REFERENCE TITLE: health insurance exchange

State of Arizona
House of Representatives
Fiftieth Legislature
Second Regular Session
2012

HB 2783

Introduced by
Representatives Meyer, Farley, Gallego, Tovar, Wheeler

AN ACT

AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 23; 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 23, to read:

CHAPTER 23

ARIZONA HEALTH INSURANCE EXCHANGE

ARTICLE 1. GENERAL PROVISIONS

20-3301. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "BOARD" MEANS THE ARIZONA HEALTH INSURANCE EXCHANGE BOARD ESTABLISHED BY SECTION 20-3321.

2. "EXCHANGE" MEANS THE ARIZONA HEALTH INSURANCE EXCHANGE ESTABLISHED BY SECTION 20-3331.

3. "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.

4. "HEALTH BENEFIT PLAN":

(a) MEANS A POLICY, CONTRACT, CERTIFICATE OR AGREEMENT OFFERED OR ISSUED BY A HEALTH INSURER 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.

5. "HEALTH INSURER" MEANS AN ENTITY THAT IS LICENSED AS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE ORGANIZATION, MEDICAL SERVICE ORGANIZATION 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.

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

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

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

7. "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 ARTICLE 3 OF THIS CHAPTER.

8. "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.

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

10. "SMALL EMPLOYER" MEANS AN EMPLOYER THAT EMPLOYED AN AVERAGE OF NOT MORE THAN FIFTY EMPLOYEES DURING THE PRECEDING CALENDAR YEAR.

ARTICLE 2. ARIZONA HEALTH INSURANCE EXCHANGE BOARD

20-3321. Arizona health insurance exchange board

A. THE ARIZONA HEALTH INSURANCE EXCHANGE BOARD IS ESTABLISHED AS THE GOVERNING BODY OF THE ARIZONA HEALTH INSURANCE EXCHANGE AND SHALL CONSIST OF THE FOLLOWING NINE MEMBERS:

1. THE DIRECTOR OF THE DEPARTMENT OF INSURANCE.

2. THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

3. THREE MEMBERS WHO ARE APPOINTED BY THE GOVERNOR.

4. ONE MEMBER WHO IS APPOINTED BY THE MAJORITY CAUCUS OF THE SENATE.

5. ONE MEMBER WHO IS APPOINTED BY THE MINORITY CAUCUS OF THE SENATE.

6. ONE MEMBER WHO IS APPOINTED BY THE MAJORITY CAUCUS OF THE HOUSE OF REPRESENTATIVES.

7. ONE MEMBER WHO IS APPOINTED BY THE MINORITY CAUCUS OF THE HOUSE OF REPRESENTATIVES.

B. EACH OF THE FOUR MEMBERS APPOINTED PURSUANT TO SUBSECTION A, PARAGRAPHS 4, 5, 6 AND 7 AND ONE OF THE MEMBERS APPOINTED PURSUANT TO SUBSECTION A, PARAGRAPH 3 SHALL BE EITHER:

1. AN INDIVIDUAL CONSUMER PURCHASING A QUALIFIED HEALTH PLAN THROUGH THE EXCHANGE.

2. A SMALL BUSINESS EMPLOYER PURCHASING A QUALIFIED HEALTH PLAN THROUGH THE EXCHANGE.

C. THE MEMBERS APPOINTED PURSUANT TO SUBSECTION A SHALL HAVE EXPERTISE IN AT LEAST TWO OF THE FOLLOWING AREAS, BUT THE GROUP SELECTED SHALL BE COMPOSED OF INDIVIDUALS WITH DIFFERENT SKILL SETS:

1. HEALTH BENEFITS PLAN ADMINISTRATION.

2. HEALTH CARE FINANCE.

3. ADMINISTERING A PUBLIC OR PRIVATE HEALTH CARE DELIVERY SYSTEM.

4. PURCHASING AND FACILITATING ENROLLMENT IN HEALTH PLAN COVERAGE.

5. PATIENT ADVOCACY.

6. ACTUARIAL SCIENCE.

D. THE SEVEN MEMBERS APPOINTED PURSUANT TO SUBSECTION A, PARAGRAPHS 3, 4, 5, 6 AND 7 SHALL ASSIGN THEMSELVES BY LOT TO INITIAL TERMS OF ONE YEAR, TWO YEARS AND FOUR YEARS IN OFFICE. ALL SUBSEQUENT MEMBERS SERVE FOUR-YEAR TERMS IN OFFICE. THE CHAIRPERSON SHALL NOTIFY THE APPOINTING AUTHORITY OF THESE TERMS.

E. ALL MEMBERS OF THE BOARD SHALL SERVE WITHOUT COMPENSATION BUT MAY RECEIVE REIMBURSEMENT OF ACTUAL EXPENSES IN PERFORMING AND ATTENDING BOARD BUSINESS AS PROVIDED BY TITLE 38, CHAPTER 4, ARTICLE 2. MEMBERS OF THE BOARD SHALL APPOINT A CHAIRPERSON FROM THE BOARD'S MEMBERSHIP.

20-3322. Duties of the board; rule making and procurement exemptions

A. THE BOARD SHALL:

1. SERVE AS THE GOVERNING BODY OF THE EXCHANGE.

2. DETERMINE THE STRUCTURE OF AND DEVELOP THE EXCHANGE TO MEET THE REQUIREMENTS OF THIS CHAPTER.

3. ENSURE THAT THE EXCHANGE IS DEVELOPED AND CERTIFIED BY THE SECRETARY NO LATER THAN JANUARY 1, 2013.

4. ENSURE THAT THE EXCHANGE IS AVAILABLE FOR OPEN ENROLLMENT FOR QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS NO LATER THAN OCTOBER 1, 2013.

5. ADOPT ALL NECESSARY RULES FOR THE OPERATION OF THE EXCHANGE CONSISTENT WITH THE REQUIREMENTS OF THIS CHAPTER, THE FEDERAL ACT AND ANY REGULATIONS PROMULGATED UNDER THE FEDERAL ACT. RULES ADOPTED BY THE BOARD SHALL NOT CONFLICT WITH OR PREVENT THE APPLICATION OF REGULATIONS PROMULGATED BY THE SECRETARY UNDER THE FEDERAL ACT. RULES ADOPTED BY THE BOARD ARE EXEMPT FROM TITLE 41, CHAPTER 6, EXCEPT THAT THE BOARD SHALL:

(a) SUBMIT THE RULES FOR PUBLICATION, AND THE SECRETARY OF STATE SHALL PUBLISH THE RULES IN THE ARIZONA ADMINISTRATIVE REGISTER.

(b) PROVIDE THIRTY DAYS FOR INTERESTED PERSONS TO COMMENT ON THE PROPOSED RULES BEFORE ADOPTION AND AFTER PUBLICATION.

6. ESTABLISH A SMALL BUSINESS HEALTH OPTIONS PROGRAM EXCHANGE THROUGH WHICH QUALIFIED EMPLOYERS MAY ACCESS COVERAGE FOR THEIR EMPLOYEES IF THE EXCHANGE DOES NOT HAVE ADEQUATE RESOURCES TO ASSIST QUALIFIED INDIVIDUALS AND EMPLOYERS IN A UNIFIED EXCHANGE. IF THE BOARD ESTABLISHES A SMALL BUSINESS HEALTH OPTIONS PROGRAM EXCHANGE, THE BOARD SHALL ADOPT RULES TO RECONCILE ELIGIBILITY CRITERIA BASED ON DOMICILE VERSUS PLACE OF EMPLOYMENT.

7. CONSULT WITH THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION REGARDING INCORPORATING ELIGIBILITY STANDARDS FOR THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM AND THE CHILDREN'S HEALTH INSURANCE PROGRAM INTO THE EXCHANGE.

8. CONTRACT WITH THE DEPARTMENT OF INSURANCE TO CONDUCT ANY INSURANCE PREMIUM REVIEW REQUIRED UNDER THIS CHAPTER.

B. THE BOARD MAY:

1. ENTER INTO CONTRACTS NECESSARY TO CARRY OUT THE PURPOSES AND REQUIREMENTS OF THIS CHAPTER.

2. ENTER INTO INFORMATION-SHARING AGREEMENTS WITH FEDERAL AND STATE AGENCIES AND OTHER STATE EXCHANGES TO CARRY OUT THE RESPONSIBILITIES OF THE EXCHANGE 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.

3. RETAIN LEGAL COUNSEL AND OTHER CONSULTANTS AS NECESSARY TO CARRY OUT THE PURPOSES OF THE EXCHANGE.

C. BEGINNING JANUARY 1, 2014, THE BOARD MAY CHARGE ASSESSMENTS OR USER FEES TO HEALTH CARRIERS AND DENTAL CARRIERS SELLING COVERAGE ON OR OFF THE EXCHANGE TO SUPPORT OPERATIONS UNDER THIS CHAPTER. THE BOARD MAY REQUIRE QUALIFIED HEALTH PLANS PARTICIPATING IN THE EXCHANGE TO CHARGE A PREMIUM SURCHARGE TO QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS PURCHASING THE PLANS ON THE EXCHANGE. ALL MONIES COLLECTED PURSUANT TO THIS SUBSECTION

SHALL BE DEPOSITED THE ARIZONA HEALTH INSURANCE EXCHANGE FUND ESTABLISHED BY SECTION 20-3336.

D. FOR THE PURPOSES OF THIS CHAPTER, THE BOARD IS EXEMPT FROM THE PROCUREMENT CODE REQUIREMENTS OF TITLE 41, CHAPTER 23.

20-3323. Employees; exemption

A. THE BOARD SHALL HIRE AN EXECUTIVE DIRECTOR OF THE EXCHANGE AND PRESCRIBE THE TERMS AND CONDITIONS OF EMPLOYMENT.

B. THE EXECUTIVE DIRECTOR IS RESPONSIBLE FOR MANAGING, ADMINISTERING AND SUPERVISING THE ACTIVITIES OF THE EXCHANGE.

C. THE EXECUTIVE DIRECTOR IS RESPONSIBLE FOR HIRING THE NECESSARY QUALIFIED STAFF TO CARRY OUT THE REQUIREMENTS OF THIS CHAPTER.

D. EMPLOYEES OF THE EXCHANGE ARE EXEMPT FROM TITLE 41, CHAPTER 4, ARTICLES 5 AND 6.

20-3324. Conflict of interest

A. WHILE SERVING ON THE BOARD OR ON THE STAFF OF THE EXCHANGE, A MEMBER OF THE BOARD OR A STAFF MEMBER OF THE EXCHANGE SHALL NOT BE OR HAVE BEEN IN THE PREVIOUS YEAR:

1. EMPLOYED BY, A CONSULTANT TO, A MEMBER OF THE BOARD OF DIRECTORS OF, AFFILIATED WITH OR A REPRESENTATIVE OF A HEALTH CARE INSURER, AN INSURANCE AGENT OR BROKER, A HEALTH CARE PROVIDER OR A HEALTH CARE FACILITY OR CLINIC.

2. A MEMBER, A BOARD MEMBER OR AN EMPLOYEE OF A TRADE ASSOCIATION REPRESENTING HEALTH CARE INSURERS, HEALTH CARE FACILITIES, HEALTH CARE CLINICS OR HEALTH CARE PROVIDERS.

B. NOTWITHSTANDING SUBSECTION A, PARAGRAPH 1, A MEMBER OF THE BOARD OR A STAFF MEMBER OF THE EXCHANGE MAY BE A HEALTH CARE PROVIDER IF THE BOARD MEMBER OR STAFF MEMBER DOES NOT RECEIVE COMPENSATION FOR RENDERING SERVICES AS A HEALTH CARE PROVIDER WHILE SERVING ON THE BOARD OR ON THE STAFF OF THE EXCHANGE AND DOES NOT HAVE AN OWNERSHIP INTEREST IN A PROFESSIONAL HEALTH CARE PRACTICE.

20-3325. Review of exchange to the legislature; annual report

ON OR BEFORE JULY 1 OF EACH YEAR, THE BOARD SHALL CONDUCT A REVIEW OF THE EXCHANGE, WHICH SHALL INCLUDE A REVIEW OF THE OPERATION AND ADMINISTRATION OF THE EXCHANGE, EXPENSES, CLAIMS STATISTICS, COMPLAINTS DATA, IF THE EXCHANGE MET ITS ANNUAL GOALS AND ANY OTHER INFORMATION THE BOARD DEEMS PERTINENT. THE BOARD SHALL CONSOLIDATE THE INFORMATION IN A REPORT AND SUBMIT THE REPORT TO THE BANKING AND INSURANCE COMMITTEE OF THE SENATE, OR ITS SUCCESSOR COMMITTEE, AND THE BANKING AND INSURANCE COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR ITS SUCCESSOR COMMITTEE.

ARTICLE 3. ARIZONA HEALTH INSURANCE EXCHANGE

20-3331. General requirements of the exchange

A. THE ARIZONA HEALTH INSURANCE EXCHANGE IS ESTABLISHED. THE EXCHANGE SHALL FACILITATE THE PURCHASE AND SALE OF QUALIFIED HEALTH PLANS AND SHALL MAKE QUALIFIED HEALTH PLANS AVAILABLE TO QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS ON OR BEFORE JANUARY 1, 2014.

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

C. THE EXCHANGE SHALL ALLOW A HEALTH INSURER 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.

D. THE EXCHANGE OR A HEALTH INSURER 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.

20-3332. Duties of exchange

THE EXCHANGE SHALL:

1. IN COORDINATION WITH THE DIRECTOR OF THE DEPARTMENT OF INSURANCE, 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 20-3325.

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

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

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

5. 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.

6. 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.

7. 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, OFFER ENROLLMENT TO THE INDIVIDUAL FOR THAT PROGRAM.

8. ESTABLISH AND MAKE AVAILABLE BY ELECTRONIC MEANS A CALCULATOR TO DETERMINE THE ACTUAL COST OF COVERAGE AFTER APPLICATION OF ANY PREMIUM TAX

CREDIT UNDER SECTION 36B OF THE INTERNAL REVENUE CODE OF 1986 AND ANY COST-SHARING REDUCTION UNDER SECTION 1402 OF THE FEDERAL ACT.

9. 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.

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

(a) A LIST OF THE INDIVIDUALS WHO ARE ISSUED A CERTIFICATION UNDER PARAGRAPH 9 OF THIS SECTION, 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.

11. PROVIDE TO EACH EMPLOYER THE NAME OF EACH EMPLOYEE OF THE EMPLOYER DESCRIBED IN PARAGRAPH 10, SUBDIVISION (b) OF THIS SECTION WHO CEASES COVERAGE UNDER A QUALIFIED HEALTH PLAN DURING A PLAN YEAR AND THE EFFECTIVE DATE OF THE CESSATION.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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, THE DEPARTMENT OF INSURANCE, THE LEGISLATURE AND THE AUDITOR GENERAL 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.

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

18. CONSIDER GEOGRAPHIC ACCESSIBILITY TO THE QUALIFIED HEALTH PLANS PARTICIPATING IN THE EXCHANGE WHEN DETERMINING WHICH QUALIFIED HEALTH PLANS MAY PARTICIPATE IN THE EXCHANGE.

20-3333. Health benefit plan certification

A. THE DIRECTOR OF THE DEPARTMENT OF INSURANCE MAY CERTIFY A HEALTH BENEFIT PLAN AS A QUALIFIED HEALTH PLAN IF:

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

3. 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 A SMALL BUSINESS HEALTH OPTIONS PROGRAM, THE PLAN'S DEDUCTIBLE DOES NOT EXCEED THE LIMITS ESTABLISHED UNDER SECTION 1302(c)(2) OF THE FEDERAL ACT.

4. THE HEALTH INSURER OFFERING THE PLAN:

(a) IS LICENSED AND IN GOOD STANDING TO OFFER HEALTH INSURANCE COVERAGE IN THIS STATE, EXCEPT THAT A HEALTH PLAN THAT IS PARTICIPATING IN THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM MAY BE CERTIFIED AS A QUALIFIED HEALTH PLAN IF THE PLAN IS NOT LICENSED BUT MEETS ALTERNATIVE CRITERIA TO LICENSURE THAT MAY BE ADOPTED BY THE SECRETARY IN REGULATION.

(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 INSURER PARTICIPATES. FOR THE PURPOSES OF THIS SUBDIVISION, "COMPONENT" MEANS EITHER THE UNIFIED EXCHANGE OR THE EXCHANGE FOR INDIVIDUAL COVERAGE AND THE SMALL BUSINESS HEALTH OPTIONS PROGRAM.

(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 INSURER OR THROUGH AN INSURANCE PRODUCER.

(d) DOES NOT CHARGE ANY CANCELLATION FEES OR PENALTIES IN VIOLATION OF SECTION 20-3331, SUBSECTION D.

(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.

5. THE PLAN MEETS THE REQUIREMENTS OF CERTIFICATION AS REQUIRED BY ANY RULES ADOPTED UNDER THIS CHAPTER OR AS PROMULGATED BY REGULATION BY THE SECRETARY UNDER SECTION 1311(c)(1) OF THE FEDERAL ACT.

6. THE EXCHANGE DETERMINES THAT MAKING THE PLAN AVAILABLE THROUGH THE EXCHANGE IS IN THE INTEREST OF QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS IN THIS STATE.

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 INSURER 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 INSURER SHALL PROMINENTLY POST THE INFORMATION ON ITS INTERNET WEBSITE. THE EXCHANGE SHALL TAKE THIS INFORMATION, ALONG WITH THE INFORMATION AND THE RECOMMENDATIONS PROVIDED TO THE EXCHANGE BY THE COMMISSIONER UNDER SECTION 2794(b) OF THE PUBLIC HEALTH SERVICE ACT, INTO CONSIDERATION WHEN DETERMINING WHETHER TO ALLOW THE HEALTH INSURER 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 OF THE DEPARTMENT OF INSURANCE, 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 INSURER SEEKING CERTIFICATION OF A QUALIFIED HEALTH PLAN, REGARDLESS OF THE TYPE OR SIZE OF THE HEALTH INSURER, 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 INSURERS PARTICIPATING IN THE EXCHANGE.

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

20-3334. Participation in the exchange

A. THE BOARD MAY DETERMINE THE MINIMUM REQUIREMENTS A QUALIFIED HEALTH PLAN MUST MEET TO BE CONSIDERED FOR PARTICIPATION IN THE EXCHANGE AND THE STANDARDS AND CRITERIA FOR SELECTING QUALIFIED HEALTH PLANS TO BE OFFERED THROUGH THE EXCHANGE THAT ARE IN THE BEST INTEREST OF QUALIFIED INDIVIDUALS AND QUALIFIED SMALL EMPLOYERS. THE BOARD SHALL CONSISTENTLY AND UNIFORMLY APPLY THESE REQUIREMENTS, STANDARDS AND CRITERIA TO ALL HEALTH INSURERS. IN THE COURSE OF SELECTIVELY CONTRACTING FOR HEALTH CARE COVERAGE OFFERED THROUGH THE EXCHANGE, THE BOARD SHALL SEEK TO CONTRACT WITH HEALTH INSURERS TO PROVIDE HEALTH CARE COVERAGE CHOICES THAT OFFER THE OPTIMAL COMBINATION OF CHOICE, VALUE, QUALITY AND SERVICE.

B. AS A CONDITION OF PARTICIPATION IN THE EXCHANGE, THE BOARD MAY REQUIRE HEALTH INSURERS TO FAIRLY AND AFFIRMATIVELY OFFER, MARKET AND SELL IN THE EXCHANGE AT LEAST ONE PRODUCT WITHIN EACH OF THE FIVE LEVELS OF COVERAGE CONTAINED IN SUBDIVISIONS (d) AND (e) OF SECTION 1302 OF THE FEDERAL ACT.

20-3335. Regulation of the exchange; qualified health plans

THE DEPARTMENT OF INSURANCE IS RESPONSIBLE FOR REGULATING THE EXCHANGE AND THE QUALIFIED HEALTH PLANS PARTICIPATING IN THE EXCHANGE CONSISTENT WITH THE APPLICABLE PROVISIONS OF THIS TITLE.

20-3336. Arizona health insurance exchange fund; exemption; planning grants

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 AND ALL PREMIUM ASSESSMENTS AND FEES CHARGED UNDER THIS CHAPTER. THE BOARD SHALL ADMINISTER THE FUND. MONIES IN THE FUND MAY BE USED FOR THE OPERATION AND ADMINISTRATION OF THE EXCHANGE AND THE NAVIGATOR PROGRAM 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 AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER, ALL MONIES RECEIVED BY THIS STATE FOR THE PLANNING AND ESTABLISHMENT OF THE EXCHANGE UNDER SECTION 1311 OF THE FEDERAL ACT SHALL BE DEPOSITED IN THE ARIZONA HEALTH INSURANCE EXCHANGE FUND. ONCE THE BOARD IS APPOINTED, THE BOARD SHALL APPLY FOR PLANNING AND ESTABLISHMENT GRANTS MADE AVAILABLE TO THE EXCHANGE PURSUANT TO SECTION 1311 OF THE FEDERAL ACT. THE BOARD IS RESPONSIBLE FOR USING THE MONIES AWARDED BY THE SECRETARY FOR THE PLANNING AND ESTABLISHMENT

OF THE EXCHANGE, CONSISTENT WITH SUBDIVISION (b) OF SECTION 1311 OF THE FEDERAL ACT.

ARTICLE 4. NAVIGATOR PROGRAM

20-3351. Navigator program grants

THE BOARD SHALL SELECT ENTITIES QUALIFIED TO SERVE AS NAVIGATORS IN ACCORDANCE WITH SECTION 1311(i) OF THE FEDERAL ACT, STANDARDS DEVELOPED BY THE SECRETARY AND CRITERIA ESTABLISHED BY THE BOARD AND SHALL AWARD GRANTS TO ENABLE NAVIGATORS TO:

1. CONDUCT PUBLIC EDUCATION ACTIVITIES TO RAISE AWARENESS OF THE AVAILABILITY OF QUALIFIED HEALTH PLANS.

2. DISTRIBUTE FAIR AND IMPARTIAL INFORMATION CONCERNING:

(a) ENROLLMENT IN QUALIFIED HEALTH PLANS.

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

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

3. FACILITATE ENROLLMENT IN QUALIFIED HEALTH PLANS.

4. 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.

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