ENROLLED ORIGINAL

AN ACT

D.C. ACT 19-269

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

JANUARY 17, 2012

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

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Health Benefit Exchange Authority Establishment Act of 2011".

Sec. 2. Definitions.

For the purposes of this act, the term:

(1) "American Health Benefit Exchange" means an entity established pursuant to section 5, and section 1311(b) of the Federal Act.

(2) "Authority" means the District of Columbia Health Benefit Exchange Authority established by section 3.

(3) "Commissioner" means the Commissioner of the Department of Insurance, Securities and Banking, as established by section 3 of the Department of Insurance and Securities, Regulation Establishment Act of 1996, effective May 21, 1997 (D.C. Law 11-268; D.C. Official Code § 31-102).

(4) "Federal Act" means the Patient Protection and Affordable Care Act, approved March 23, 2010 (124 Stat. 119; 42 U.S.C. § 18001, note), as amended by the Health Care and Education Reconciliation Act of 2010 approved March 30, 2010 (124 Stat. 1029; 42 U.S.C. § 1305, note), and any amendments, regulations, or guidance issued pursuant to the Federal Act.

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

(B) The term "health benefit plan" does not include:

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

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

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

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

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

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, approved August 21, 1996 (110 Stat. 1936; 42 U.S.C. § 201, note) ("HIPAA"), under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance, or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

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

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

(D) The term "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance, and 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:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) The term "health benefit plan" does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

(i) A Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 *et seq.*; or

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

(6) "Health carrier" means an entity subject to the insurance laws and regulations of the District 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) An accident and sickness insurance company;

(B) A health maintenance organization;

(C) A hospital and medical services corporation; or

(D) Any other entity providing a health benefit plan.

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

(8) "Internal Revenue Code of 1986" means the Internal Revenue Code of 1986, approved August 16, 1954 (100 Stat. 2095; 26 U.S.C. § 1 *et seq.*).

(9) "PHSA" means the Public Health Service Act, approved July 1, 1944 (58 Stat. 682; 42 U.S.C. § 201 *et seq.*).

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

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

(A) Has its principal place of business in the District and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the District.

(12) "Qualified health plan" means a health benefit plan that has a certification validating that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 10.

(13) "Qualified individual" means an individual, including a minor, who:

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

(B) Resides in the District;

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

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

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services.

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

(16)(A) "Small employer" means a single employer that employed an average of not more than 50 employees during the preceding calendar year.

(B) For the purposes of this paragraph:

(i) All persons treated as a single employer under section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986 (26 U.S.C. § 414(b), (c), (m), or (o)) shall be treated as a single employer.

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

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

(iv) 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 employer is reasonably expected to employ in the current calendar year.

(v) 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.

(17) "Social Security Act" means the Social Security Act, approved August 14, 1935 (49 Stat. 620; 42 U.S.C. § 301 *et seq.*), as amended.

Sec. 3. Establishment and purpose.

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

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

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

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

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

(4) Reduce the number of uninsured;

(5) Provide a transparent marketplace for health benefit plans;

(6) Educate consumers; and

(7) Assist individuals and groups to access programs, premium assistance tax credits, and cost-sharing reductions.

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

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

(b) The Fund shall consist of:

(1) Any user fees, licensing fees, or other assessments collected by the Authority;

(2) Income from investments made on behalf of the Fund;

(3) Interest on money in the Fund;

(4) Money collected by the executive board as a result of a legal or other action;

(5) Donations;

(6) Grants;

(7) All general revenue funds appropriated by a line item in the budget submitted pursuant to section 446 of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 801; D.C. Official Code § 1-204.46), and authorized by Congress for the purposes of the Authority; and

(8) Any other money from any other source accepted for the benefit of the Fund.

(c) All revenues, income from investments, proceeds, and other monies, from whatever source derived, that are collected or received by the Authority shall be deposited into the Fund. All funds deposited into the Fund, and any interest earned on those funds, shall not revert to the unrestricted fund balance of the General Fund of the District of Columbia at the end of a fiscal year, or at any other time, but shall be continually available for the uses and purposes set forth in this act without regard to fiscal year limitation, subject to authorization by Congress.

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

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

(A) User fees;

(B) Licensing fees; and

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

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

Sec. 5. Authority duties and powers.

(a) The Authority shall:

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

(2) Establish a SHOP Exchange through which qualified employers may access coverage for their employees and 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;

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

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

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

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

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

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

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

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

(11) Assign a rating to each qualified health plan offered through the exchanges 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;

(12) Use a standardized format for presenting health benefit options in the exchanges, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

(13) Conduct eligibility determinations, in accordance with section 1413 of the Federal Act for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program under title XXI of the Social Security Act, or any other applicable District program pursuant to the policies and procedures established by the Department of Health Care Finance;

(14) Establish and make available, through a website that is publicly available, 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, and, if feasible, which is designed to provide consumers with

information on out-of-pocket costs for in-network and out-of-network services, taking into account any cost-sharing reductions;

(15) Grant a certification, subject to section 1411 of the Federal Act, 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:

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

(B) The individual meets the requirements for another exemption from the individual responsibility requirement or penalty;

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

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

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

(i) Did not provide minimum essential coverage; or

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

(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 the 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;

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

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

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

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

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

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

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

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

(D) The Department of Health Care Finance;

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

(F) Public health experts;

(G) Health care providers; and

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

(22) Meet the following financial integrity requirements:

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

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

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

(i) Investigate the affairs of the Authority;

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

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

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

(i) Staff retreats;

(ii) Promotional giveaways;

(iii) Excessive executive compensation; or

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

(b) In addition to certifying qualified health plans, the Authority 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 exchanges, 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 Authority nor a health carrier offering qualified health plans through the exchanges 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 unaffordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

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

Sec. 6. Executive board establishment and membership.

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

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

(2) Four nonvoting, ex-officio members, or their designees, who shall be the:

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

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

(C) Director of the Department of Health; and

(D) Director of the Department of Human Services.

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

(A) Two shall be for a term of 2 years;

(B) One shall be for a term of 3 years;

(C) Two shall be for a term of 4 years; and

(D) Two shall be for a term of 5 years.

(2)(A) A member of the executive board may continue to serve until his or her successor has been approved by the Council and appointed by the Mayor.

(B) Vacancies shall be filled by Mayoral appointment for the unexpired term in the same manner of the original appointment.

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

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

(A) Individual or small employer health care coverage;
(B) Health benefits plan administration;
(C) Health care finance;
(D) Administering a public or private health care delivery system;
(E) Purchasing health plan coverage;
(F) Prior experience in commercial insurance management;
(G) Actuarial analysis;
(H) Health care economics;
(I) Human services administration;
(J) Health care consumer interest advocacy;
(K) Public health programs; or
(L) Enrolling individuals into health benefit plans.

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

(3) At least one voting member of the executive board shall have demonstrated knowledge in health care consumer interest advocacy.

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

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

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

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

Sec. 7. Powers and duties of executive board.

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

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

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

(1) Adopt and alter an official seal;

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

(3) Adopt bylaws, rules, and policies;

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

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

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

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

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

(A) Department of Health Care Finance;

(B) Department of Human Services;

(C) Department of Insurance, Securities and Banking;

(D) Insurance producers and third-party administrators registered in the District; and

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

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

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

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

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

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

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

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

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

Sec. 8. Advisory board.

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

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

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

(1) Insurance standards;

(2) Covered benefits;

(3) Premiums;

(4) Plan certification;

(5) Internet technology system development; and

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

(d) The executive board shall:

(1) Select the members of the advisory boards;

(2) Establish the terms of the members;

(3) Ensure that at least one member of the standing advisory board demonstrates expertise as a health insurance broker or agent;

(4) Appoint the chair of the standing advisory board;

(5) Determine the residency requirement of any additional advisory board created; and

(6) Appoint the chair of any additional advisory boards created.

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

(2) Vacancies shall be filled by appointment by the executive board for the unexpired term of the appointee's predecessor.

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

(1) Health professionals;

(2) Health insurance consumers;

(3) Disease and demographic-specific advocacy groups;

(4) Commercial sector health plans;

(5) Public sector health plans;

(6) Health insurance brokers;

(7) Health care consumer interest advocacy;

(8) Health care foundations;

(9) Exchange consumers; or

(10) Such other interests considered necessary.

Sec. 9. Executive director and Authority staff.

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

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

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

(b)The executive board shall determine the appropriate compensation for the executive director; provided, that the executive director's compensation shall not exceed the maximum allowable salary in the District of Columbia Excepted Service salary schedule.

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

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

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

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

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

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

(A) Attorneys;

(B) Financial consultants; and

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

(3) Employee compensation shall not exceed the maximum allowable salary in the District of Columbia Excepted Service salary schedule.

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

Sec. 10. Health benefit plan certification.

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

(1) Provide 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) of this section, if:

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

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

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

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

(4) Ensure that the cost-sharing requirements of the plan 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) Be offered by a health carrier that:

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

(B)(i) Offers at least one qualified health plan at the silver level and at least one plan at the gold level through each component of the Authority in which the health carrier participates;

(ii) For the purposes of this subparagraph, the term "component" refers to the SHOP Exchange and the exchange for individual coverage within the American Health Benefit Exchange;

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

(D) Does not charge any cancellation fees or penalties in violation of section 5(c); and

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

(6) Meet the requirements of certification pursuant to the authority provided in this act and by the Secretary under section 1311(c) of the Federal Act, and rules promulgated pursuant to this act or the Federal Act, which include:

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

(B) Network adequacy;

(C) Essential community providers in underserved areas;

(D) Accreditation;

(E) Quality improvement;

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

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

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

(b) The Authority shall not withhold certification from 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 Authority; or

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

(c) The Authority 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, and prominently post the information on its publically accessible website;

(2)(A) Make available to the public, in the format described in subparagraph (B) of this paragraph, and submit to the Authority, 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.

(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;

(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 and make this information available to the individual through a website that is publically accessible, and through other means for individuals without access to the Internet; and

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

(d) The Authority shall not exempt any health carrier seeking certification as a qualified health plan, regardless of the type or size of the health carrier, from District 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 exchanges.

(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 Authority.

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

(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 Authority or the Secretary may specify by regulation.

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

(f) The Authority shall take the information required by subsection (c)(1) of this section, along with the information and the recommendations provided to the Authority by the Commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the health carrier to make plans available through the exchanges.

Sec. 11. Conflicts of interest.

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

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

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

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

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

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without

regard to official status, aggregating $250 or more in value provided to, received by, or promised to the member within 12 months prior to the time when the decision is made.

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

Sec. 12. Open meetings.

The executive and advisory boards shall be subject to the Open Meetings Amendment Act of 2010 , effective March 31, 2011 (D.C. Law 18-350; D.C. Official Code § 2-571 *et seq.*); except, that the executive board may hold closed sessions when considering matters related to litigation, personnel, contracting, or rates.

Sec. 13. Limitation of liability.

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

Sec. 14. Relation to other laws.

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

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

Sec. 15. Powers of the Mayor.

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

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

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

Sec. 16. Dissolution of the Authority.

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

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

(2) Any net earnings of the Authority, beyond that necessary for retirement of any indebtedness or to implement a public purpose or program of the District authorized under this act, shall not inure to the benefit of any person other than the District;

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

Sec. 17. Implementation and reports.

(a) The executive board shall:

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

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

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

(I) Promoting patient–centered medical homes;

(II) Adopting electronic health records;

(III) Meeting minimum outcome standards;

(IV) Implementing payment reforms to reduce medical errors and preventable hospitalizations;

(V) Reducing disparities;

(VI) Ensuring adequate reimbursements;

(VII) Enrolling high–risk members and underserved populations;

(VIII) Managing chronic conditions and promoting healthy consumer lifestyles;

(IX) Value–based insurance design;

(X) Adhering to transparency guidelines; and

(XI) Uniform price and quality reporting;

(ii) Multistate contracting; and

(iii) Entering into a regional exchange;

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

(i) Whether any benefits should be required of qualified health plans beyond those mandated by the Federal Act, and whether any such additional benefits should be required of health benefit plans offered outside the exchanges;

(ii) Whether health carriers offering health benefit plans outside the exchanges should be required to offer either all the same health benefit plans inside the exchanges or, alternatively, at least one health benefit plan inside the exchanges;

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

(iv) Whether health carriers offering health benefit plans inside the exchanges should be required to also participate in the District medical assistance program; and

(v) Which provisions applicable to qualified health plans should be made applicable to qualified dental plans;

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) How the Authority will ensure financial integrity in compliance with the Federal Act, including:

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

(ii) The user fees, licensing fees, or other assessments that should be imposed by the Authority to fund its operations, including what type of user fee cap or other

methodology would be appropriate to ensure that the income of the Authority comports with the expenditures of the Authority; and

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

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

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

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

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

Sec. 18. Rules.

(a) The Authority, pursuant to Title 1 of the District of Columbia Administrative Procedure Act of 1968, approved October 21, 1968 (82 Stat.1204; D.C. Official Code §2-501 *et seq.*), shall issue rules to implement the provisions of this act.

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

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

Sec. 19. Applicability.

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

Sec. 20. Fiscal impact statement.

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

Sec. 21. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review

as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia
APPROVED
January 17, 2012