

REFERENCE TITLE: health insurance exchange

State of Arizona
House of Representatives
Fifty-first Legislature
Second Regular Session
2014

HB 2557

Introduced by
Representatives Meyer, Mendez, Steele, Senator Gallardo: Representatives
Alston, McCune Davis, Quezada

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)

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

2 Section 1. Title 20, Arizona Revised Statutes, is amended by adding
3 chapter 23, to read:

4 CHAPTER 23

5 ARIZONA HEALTH INSURANCE EXCHANGE

6 ARTICLE 1. GENERAL PROVISIONS

7 20-3301. Definitions

8 IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

9 1. "BOARD" MEANS THE ARIZONA HEALTH INSURANCE EXCHANGE BOARD.

10 2. "EXCHANGE" MEANS THE ARIZONA HEALTH INSURANCE EXCHANGE.

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

15 4. "HEALTH BENEFIT PLAN":

16 (a) MEANS A POLICY, CONTRACT, CERTIFICATE OR AGREEMENT OFFERED OR
17 ISSUED BY A HEALTH INSURER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR OR
18 REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

19 (b) DOES NOT INCLUDE:

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

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

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

25 (iv) WORKERS' COMPENSATION OR SIMILAR INSURANCE.

26 (v) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

27 (vi) CREDIT-ONLY INSURANCE.

28 (vii) COVERAGE FOR ON-SITE MEDICAL CLINICS.

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

32 (c) DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THE BENEFITS ARE
33 PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE OR CONTRACT OF INSURANCE OR ARE
34 OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:

35 (i) LIMITED SCOPE DENTAL OR VISION BENEFITS.

36 (ii) BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE,
37 COMMUNITY-BASED CARE OR ANY COMBINATION OF THOSE BENEFITS.

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

40 (d) DOES NOT INCLUDE THE FOLLOWING BENEFITS IF THE BENEFITS ARE
41 PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE OR CONTRACT OF INSURANCE, THERE
42 IS NO COORDINATION BETWEEN THE PROVISION OF THE BENEFITS AND ANY EXCLUSION OF
43 BENEFITS UNDER ANY GROUP HEALTH PLAN MAINTAINED BY THE SAME PLAN SPONSOR AND
44 THE BENEFITS ARE PAID WITH RESPECT TO AN EVENT WITHOUT REGARD TO WHETHER

1 BENEFITS ARE PROVIDED WITH RESPECT TO SUCH AN EVENT UNDER ANY GROUP HEALTH
2 PLAN MAINTAINED BY THE SAME PLAN SPONSOR:

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

4 (ii) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.

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

7 (i) MEDICARE SUPPLEMENTAL HEALTH INSURANCE AS DEFINED UNDER SECTION
8 1882(g)(1) OF THE SOCIAL SECURITY ACT.

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

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

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

20 6. "QUALIFIED EMPLOYER" MEANS A SMALL EMPLOYER THAT ELECTS TO MAKE ITS
21 FULL-TIME EMPLOYEES ELIGIBLE FOR ONE OR MORE QUALIFIED HEALTH PLANS OFFERED
22 THROUGH THE EXCHANGE, AND AT THE OPTION OF THE EMPLOYER, SOME OR ALL OF ITS
23 PART-TIME EMPLOYEES, IF THE EMPLOYER EITHER:

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

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

29 7. "QUALIFIED HEALTH PLAN" MEANS A HEALTH BENEFIT PLAN THAT HAS IN
30 EFFECT A CERTIFICATION THAT THE PLAN MEETS THE CRITERIA FOR CERTIFICATION
31 DESCRIBED IN SECTION 1311(c) OF THE FEDERAL ACT AND ARTICLE 3 OF THIS
32 CHAPTER.

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

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

36 (b) RESIDES IN THIS STATE.

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

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

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

44 10. "SMALL EMPLOYER" MEANS AN EMPLOYER THAT EMPLOYED AN AVERAGE OF NOT
45 MORE THAN ONE HUNDRED 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 CONSISTS 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 OF THIS SECTION AND ONE OF THE MEMBERS APPOINTED PURSUANT TO SUBSECTION A, PARAGRAPH 3 OF THIS SECTION MUST 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 OF THIS SECTION MUST HAVE EXPERTISE IN AT LEAST TWO OF THE FOLLOWING AREAS, BUT THE GROUP SELECTED MUST 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 OF THIS SECTION 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. Powers and duties of the board; rulemaking and procurement exemptions

A. THE BOARD SHALL:

1. SERVE AS THE GOVERNING BODY OF THE EXCHANGE.

- 1 2. DETERMINE THE STRUCTURE OF AND DEVELOP THE EXCHANGE TO MEET THE
2 REQUIREMENTS OF THIS CHAPTER.
- 3 3. ENSURE THAT THE EXCHANGE IS DEVELOPED AND CERTIFIED BY THE
4 SECRETARY.
- 5 4. ENSURE THAT THE EXCHANGE IS AVAILABLE FOR OPEN ENROLLMENT FOR
6 QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS NO LATER THAN OCTOBER 1, 2015.
- 7 5. ADOPT ALL NECESSARY RULES FOR THE OPERATION OF THE EXCHANGE
8 CONSISTENT WITH THE REQUIREMENTS OF THIS CHAPTER, THE FEDERAL ACT AND ANY
9 REGULATIONS PROMULGATED UNDER THE FEDERAL ACT. RULES ADOPTED BY THE BOARD
10 MAY NOT CONFLICT WITH OR PREVENT THE APPLICATION OF REGULATIONS PROMULGATED
11 BY THE SECRETARY UNDER THE FEDERAL ACT. RULES ADOPTED BY THE BOARD ARE
12 EXEMPT FROM TITLE 41, CHAPTER 6, EXCEPT THAT THE BOARD SHALL:
13 (a) SUBMIT THE RULES FOR PUBLICATION, AND THE SECRETARY OF STATE SHALL
14 PUBLISH THE RULES IN THE ARIZONA ADMINISTRATIVE REGISTER.
15 (b) PROVIDE THIRTY DAYS FOR INTERESTED PERSONS TO COMMENT ON THE
16 PROPOSED RULES BEFORE ADOPTION AND AFTER PUBLICATION.
- 17 6. ESTABLISH A SMALL BUSINESS HEALTH OPTIONS PROGRAM EXCHANGE THROUGH
18 WHICH QUALIFIED EMPLOYERS MAY ACCESS COVERAGE FOR THEIR EMPLOYEES IF THE
19 EXCHANGE DOES NOT HAVE ADEQUATE RESOURCES TO ASSIST QUALIFIED INDIVIDUALS AND
20 EMPLOYERS IN A UNIFIED EXCHANGE. IF THE BOARD ESTABLISHES A SMALL BUSINESS
21 HEALTH OPTIONS PROGRAM EXCHANGE, THE BOARD SHALL ADOPT RULES TO RECONCILE
22 ELIGIBILITY CRITERIA BASED ON DOMICILE VERSUS PLACE OF EMPLOYMENT.
- 23 7. CONSULT WITH THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
24 ADMINISTRATION REGARDING INCORPORATING ELIGIBILITY STANDARDS FOR THE ARIZONA
25 HEALTH CARE COST CONTAINMENT SYSTEM AND THE CHILDREN'S HEALTH INSURANCE
26 PROGRAM INTO THE EXCHANGE.
- 27 8. CONTRACT WITH THE DEPARTMENT OF INSURANCE TO CONDUCT ANY INSURANCE
28 PREMIUM REVIEW REQUIRED UNDER THIS CHAPTER.
- 29 B. THE BOARD MAY:
30 1. ENTER INTO CONTRACTS NECESSARY TO CARRY OUT THE PURPOSES AND
31 REQUIREMENTS OF THIS CHAPTER.
32 2. ENTER INTO INFORMATION-SHARING AGREEMENTS WITH FEDERAL AND STATE
33 AGENCIES AND OTHER STATE EXCHANGES TO CARRY OUT THE RESPONSIBILITIES OF THE
34 EXCHANGE UNDER THIS CHAPTER IF THE AGREEMENTS INCLUDE ADEQUATE PROTECTIONS
35 WITH RESPECT TO THE CONFIDENTIALITY OF THE INFORMATION TO BE SHARED AND
36 COMPLY WITH ALL STATE AND FEDERAL LAWS AND REGULATIONS.
37 3. RETAIN LEGAL COUNSEL AND OTHER CONSULTANTS AS NECESSARY TO CARRY
38 OUT THE PURPOSES OF THE EXCHANGE.
- 39 C. BEGINNING JANUARY 1, 2016, THE BOARD MAY CHARGE ASSESSMENTS OR USER
40 FEES TO HEALTH CARRIERS AND DENTAL CARRIERS SELLING COVERAGE ON OR OFF THE
41 EXCHANGE TO SUPPORT OPERATIONS UNDER THIS CHAPTER. THE BOARD MAY REQUIRE
42 QUALIFIED HEALTH PLANS PARTICIPATING IN THE EXCHANGE TO CHARGE A PREMIUM
43 SURCHARGE TO QUALIFIED INDIVIDUALS AND QUALIFIED EMPLOYERS PURCHASING THE
44 PLANS ON THE EXCHANGE. ALL MONIES COLLECTED PURSUANT TO THIS SUBSECTION MUST

1 BE DEPOSITED IN THE ARIZONA HEALTH INSURANCE EXCHANGE FUND ESTABLISHED BY
2 SECTION 20-3336.

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

5 20-3323. Employees; exemption

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

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

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

12 D. EMPLOYEES OF THE EXCHANGE ARE EXEMPT FROM TITLE 41, CHAPTER 4,
13 ARTICLE 4.

14 20-3324. Conflict of interest

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

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

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

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

31 20-3325. Review of exchange to the legislature; annual report

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

40 ARTICLE 3. ARIZONA HEALTH INSURANCE EXCHANGE

41 20-3331. General requirements of the exchange

42 A. THE ARIZONA HEALTH INSURANCE EXCHANGE IS ESTABLISHED. THE EXCHANGE
43 SHALL FACILITATE THE PURCHASE AND SALE OF QUALIFIED HEALTH PLANS AND SHALL
44 MAKE QUALIFIED HEALTH PLANS AVAILABLE TO QUALIFIED INDIVIDUALS AND QUALIFIED
45 EMPLOYERS ON OR BEFORE JANUARY 1, 2016.

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

3 C. THE EXCHANGE SHALL ALLOW A HEALTH INSURER TO OFFER A PLAN THAT
4 PROVIDES LIMITED SCOPE DENTAL BENEFITS MEETING THE REQUIREMENT OF SECTION
5 9832(c)(2)(A) OF THE INTERNAL REVENUE CODE OF 1986 THROUGH THE EXCHANGE,
6 EITHER SEPARATELY OR IN CONJUNCTION WITH A QUALIFIED HEALTH PLAN, IF THE PLAN
7 PROVIDES PEDIATRIC DENTAL BENEFITS MEETING THE REQUIREMENTS OF SECTION
8 1302(b)(1)(J) OF THE FEDERAL ACT.

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

16 20-3332. Duties of exchange

17 THE EXCHANGE SHALL:

18 1. IN COORDINATION WITH THE DIRECTOR OF THE DEPARTMENT OF INSURANCE,
19 IMPLEMENT PROCEDURES FOR THE CERTIFICATION, RECERTIFICATION AND
20 DECERTIFICATION OF HEALTH BENEFIT PLANS AS QUALIFIED HEALTH PLANS, CONSISTENT
21 WITH GUIDELINES DEVELOPED BY THE SECRETARY UNDER SECTION 1311(c) OF THE
22 FEDERAL ACT AND SECTION 20-3333.

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

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

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

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

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

38 7. IN ACCORDANCE WITH SECTION 1413 OF THE FEDERAL ACT, INFORM
39 INDIVIDUALS OF ELIGIBILITY REQUIREMENTS FOR THE ARIZONA HEALTH CARE COST
40 CONTAINMENT SYSTEM AND THE CHILDREN'S HEALTH INSURANCE PROGRAM AND, IF
41 THROUGH SCREENING OF AN APPLICATION BY THE EXCHANGE THE EXCHANGE DETERMINES
42 THAT ANY INDIVIDUAL IS ELIGIBLE FOR EITHER PROGRAM, OFFER ENROLLMENT TO THE
43 INDIVIDUAL FOR THAT PROGRAM.

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

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

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

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

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

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

14 (a) A LIST OF THE INDIVIDUALS WHO ARE ISSUED A CERTIFICATION UNDER
15 PARAGRAPH 9 OF THIS SECTION, INCLUDING THE NAME AND TAXPAYER IDENTIFICATION
16 NUMBER OF EACH INDIVIDUAL.

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

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

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

27 (c) THE NAME AND TAXPAYER IDENTIFICATION NUMBER OF:

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

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

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

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

41 13. REVIEW THE RATE OF PREMIUM GROWTH IN THE EXCHANGE AND OUTSIDE OF
42 THE EXCHANGE AND CONSIDER THE INFORMATION IN DEVELOPING RECOMMENDATIONS ON
43 WHETHER TO CONTINUE LIMITING QUALIFIED EMPLOYER STATUS TO SMALL EMPLOYERS.

44 14. CREDIT THE AMOUNT OF ANY FREE CHOICE VOUCHER TO THE MONTHLY PREMIUM
45 OF THE PLAN IN WHICH A QUALIFIED EMPLOYEE IS ENROLLED, IN ACCORDANCE WITH

1 SECTION 10108 OF THE FEDERAL ACT, AND COLLECT THE AMOUNT CREDITED FROM THE
2 OFFERING EMPLOYER.

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

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

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

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

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

11 (e) ADVOCATES FOR ENROLLING HARD-TO-REACH POPULATIONS.

12 16. MEET THE FOLLOWING FINANCIAL INTEGRITY REQUIREMENTS:

13 (a) KEEP AN ACCURATE ACCOUNTING OF ALL ACTIVITIES, RECEIPTS AND
14 EXPENDITURES AND ANNUALLY SUBMIT TO THE SECRETARY, THE GOVERNOR, THE
15 DIRECTOR, THE DEPARTMENT OF INSURANCE, THE LEGISLATURE AND THE AUDITOR
16 GENERAL A REPORT CONCERNING SUCH ACCOUNTINGS.

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

21 (i) INVESTIGATE THE AFFAIRS OF THE EXCHANGE.

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

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

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

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

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

34 20-3333. Health benefit plan certification

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

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

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

43 (b) THE HEALTH INSURER MAKES PROMINENT DISCLOSURE AT THE TIME IT
44 OFFERS THE PLAN, IN A FORM APPROVED BY THE EXCHANGE, THAT THE PLAN DOES NOT
45 PROVIDE THE FULL RANGE OF ESSENTIAL PEDIATRIC BENEFITS, AND THE QUALIFIED

1 DENTAL PLANS PROVIDING THOSE BENEFITS AND OTHER DENTAL BENEFITS NOT COVERED
2 BY THE PLAN ARE OFFERED THROUGH THE EXCHANGE.

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

7 3. THE PLAN'S COST-SHARING REQUIREMENTS DO NOT EXCEED THE LIMITS
8 ESTABLISHED UNDER SECTION 1302(c)(1) OF THE FEDERAL ACT, AND IF THE PLAN IS
9 OFFERED THROUGH A SMALL BUSINESS HEALTH OPTIONS PROGRAM, THE PLAN'S
10 DEDUCTIBLE DOES NOT EXCEED THE LIMITS ESTABLISHED UNDER SECTION 1302(c)(2) OF
11 THE FEDERAL ACT.

12 4. THE HEALTH INSURER OFFERING THE PLAN:

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

18 (b) OFFERS AT LEAST ONE QUALIFIED HEALTH PLAN IN THE SILVER LEVEL AND
19 AT LEAST ONE PLAN IN THE GOLD LEVEL THROUGH EACH COMPONENT OF THE EXCHANGE IN
20 WHICH THE HEALTH INSURER PARTICIPATES. FOR THE PURPOSES OF THIS SUBDIVISION,
21 "COMPONENT" MEANS EITHER THE UNIFIED EXCHANGE OR THE EXCHANGE FOR INDIVIDUAL
22 COVERAGE AND THE SMALL BUSINESS HEALTH OPTIONS PROGRAM.

23 (c) CHARGES THE SAME PREMIUM RATE FOR EACH QUALIFIED HEALTH PLAN
24 WITHOUT REGARD TO WHETHER THE PLAN IS OFFERED THROUGH THE EXCHANGE AND
25 WITHOUT REGARD TO WHETHER THE PLAN IS OFFERED DIRECTLY FROM THE HEALTH
26 INSURER OR THROUGH AN INSURANCE PRODUCER.

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

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

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

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

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

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

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

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

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

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

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

14 (a) CLAIMS PAYMENT POLICIES AND PRACTICES.

15 (b) PERIODIC FINANCIAL DISCLOSURES.

16 (c) DATA ON ENROLLMENT.

17 (d) DATA ON DISENROLLMENT.

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

19 (f) DATA ON RATING PRACTICES.

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

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

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

25 3. PERMIT INDIVIDUALS TO LEARN, IN A TIMELY MANNER ON THE REQUEST OF
26 THE INDIVIDUAL, THE AMOUNT OF COST-SHARING, INCLUDING DEDUCTIBLES, COPAYMENTS
27 AND COINSURANCE, UNDER THE INDIVIDUAL'S PLAN OR COVERAGE THAT THE INDIVIDUAL
28 WOULD BE RESPONSIBLE FOR PAYING WITH RESPECT TO THE FURNISHING OF A SPECIFIC
29 ITEM OR SERVICE BY A PARTICIPATING PROVIDER. AT A MINIMUM, THIS INFORMATION
30 MUST BE MADE AVAILABLE TO THE INDIVIDUAL THROUGH AN INTERNET WEBSITE AND
31 THROUGH OTHER MEANS FOR INDIVIDUALS WITHOUT ACCESS TO THE INTERNET.

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

37 E. THE PROVISIONS OF THIS CHAPTER THAT ARE APPLICABLE TO QUALIFIED
38 HEALTH PLANS ALSO APPLY TO THE EXTENT RELEVANT TO QUALIFIED DENTAL PLANS,
39 EXCEPT AS MODIFIED IN ACCORDANCE WITH THE FOLLOWING:

40 1. THE HEALTH INSURER MUST BE LICENSED TO OFFER DENTAL COVERAGE, BUT
41 NEED NOT BE LICENSED TO OFFER OTHER HEALTH BENEFITS.

42 2. THE PLAN MUST BE LIMITED TO DENTAL AND ORAL HEALTH BENEFITS,
43 WITHOUT SUBSTANTIALLY DUPLICATING THE BENEFITS TYPICALLY OFFERED BY HEALTH
44 BENEFIT PLANS WITHOUT DENTAL COVERAGE AND MUST INCLUDE, AT A MINIMUM, THE
45 ESSENTIAL PEDIATRIC DENTAL BENEFITS PRESCRIBED BY THE SECRETARY PURSUANT TO

1 SECTION 1302(b)(1)(J) OF THE FEDERAL ACT, AND SUCH OTHER DENTAL BENEFITS AS
2 THE EXCHANGE OR THE SECRETARY MAY SPECIFY BY REGULATION.

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

9 20-3334. Participation in the exchange

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

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

24 20-3335. Regulation of the exchange; qualified health plans

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

28 20-3336. Arizona health insurance exchange fund; exemption;
29 planning grants

30 A. THE ARIZONA HEALTH INSURANCE EXCHANGE FUND IS ESTABLISHED
31 CONSISTING OF ALL MONIES RECEIVED BY THIS STATE FOR THE PLANNING AND
32 ESTABLISHMENT OF THE EXCHANGE UNDER SECTION 1311 OF THE FEDERAL ACT AND ALL
33 PREMIUM ASSESSMENTS AND FEES CHARGED UNDER THIS CHAPTER. THE BOARD SHALL
34 ADMINISTER THE FUND. MONIES IN THE FUND MAY BE USED FOR THE OPERATION AND
35 ADMINISTRATION OF THE EXCHANGE AND ANY OTHER PURPOSES SPECIFIED IN THIS
36 CHAPTER. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT
37 FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS.

38 B. ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER, ALL MONIES
39 RECEIVED BY THIS STATE FOR THE PLANNING AND ESTABLISHMENT OF THE EXCHANGE
40 UNDER SECTION 1311 OF THE FEDERAL ACT MUST BE DEPOSITED IN THE ARIZONA HEALTH
41 INSURANCE EXCHANGE FUND. ONCE THE BOARD IS APPOINTED, THE BOARD SHALL APPLY
42 FOR PLANNING AND ESTABLISHMENT GRANTS MADE AVAILABLE TO THE EXCHANGE PURSUANT
43 TO SECTION 1311 OF THE FEDERAL ACT. THE BOARD IS RESPONSIBLE FOR USING THE
44 MONIES AWARDED BY THE SECRETARY FOR THE PLANNING AND ESTABLISHMENT OF THE
45 EXCHANGE, CONSISTENT WITH SUBDIVISION (b) OF SECTION 1311 OF THE FEDERAL ACT.