REFERENCE TITLE: health insurance; exchange

State of Arizona
House of Representatives
Fiftieth Legislature
First Regular Session
2011

HB 2666

Introduced by
Representatives McLain, Ash, Senator McComish

AN ACT

AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 22; RELATING TO THE ARIZONA HEALTH INSURANCE EXCHANGE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 20, Arizona Revised Statutes, is amended by adding chapter 22, to read:

CHAPTER 22

ARIZONA HEALTH INSURANCE EXCHANGE

ARTICLE 1. GENERAL PROVISIONS

20-3201. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "DENTAL CARRIER" MEANS AN ENTITY THAT IS LICENSED UNDER THIS TITLE TO OFFER A LIMITED SCOPE DENTAL PLAN.

2. "EXCHANGE" MEANS THE ARIZONA HEALTH INSURANCE EXCHANGE ESTABLISHED BY SECTION 20-3211.

3. "EXCHANGE BOARD" MEANS THE ARIZONA HEALTH INSURANCE EXCHANGE BOARD OF DIRECTORS ESTABLISHED BY SECTION 20-3211.

4. "FEDERAL ACT" MEANS THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152), AND ANY REGULATIONS OR GUIDANCE ISSUED UNDER THOSE ACTS.

5. "HEALTH BENEFIT PLAN":

(a) 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) DOES NOT INCLUDE:

(i) COVERAGE ONLY FOR ACCIDENT, OR DISABILITY INCOME INSURANCE, OR ANY COMBINATION OF THOSE COVERAGES.

(ii) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE.

(iii) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE.

(iv) WORKERS' COMPENSATION OR SIMILAR INSURANCE.

(v) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

(vi) CREDIT-ONLY INSURANCE.

(vii) COVERAGE FOR ON-SITE MEDICAL CLINICS.

(viii) OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO PUBLIC LAW 104-191, UNDER WHICH BENEFITS FOR HEALTH CARE SERVICES ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS.

(c) DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THE BENEFITS ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE 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 OF THOSE BENEFITS.

(iii) OTHER SIMILAR, LIMITED BENEFITS SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO PUBLIC LAW 104-191.

(d) DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THE BENEFITS ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE OR CONTRACT OF INSURANCE, THERE

IS NO COORDINATION BETWEEN THE PROVISION OF THE BENEFITS AND ANY EXCLUSION OF BENEFITS UNDER ANY GROUP HEALTH PLAN MAINTAINED BY THE SAME PLAN SPONSOR AND THE BENEFITS ARE PAID WITH RESPECT TO AN EVENT WITHOUT REGARD TO WHETHER BENEFITS ARE PROVIDED WITH RESPECT TO SUCH AN EVENT UNDER ANY GROUP HEALTH PLAN MAINTAINED BY THE SAME PLAN SPONSOR:

(i) COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS.

(ii) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.

(e) DOES NOT INCLUDE THE FOLLOWING IF OFFERED AS A SEPARATE POLICY, CERTIFICATE OR CONTRACT OF INSURANCE:

(i) MEDICARE SUPPLEMENTAL HEALTH INSURANCE AS DEFINED UNDER SECTION 1882(g)(1) OF THE SOCIAL SECURITY ACT.

(ii) COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED UNDER 10 UNITED STATES CODE CHAPTER 55.

(iii) SIMILAR SUPPLEMENTAL COVERAGE PROVIDED UNDER A GROUP HEALTH PLAN.

6. "HEALTH CARRIER" MEANS AN ENTITY THAT IS LICENSED AS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICES CORPORATION OR HOSPITAL AND MEDICAL SERVICES CORPORATION PURSUANT TO THE INSURANCE LAWS AND RULES OF THIS STATE AND THAT CONTRACTS OR OFFERS TO CONTRACT TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

7. "HEALTH INSURANCE PRODUCER" MEANS AN INDIVIDUAL LICENSED TO SELL HEALTH INSURANCE IN THIS STATE PURSUANT TO SECTION 20-286, SUBSECTION A, PARAGRAPH 2.

8. "QUALIFIED DENTAL PLAN" MEANS A LIMITED SCOPE DENTAL PLAN THAT HAS BEEN CERTIFIED PURSUANT TO SECTION 20-3214.

9. "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 SHOP EXCHANGE, AND AT THE OPTION OF THE EMPLOYER, SOME OR ALL OF ITS PART-TIME EMPLOYEES, IF THE EMPLOYER EITHER:

(a) HAS ITS HEADQUARTERS OR A PRINCIPAL PLACE OF BUSINESS IN THIS STATE AND ELECTS TO PROVIDE COVERAGE THROUGH THE SHOP EXCHANGE TO ALL OF ITS ELIGIBLE EMPLOYEES, WHEREVER EMPLOYED.

(b) ELECTS TO PROVIDE COVERAGE THROUGH THE SHOP EXCHANGE TO ALL OF ITS ELIGIBLE EMPLOYEES WHO ARE PRINCIPALLY EMPLOYED IN THIS STATE.

10. "QUALIFIED HEALTH PLAN" MEANS A HEALTH BENEFIT PLAN THAT HAS IN EFFECT A CERTIFICATION THAT THE PLAN MEETS THE CRITERIA FOR CERTIFICATION DESCRIBED IN SECTION 1311(c) OF THE FEDERAL ACT AND SECTION 20-3214.

11. "QUALIFIED INDIVIDUAL" MEANS AN INDIVIDUAL, INCLUDING A MINOR, WHO:

(a) IS SEEKING TO ENROLL IN A QUALIFIED HEALTH PLAN OFFERED TO INDIVIDUALS THROUGH THE EXCHANGE.

(b) RESIDES IN THIS STATE.

(c) AT THE TIME OF ENROLLMENT, IS NOT INCARCERATED, OTHER THAN INCARCERATION PENDING THE DISPOSITION OF CHARGES.

(d) IS, AND IS REASONABLY EXPECTED TO BE, FOR THE ENTIRE PERIOD FOR WHICH ENROLLMENT IS SOUGHT, A CITIZEN OR NATIONAL OF THE UNITED STATES OR AN ALIEN LAWFULLY PRESENT IN THE UNITED STATES.

12. "QUALIFIED NAVIGATOR" MEANS AN ENTITY THAT MEETS THE REQUIREMENTS OF SECTION 1311(i) OF THE FEDERAL ACT AND THE STANDARDS DEVELOPED BY THE SECRETARY AND WHOSE EMPLOYEES THAT FACILITATE ENROLLMENT IN A QUALIFIED HEALTH PLAN ARE HEALTH INSURANCE PRODUCERS.

13. "SECRETARY" MEANS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

14. "SHOP EXCHANGE" MEANS THE SMALL BUSINESS HEALTH OPTIONS PROGRAM ESTABLISHED UNDER SECTION 20-3211.

15. "SMALL EMPLOYER" MEANS A SINGLE EMPLOYER THAT EMPLOYED AN AVERAGE OF NOT MORE THAN FIFTY EMPLOYEES DURING THE PRECEDING CALENDAR YEAR. FOR THE PURPOSES OF THIS PARAGRAPH:

(a) "SINGLE EMPLOYER" MEANS:

(i) ALL PERSONS TREATED AS A SINGLE EMPLOYER UNDER SUBSECTION (b), (c), (m) OR (o) OF SECTION 414 OF THE INTERNAL REVENUE CODE OF 1986.

(ii) AN EMPLOYER AND ANY PREDECESSOR EMPLOYER.

(b) EMPLOYEES SHALL BE COUNTED IN A MANNER THAT IS CONSISTENT WITH THE FEDERAL ACT.

(c) 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 ON BUSINESS DAYS IN THE CURRENT CALENDAR YEAR.

(d) AN EMPLOYER THAT WOULD CEASE TO BE A SMALL EMPLOYER BY REASON OF AN INCREASE IN THE NUMBER OF ITS EMPLOYEES SHALL CONTINUE TO BE TREATED AS A SMALL EMPLOYER FOR PURPOSES OF THIS CHAPTER IF THE EMPLOYER CONTINUOUSLY MAKES ENROLLMENT THROUGH THE SHOP EXCHANGE AVAILABLE TO ITS EMPLOYEES.

20-3202. Interpretation; premium controls

THIS CHAPTER DOES NOT PERMIT THE EXCHANGE OR THE DIRECTOR TO IMPOSE PREMIUM CONTROLS ON HEALTH CARRIERS.

ARTICLE 2. ARIZONA HEALTH INSURANCE EXCHANGE

20-3211. Arizona health insurance exchange; establishment; governance

A. THE ARIZONA HEALTH INSURANCE EXCHANGE IS ESTABLISHED IN THE DEPARTMENT. THE EXCHANGE SHALL SERVE AS THE AMERICAN HEALTH BENEFIT EXCHANGE FOR INDIVIDUALS AND THE SMALL BUSINESS HEALTH OPTIONS PROGRAM PURSUANT TO SECTION 1311 OF THE FEDERAL ACT. THE INDIVIDUAL AND SMALL GROUP MARKETS SHALL REMAIN SEPARATE.

B. THE ARIZONA HEALTH INSURANCE EXCHANGE BOARD OF DIRECTORS IS ESTABLISHED CONSISTING OF THE FOLLOWING ELEVEN MEMBERS APPOINTED BY THE GOVERNOR:

1. ONE REPRESENTATIVE OF EACH OF THE TWO LARGEST HEALTH CARRIERS BY MARKET SHARE IN THE INDIVIDUAL MARKET ON THE EXCHANGE. MARKET SHARE SHALL BE DETERMINED BY THE DEPARTMENT.

2. ONE REPRESENTATIVE OF EACH OF THE TWO LARGEST HEALTH CARRIERS BY MARKET SHARE IN THE SMALL GROUP MARKET ON THE EXCHANGE THAT ARE NOT ALREADY REPRESENTED AS THE LARGEST INDIVIDUAL HEALTH CARRIERS ON THE EXCHANGE. A CARRIER IS ALREADY REPRESENTED IF THE CARRIER OR A COMPANY BY WHICH IT IS CONTROLLED OR WITH WHICH IT IS UNDER COMMON CONTROL IS ALREADY ON THE EXCHANGE BOARD AS AN INDIVIDUAL HEALTH CARRIER. MARKET SHARE SHALL BE DETERMINED BY THE DEPARTMENT.

3. A REPRESENTATIVE OF A LIMITED SCOPE DENTAL PLAN THAT OFFERS COVERAGE ON THE EXCHANGE.

4. A HEALTH INSURANCE PRODUCER WHO SELLS INDIVIDUAL COVERAGE ON THE EXCHANGE.

5. A HEALTH INSURANCE PRODUCER WHO SELLS SMALL GROUP COVERAGE ON THE EXCHANGE.

6. A SMALL BUSINESS THAT PURCHASES HEALTH INSURANCE ON THE EXCHANGE OR AN ASSOCIATION OR CHAMBER OF COMMERCE REPRESENTING SMALL BUSINESSES.

7. AN INDIVIDUAL WHO PURCHASES INDIVIDUAL COVERAGE ON THE EXCHANGE.

8. THE DIRECTOR, WHO SHALL BE A NONVOTING MEMBER.

9. THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, WHO SHALL BE A NONVOTING MEMBER.

C. EXCHANGE BOARD MEMBERS ARE NOT ELIGIBLE FOR COMPENSATION OR REIMBURSEMENT OF EXPENSES.

D. AN EXCHANGE BOARD MEMBER SHALL NOT TAKE ANY ACTION IN WHICH THE MEMBER OR THE ENTITY THE MEMBER IS REPRESENTING HAS A CONFLICT OF INTEREST.

E. THE EXCHANGE BOARD SHALL OVERSEE THE OPERATION OF THE EXCHANGE, INCLUDING THE HIRING OF AN EXECUTIVE DIRECTOR, PREPARATION OF REQUESTS FOR PROPOSALS AND AWARDING CONTRACTS TO OPERATE THE EXCHANGE, SETTING PERFORMANCE STANDARDS FOR CONTRACTORS AND ENSURING COMPLIANCE WITH THE STANDARDS.

F. THE EXECUTIVE DIRECTOR REPORTS TO THE EXCHANGE BOARD. THE EXECUTIVE DIRECTOR SHALL BE RESPONSIBLE FOR THE DAY TO DAY OPERATIONS OF THE EXCHANGE, INCLUDING HIRING ADDITIONAL STAFF IF NEEDED.

G. THE EXCHANGE BOARD DOES NOT HAVE RULE MAKING AUTHORITY.

H. BEGINNING JANUARY 1, 2015, EXCHANGE BOARD MEMBERS SHALL BE SUBJECT TO THE FOLLOWING TERMS:

1. THE TERMS OF HEALTH CARRIERS APPOINTED TO THE EXCHANGE BOARD PURSUANT TO THIS SECTION ARE THREE YEARS. THE DEPARTMENT SHALL SUBMIT MARKET SHARE INFORMATION TO THE GOVERNOR FOR THESE APPOINTMENTS.

2. THE TERMS OF ALL OTHER APPOINTED MEMBERS ARE THREE YEARS. MEMBERS APPOINTED TO TERMS BEGINNING JANUARY 1, 2015 SHALL ASSIGN THEMSELVES BY LOT TO TWO TERMS OF TWO YEARS, TWO TERMS OF THREE YEARS AND ONE TERM OF FOUR YEARS IN OFFICE. ALL SUBSEQUENT MEMBERS SERVE THREE YEAR TERMS OF OFFICE. THE CHAIRPERSON SHALL NOTIFY THE GOVERNOR'S OFFICE ON APPOINTMENTS OF THESE TERMS.

20-3212. Duties of the exchange

A. THE EXCHANGE SHALL:

1. FACILITATE THE PURCHASE AND SALE OF QUALIFIED HEALTH PLANS AND SHALL MAKE QUALIFIED HEALTH PLANS AVAILABLE TO QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS BEGINNING JANUARY 1, 2014. EXCEPT FOR THE FUNCTIONS DESCRIBED IN THIS SECTION, EMPLOYEES OR CONTRACTORS OF THE EXCHANGE SHALL NOT SELL, SOLICIT OR NEGOTIATE HEALTH BENEFIT PLANS OR STEER QUALIFIED INDIVIDUALS OR QUALIFIED SMALL BUSINESSES TOWARD SPECIFIC OPTIONS ON THE EXCHANGE.

2. PROVIDE FOR THE ESTABLISHMENT OF A SHOP EXCHANGE TO ASSIST QUALIFIED SMALL EMPLOYERS IN THIS STATE IN FACILITATING THE ENROLLMENT OF THEIR EMPLOYEES IN QUALIFIED HEALTH PLANS.

3. CONTRACT WITH AN ELIGIBLE ENTITY FOR THE NONREGULATORY FUNCTIONS DESCRIBED IN THIS CHAPTER. AN ELIGIBLE ENTITY MUST HAVE EXPERIENCE IN INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE, BENEFIT ADMINISTRATION OR OTHER EXPERIENCE RELEVANT TO THE RESPONSIBILITIES TO BE ASSUMED BY THE ENTITY. A HEALTH CARRIER OR AN AFFILIATE OF A HEALTH CARRIER IS NOT AN ELIGIBLE ENTITY. THE ELIGIBLE ENTITY SHALL NOT HAVE A CONFLICT OF INTEREST.

4. PAY A HEALTH INSURANCE PRODUCER, OTHER THAN A HEALTH INSURANCE PRODUCER EMPLOYED BY A QUALIFIED NAVIGATOR, A COMMISSION FOR THE SALE BY THE HEALTH INSURANCE PRODUCER OF A QUALIFIED HEALTH PLAN ON THE EXCHANGE TO AN INDIVIDUAL OR SMALL EMPLOYER. HEALTH INSURANCE PRODUCER COMMISSIONS OR FEES PAID BY THE EXCHANGE SHALL BE BASED ON A COMMISSION SCHEDULE ESTABLISHED BY THE EXCHANGE BOARD THAT IS COMMENSURATE WITH THE AVERAGE COMMISSION OR FEE PAID BY HEALTH CARRIERS IN THIS STATE TO HEALTH INSURANCE PRODUCERS FOR SIMILAR HEALTH INSURANCE PLANS SOLD OUTSIDE THE EXCHANGE.

5. IMPLEMENT PROCEDURES FOR THE CERTIFICATION, RECERTIFICATION AND DECERTIFICATION OF HEALTH BENEFIT PLANS AS QUALIFIED HEALTH PLANS, CONSISTENT WITH GUIDELINES DEVELOPED BY THE SECRETARY UNDER SECTION 1311(c) OF THE FEDERAL ACT AND SECTION 20-3214.

6. PROVIDE FOR THE OPERATION OF A TOLL-FREE TELEPHONE HOTLINE TO RESPOND TO REQUESTS FOR ASSISTANCE.

7. PROVIDE FOR ENROLLMENT PERIODS, AS DETERMINED BY THE SECRETARY UNDER SECTION 1311(c)(6) OF THE FEDERAL ACT.

8. MAINTAIN AN INTERNET WEBSITE THROUGH WHICH ENROLLEES AND PROSPECTIVE ENROLLEES OF QUALIFIED HEALTH PLANS MAY OBTAIN STANDARDIZED COMPARATIVE INFORMATION ON THE PLANS.

9. USE A STANDARDIZED FORMAT FOR PRESENTING HEALTH BENEFIT OPTIONS IN THE EXCHANGE, INCLUDING THE USE OF THE UNIFORM OUTLINE OF COVERAGE ESTABLISHED UNDER SECTION 2715 OF THE PUBLIC HEALTH SERVICE ACT.

10. IN ACCORDANCE WITH SECTION 1413 OF THE FEDERAL ACT, INFORM INDIVIDUALS OF ELIGIBILITY REQUIREMENTS FOR THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM AND THE CHILDREN'S HEALTH INSURANCE PROGRAM AND IF THROUGH SCREENING OF AN APPLICATION BY THE EXCHANGE, THE EXCHANGE DETERMINES THAT ANY INDIVIDUAL IS ELIGIBLE FOR EITHER PROGRAM, ENROLL THE INDIVIDUAL IN THAT PROGRAM. THE EXCHANGE SHALL COORDINATE ELIGIBILITY DETERMINATIONS UNDER THIS

PARAGRAPH WITH THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

11. ESTABLISH AND MAKE AVAILABLE BY ELECTRONIC MEANS A CALCULATOR TO DETERMINE THE ACTUAL COST OF COVERAGE AFTER APPLICATION OF ANY PREMIUM TAX CREDIT UNDER SECTION 36B OF THE INTERNAL REVENUE CODE OF 1986 AND ANY COST-SHARING REDUCTION UNDER SECTION 1402 OF THE FEDERAL ACT.

12. ESTABLISH A SHOP EXCHANGE THROUGH WHICH QUALIFIED EMPLOYERS MAY ELECT TO EITHER MAKE ITS EMPLOYEES ELIGIBLE FOR ONE OR MORE QUALIFIED HEALTH PLANS OFFERED THROUGH THE SHOP EXCHANGE OR SPECIFY A LEVEL OF COVERAGE SO THAT ANY OF ITS EMPLOYEES MAY ENROLL IN ANY QUALIFIED HEALTH PLAN OFFERED THROUGH THE EXCHANGE AT THE SPECIFIED LEVEL OF COVERAGE.

13. SUBJECT TO SECTION 1411 OF THE FEDERAL ACT, GRANT A CERTIFICATION ATTESTING THAT, FOR PURPOSES OF THE INDIVIDUAL RESPONSIBILITY PENALTY UNDER SECTION 5000A OF THE INTERNAL REVENUE CODE OF 1986, AN INDIVIDUAL IS EXEMPT FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT OR FROM THE PENALTY IMPOSED BY THAT SECTION BECAUSE EITHER:

(a) THERE IS NO AFFORDABLE QUALIFIED HEALTH PLAN AVAILABLE THROUGH THE EXCHANGE, OR THE INDIVIDUAL'S EMPLOYER, COVERING THE INDIVIDUAL.

(b) THE INDIVIDUAL MEETS THE REQUIREMENTS FOR ANY OTHER SUCH EXEMPTION FROM THE INDIVIDUAL RESPONSIBILITY REQUIREMENT OR PENALTY.

14. TRANSFER TO THE UNITED STATES SECRETARY OF THE TREASURY THE FOLLOWING:

(a) A LIST OF THE INDIVIDUALS WHO ARE ISSUED A CERTIFICATION UNDER PARAGRAPH 13, INCLUDING THE NAME AND TAXPAYER IDENTIFICATION NUMBER OF EACH INDIVIDUAL.

(b) THE NAME AND TAXPAYER IDENTIFICATION NUMBER OF EACH INDIVIDUAL WHO WAS AN EMPLOYEE OF AN EMPLOYER BUT WHO WAS DETERMINED TO BE ELIGIBLE FOR THE PREMIUM TAX CREDIT UNDER SECTION 36B OF THE INTERNAL REVENUE CODE OF 1986 BECAUSE EITHER:

(i) THE EMPLOYER DID NOT PROVIDE MINIMUM ESSENTIAL HEALTH BENEFITS COVERAGE.

(ii) THE EMPLOYER PROVIDED THE MINIMUM ESSENTIAL HEALTH BENEFITS COVERAGE, BUT IT WAS DETERMINED UNDER SECTION 36B(c)(2)(C) OF THE INTERNAL REVENUE CODE EITHER TO BE UNAFFORDABLE TO THE EMPLOYEE OR NOT PROVIDE THE REQUIRED MINIMUM ACTUARIAL VALUE.

(c) THE NAME AND TAXPAYER IDENTIFICATION NUMBER OF:

(i) EACH INDIVIDUAL WHO NOTIFIES THE EXCHANGE UNDER SECTION 1411(b)(4) OF THE FEDERAL ACT THAT THE INDIVIDUAL HAS CHANGED EMPLOYERS.

(ii) EACH INDIVIDUAL WHO CEASES COVERAGE UNDER A QUALIFIED HEALTH PLAN DURING A PLAN YEAR AND THE EFFECTIVE DATE OF THAT CESSATION.

15. PROVIDE TO EACH EMPLOYER THE NAME OF EACH EMPLOYEE OF THE EMPLOYER DESCRIBED IN PARAGRAPH 14, SUBDIVISION (b) WHO CEASES COVERAGE UNDER A QUALIFIED HEALTH PLAN DURING A PLAN YEAR AND THE EFFECTIVE DATE OF THE CESSATION.

16. PERFORM DUTIES REQUIRED OF THE EXCHANGE BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES OR THE UNITED STATES SECRETARY OF THE TREASURY RELATED TO DETERMINING ELIGIBILITY FOR PREMIUM TAX CREDITS, REDUCED COST-SHARING OR INDIVIDUAL RESPONSIBILITY REQUIREMENT EXEMPTIONS.

17. SELECT QUALIFIED NAVIGATORS AND SHALL AWARD GRANTS TO ENABLE QUALIFIED NAVIGATORS TO:

(a) CONDUCT PUBLIC EDUCATION ACTIVITIES TO RAISE AWARENESS OF THE AVAILABILITY OF QUALIFIED HEALTH PLANS.

(b) DISTRIBUTE FAIR AND IMPARTIAL INFORMATION CONCERNING:

(i) ENROLLMENT IN QUALIFIED HEALTH PLANS.

(ii) THE AVAILABILITY OF PREMIUM TAX CREDITS UNDER SECTION 36B OF THE INTERNAL REVENUE CODE OF 1986.

(iii) COST-SHARING REDUCTIONS UNDER SECTION 1402 OF THE FEDERAL ACT.

(c) FACILITATE ENROLLMENT IN QUALIFIED HEALTH PLANS.

(d) PROVIDE REFERRALS TO THE APPROPRIATE STATE AGENCY FOR ANY ENROLLEE WITH A GRIEVANCE, COMPLAINT OR QUESTION REGARDING THE ENROLLEE'S HEALTH BENEFIT PLAN OR COVERAGE OR A DETERMINATION UNDER THAT PLAN OR COVERAGE.

(e) PROVIDE INFORMATION IN A MANNER THAT IS CULTURALLY AND LINGUISTICALLY APPROPRIATE TO THE NEEDS OF THE POPULATION BEING SERVED BY THE EXCHANGE.

18. CREDIT THE AMOUNT OF ANY FREE CHOICE VOUCHER TO THE MONTHLY PREMIUM OF THE PLAN IN WHICH A QUALIFIED EMPLOYEE IS ENROLLED, IN ACCORDANCE WITH SECTION 10108 OF THE FEDERAL ACT, AND COLLECT THE AMOUNT CREDITED FROM THE OFFERING EMPLOYER.

19. CONSULT WITH STAKEHOLDERS RELEVANT TO CARRYING OUT THE ACTIVITIES REQUIRED UNDER THIS CHAPTER, INCLUDING:

(a) EDUCATED HEALTH CARE CONSUMERS WHO ARE ENROLLEES IN QUALIFIED HEALTH PLANS.

(b) INDIVIDUALS AND ENTITIES WITH EXPERIENCE IN FACILITATING ENROLLMENT IN QUALIFIED HEALTH PLANS.

(c) REPRESENTATIVES OF SMALL BUSINESSES AND SELF-EMPLOYED INDIVIDUALS.

(d) THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

(e) ADVOCATES FOR ENROLLING HARD TO REACH POPULATIONS.

(f) NONPROFIT AND FOR PROFIT HEALTH CARRIERS.

(g) HEALTH INSURANCE PRODUCERS WHO SELL HEALTH INSURANCE IN THE INDIVIDUAL AND SMALL GROUP MARKETS.

20. MEET THE FOLLOWING FINANCIAL INTEGRITY REQUIREMENTS:

(a) KEEP AN ACCURATE ACCOUNTING OF ALL ACTIVITIES, RECEIPTS AND EXPENDITURES AND ANNUALLY SUBMIT TO THE SECRETARY, THE GOVERNOR, THE DIRECTOR AND THE LEGISLATURE A REPORT CONCERNING SUCH ACCOUNTINGS.

(b) FULLY COOPERATE WITH ANY INVESTIGATION CONDUCTED BY THE SECRETARY PURSUANT TO THE SECRETARY'S AUTHORITY UNDER THE FEDERAL ACT AND ALLOW THE SECRETARY, IN COORDINATION WITH THE INSPECTOR GENERAL OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO:

(i) INVESTIGATE THE AFFAIRS OF THE EXCHANGE.

(ii) EXAMINE THE PROPERTIES AND RECORDS OF THE EXCHANGE.

(iii) REQUIRE PERIODIC REPORTS IN RELATION TO THE ACTIVITIES UNDERTAKEN BY THE EXCHANGE.

(c) NOT USE ANY MONIES INTENDED FOR THE ADMINISTRATIVE AND OPERATIONAL EXPENSES OF THE EXCHANGE FOR STAFF RETREATS, PROMOTIONAL GIVEAWAYS, EXCESSIVE EXECUTIVE COMPENSATION OR THE PROMOTION OF FEDERAL OR STATE LEGISLATIVE OR REGULATORY MODIFICATIONS.

21. ENSURE THAT ALL PARTICIPATING QUALIFIED HEALTH BENEFIT PLANS COMPLY WITH ALL FEDERAL REGULATORY STANDARDS ESTABLISHED BY THE SECRETARY.

B. THE EXCHANGE MAY ENTER INTO INFORMATION-SHARING AGREEMENTS WITH FEDERAL AND STATE AGENCIES AND OTHER STATE EXCHANGES TO CARRY OUT ITS RESPONSIBILITIES UNDER THIS CHAPTER IF THE AGREEMENTS INCLUDE ADEQUATE PROTECTIONS WITH RESPECT TO THE CONFIDENTIALITY OF THE INFORMATION TO BE SHARED AND COMPLY WITH ALL STATE AND FEDERAL LAWS AND REGULATIONS.

C. THE EXCHANGE SHALL NOT BE THE SOLE MARKETPLACE FOR INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE IN THIS STATE. CONSUMERS MAY PURCHASE COVERAGE ON OR OFF OF THE EXCHANGE. HEALTH CARRIERS MAY SELL HEALTH INSURANCE ON THE EXCHANGE, IF THEY ARE QUALIFIED, OR OFF OF THE EXCHANGE, OR BOTH.

D. THE EXCHANGE SHALL BE THE ONLY EXCHANGE IN THIS STATE AND THIS STATE SHALL NOT HAVE SUBSIDIARY EXCHANGES OR PARTICIPATE IN REGIONAL EXCHANGES.

E. THE EXCHANGE MAY NOT MAKE AVAILABLE ANY HEALTH BENEFIT PLAN THAT IS NOT A QUALIFIED HEALTH PLAN.

F. THE EXCHANGE SHALL ALLOW A HEALTH CARRIER TO OFFER A PLAN THAT PROVIDES LIMITED SCOPE DENTAL BENEFITS MEETING THE REQUIREMENT OF SECTION 9832(c)(2)(A) OF THE INTERNAL REVENUE CODE OF 1986 THROUGH THE EXCHANGE, EITHER SEPARATELY OR IN CONJUNCTION WITH A QUALIFIED HEALTH PLAN, IF THE PLAN PROVIDES PEDIATRIC DENTAL BENEFITS MEETING THE REQUIREMENTS OF SECTION 1302(b)(1)(J) OF THE FEDERAL ACT.

G. THE EXCHANGE OR A HEALTH CARRIER OFFERING HEALTH BENEFIT PLANS THROUGH THE EXCHANGE MAY NOT CHARGE AN INDIVIDUAL A FEE OR PENALTY FOR TERMINATION OF COVERAGE IF THE INDIVIDUAL ENROLLS IN ANOTHER TYPE OF MINIMUM ESSENTIAL COVERAGE BECAUSE THE INDIVIDUAL HAS BECOME NEWLY ELIGIBLE FOR THAT COVERAGE OR BECAUSE THE INDIVIDUAL'S EMPLOYER-SPONSORED COVERAGE HAS BECOME AFFORDABLE UNDER THE STANDARDS OF SECTION 36B(c)(2)(C) OF THE INTERNAL REVENUE CODE OF 1986.

20-3213. Director's duties

A. THE DIRECTOR SHALL ASSIGN A RATING TO EACH QUALIFIED HEALTH PLAN OFFERED THROUGH THE EXCHANGE IN ACCORDANCE WITH THE CRITERIA DEVELOPED BY THE SECRETARY UNDER SECTION 1311(c)(3) OF THE FEDERAL ACT AND DETERMINE EACH QUALIFIED HEALTH PLAN'S LEVEL OF COVERAGE IN ACCORDANCE WITH REGULATIONS ISSUED BY THE SECRETARY UNDER SECTION 1302(d)(2)(A) OF THE FEDERAL ACT.

B. THE DIRECTOR SHALL REVIEW THE RATE OF PREMIUM GROWTH IN THE EXCHANGE AND OUTSIDE OF THE EXCHANGE AND CONSIDER THE INFORMATION IN

DEVELOPING RECOMMENDATIONS ON WHETHER TO CONTINUE LIMITING QUALIFIED EMPLOYER STATUS TO SMALL EMPLOYERS.

20-3214. Health benefit plan certification

A. THE EXCHANGE SHALL CERTIFY A HEALTH BENEFIT PLAN AS A QUALIFIED HEALTH PLAN IF:

1. THE PLAN PROVIDES THE ESSENTIAL HEALTH BENEFITS PACKAGE DESCRIBED IN SECTION 1302(a) OF THE FEDERAL ACT, EXCEPT THAT THE PLAN IS NOT REQUIRED TO PROVIDE ESSENTIAL BENEFITS THAT DUPLICATE THE MINIMUM BENEFITS OF QUALIFIED DENTAL PLANS, AS PROVIDED IN SUBSECTION E OF THIS SECTION, IF:

(a) THE EXCHANGE HAS DETERMINED THAT AT LEAST ONE QUALIFIED DENTAL PLAN IS AVAILABLE TO SUPPLEMENT THE PLAN'S COVERAGE.

(b) THE HEALTH CARRIER MAKES PROMINENT DISCLOSURE AT THE TIME IT OFFERS THE PLAN, IN A FORM APPROVED BY THE EXCHANGE, THAT THE PLAN DOES NOT PROVIDE THE FULL RANGE OF ESSENTIAL PEDIATRIC BENEFITS, AND THE QUALIFIED DENTAL PLANS PROVIDING THOSE BENEFITS AND OTHER DENTAL BENEFITS NOT COVERED BY THE PLAN ARE OFFERED THROUGH THE EXCHANGE.

2. THE CONTRACT LANGUAGE AND PREMIUM RATES HAVE BEEN FILED WITH THE DIRECTOR IF REQUIRED BY THIS TITLE OR THE FEDERAL ACT.

3. THE PLAN PROVIDES AT LEAST A BRONZE LEVEL OF COVERAGE, UNLESS THE PLAN IS CERTIFIED AS A QUALIFIED CATASTROPHIC PLAN, MEETS THE REQUIREMENTS OF THE FEDERAL ACT FOR CATASTROPHIC PLANS AND WILL ONLY BE OFFERED TO INDIVIDUALS ELIGIBLE FOR CATASTROPHIC COVERAGE.

4. THE PLAN'S COST-SHARING REQUIREMENTS DO NOT EXCEED THE LIMITS ESTABLISHED UNDER SECTION 1302(c)(1) OF THE FEDERAL ACT, AND IF THE PLAN IS OFFERED THROUGH THE SHOP EXCHANGE, THE PLAN'S DEDUCTIBLE DOES NOT EXCEED THE LIMITS ESTABLISHED UNDER SECTION 1302(c)(2) OF THE FEDERAL ACT.

5. THE HEALTH CARRIER OFFERING THE PLAN:

(a) IS LICENSED UNDER THIS TITLE AND IN GOOD STANDING TO OFFER HEALTH INSURANCE COVERAGE IN THIS STATE.

(b) OFFERS AT LEAST ONE QUALIFIED HEALTH PLAN IN THE SILVER LEVEL AND AT LEAST ONE PLAN IN THE GOLD LEVEL THROUGH EACH COMPONENT OF THE EXCHANGE IN WHICH THE HEALTH CARRIER PARTICIPATES. FOR THE PURPOSES OF THIS SUBDIVISION, "COMPONENT" MEANS THE EXCHANGE FOR INDIVIDUAL COVERAGE AND THE SHOP EXCHANGE.

(c) CHARGES THE SAME PREMIUM RATE FOR EACH QUALIFIED HEALTH PLAN WITHOUT REGARD TO WHETHER THE PLAN IS OFFERED THROUGH THE EXCHANGE AND WITHOUT REGARD TO WHETHER THE PLAN IS OFFERED DIRECTLY FROM THE HEALTH CARRIER OR THROUGH A HEALTH INSURANCE PRODUCER.

(d) DOES NOT CHARGE ANY CANCELLATION FEES OR PENALTIES IN VIOLATION OF SECTION 20-3212, SUBSECTION G.

(e) COMPLIES WITH THE REGULATIONS DEVELOPED BY THE SECRETARY UNDER SECTION 1311(d) OF THE FEDERAL ACT AND SUCH OTHER REQUIREMENTS AS THE EXCHANGE MAY ESTABLISH.

6. THE PLAN MEETS THE REQUIREMENTS OF CERTIFICATION AS PROMULGATED BY REGULATION BY THE SECRETARY UNDER SECTION 1311(c)(1) OF THE FEDERAL ACT, WHICH INCLUDE MINIMUM STANDARDS IN THE AREAS OF MARKETING PRACTICES, NETWORK

ADEQUACY, ESSENTIAL COMMUNITY PROVIDERS IN UNDERSERVED AREAS, ACCREDITATION, QUALITY IMPROVEMENT, UNIFORM ENROLLMENT FORMS AND DESCRIPTIONS OF COVERAGE AND INFORMATION ON QUALITY MEASURES FOR HEALTH BENEFIT PLAN PERFORMANCE.

7. THE EXCHANGE DETERMINES THAT MAKING THE PLAN AVAILABLE THROUGH THE EXCHANGE IS IN THE INTEREST OF QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS IN THIS STATE. A PLAN THAT SATISFIES THE QUALIFIED HEALTH PLAN STANDARDS ISSUED BY THE SECRETARY IS DEEMED TO BE IN THE BEST INTERESTS OF QUALIFIED INDIVIDUALS AND QUALIFIED SMALL EMPLOYERS.

B. THE EXCHANGE SHALL NOT EXCLUDE A HEALTH BENEFIT PLAN FOR ANY OF THE FOLLOWING:

1. ON THE BASIS THAT THE PLAN IS A FEE-FOR-SERVICE PLAN.

2. THROUGH THE IMPOSITION OF PREMIUM PRICE CONTROLS BY THE EXCHANGE.

3. ON THE BASIS THAT THE HEALTH BENEFIT PLAN PROVIDES TREATMENTS NECESSARY TO PREVENT PATIENTS' DEATHS IN CIRCUMSTANCES THE EXCHANGE DETERMINES ARE INAPPROPRIATE OR TOO COSTLY.

C. THE EXCHANGE SHALL REQUIRE EACH HEALTH CARRIER SEEKING CERTIFICATION OF A PLAN AS A QUALIFIED HEALTH PLAN TO:

1. SUBMIT A JUSTIFICATION FOR ANY PREMIUM INCREASE BEFORE IMPLEMENTATION OF THAT INCREASE. THE HEALTH CARRIER SHALL PROMINENTLY POST THE INFORMATION ON ITS INTERNET WEBSITE. THE EXCHANGE SHALL TAKE THIS INFORMATION, ALONG WITH THE INFORMATION AND THE RECOMMENDATIONS PROVIDED TO THE EXCHANGE BY THE DIRECTOR UNDER SECTION 2794(b) OF THE PUBLIC HEALTH SERVICE ACT, INTO CONSIDERATION WHEN DETERMINING WHETHER TO ALLOW THE HEALTH CARRIER TO MAKE PLANS AVAILABLE THROUGH THE EXCHANGE.

2. MAKE AVAILABLE TO THE PUBLIC IN PLAIN LANGUAGE, AS THAT TERM IS DEFINED IN SECTION 1311(e)(3)(B) OF THE FEDERAL ACT, AND SUBMIT TO THE EXCHANGE, THE SECRETARY AND THE DIRECTOR, ACCURATE AND TIMELY DISCLOSURE OF THE FOLLOWING:

(a) CLAIMS PAYMENT POLICIES AND PRACTICES.

(b) PERIODIC FINANCIAL DISCLOSURES.

(c) DATA ON ENROLLMENT.

(d) DATA ON DISENROLLMENT.

(e) DATA ON THE NUMBER OF CLAIMS THAT ARE DENIED.

(f) DATA ON RATING PRACTICES.

(g) INFORMATION ON COST-SHARING AND PAYMENTS WITH RESPECT TO ANY OUT-OF-NETWORK COVERAGE.

(h) INFORMATION ON ENROLLEE AND PARTICIPANT RIGHTS UNDER TITLE I OF THE FEDERAL ACT.

(i) OTHER INFORMATION AS DETERMINED APPROPRIATE BY THE SECRETARY.

3. PERMIT INDIVIDUALS TO LEARN, IN A TIMELY MANNER ON THE REQUEST OF THE INDIVIDUAL, THE AMOUNT OF COST-SHARING, INCLUDING DEDUCTIBLES, COPAYMENTS AND COINSURANCE, UNDER THE INDIVIDUAL'S PLAN OR COVERAGE THAT THE INDIVIDUAL WOULD BE RESPONSIBLE FOR PAYING WITH RESPECT TO THE FURNISHING OF A SPECIFIC ITEM OR SERVICE BY A PARTICIPATING PROVIDER. AT A MINIMUM, THIS INFORMATION

SHALL BE MADE AVAILABLE TO THE INDIVIDUAL THROUGH AN INTERNET WEBSITE AND THROUGH OTHER MEANS FOR INDIVIDUALS WITHOUT ACCESS TO THE INTERNET.

D. THE EXCHANGE SHALL NOT EXEMPT ANY HEALTH CARRIER SEEKING CERTIFICATION OF A QUALIFIED HEALTH PLAN, REGARDLESS OF THE TYPE OR SIZE OF THE HEALTH CARRIER, FROM STATE LICENSURE OR SOLVENCY REQUIREMENTS AND SHALL APPLY THE CRITERIA OF THIS SECTION IN A MANNER THAT ENSURES A LEVEL PLAYING FIELD BETWEEN OR AMONG HEALTH CARRIERS PARTICIPATING IN THE EXCHANGE.

E. A LIMITED SCOPE DENTAL PLAN MAY BE A QUALIFIED DENTAL PLAN AND OFFER DENTAL COVERAGE ON THE EXCHANGE. THE PROVISIONS OF THIS CHAPTER THAT ARE APPLICABLE TO QUALIFIED HEALTH PLANS ALSO SHALL APPLY TO THE EXTENT RELEVANT TO QUALIFIED DENTAL PLANS, EXCEPT AS MODIFIED IN ACCORDANCE WITH THE FOLLOWING:

1. THE HEALTH CARRIER SHALL BE LICENSED TO OFFER DENTAL COVERAGE, BUT NEED NOT BE LICENSED TO OFFER OTHER HEALTH BENEFITS.

2. THE PLAN SHALL BE LIMITED TO DENTAL AND ORAL HEALTH BENEFITS, WITHOUT SUBSTANTIALLY DUPLICATING THE BENEFITS TYPICALLY OFFERED BY HEALTH BENEFIT PLANS WITHOUT DENTAL COVERAGE AND SHALL INCLUDE, AT A MINIMUM, THE ESSENTIAL PEDIATRIC DENTAL BENEFITS PRESCRIBED BY THE SECRETARY PURSUANT TO SECTION 1302(b)(1)(J) OF THE FEDERAL ACT, AND SUCH OTHER DENTAL BENEFITS AS THE EXCHANGE OR THE SECRETARY MAY SPECIFY BY REGULATION.

3. HEALTH CARRIERS MAY JOINTLY OFFER A COMPREHENSIVE PLAN THROUGH THE EXCHANGE IN WHICH THE DENTAL BENEFITS ARE PROVIDED BY A HEALTH CARRIER THROUGH A QUALIFIED DENTAL PLAN AND THE OTHER BENEFITS ARE PROVIDED BY A HEALTH CARRIER THROUGH A QUALIFIED HEALTH PLAN, IF THE PLANS ARE PRICED SEPARATELY AND ALSO ARE MADE AVAILABLE FOR PURCHASE SEPARATELY AT THE SAME PRICE.

F. THE EXCHANGE SHALL NOT REQUIRE A HEALTH BENEFIT PLAN TO MEET MORE THAN THE MINIMUM STANDARDS REQUIRED BY THE FEDERAL ACT AND THE REGULATIONS PROMULGATED UNDER THE FEDERAL ACT IN ORDER TO RECEIVE CERTIFICATION AS A QUALIFIED HEALTH PLAN UNDER THIS CHAPTER.

G. NOTWITHSTANDING ANY OTHER LAW, A QUALIFIED HEALTH PLAN SHALL NOT BE REQUIRED TO COVER STATE-MANDATED HEALTH INSURANCE BENEFITS THAT ARE NOT INCLUDED IN THE ESSENTIAL BENEFITS SPECIFIED IN SECTION 1302(b) OF THE FEDERAL ACT AND THE REGULATIONS PROMULGATED UNDER THE FEDERAL ACT.

20-3215. Fees; publication of costs

A. BEGINNING JANUARY 1, 2015, THE EXCHANGE MAY CHARGE ASSESSMENTS OR USER FEES TO HEALTH CARRIERS AND DENTAL CARRIERS SELLING COVERAGE ON THE EXCHANGE TO SUPPORT ITS OPERATIONS UNDER THIS CHAPTER. ANY ASSESSMENTS OR FEES ESTABLISHED PURSUANT TO THIS SECTION ARE SEPARATE FROM THE PREMIUM AMOUNTS CHARGED FOR A HEALTH BENEFIT PLAN SOLD ON THE EXCHANGE. THE EXCHANGE SHALL SEPARATELY DISCLOSE TO THE PURCHASER OF A QUALIFIED HEALTH PLAN ALL ASSESSMENTS AND FEES ASSOCIATED WITH THE SALE OF THE HEALTH INSURANCE. THE EXCHANGE SHALL BE SELF-SUSTAINING ON OR BEFORE JANUARY 1, 2015, AS REQUIRED BY THE FEDERAL ACT.

B. THE EXCHANGE SHALL PUBLISH THE AVERAGE COSTS OF LICENSING, REGULATORY FEES AND ANY OTHER PAYMENTS REQUIRED BY THE EXCHANGE AND THE ADMINISTRATIVE COSTS OF THE EXCHANGE ON AN INTERNET WEBSITE TO EDUCATE CONSUMERS ON THE COSTS. THIS INFORMATION SHALL INCLUDE INFORMATION ON MONIES LOST TO WASTE, FRAUD AND ABUSE.

20-3216. Risk adjustment

THE EXCHANGE SHALL DEVELOP OR PARTICIPATE IN THE REINSURANCE, RISK CORRIDOR AND RISK ADJUSTMENT PROGRAMS REQUIRED IN SECTIONS 1341, 1342 AND 1343 OF THE FEDERAL ACT.

20-3217. Arizona health insurance exchange fund

A. THE ARIZONA HEALTH INSURANCE EXCHANGE FUND IS ESTABLISHED CONSISTING OF ALL MONIES RECEIVED BY THIS STATE FOR THE PLANNING AND ESTABLISHMENT OF THE EXCHANGE UNDER SECTION 1311 OF THE FEDERAL ACT, ALL ASSESSMENTS AND FEES CHARGED PURSUANT TO SECTION 20-3215, MONIES RECEIVED PURSUANT TO SUBSECTION C OF THIS SECTION AND ANY OTHER MONIES PROVIDED IN SUPPORT OF THE EXCHANGE'S OPERATIONS. THE EXCHANGE BOARD SHALL ADMINISTER THE FUND. MONIES IN THE FUND MAY BE USED FOR THE OPERATION AND ADMINISTRATION OF THE EXCHANGE AND ANY OTHER PURPOSES SPECIFIED IN THIS CHAPTER. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS.

B. ON NOTICE FROM THE EXCHANGE BOARD, THE STATE TREASURER SHALL INVEST AND DIVEST MONIES IN THE FUND AS PROVIDED IN SECTION 35-313, AND MONIES EARNED FROM INVESTMENT SHALL BE CREDITED TO THE FUND.

C. THE EXCHANGE BOARD MAY ACCEPT AND SPEND FEDERAL MONIES AND PRIVATE GRANTS, GIFTS, CONTRIBUTIONS AND DEVISES TO ASSIST IN CARRYING OUT THE PURPOSES OF THIS CHAPTER.

Sec. 2. Arizona health insurance exchange board; initial appointments; terms

A. Notwithstanding section 20-3211, Arizona Revised Statutes, as added by this act, the initial appointments for board members of the Arizona health insurance exchange board of directors are as follows:

1. One representative of the largest health carrier, as defined in section 20-3201, Arizona Revised Statutes, as added by this act, by Arizona market share in the individual market that intends to offer individual coverage on the exchange. Market share shall be determined by the department of insurance.

2. One representative of the largest health carrier, as defined in section 20-3201, Arizona Revised Statutes, as added by this act, by Arizona market share in the small group market, that is not already represented as the largest individual health carrier and that intends to offer small group coverage on the exchange. A carrier is already represented if the carrier or a company by whom it is controlled or with whom it is under common control is already serving on the board as an individual health carrier.

3. Two health carriers, as defined in section 20-3201, Arizona Revised Statutes, as added by this act, that are not represented in paragraph 1 or 2 and that intend to offer coverage on the exchange.

4. A dental carrier, as defined in section 20-3201, Arizona Revised Statutes, as added by this act, that intends to offer a limited scope dental plan on the exchange.

5. A health insurance producer, as defined in section 20-3201, Arizona Revised Statutes, as added by this act, who intends to sell individual coverage on the exchange.

6. A health insurance producer, as defined in section 20-3201, Arizona Revised Statutes, as added by this act, who intends to sell small group coverage on the exchange.

7. A small business that will consider purchasing health insurance coverage on the exchange or an association or chamber of commerce representing small businesses.

8. An individual who will consider purchasing health insurance coverage on the exchange.

B. The terms of the members of the Arizona health insurance exchange board of directors appointed pursuant to this section end January 1, 2015.

Sec. 3. Conditional repeal; notice; definition

A. Title 20, chapter 22, Arizona Revised Statutes, as added by this act, is repealed as of the date that the federal act in its entirety or section 1311 of the federal act is declared to be unconstitutional by the United States Supreme Court or is repealed by the United States Congress.

B. The director of the department of insurance shall notify in writing the director of the Arizona legislative council of this date.

C. For the purposes of this section, "federal act" means the federal patient protection and affordable care act (P.L. 111-148), as amended by the federal health care and education reconciliation act of 2010 (P.L. 111-152).