SENATE MOTION

MADAM PRESIDENT:

I move that Senate Bill 461 be amended to read as follows:

Page 21, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 27. IC 27-18 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2011]:

ARTICLE 18. INDIANA HEALTH EXCHANGE

Chapter 1. Definitions

Sec. 1. (a) The definitions in this chapter apply throughout this article.

(b) As used in this article, a reference to any of the following is a reference to the act as in effect on July 1, 2011:

(1) The federal Public Health Service Act.

(2) The Internal Revenue Code.

(3) The federal Social Security Act.

Sec. 2. "Carrier" means an entity regulated under this title that contracts to provide, deliver, arrange for, pay for, or reimburse the cost of health care services.

Sec. 3. "Commissioner" refers to the commissioner of insurance appointed under IC 27-1-1-2.

Sec. 4. "Department" refers to the department of insurance created by IC 27-1-1-1.

Sec. 5. "Educated consumer" means an individual who is knowledgeable about the health care system and has experience in making informed decisions regarding health, medical, and scientific matters.

Sec. 6. (a) "Eligible entity" means an entity that has experience in individual and small group health insurance or benefit administration, or other experience relevant to the responsibilities of the exchange.

(b) The term includes the office of Medicaid policy and planning.

(c) The term does not include a carrier or an affiliate of a carrier.

Sec. 7. "Exchange" means the Indiana health exchange established under IC 27-18-2-1.

Sec. 8. (a) "Health plan" means a policy, contract, certificate, or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse the costs of health care services.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy.

(5) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(6) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(7) Worker's compensation or similar insurance.

(8) A student health plan.

(9) A supplemental plan that always pays in addition to other coverage.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

Sec. 9. "Plain language" has the meaning set forth in Section 1311(e)(3)(B) of the PPACA.

Sec. 10. "PPACA" refers to 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 regulations or guidance issued under those acts, as in effect on July 1, 2011.

Sec. 11. "Qualified dental plan" means a limited scope dental plan that is certified under IC 27-18-4.

Sec. 12. "Qualified employer" means a small employer that:

(1) elects to make its full time employees eligible for at least one (1) qualified health plan offered through the small business health options program; and

(2) either:

(A) elects to provide coverage through the small business health options program to all of its eligible employees who

are principally employed in Indiana; or

(B) has its principal place of business in Indiana and elects to provide coverage through the small business health options program to all of its eligible employees, regardless of where the eligible employees are employed.

Sec. 13. "Qualified health plan" means a health plan that has in effect a certification that the health plan meets the criteria for certification described in Section 1311(c) of the PPACA and IC 27-18-4.

Sec. 14. "Qualified individual" means an individual, regardless of age, who:

(1) seeks to enroll in a qualified health plan offered to individuals through the exchange;

(2) is an Indiana resident;

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

(4) 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.

Sec. 15. "Secretary" refers to the secretary of the United States Department of Health and Human Services.

Sec. 16. (a) "Small employer" means an employer that employed an average of not more than one hundred (100) employees during the preceding calendar year.

(b) For purposes of this section, the following apply:

(1) Persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code are considered a single employer.

(2) An employer and a predecessor employer are considered a single employer.

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

(4) If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer must be based on the average number of employees that is reasonably expected to be employed by the employer on business days in the current calendar year.

(5) An employer that:

(A) makes enrollment in a qualified health plan available to the employer's employees through the small business health option program; and

(B) would cease to be a small employer by reason of an increase in the number of the employer's employees;

is considered a small employer for purposes of this article until the employer ceases to make enrollment through the

small business health option program available to the employer's employees.

Chapter 2. Indiana Health Exchange

Sec. 1. The Indiana health exchange shall be established by the commissioner to:

(1) facilitate the purchase of qualified health plans by individuals in the individual insurance market; and

(2) provide for establishment of a small business health options program to facilitate enrollment of employees of qualified small employers in qualified health plans offered in the small group insurance market.

Sec. 2. (a) The commissioner and the secretary of family and social services shall, not later than September 30, 2011:

(1) hold public meetings with health care providers, insurers, consumers, and other interested parties concerning the design, establishment, and administration of the exchange; and

(2) make a recommendation to the health finance commission established by IC 2-5-23-3 concerning the following:

(A) Whether the exchange should be administered by an agency of the state or a nonprofit organization.

(B) A list of states with which the state of Indiana should cooperate to form an interstate exchange.

(C) Other provisions necessary for the implementation of the exchange.

(b) This section expires December 31, 2012.

Sec. 3. (a) The health finance commission established by IC 2-5-23-3 shall, not later than October 31, 2011, study and make a recommendation to the general assembly for legislation necessary to design, establish, and implement the exchange, including the following:

(1) The administrator described in section 2(a)(2)(A) of this chapter.

(2) Any necessary governing structure for the exchange.

(3) Authority and responsibilities of the exchange, including procedures for staff hiring and procurement of resources.

(4) Responsibilities of state agencies in coordination of activities with the exchange.

(5) Other recommendations determined appropriate by the health finance commission.

(b) The commissioner shall apply for federal certification of the exchange not later than October 1, 2012.

(c) This section expires December 31, 2014.

Sec. 4. As the funds become available, the commissioner and the secretary of family and social services shall apply for federal grant funds related to the development or implementation of the exchange.

Sec. 5. The exchange shall do the following:

(1) Facilitate the purchase and sale of qualified health plans.

(2) Provide for the establishment of a small business health option program to assist qualified small employers in Indiana in facilitating the enrollment of employees in qualified health plans.

(3) Maintain, or require employees of the exchange to maintain, a producer license under IC 27-1-15.6.

Sec. 6. The exchange may do the following:

(1) Contract with an eligible entity for any of the functions of the exchange described in this article.

(2) Enter into information sharing agreements with federal and state agencies and other states' exchanges to carry out the responsibilities of the exchange under this article. An agreement entered into under this subdivision must include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal law.

Chapter 3. Functions of the Exchange

Sec. 1. The exchange shall make qualified health plans available to qualified individuals and qualified employers, beginning with effective dates not later than January 1, 2014.

Sec. 2. The exchange shall not make available a health plan that is not a qualified health plan.

Sec. 3. The exchange shall allow a carrier to offer a health plan that provides limited scope dental benefits that meet the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code through the exchange, either separately or in conjunction with a qualified health plan, if the health plan provides pediatric dental benefits that meet the requirements of Section 1302(b)(1)(J) of the PPACA.

Sec. 4. The exchange or a carrier that offers health 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 the 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.

Sec. 5. The exchange shall do the following:

(1) Implement procedures for certification, recertification, and decertification, consistent with guidelines developed by the secretary under Section 1311(c) of the PPACA and IC 27-18-4, of health plans as qualified health plans.

(2) Provide for the operation of a toll free telephone hotline to respond to requests for assistance.

(3) Provide for enrollment periods, as provided under Section

1311(c)(6) of the PPACA.

(4) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information concerning the qualified health 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 PPACA, 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 PPACA.

(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 federal Public Health Service Act.

(7) In accordance with Section 1413 of the PPACA:

(A) inform individuals of eligibility requirements for the Medicaid program under Title XIX of the federal Social Security Act, the Children's Health Insurance Program under Title XXI of the federal Social Security Act, or an applicable state or local public program; and

(B) if through screening of the application by the exchange, the exchange determines that an individual is eligible for a program listed in clause (A), enroll the individual in the 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 and any cost sharing reduction under Section 1402 of the PPACA.

(9) Establish a small business health option program through which qualified employers may access coverage for employees, which must enable a qualified employer to specify a level of coverage so that any of the employees may enroll in any qualified health plan offered through the small business health option program at the specified level of coverage.

(10) Subject to Section 1411 of the PPACA, grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by Section 5000A of the Internal Revenue Code because:

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

(B) the individual meets the requirements for any other exemption from the individual responsibility requirement

or penalty.

(11) Transfer to the federal secretary of the treasury the following:

(A) A list of the individuals who are issued a certification under subdivision (10), 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 because:

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not to 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 PPACA that the individual has changed employers; and

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

(12) Provide to each employer the name of each employee of the employer described in subdivision (11)(B) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

(13) Perform duties required of the exchange by the secretary of the federal secretary of the treasury related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility requirement exemptions.

(14) Select entities qualified to serve as navigators in accordance with Section 1311(i) of the PPACA, and standards developed by the secretary, and award grants to enable navigators to do the following:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans.

(B) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost sharing reductions under Section 1402 of the PPACA.

(C) Facilitate enrollment in qualified health plans.

(D) Provide referrals to an applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal

Public Health Service Act, or another appropriate state agency, for an enrollee with a grievance, complaint, or question regarding a health plan, coverage, or a determination under the health 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.

(15) Review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

(16) Credit the amount of any free choice voucher to the monthly premium of the health plan in which a qualified employee is enrolled, in accordance with Section 10108 of the PPACA, and collect the amount credited from the offering employer.

(17) Consult with interested parties relevant to carrying out the activities required by the article, including the following:

(A) Educated 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 office of Medicaid policy and planning.

(E) Advocates for enrolling hard to reach populations.

(18) 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 commissioner, and the general assembly in an electronic format under IC 5-14-6 a report concerning the accounting.

(B) Fully cooperate with any investigation conducted by the commissioner, or the secretary under the secretary's authority under the PPACA, and allow the secretary, in coordination with the inspector general of the United States Department of Health and Human Services, to do the following:

(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) In carrying out its activities under this article, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

Chapter 4. Health Plan Certification

Sec. 1. The exchange may certify a health plan as a qualified health plan if the health plan meets the following requirements:

(1) The health plan provides the essential health benefits package described in Section 1302(a) of the PPACA, except that the health plan is not required to provide essential health benefits that duplicate the minimum benefits of qualified dental plans, as provided in section 5 of this chapter, if:

(A) the exchange determines that at least one (1) qualified dental plan is available to supplement the health plan's coverage; and

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

(2) The premium rates and contract language have been approved by the commissioner.

(3) The health plan provides at least a bronze level of coverage, as determined under IC 27-18-3-5(5), unless the health plan is certified as a qualified catastrophic plan, meets the requirements of the PPACA for catastrophic plans, and will be offered only to individuals who are eligible for catastrophic coverage.

(4) The health plan's cost sharing requirements do not exceed the limits established under Section 1302(c)(1) of the PPACA, and if the health plan is offered through the small business health option program, the health plan's deductible does not exceed the limits established under Section 1302(c)(2) of the PPACA.

(5) The carrier that offers the health plan meets the following requirements:

(A) Is licensed and in good standing to offer health insurance coverage in Indiana.

(B) Offers at least one (1) qualified health plan in the silver level and at least one (1) qualified health plan in the gold level through the individual exchange and the small business health option program.

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

(D) Does not charge cancellation fees or penalties in violation of IC 27-18-3-4.

(E) Complies with the regulations developed by the secretary under Section 1311(d) of the PPACA and any requirements established by the exchange.

(6) The health plan meets the requirements of certification as specified in rules adopted under IC 27-18-6 and regulations adopted by the secretary under Section 1311(c) of the PPACA, including minimum standards in the following areas:

(A) Marketing practices.

(B) Network adequacy.

(C) Essential community providers in underserved areas.

(D) Accreditation.

(E) Quality improvement.

(F) Uniform enrollment forms.

(G) Descriptions of coverage.

(H) Information concerning quality measures for health plan performance.

(7) The exchange determines that making the health plan available through the exchange is in the interest of qualified individuals and qualified employers in Indiana.

Sec. 2. The exchange may not exclude a health plan from certification:

(1) on the basis that the health plan is a fee for service health plan;

(2) through the imposition of premium price controls by the exchange; or

(3) on the basis that the health plan provides treatments necessary to prevent patient deaths in circumstances that the exchange determines are inappropriate or too costly.

Sec. 3. The exchange shall require each carrier that seeks certification of a health plan as a qualified health plan to do the following:

(1) Submit a justification for any premium increase before implementation of the increase in conformity with IC 27-8-5-1.5. The carrier shall prominently post the information on the carrier's Internet web site. The exchange shall consider the justifying information and the recommendations provided to the exchange by the commissioner under Section 2794(b) of the federal Public Health Service Act in determining whether to allow the carrier to make a health plan available through the exchange.

(2) In plain language, make available to the public and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of the following:

(A) Claim payment policies and practices.

(B) Periodic financial disclosures.

(C) Enrollment data.

(D) Disenrollment data.

(E) Data concerning the number of claims denied.

(F) Data concerning rating practices.

(G) Information concerning cost sharing and payments with respect to out of network coverage.

(H) Information concerning enrollee and participant rights under Title 1 of the PPACA.

(I) Other information determined appropriate by the secretary.

(3) Permit individuals to learn in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments, and coinsurance, under the individual's health 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. Minimally, the information must be available to the individual through an Internet web site and through other means for individuals without access to the Internet.

Sec. 4. The exchange shall not exempt a carrier seeking certification of a health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this chapter in a manner that excludes any discrimination among carriers participating in the exchange.

Sec. 5. Except as modified by the following or by rules adopted by the exchange, a dental plan is subject to the requirements of this chapter for certification as a qualified dental plan:

(1) The carrier:

(A) must be authorized under this title to offer dental coverage; and

(B) is not required to be authorized under this title to offer other health benefits.

(2) The dental plan must:

(A) be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by a health plan that does not provide dental coverage; and

(B) include at least the pediatric essential dental benefits prescribed by the secretary under Section 1302(b)(1)(J) of the PPACA and other benefits determined necessary by the exchange or the secretary.

(3) Carriers may jointly offer a comprehensive health plan through the exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan if the qualified dental plan and the qualified health plan are priced separately and are made available for purchase separately at the same price.

Chapter 5. Exchange Funding

Sec. 1. The exchange may charge assessments or user fees to

carriers or otherwise may generate the funds necessary to support the operations of the exchange under this article.

Sec. 2. The exchange shall publish the average cost of licensing, regulatory fees, and other payments required by the exchange, and the administrative costs of the exchange, on an Internet web site to educate consumers on the costs. The information published must include information concerning money lost to waste, fraud, and abuse.

Chapter 6. Rules

Sec. 1. The exchange may adopt rules under IC 4-22-2 to implement this article.

Sec. 2. Rules adopted under this chapter may not conflict or prevent the application of regulations adopted by the secretary under the PPACA.

Chapter 7. Relation to Other Law

Sec. 1. Except as provided in this chapter, to the extent that this article conflicts with the commissioner's authority to regulate the business of insurance under another provision of IC 27, the other provision is controlling.".

Renumber all SECTIONS consecutively.

(Reference is to SB 461 as printed January 21, 2011.)

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Senator SIMPSON