As Introduced

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Senator Skindell

Cosponsors: Senators Turner, Tavares

A B I L L

To amend sections 124.14 and 3924.01 and to enact sections 3965.01 to 3965.14 of the Revised Code to establish the Ohio Health Benefit Exchange Agency and to establish the Ohio Health Benefit Exchange Program consisting of an exchange for individual coverage and a Small Business Health Options Program.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 124.14 and 3924.01 be amended and sections 3965.01, 3965.02, 3965.03, 3965.04, 3965.05, 3965.06, 3965.07, 3965.08, 3965.09, 3965.10, 3965.11, 3965.12, 3965.13, and 3965.14 of the Revised Code be enacted to read as follows:

Sec. 124.14. (A)(1) The director of administrative services shall establish, and may modify or rescind, by rule, a job classification plan for all positions, offices, and employments the salaries of which are paid in whole or in part by the state. The director shall group jobs within a classification so that the positions are similar enough in duties and responsibilities to be described by the same title, to have the same pay assigned with equity, and to have the same qualifications for selection applied.

The director shall, by rule, assign a classification title to each classification within the classification plan. However, the director shall consider in establishing classifications, including classifications with parenthetical titles, and assigning pay ranges such factors as duties performed only on one shift, special skills in short supply in the labor market, recruitment problems, separation rates, comparative salary rates, the amount of training required, and other conditions affecting employment. The director shall describe the duties and responsibilities of the class, establish the qualifications for being employed in each position in the class, and file with the secretary of state a copy of specifications for all of the classifications. The director shall file new, additional, or revised specifications with the secretary of state before they are used.

The director shall, by rule, assign each classification, either on a statewide basis or in particular counties or state institutions, to a pay range established under section 124.15 or section 124.152 of the Revised Code. The director may assign a classification to a pay range on a temporary basis for a period of six months. The director may establish, by rule adopted under Chapter 119. of the Revised Code, experimental classification plans for some or all employees paid directly by warrant of the director of budget and management. The rule shall include specifications for each classification within the plan and shall specifically address compensation ranges, and methods for advancing within the ranges, for the classifications, which may be assigned to pay ranges other than the pay ranges established under section 124.15 or 124.152 of the Revised Code.

(2) The director of administrative services may reassign to a proper classification those positions that have been assigned to an improper classification. If the compensation of an employee in such a reassigned position exceeds the maximum rate of pay for the

employee's new classification, the employee shall be placed in pay step X and shall not receive an increase in compensation until the maximum rate of pay for that classification exceeds the employee's compensation.

(3) The director may reassign an exempt employee, as defined in section 124.152 of the Revised Code, to a bargaining unit classification if the director determines that the bargaining unit classification is the proper classification for that employee. Notwithstanding Chapter 4117. of the Revised Code or instruments and contracts negotiated under it, these placements are at the director's discretion.

(4) The director shall, by rule, assign related classifications, which form a career progression, to a classification series. The director shall, by rule, assign each classification in the classification plan a five-digit number, the first four digits of which shall denote the classification series to which the classification is assigned. When a career progression encompasses more than ten classifications, the director shall, by rule, identify the additional classifications belonging to a classification series. The additional classifications shall be part of the classification series, notwithstanding the fact that the first four digits of the number assigned to the additional classifications do not correspond to the first four digits of the numbers assigned to other classifications in the classification series.

(B) Division (A) of this section and sections 124.15 and 124.152 of the Revised Code do not apply to the following persons, positions, offices, and employments:

(1) Elected officials;

(2) Legislative employees, employees of the legislative service commission, employees in the office of the governor,

employees who are in the unclassified civil service and exempt from collective bargaining coverage in the office of the secretary of state, auditor of state, treasurer of state, and attorney general, and employees of the supreme court;

(3) Any position for which the authority to determine compensation is given by law to another individual or entity;

(4) Employees of the bureau of workers' compensation whose compensation the administrator of workers' compensation establishes under division (B) of section 4121.121 of the Revised Code;

(5) Employees of the Ohio health benefit exchange program whose compensation the board of the Ohio health benefit exchange agency establishes under division (H) of section 3965.03 of the Revised Code.

(C) The director may employ a consulting agency to aid and assist the director in carrying out this section.

(D)(1) When the director proposes to modify a classification or the assignment of classes to appropriate pay ranges, the director shall send written notice of the proposed rule to the appointing authorities of the affected employees thirty days before a hearing on the proposed rule. The appointing authorities shall notify the affected employees regarding the proposed rule. The director also shall send those appointing authorities notice of any final rule that is adopted within ten days after adoption.

(2) When the director proposes to reclassify any employee in the service of the state so that the employee is adversely affected, the director shall give to the employee affected and to the employee's appointing authority a written notice setting forth the proposed new classification, pay range, and salary. Upon the request of any classified employee in the service of the state who is not serving in a probationary period, the director shall

perform a job audit to review the classification of the employee's position to determine whether the position is properly classified. The director shall give to the employee affected and to the employee's appointing authority a written notice of the director's determination whether or not to reclassify the position or to reassign the employee to another classification. An employee or appointing authority desiring a hearing shall file a written request for the hearing with the state personnel board of review within thirty days after receiving the notice. The board shall set the matter for a hearing and notify the employee and appointing authority of the time and place of the hearing. The employee, the appointing authority, or any authorized representative of the employee who wishes to submit facts for the consideration of the board shall be afforded reasonable opportunity to do so. After the hearing, the board shall consider anew the reclassification and may order the reclassification of the employee and require the director to assign the employee to such appropriate classification as the facts and evidence warrant. As provided in division (A)(1) of section 124.03 of the Revised Code, the board may determine the most appropriate classification for the position of any employee coming before the board, with or without a job audit. The board shall disallow any reclassification or reassignment classification of any employee when it finds that changes have been made in the duties and responsibilities of any particular employee for political, religious, or other unjust reasons.

(E)(1) Employees of each county department of job and family services shall be paid a salary or wage established by the board of county commissioners. The provisions of section 124.18 of the Revised Code concerning the standard work week apply to employees of county departments of job and family services. A board of county commissioners may do either of the following:

(a) Notwithstanding any other section of the Revised Code,

supplement the sick leave, vacation leave, personal leave, and other benefits of any employee of the county department of job and family services of that county, if the employee is eligible for the supplement under a written policy providing for the supplement;

(b) Notwithstanding any other section of the Revised Code, establish alternative schedules of sick leave, vacation leave, personal leave, or other benefits for employees not inconsistent with the provisions of a collective bargaining agreement covering the affected employees.

(2) Division (E)(1) of this section does not apply to employees for whom the state employment relations board establishes appropriate bargaining units pursuant to section 4117.06 of the Revised Code, except in either of the following situations:

(a) The employees for whom the state employment relations board establishes appropriate bargaining units elect no representative in a board-conducted representation election.

(b) After the state employment relations board establishes appropriate bargaining units for such employees, all employee organizations withdraw from a representation election.

(F)(1) Notwithstanding any contrary provision of sections 124.01 to 124.64 of the Revised Code, the board of trustees of each state university or college, as defined in section 3345.12 of the Revised Code, shall carry out all matters of governance involving the officers and employees of the university or college, including, but not limited to, the powers, duties, and functions of the department of administrative services and the director of administrative services specified in this chapter. Officers and employees of a state university or college shall have the right of appeal to the state personnel board of review as provided in this

chapter.

(2) Each board of trustees shall adopt rules under section 111.15 of the Revised Code to carry out the matters of governance described in division (F)(1) of this section. Until the board of trustees adopts those rules, a state university or college shall continue to operate pursuant to the applicable rules adopted by the director of administrative services under this chapter.

(G)(1) Each board of county commissioners may, by a resolution adopted by a majority of its members, establish a county personnel department to exercise the powers, duties, and functions specified in division (G) of this section. As used in division (G) of this section, "county personnel department" means a county personnel department established by a board of county commissioners under division (G)(1) of this section.

(2)(a) Each board of county commissioners, by a resolution adopted by a majority of its members, may designate the county personnel department of the county to exercise the powers, duties, and functions specified in sections 124.01 to 124.64 and Chapter 325. of the Revised Code with regard to employees in the service of the county, except for the powers and duties of the state personnel board of review, which powers and duties shall not be construed as having been modified or diminished in any manner by division (G)(2) of this section, with respect to the employees for whom the board of county commissioners is the appointing authority or co-appointing authority.

(b) Nothing in division (G)(2) of this section shall be construed to limit the right of any employee who possesses the right of appeal to the state personnel board of review to continue to possess that right of appeal.

(c) Any board of county commissioners that has established a county personnel department may contract with the department of

administrative services, in accordance with division (H) of this section, another political subdivision, or an appropriate public or private entity to provide competitive testing services or other appropriate services.

(3) After the county personnel department of a county has been established as described in division (G)(2) of this section, any elected official, board, agency, or other appointing authority of that county, upon written notification to the county personnel department, may elect to use the services and facilities of the county personnel department. Upon receipt of the notification by the county personnel department, the county personnel department shall exercise the powers, duties, and functions as described in division (G)(2) of this section with respect to the employees of that elected official, board, agency, or other appointing authority.

(4) Each board of county commissioners, by a resolution adopted by a majority of its members, may disband the county personnel department.

(5) Any elected official, board, agency, or appointing authority of a county may end its involvement with a county personnel department upon actual receipt by the department of a certified copy of the notification that contains the decision to no longer participate.

(6) A county personnel department, in carrying out its duties, shall adhere to merit system principles with regard to employees of county departments of job and family services, child support enforcement agencies, and public child welfare agencies so that there is no threatened loss of federal funding for these agencies, and the county is financially liable to the state for any loss of federal funds due to the action or inaction of the county personnel department.

(H) County agencies may contract with the department of administrative services for any human resources services, including, but not limited to, establishment and modification of job classification plans, competitive testing services, and periodic audits and reviews of the county's uniform application of the powers, duties, and functions specified in sections 124.01 to 124.64 and Chapter 325. of the Revised Code with regard to employees in the service of the county. Nothing in this division modifies the powers and duties of the state personnel board of review with respect to employees in the service of the county. Nothing in this division limits the right of any employee who possesses the right of appeal to the state personnel board of review to continue to possess that right of appeal.

(I) The director of administrative services shall establish the rate and method of compensation for all employees who are paid directly by warrant of the director of budget and management and who are serving in positions that the director of administrative services has determined impracticable to include in the state job classification plan. This division does not apply to elected officials, legislative employees, employees of the legislative service commission, employees who are in the unclassified civil service and exempt from collective bargaining coverage in the office of the secretary of state, auditor of state, treasurer of state, and attorney general, employees of the courts, employees of the bureau of workers' compensation whose compensation the administrator of workers' compensation establishes under division (B) of section 4121.121 of the Revised Code, or employees of an appointing authority authorized by law to fix the compensation of those employees.

(J) The director of administrative services shall set the rate of compensation for all intermittent, seasonal, temporary, emergency, and casual employees in the service of the state who

are not considered public employees under section 4117.01 of the Revised Code. Those employees are not entitled to receive employee benefits. This rate of compensation shall be equitable in terms of the rate of employees serving in the same or similar classifications. This division does not apply to elected officials, legislative employees, employees of the legislative service commission, employees who are in the unclassified civil service and exempt from collective bargaining coverage in the office of the secretary of state, auditor of state, treasurer of state, and attorney general, employees of the courts, employees of the bureau of workers' compensation whose compensation the administrator establishes under division (B) of section 4121.121 of the Revised Code, or employees of an appointing authority authorized by law to fix the compensation of those employees.

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the Revised Code:

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and methods used by, the carrier relative to establishing premium rates for the health benefit plans.

(B) "Adjusted average market premium price" means the average market premium price as determined by the board of directors of the Ohio health reinsurance program either on the basis of the arithmetic mean of all carriers' premium rates for an OHC plan sold to groups with similar case characteristics by all carriers

selling OHC plans in the state, or on any other equitable basis determined by the board.

(C) "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics.

(D) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state or a MEWA. A sickness and accident insurance company that owns or operates a health insuring corporation, either as a separate corporation or as a line of business, shall be considered as a separate carrier from that health insuring corporation for purposes of sections 3924.01 to 3924.14 of the Revised Code.

(E) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees work; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier; the number of employees and dependents; and such other objective criteria as may be established by the carrier. "Case characteristics" does not include claims experience, health status, or duration of coverage from the date of issue.

(F) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

(G) "Eligible employee" means an employee who works a normal work week of twenty-five or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of

natural or suitable times or circumstances.

(H) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(I) "Late enrollee" means an eligible employee or dependent who enrolls in a small employer's health benefit plan other than during the first period in which the employee or dependent is eligible to enroll under the plan or during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended.

(J) "MEWA" means any "multiple employer welfare arrangement" as defined in section 3 of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, except for any arrangement which is fully insured as defined in division (b)(6)(D) of section 514 of that act.

(K) "Midpoint rate" means, for small employers with similar case characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest

premium rate.

(L) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's enrollment date as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the enrollment date. Genetic information shall not be treated as such a condition in the absence of a diagnosis of the condition related to such information.

For purposes of this division, "enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(M) "Service waiting period" means the period of time after employment begins before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer.

(N)(1) "Small employer" means, <u>until January 1, 2016,</u> in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year <u>and, on and after January 1, 2016, an employer that employed an average of not more than one hundred employees during the preceding calendar year</u>.

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one

employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to 3924.14 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

(O) "OHC plan" means an Ohio health care plan, which is the basic, standard, or carrier reimbursement plan for small employers and individuals established in accordance with section 3924.10 of the Revised Code.

Sec. 3965.01. (A) The purpose of this chapter is to provide for the establishment of an Ohio health benefit exchange agency and an Ohio health benefit exchange program to facilitate the purchase and sale of qualified health plans in the individual market in this state, and to provide for the establishment of a small business health options program as a part of the Ohio health benefit exchange program to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

(B) The Ohio general assembly declares that the following objectives are to be served by this chapter:

(1) Extend access to high quality, affordable health plans to all Ohioans;

(2) Reduce the number of uninsured Ohioans by creating a cost-effective, user-friendly, and transparent marketplace to help

consumers and employers select high quality, affordable health plans and claim available federal tax credits and cost-sharing subsidies;

(3) Strengthen the health care delivery system;

(4) Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers;

(5) Require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, not on risk selection;

(6) Meet the requirements of the federal act and applicable federal guidance and regulations.

Sec. 3965.02. As used in this chapter:

(A) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state.

(B) "Exchange" or "exchange program" means the Ohio health benefit exchange program established in section 3965.05 of the Revised Code.

(C) "Exchange agency" means the Ohio health benefit exchange agency established in section 3965.03 of the Revised Code.

(D) "Federal act" means the federal "Patient Protection and Affordable Care Act of 2010," 124 Stat. 119, as amended by the federal "Health Care and Education Reconciliation Act of 2010," 124 Stat. 1029, and any amendments to those acts, or regulations or guidance issued under those acts.

(E) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a carrier to

provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" does not include any of the following:

(1) Policies covering only accident or disability income;

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

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

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics;

(8) Other similar insurance coverage under which benefits for health care services are secondary or incidental to other insurance benefits;

(9) Any plan offering the benefits or coverage described in division (D) of section 3965.06 of the Revised Code.

(F) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 3965.07 of the Revised Code.

(G) "Qualified employer" means a small employer that meets the criteria for a qualified employer established in section 3965.11 of the Revised Code.

(H) "Qualified health plan" means a health benefit plan that has been certified pursuant to section 3965.06 of the Revised Code.

(I) "Qualified individual" means an individual who meets the criteria for a qualified individual established in section 3965.10 of the Revised Code.

(J) "Secretary" means the secretary of the United States

department of health and human services.

(K) "SHOP exchange" means the small business health options program established in section 3965.11 of the Revised Code.

(L)(1) "Small employer" means, until January 1, 2016, an employer that employed an average of not more than fifty employees during the preceding calendar year and, on and after January 1, 2016, an employer that employed an average of not more than one hundred employees during the preceding calendar year.

(2) For the purposes of division (L)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended, shall be treated as a single employer. Any reference in division (L) of this section to an "employer" includes any predecessor of the employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that the employer is reasonably expected to employ on business days in the current calendar year. All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

Sec. 3965.03. (A) The Ohio health benefit exchange agency is hereby created. The agency shall have a board of directors consisting of the following members:

(1) The following individuals, as part of their appointed roles:

(a) The superintendent of insurance, or the superintendant's designee;

(b) The director of medicaid, or the director's designee;

(c) The director of health, or the director's designee.

(2) The following members appointed by the governor following the nomination process described in section 3965.04 of the Revised Code. Not more than half shall be members of the same political party, none shall have been employed by or worked as an insurance agent or health care provider in the three years prior to appointment, and all shall be residents of this state. At least one of the six appointed members of the board shall have knowledge of best practices used to address disparities in quality, access, and affordability of health care.

(a) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as a union representative;

(b) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as a consumer representative;

(c) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as a small business representative;

(d) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as an actuary;

(e) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as an economist;

(f) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as an employee benefits specialist.

(B) The board shall not include health care providers or their representatives, or insurers or their representatives, brokers, or agents.

(C)(1) Of the initial appointments made to the board under division (A)(2) of this section, the governor shall appoint two members to a term ending on June 30, 2014, two members to a term ending on June 30, 2015, and two members to a term ending on June 30, 2016. Thereafter, terms of office shall be for three years, with each term ending on the same day of the same month as did the term that it succeeds. Each member shall hold office from the date of the member's appointment until the end of the term for which the member was appointed.

(2) The governor shall not appoint any person to more than two full terms of office on the board. This restriction does not prevent the governor from appointing a person to fill a vacancy caused by the death, resignation, or removal of a board member and also appointing that person twice to full terms on the board, or from appointing a person previously appointed to fill less than a full term twice to full terms on the board.

(3) Vacancies shall be filled in accordance with division (F) of section 3965.04 of the Revised Code. Any member appointed to fill a vacancy occurring prior to the expiration date of the term for which the member's predecessor was appointed shall hold office as a member for the remainder of that term. A member shall continue in office subsequent to the expiration date of the member's term until a successor takes office or until a period of sixty days has elapsed, whichever occurs first.

(D) All members of the board shall receive their reasonable and necessary expenses pursuant to section 126.31 of the Revised Code while engaged in the performance of their duties as members and all members described in division (A)(2) of this section also shall receive an annual salary not to exceed sixty thousand dollars in total, payable on the following basis:

(1) Except as provided in division (D)(2) of this section, a member shall receive five thousand dollars during a month in which

the member attends one or more meetings of the board and shall receive no payment during a month in which the member attends no meeting of the board.

(2) A member may receive not more than sixty thousand dollars per year to compensate the member for attending meetings of the board, regardless of the number of meetings held by the board during a year or the number of meetings in excess of twelve within a year that the member attends.

(E) The board shall set meeting dates as necessary to perform the duties of the board under this chapter. The board shall meet at least twelve times per year. A majority of the members shall constitute a quorum.

(F) Before entering the duties of office, each appointed member to the board described in division (A)(2) of this section shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code.

(G) The board may appoint an advisory committee to the board that shall consist of ten, eleven, or twelve individuals who represent stakeholders, but who shall not vote on the matters before the board. The advisory committee may include all of the following individuals:

(1) Representatives of health insuring corporations;

(2) Insurance brokers;

(3) Health care providers;

(4) Consumers, including persons with disabilities;

(5) Small business owners;

(6) Representatives of organizations or community members that represent ethnic, racial, and rural communities;

(7) Others as the board sees fit.

(H) The board is responsible for the effective operation of all exchange agency responsibilities and the compliance of the exchange agency and the exchange program with all federal and state rules and regulations. The board shall do all of the following:

(1) Exercise all powers reasonably necessary to carry out and comply with the duties, responsibilities, and requirements of this chapter and the federal act;

(2) Hire an executive director who shall be in the unclassified civil service. The executive director shall be responsible for the operation of the exchange program.

(3) Set the salaries for staff hired by the executive director pursuant to section 3965.05 of the Revised Code that are in amounts reasonably necessary to attract and retain individuals of superior qualifications, publish those salaries in the board's annual budget, and post the board's annual budget on the web site of the exchange agency.

(4) Consult with stakeholders relevant to carrying out the activities applicable to the board under this chapter, including all of the following:

(a) Health care consumers who are enrolled in health plans;

(b) Individuals and entities with experience in facilitating enrollment in health plans;

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

(d) Advocates for enrolling hard-to-reach populations.

(5) Develop standardized quality measures to evaluate health benefit plans pursuant to division (A)(7)(g) of section 3965.06 of the Revised Code;

(6) Establish a navigator program in accordance with section

3965.09 of the Revised Code and select individuals and entities for the navigator program using the criteria listed in that section;

(7) Develop privacy policies in accordance with relevant federal and state law, rule, and regulation to protect sensitive applicant and enrollee information;

(8) Adopt bylaws for the regulation of its affairs and the conduct of its business.

(I) The board may sue and be sued in the name of the exchange agency.

Sec. 3965.04. (A) There is hereby created an exchange agency board of directors nominating council consisting of the following individuals:

(1) The chief executive officer of AARP, or that officer's designee;

(2) The executive director of the Ohio developmental disabilities council, or the executive director's designee;

(3) The director or equivalent representative of the Ohio small business council of the Ohio chamber of commerce, or the director or equivalent representative's designee;

(4) The chairperson of the board of directors of the council of smaller enterprises, or the chairperson's designee;

(5) The executive director of the universal health care action network of Ohio, or the executive director's designee;

(6) The president of the Ohio AFL-CIO, or the president's designee;

(7) The president or equivalent representative of the largest public employee organization in this state, or the president or equivalent representative's designee;

(8) The president of the health policy institute of Ohio, or the president's designee;

(9) The executive director of the Ohio commission on minority health, or the executive director's designee;

(10) The chairperson of the department of economics at the Ohio state university, or the chairperson's designee;

(11) The president of the Ohio association of health plans, or the president's designee;

(12) The president of the Ohio state medical association, or the president's designee;

(13) The chief executive officer of the Ohio hospital association, or that officer's designee;

(14) An individual selected by the president of the senate;

(15) An individual selected by the speaker of the house of representatives.

(B) At its first meeting each calendar year, the council shall select from among its members a chairperson and secretary. The council may adopt bylaws governing its proceedings.

(C) The council shall keep a record of its proceedings. Special meetings may be called by the chairperson, and shall be called by the chairperson upon receipt of a written request for a meeting signed by two or more members of the council. Written notice of the time and place of each meeting shall be sent to each member of the council. Eight members, or their alternates, constitute a quorum.

(D) The council shall:

(1) Review and evaluate possible appointees for the office of exchange board director of the Ohio health benefit exchange agency;

(2) Consistent with section 3965.03 of the Revised Code, not more than eighty-five nor less than sixty days prior to the expiration of the term of an exchange board director or not more than thirty days after the death of, resignation of, or termination of service by, an exchange board director, provide the governor with a list of four individuals who are, in the judgment of the council, the most fully qualified to accede to the office of exchange board director. The council shall not include the name of an individual upon the list, if the appointment of that individual by the governor would result in more than three appointed members of the board of directors belonging to or being affiliated with the same political party.

(E) In reviewing and evaluating possible appointees for the office of exchange board director, the council may accept comments from, cooperate with, and request information from any person. The council may make recommendations to the general assembly concerning changes in legislation to assist the council in the performance of its duties.

(F) Within thirty days of receipt of the council's recommendations, the governor shall fill a vacancy occurring in the office of exchange board director by appointment of one of the persons recommended by the council. Nothing in this section shall prevent the governor in the governor's discretion from rejecting all of the nominees of the council and reconvening the council in order to select four additional nominees. However, when the governor has reconvened the council and the council has provided the governor with a second list of four names, the governor shall make the appointment from one of the names on the first list or the second list. Each appointment by the governor shall be subject to the advice and consent of the senate.

(G) Members of the council shall be compensated on a per diem basis pursuant to the procedures set forth in section 124.14 of

the Revised Code plus reasonable travel expenses. All the expenses of the nominating council shall be paid from moneys appropriated to the exchange agency for that purpose.

Sec. 3965.05. (A) There is hereby created the Ohio health benefit exchange program within the Ohio health benefit exchange agency consisting of an exchange for individual coverage and a SHOP exchange. The executive director of the exchange agency shall be responsible for operating the exchange and shall hire all necessary staff to meet the responsibilities of the executive director as described in this section. All staff hired by the executive director shall be in the classified civil service.

(B) The executive director shall do all of the following:

(1) Make qualified health plans available to qualified individuals and qualified employers beginning on January 1, 2014;

(2) Establish procedures by rule for the certification, recertification, and decertification of health benefit plans as qualified health plans pursuant to section 3965.06 of the Revised Code and consistent with guidelines developed by the secretary under section 1311(c) of the federal act;

(3) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance regarding the exchange;

(4) Establish enrollment periods, consistent with the requirements of section 1311(c)(6) of the federal act;

(5) Maintain a web site through which individuals can enroll in qualified health plans, and through which enrollees and applicants can obtain standardized comparative information on such plans;

(6) 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 the level of coverage of each qualified health plan in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the federal act;

(7) Ensure that throughout the state a choice of qualified health plans are provided at the catastrophic, bronze, silver, gold, and platinum levels of coverage as those levels are described in sections 1302(d) and (e) of the federal act. A particular plan may be available in one region of the state and not others so long as throughout the state there is a comparable selection of options at each coverage level.

(8) 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," 124 Stat. 132, 42 U.S.C. 300gg-15 (2010);

(9) Inform individuals of eligibility requirements for the programs listed in division (B) of section 3965.10 of the Revised Code and enroll all eligible individuals in those programs;

(10) Grant certifications attesting that individuals are exempt from the individual responsibility requirement and penalty under section 5000A of the "Internal Revenue Code of 1986," 124 Stat. 1215, if individuals meet the criteria listed in division (C) of section 3965.10 of the Revised Code;

(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," 125 Stat. 168, and any cost-sharing reduction under section 1402 of the federal act;

(12) Transfer to the United States secretary of the treasury all of the following:

(a) A list of the individuals who are issued a certification

under division (B)(10) 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," 125 Stat. 168, because of either of the following reasons:

(i) The employer did not provide minimum essential coverage.

(ii) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the "Internal Revenue Code of 1986," 125 Stat. 168, to either be unaffordable to the employee or not to provide the required minimum actuarial value.

(c) The name and taxpayer identification number of both of the following:

(i) Each individual who notifies the executive director pursuant to 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.

(13) Provide to each employer the name of each employee of the employer described in division (B)(12)(c)(ii) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(14) Review the rate of premium growth within the exchange and outside the exchange, and consider the information in making recommendations to the board of the exchange agency on whether to continue limiting qualified employer status to small employers;

(15) Meet the following financial integrity requirements:

(a) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the secretary an accounting report as required by section 1313 of the federal act;

(b) Conduct an annual fiscal audit;

(c) Annually prepare a written report on the implementation and performance of the exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this chapter. This report shall be transmitted to the general assembly and the governor and shall be made available to the public on the web site of the exchange.

(d) 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 do all of 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.

(e) In carrying out the activities of the exchange under this chapter, 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.

(16) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the "Public Health Service Act," 124 Stat. 138, 42 U.S.C. 300gg-93 (2010), or the department of

insurance for any enrollee with a grievance, complaint, or question regarding the enrollee's health plan, coverage, or a determination under that plan or coverage;

(17) Market and publicize the availability of health care coverage and federal subsidies through the exchange including efforts to reach hard-to-reach populations;

(18) Before January 1, 2019, conduct an ongoing study of exchange activities and the enrollees in qualified health plans offered through the exchange, including all of the following:

(a) A survey of the cost and affordability of insurance provided under both the exchange for individual coverage and the SHOP exchange;

(b) The number of physicians by area and specialty who are not taking or accepting new patients who are enrolled in qualified health plans through the exchange;

(c) The adequacy of provider networks of qualified health plans.

(19) Collaborate with agencies and departments of this state, including the department of job and family services and the department of insurance, to allow an individual to remain enrolled with the individual's carrier and provider network if the individual loses eligibility for premium tax credits and becomes eligible for medicaid, or loses eligibility for medicaid and becomes eligible for premium tax credits through the exchange;

(20) Ensure that the privacy of applicants and enrollees in the exchange is protected by enforcing the privacy policies developed by the board of the exchange agency pursuant to division (H)(7) of section 3965.03 of the Revised Code.

(C) The executive director may do any of the following:

(1) Contract with an eligible entity for any of the functions

of the exchange described in this chapter, including the department of job and family services or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity. A carrier or an affiliate of a carrier is not an eligible entity.

(2) Enter into information-sharing agreements with federal and state agencies and departments and other state health benefit exchange agencies to carry out the responsibilities of the exchange under this chapter, provided those agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules, and regulations.

(3) Make available supplemental coverage for enrollees of the exchange to the extent permitted by the federal act, provided that funds in the Ohio health benefit exchange operating fund established in section 3965.12 of the Revised Code are not used to pay the cost of that coverage. Any supplemental coverage offered in the exchange shall be subject to the charge imposed on qualified health plans under section 3965.12 of the Revised Code.

(D) Neither the executive director nor any carrier offering a health benefit plan through the exchange shall do either of the following:

(1) Make available on the exchange any health plan that is not a qualified health plan;

(2) 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," 125 Stat. 168.

(E) All data collection performed by the executive director pursuant to this chapter shall include demographic information, including racial and ethnic information as specified by the executive director in rules adopted in accordance with section 3965.13 of the Revised Code.

Sec. 3965.06. (A) The executive director of the exchange may certify a health benefit plan as a qualified health plan if all of the following conditions are met:

(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 section 3965.07 of the Revised Code, if both of the following are true:

(a) The executive director has determined that at least one qualified dental plan is available to supplement the qualified health plan's coverage.

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

(2) The premium rates and contract language have been approved by the superintendent of insurance.

(3) The plan provides at least a bronze level of coverage, as determined pursuant to division (B)(6) of section 3965.05 of the Revised Code unless the plan is certified as a qualified catastrophic plan, which 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 carrier offering the plan meets all of the following criteria:

(a) The carrier is licensed and in good standing to offer health insurance coverage in this state.

(b) The carrier offers at least one qualified catastrophic health plan, at least one qualified health plan in the bronze level, at least one qualified health plan in the silver level, at least one qualified health plan in the gold level, and at least one qualified health plan in the platinum level, as determined by the executive director pursuant to division (B)(6) of section 3965.05 of the Revised Code, through the SHOP exchange or the exchange for individual coverage or both if the carrier participates in both the SHOP exchange and the exchange for individual coverage.

(c) The carrier 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 carrier or through an insurance agent.

(d) The carrier does not charge any fee or penalty for termination of coverage in violation of division (D)(2) of section 3965.05 of the Revised Code.

(e) The carrier complies with the regulations developed by the secretary under section 1311(d) of the federal act and such other requirements as the executive director may establish.

(6) The plan meets the requirements of certification as established by rule pursuant to division (B)(2) of section 3965.05 of the Revised Code and by the secretary under section 1311(c) of the federal act.

(7) The executive director determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state. In making such a determination, the executive director shall consider all of the following:

(a) Plans should not make use of marketing practices that would discourage enrollment by people with significant health needs.

(b) Plans must provide a sufficient choice of providers and, where available, must include essential community providers that serve low-income, medically underserved individuals.

(c) Plans must be accredited by a recognized accreditation organization, or achieve accreditation from a recognized accreditation organization within a time period defined by the board of the exchange agency, based on a review of their clinical quality, patient experience, access, utilization management, quality assurance, provider credentialing, complaints and appeals processes, network adequacy and access, and patient information programs.

(d) Plans must have a quality improvement strategy.

(e) Plans must use a uniform enrollment form for individuals and small employers.

(f) Plans must use a standard format for presenting plan options.

(g) Plans must provide information about their performance on standardized quality measures as determined by the board of the

exchange agency under division (H)(5) of section 3965.03 of the Revised Code to enrollees and prospective enrollees.

(h) Plans must report annually to the federal government on the quality of their pediatric care.

(8) The plan does not offer benefits or coverage described in division (D) of this section.

(B) The executive director shall not exclude a health benefit plan from certification for any of the following reasons:

(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 executive director determines are inappropriate or too costly.

(C) The executive director shall require each carrier seeking certification of a plan as a qualified health plan to do all of the following:

(1) Submit a justification to the executive director for any premium increase before implementation of that increase;

(2) Prominently post any information regarding a premium increase on its web site. The executive director shall take this information, along with the information and the recommendations provided to the exchange by the secretary under section 2794(b) of the "Public Health Service Act," 124 Stat. 139, 42 U.S.C. 300gg-94 (2010), into consideration when determining whether to allow the carrier to make plans available through the exchange.

(3) Make available to the public, in language that the intended audience, including individuals with limited English proficiency, can readily understand, and submit to the exchange, the secretary, and the superintendent of insurance, accurate and

timely disclosure of all of the following information:

(a) Claims payment policies and practices;

(b) Periodic financial disclosures;

(c) Data on enrollment, disenrollment, the number of claims that are denied, and rating practices;

(d) Information on cost-sharing and payments with respect to any out-of-network coverage;

(e) Information on enrollee and participant rights under Title I of the federal act;

(f) Other information as determined appropriate by the secretary pursuant to section 1303 of the federal act.

(4) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through a web site and through other means for individuals without access to the internet.

(D) The executive director shall not consider any health benefit plan for certification as a qualified health plan if the health benefit plan includes any of the following:

(1) Any of the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, or community-based care;

(c) Other similar, limited benefits specified in federal regulations issued pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1936 (1996).

(2) Either of 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 health benefit plan maintained by the same carrier, 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 health benefit plan maintained by the same carrier:

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

(b) Hospital indemnity or other fixed indemnity insurance.

(3) Any of the following if offered as a separate policy, certificate, or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the "Social Security Act," 124 Stat. 460, 42 U.S.C. 1395ss (2010);

(b) Coverage supplemental to the coverage provided under chapter 55 of Title 10 of the United States Code;

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

(E) The executive director shall not exempt any carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among carriers participating in the exchange.

Sec. 3965.07. (A) The executive director may certify a dental plan as a qualified dental plan if all of the following conditions

are met:

(1) The plan provides limited scope dental benefits that are offered separately from any qualified health plan.

(2) The plan does not substantially duplicate the benefits typically offered by health benefit plans without dental coverage.

(3) The plan includes, 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 executive director or the secretary may specify by rule or regulation.

(B) The provisions of this chapter that are applicable to qualified health plans shall also apply to qualified dental plans to the extent relevant with the following exceptions:

(1) A carrier that is licensed to offer dental coverage need not be licensed to offer other health benefits.

(2) Carriers may jointly offer a comprehensive 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, provided that the plans are priced separately and are also made available for purchase separately at the same price.

(C) The executive director may adopt additional rules concerning qualified dental health plans.

Sec. 3965.08. (A) Health plans that are certified as qualified health plans pursuant to section 3965.06 of the Revised Code and dental plans that are certified as qualified dental plans pursuant to section 3965.07 of the Revised Code may bid to participate in the exchange for individual coverage and the SHOP exchange. Bidding plans will be scored by the executive director

of the exchange based on the following criteria:

(1) The cost of the plan to individuals in terms of premiums and typical out-of-pocket expenses;

(2) The carrier's overall offering and plan design. Preferred features of health benefit plans include the following:

(a) Use of a select, high-performance network;

(b) Centers of excellence for complex conditions or procedures;

(c) Innovative pharmacy management;

(d) Active consumer engagement;

(e) Wellness incentives and management;

(f) Preventive and flex benefits for chronic conditions.

(3) Use of multilingual community outreach or nontraditional media outlets to reach hard-to-reach communities for marketing purposes;

(4) The ability of the plan to confirm its compliance with various program rules and reporting requirements;

(5) The design of the plan's enrollment process, including the following considerations:

(a) Level of burden to the consumer;

(b) Ease of use with regard to populations that may experience barriers to enrollment such as the disabled and those with limited English language proficiency.

(6) A determination of whether including a given plan in the exchange will encourage a robust system of regional plans.

(B) After consideration of the criteria listed in division (A) of this section, the executive director shall select qualified health plans and qualified dental plans to participate in the

exchange. There shall not be a set minimum or maximum number of qualified health or dental plans that are required to exist in the exchange.

(C) In the course of selectively contracting for health care coverage, the executive director shall do both of the following:

(a) Seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service;

(b) Maintain a robust system of regional plans.

Sec. 3965.09. (A) The board of the exchange agency shall establish a navigator program in accordance with section 1311(i) of the federal act, designed to advise individual consumers and employers on the use of the exchange.

(B) The board shall select individuals and entities to be part of the navigator program. To be considered for a grant under the navigator program, an individual or entity shall meet all of the following criteria:

(1) The individual or entity shall demonstrate to the board that the individual or entity has existing relationships or could readily establish relationships with consumers, employers and employees, or self-employed individuals, likely to be qualified to enroll in a qualified health plan;

(2) The individual or entity shall not be a health insurance issuer or receive any compensation, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan;

(3) The individual or entity shall be capable of carrying out the duties listed in division (C) of this section.

(C) Navigators shall do all of the following:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) 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 of 1986," 125 Stat. 168, and cost-sharing reductions under section 1402 of the federal act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the "Public Health Service Act," 124 Stat. 138, 42 U.S.C. 300gg-93 (2010), or the department of insurance, for any enrollee with a grievance, complaint, or question regarding their 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.

(D) The board shall award grants to individuals and entities approved by the board to perform work as navigators in order to fund the required duties described in division (C) of this section. Funds for grants shall be withdrawn from the Ohio health benefit exchange operating fund established in section 3965.12 of the Revised Code.

Sec. 3965.10. (A) Only qualified individuals shall be permitted to purchase health insurance through the exchange. A qualified individual is an individual, including a minor, who meets all of the following criteria:

(1) The individual is seeking to enroll in a qualified health plan offered to individuals through the exchange.

(2) The individual resides in this state.

(3) The individual is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges.

(4) The individual 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.

(B) If the executive director of the exchange program determines that an individual seeking to purchase health insurance through the exchange is eligible for the medicaid program under Title XIX of the "Social Security Act," 124 Stat. 328, 42 U.S.C. 1396 (2010), the children's health insurance program under Title XXI of the "Social Security Act," 111 Stat. 552, 42 U.S.C. 1397aa (1997), or any applicable state or local public program, the executive director shall enroll the individual in that program.

(C) An individual shall be exempt from the individual responsibility requirement under section 5000A of the "Internal Revenue Code of 1986," 124 Stat. 1215, or from the penalty imposed by that section for either of the following reasons:

(1) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual.

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

Sec. 3965.11. (A) As a part of the exchange there shall exist a SHOP exchange through which qualified employers may access coverage for their employees, and that shall enable any qualified employer to specify a level of coverage so that any of its

employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage.

(B) Only qualified employers shall be permitted to participate in the SHOP exchange. A qualified employer is 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, provided that the employer meets either of the following criteria:

(1) The employer has its principal place of business in this state and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed;

(2) The employer elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in this state.

(C) If an employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange would cease to be a small employer by reason of an increase in the number of its employees, the employer shall continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP exchange available to its employees.

Sec. 3965.12. (A)(1) The exchange agency may charge assessments or user fees to carriers or otherwise may generate funding necessary to support its operations and the operations of the exchange.

(2) All funds collected by the exchange agency pursuant to division (A)(1) of this section shall be paid into the state treasury to the credit of the Ohio health benefit exchange operating fund, which is hereby created.

(B) The exchange agency shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange agency and the exchange, and the administrative costs of the exchange agency and the exchange, on a web site to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

Sec. 3965.13. The board of the exchange agency and the executive director of the exchange may adopt rules to implement the provisions of this chapter. Rules adopted pursuant to this section shall not conflict with or prevent the application of regulations promulgated by the secretary under the federal act.

Sec. 3965.14. Nothing in this chapter, and no action taken by the board of the exchange agency or the executive director of the exchange pursuant to this chapter, shall be construed to preempt or supersede the authority of the superintendent of insurance to regulate the business of insurance within this state. Except as expressly provided to the contrary in this chapter, all carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and rules adopted and orders issued by the superintendent.

Section 2. That existing sections 124.14 and 3924.01 of the Revised Code are hereby repealed.

Section 3. Within ninety days after the effective date of this act, the exchange agency board of directors nominating council established in section 3965.04 of the Revised Code as enacted in this act shall produce two, three, or four nominees for each position described in division (A)(2) of section 3965.03 of the Revised Code. Following nomination, the Governor shall appoint the members described in that division to the board of the Ohio Health Benefit Exchange Agency in accordance with division (F) of

section 3965.04 of the Revised Code as enacted in this act. At the time of appointment, the Governor shall determine which members of the board shall serve the terms described in division (C)(1) of section 3965.03 of the Revised Code. For each subsequent nomination period, the nominating council shall produce four nominees for each position as required by division (D)(2) of section 3965.04 of the Revised Code.