Health benefit plan certification.

1 (a) To be certified as a qualified health plan, a health benefit plan shall, at a minimum:

2 (1) Provide the essential health benefits package described in section 1302(a) of
3 the Federal Act, except that the plan is not required to provide essential benefits that duplicate
4 the minimum benefits of qualified dental plans, as provided in paragraph (e) of this section, if:

5 (A) The Authority has determined that at least one qualified dental plan is
6 available to supplement the plan's coverage; and

7 (B) The health carrier makes prominent disclosure at the time it offers the
8 plan, in a form approved by the Authority, that the plan does not provide the full range of
9 essential pediatric dental benefits, and that qualified dental plans providing those benefits and
10 other dental benefits not covered by the plan are offered through the exchanges;

11 (2) Obtain prior approval of premium rates and contract language from the
12 Commissioner;

13 (3) Provide at least a bronze level of coverage, as determined by section 5(a)(11)
14 of this act unless the plan is certified as a qualified catastrophic plan, meets the requirements of
15 section 1302(e) of the Federal Act, and will only be offered to individuals eligible for
16 catastrophic coverage;

17 (4) Ensure the cost-sharing requirements of the plan do not exceed the limits
18 established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the
19 SHOP Exchange, the plan's deductible does not exceed the limits established under section
20 1302(c)(2) of the Federal Act;

21 (5) Be offered by a health carrier that:

22 (A) Is licensed and in good standing to offer health insurance coverage in
23 the District;

1 (B) Offers at least one qualified health plan at the silver level and at least
2 one plan at the gold level through each component of the Authority in which the health carrier
3 participates, where “component” refers to the SHOP Exchange and the exchange for individual
4 coverage within the American Health Benefit Exchange;

5 (C) Charges the same premium rate for each qualified health plan without
6 regard to whether the plan is offered through the exchanges and without regard to whether the
7 plan is offered directly from the health carrier or through an insurance producer;

8 (D) Does not charge any cancellation fees or penalties in violation of
9 section 5(a)(3)(C); and

10 (E) Complies with the regulations established by the Secretary under
11 section 1311(d) of the Federal Act and such other requirements as the Authority may establish;

12 (6) Meet the requirements of certification pursuant to the authority provided in
13 this act and by the Secretary under section 1311(c) of the Federal Act, and the rules promulgated
14 thereunder, respectively, which include, but are not limited to:

15 (A) Minimum standards in the areas of marketing practices;

16 (B) Network adequacy;

17 (C) Essential community providers in underserved areas;

18 (D) Accreditation;

19 (E) Quality improvement;

20 (F) Uniform enrollment forms and descriptions of coverage; and

21 (G) Information on quality measures for health benefit plan performance;

22 (7) Be determined by the Authority that making the plan available through the
23 exchanges is in the interest of qualified individuals and qualified employers.

1 (b) The Authority shall not withhold certification from a health benefit plan:

2 (1) On the basis that the plan is a fee-for-service plan;

3 (2) Through the imposition of premium price controls by the Authority; or

4 (3) On the basis that the health benefit plan provides treatments necessary to
5 prevent patients' deaths in circumstances the Authority determines are inappropriate or too
6 costly.

7 (c) The Authority shall require each health carrier seeking certification of a plan as a
8 qualified health plan to:

9 (1) Submit a justification for any premium increase before implementation of that
10 increase. The health carrier shall prominently post the information on its publically accessible
11 website. The Authority shall take this information, along with the information and the
12 recommendations provided to the Authority by the Commissioner under section 2794(b) of the
13 PHSA, into consideration when determining whether to allow the health carrier to make plans
14 available through the exchanges;

15 (2)(A) Make available to the public, in the format described in subparagraph (B)
16 of this paragraph, and submit to the Authority, the Secretary, and the Commissioner, accurate
17 and timely disclosure of the following:

18 (i) Claims payment policies and practices;

19 (ii) Periodic financial disclosures;

20 (iii) Data on enrollment;

21 (iv) Data on disenrollment;

22 (v) Data on the number of claims that are denied;

23 (vi) Data on rating practices;

1 (vii) Information on cost-sharing and payments with respect to any
2 out-of-network coverage;

3 (viii) Information on enrollee and participant rights under title I of
4 the Federal Act; and

5 (ix) Other information as determined appropriate by the Secretary.

6 (B) The information required in subparagraph (A) of this paragraph shall
7 be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act;
8 and

9 (3) Permit individuals to learn, in a timely manner upon the request of the
10 individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance,
11 under the individual's plan or coverage that the individual would be responsible for paying with
12 respect to the furnishing of a specific item or service by a participating provider. At a minimum,
13 this information shall be made available to the individual through a website, that is publically
14 accessible, and through other means for individuals without access to the Internet.

15 (4) Promptly notify affected individuals of price and benefit changes, or other
16 changes in circumstances that could materially impact enrollment or coverage.

17 (d) The Authority shall not exempt any health carrier seeking certification as a qualified
18 health plan, regardless of the type or size of the health carrier, from District licensure or solvency
19 requirements, and shall apply the criteria of this section in a manner that assures a level playing
20 field between or among health carriers participating in the exchanges.

21 (e)(1) The provisions of this act that are applicable to qualified health plans shall also
22 apply, to the extent relevant, to qualified dental plans except as modified in accordance with the

1 provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the
2 Authority;

3 (2) The health carrier shall be licensed to offer dental coverage, but need not be
4 licensed to offer other health benefits;

5 (3) The plan shall be limited to dental and oral health benefits, without
6 substantially duplicating the benefits typically offered by health benefit plans without dental
7 coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by
8 the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other dental benefits
9 as the Authority or the Secretary may specify by regulation;

10 (4) Health carriers may jointly offer a comprehensive plan through the exchanges
11 in which the dental benefits are provided by a health carrier through a qualified dental plan and
12 the other benefits are provided by a health carrier through a qualified health plan, provided that
13 the plans are priced separately and are also made available for purchase separately at the same
14 price.

15 Sec. 11. Conflicts of interest.

16 (a)(1) A member of the executive board or of the staff of the Authority shall not be
17 employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise
18 a representative of, a health carrier or other insurer, an agent or broker, a health professional, or a
19 health care facility or health clinic while serving on the board or on the staff of the Authority.

20 (2) A member of the executive board or of the staff of the Authority shall not be a
21 member, a board member, or an employee of a trade association of health carriers, health
22 facilities, health clinics, or health professionals while serving on the board or on the staff of the
23 Authority.

1 (3) A member of the executive board or of the staff of the Authority shall not be a
2 health professional unless he or she receives no compensation for rendering services as a health
3 professional and does not have an ownership interest in a professional health care practice.

4 (b) No member of the executive board or of the staff of the Authority shall, for one year
5 after the end of such member's service on the board or employment by the Authority, accept
6 employment with any health carrier that offers a qualified health benefit plan through the
7 exchanges.

8 (c) No member of the executive board shall make, participate in making, or in any way
9 attempt to use his or her official position to influence the making of any decision that he or she
10 knows or has reason to know will have a reasonably foreseeable material financial effect,
11 distinguishable from its effect on the public generally, on him or her or a member of his or her
12 immediate family, or on either of the following:

13 (1) Any source of income, other than gifts and other than loans by a commercial
14 lending institution in the regular course of business on terms available to the public without
15 regard to official status aggregating two hundred fifty dollars (\$250) or more in value provided
16 to, received by, or promised to the member within 12 months prior to the time when the decision
17 is made.

18 (2) Any business entity in which the member is a director, officer, partner, trustee,
19 employee, or holds any position of management.

20 Sec. 12. Open Meetings.

21 The executive and advisory boards shall be subject to the Open Meetings Act, effective
22 March 31, 2011 (D.C. Law 18-350; D.C. Official Code § 2-571 *et seq.*), except that the executive

1 board may hold closed sessions when considering matters related to litigation, personnel,
2 contracting, or rates.

3 Sec. 13. Limitation of liability.

4 There shall not be any liability, in a private capacity, on the part of the executive or
5 advisory board members, or any officer, or employee of the executive or advisory boards, for or
6 on account of any act performed or obligation entered into in an official capacity, when done in
7 good faith, without intent to defraud, and in connection with the administration, management, or
8 conduct of this act or affairs related to this act.

9 Sec. 14. Relation to other laws.

10 (a) Nothing in this act, and no action taken by the Authority pursuant to this act, shall be
11 construed to preempt or supersede the authority of the Commissioner to regulate the business of
12 insurance within the District. Except as expressly provided to the contrary in this act, all health
13 carriers offering qualified health plans and qualified dental plans in the District shall comply
14 fully with all applicable health insurance laws of the District and regulations adopted and orders
15 issued by the Commissioner.

16 (b) Nothing in this act, and no action taken by the Authority pursuant to this act, shall be
17 construed to preempt or supersede the authority of the Department of Health Care Finance, as the
18 single state agency, to establish policy and enforce the rules and regulations governing Titles
19 XIX and XXI of the Social Security Act and other health care programs under its jurisdiction.

20 Sec. 15. Powers of the Mayor.

21 Notwithstanding any other provision of this Act, all powers and authority vested by this
22 act in the Authority shall remain with the Mayor until:

1 1) A majority of members of the executive board have been confirmed by the
2 Council; and

3 (2) The executive board has hired an executive director.

4 Sec. 156. Dissolution of Authority.

5 Upon dissolution, liquidation or other termination of the Authority:

6 (1) All rights and properties of the Authority shall pass to and be vested in the
7 District, subject to the rights of lien holders and other creditors;

8 (2) Any net earnings of the Authority, beyond that necessary for retirement of any
9 indebtedness or to implement the public purpose or purposes or program of the District, shall not
10 inure to the benefit of any person other than the District;

11 (3) The expenditure of any such net earnings shall be restricted to costs related to
12 the direct delivery of health care to residents of the District.

13 Sec. 167. Implementation and Reports.

14 (a) The executive board shall:

15 (1) Study, in consultation with the advisory boards established under this act and
16 with other stakeholders:

17 (A) The feasibility and desirability of the Authority engaging in:

18 (i) Selective contracting, either through competitive bidding or a
19 negotiation process similar to that used by large employers, to reduce health care costs and
20 improve quality of care by certifying only those health benefit plans that meet certain
21 requirements such as:

22 (I) Promoting patient-centered medical homes;

23 (II) Adopting electronic health records;

- 1 (III) Meeting minimum outcome standards;
- 2 (IV) Implementing payment reforms to reduce medical
- 3 errors and preventable hospitalizations;
- 4 (V) Reducing disparities;
- 5 (VI) Ensuring adequate reimbursements;
- 6 (VII) Enrolling high-risk members and underserved
- 7 populations;
- 8 (VIII) Managing chronic conditions and promoting healthy
- 9 consumer lifestyles;
- 10 (IX) Value-based insurance design;
- 11 (X) Adhering to transparency guidelines; and
- 12 (XI) Uniform price and quality reporting.
- 13 (ii) Multistate contracting; and
- 14 (iii) Entering into a regional exchange.

15 (B) The rules under which health benefit plans should be offered inside
16 and outside the exchanges in order to mitigate adverse selection and encourage enrollment in the
17 exchanges, including:

- 18 (i) Whether any benefits should be required of qualified health
- 19 plans beyond those mandated by the Federal Act, and whether any such additional benefits
- 20 should be required of health benefit plans offered outside the exchanges;
- 21 (ii) Whether health carriers offering health benefit plans outside
- 22 the exchanges should be required to offer either all the same health benefit plans inside the
- 23 exchanges, or alternatively, at least one health benefit plan inside the exchanges; and

1 (iii) Whether managed care organizations with Health Choice
2 contracts should be required to offer products inside the exchanges;

3 (iv) Whether health carriers offering health benefit plans inside the
4 exchanges should be required to also participate in the District Medical Assistance Program; and

5 (v) Which provisions applicable to qualified health plans should be
6 made applicable to qualified dental plans.

7 (C) The design and operation of the Authority's Navigator Program and
8 any other appropriate consumer assistance mechanisms, including:

9 (i) How the Navigator Program could utilize, interact with, or
10 complement private sector resources, including insurance producers;

11 (ii) The infrastructure of the existing private sector health
12 insurance distribution system in the District to determine whether private sector resources may
13 be available and suitable for use by the Authority;

14 (iii) The effect the exchanges may have on private sector
15 employment in the health insurance distribution system in the District;

16 (iv) What functions, in addition to those required by the Federal
17 Act, should be performed by Navigators;

18 (v) What training and expertise should be required of Navigators,
19 and whether different markets and populations require Navigators with different qualifications;

20 (vi) How Navigators should be retained and compensated, and how
21 disparities between Navigator compensation and the compensation of insurance producers
22 outside the exchanges can be minimized or avoided;

1 (vii) How to ensure that Navigators provide information in manner
2 culturally, linguistically, and otherwise appropriate to the needs of the diverse populations served
3 by the Authority, and that Navigators have the capacity to meet these needs; and

4 (viii) What other means of consumer assistance may be appropriate
5 and feasible, and how they should be designed and implemented;

6 (D) The design and function of the SHOP Exchange beyond the
7 requirements of the Federal Act, to promote quality, affordability, and portability, including:

8 (i) Whether it should be a defined contribution/employee choice
9 model or whether employers should choose the qualified health plan to offer their employees;

10 (ii) Whether the current individual and small group markets should
11 be merged; and

12 (iii) Whether the SHOP Exchange should be made available to
13 employers with 50 to 100 employees prior to 2016, as authorized by the Federal Act.

14 (E) How the Authority will ensure financial integrity can be self-
15 sustaining by 2015 in compliance with the Federal Act, including:

16 (i) A recommended plan for the budget of the Authority;

17 (ii) The user fees, licensing fees, or other assessments that should
18 be imposed by the Authority to fund its operations, including what type of user fee cap or other
19 methodology would be appropriate to ensure that the income of the Authority comports with the
20 expenditures of the Authority; and

21 (iii) A recommended plan for how to prevent fraud, waste, and
22 abuse; and

1 (F) How the Authority should conduct its public relations and advertising
2 campaign, including what type of solicitation, if any, of individual consumers or employers,
3 would be desirable and appropriate; and

4 (2) Report its findings to the Mayor, Council and public under paragraph (1) of
5 this subsection within 180 days of the effective date of this act.

6 (b)(1) The executive board shall prepare a plan that identifies how the Authority will be
7 financially self-sustaining by January 1, 2015.

8 (2) The plan shall be certified by an independent actuary as actuarially sound and
9 shall be submitted to the Mayor and Council not later than December 15, 2013.

10 Sec. 178. Rulemaking authority.

11 (a) The Authority shall promulgate rules and regulations in accordance with the District
12 of Columbia Administrative Procedures Act of 1968, approved October 21, 1968 (82 Stat.1204;
13 D.C. Official Code §2-501 *et seq.*);

14 (b) The Authority shall submit all proposed rules adopted by the Authority to the Council
15 for a 30-day period of review, excluding Saturdays, Sundays, legal holidays, and days of Council
16 recess. If the Council does not approve or disapprove the proposed rules, in whole or in part, by
17 resolution, within this 30-day review period, the proposed rules shall be deemed approved.

18 (c) Regulations promulgated under this section shall not conflict with or prevent the
19 application of regulations promulgated by the Secretary under the Federal Act.

20 Sec. 189. Applicability.

21 This act shall apply upon the inclusion of its fiscal effect in an approved budget and
22 financial plan.

23 Sec. 1920. Fiscal impact statement.

1 The Council adopts the fiscal impact statement ~~in the committee report prepared by the~~
2 Chief Financial Officer as the fiscal impact statement required by section 602(c)(3) of the
3 District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official
4 Code § 2-206.02(c)(3)).

5 Sec. 201. Effective date.

6 This act shall take effect following approval by the Mayor (or in the event of veto by the
7 Mayor, action by the Council to override the veto), and a 30-day period of Congressional review
8 as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
9 24, 1973 (87 Stat. 813; D.C. Code § 1-206(c)(1)), and publication in the District of Columbia
10 Register.