COMMITTEE SUBSTITUTE

FOR

Senate Bill No. 408

(By Senators Minard, Foster, Jenkins, Kessler (Acting President), Chafin and Stollings)

_____

[Originating in the Committee on Health and Human Resources; reported February 16, 2011.]

_____

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article, designated §33-16G-1, §33-16G-2, §33-16G-3, §33-16G-4, §33-16G-5, §33-16G-6, §33-16G-7, §33-16G-8, §33-16G-9 and §33-16G-10, all relating generally to the health benefit exchange; setting forth purpose; defining terms; providing for the establishment of the West Virginia Health Benefit Exchange; establishing the governing board of directors; providing for membership on the board of directors; setting forth meeting requirements of the board of directors; allowing the board of directors to hire an executive director and appropriate staff; providing for an annual report by the board of directors; setting forth the functions of the exchange; outlining the board's duties and authority; setting forth a health benefit plan certification process; authorizing emergency and legislative rulemaking; establishing

a special revenue account; and authorizing assessment of fees.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new article, designated §33-16G-1, §33-16G-2, §33-16G-3, §33-16G-4, §33-16G-5, §33-16G-6, §33-16G-7, §33-16G-8, §33-16G-9 and §33-16G-10, all to read as follows:

ARTICLE 16G. WEST VIRGINIA HEALTH BENEFIT EXCHANGE ACT.

§33-16G-1. Purpose.

The purpose of this article is to establish a West Virginia Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state and a Small Business Health Options Program within the exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans.

§33-16G-2. Definitions.

For purposes of this article:

(a) "Board" means the board established in section five of this article.

(a) "Commissioner" means the West Virginia Insurance Commissioner.

(b) "Exchange" means the West Virginia Health Benefit Exchange established pursuant to section four of this article.

(c) "Federal Act" means the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law

111-152), and any amendments thereto, or regulations or guidance issued thereunder.

(d) "Free Choice Voucher" means those persons, groups or organizations set forth in section 10108 of the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

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

(1) "Health benefit plan" does not include:

(A) Coverage only for accident, or disability income insurance, or any combination thereof;

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

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

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics; or

(H) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(2) "Health benefit plan" also does not include 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, community-based care, or any combination thereof; or

(C) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(3) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

(B) Hospital indemnity or other fixed indemnity insurance.

(4) "Health benefit plan" does not include 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;

(B) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

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

(f) "Health carrier" or "carrier" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

(g) "Levels of Coverage" means those coverage levels set forth in section 1302 of the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). These levels shall be as follows:

(1) "Bronze level" means a plan shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(2) "Silver level" means a plan shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(3) "Gold level" means a plan shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the

benefits provided under the plan.

(4) "Platinum level" means a plan shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(h) "Navigator" means those persons, groups or organizations set forth in section 1311(i) of the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(i) "Public Health Service Act" or "PHSA" means the provisions of 42 U.S.C. §300g *et seq.*, and any amendments thereto, or regulations or guidance issued thereunder.

(j) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with this article.

(k) "Qualified employee" means the same as that term is used in the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(l) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) 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; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this state.

(m) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in this article.

(n) "Qualified individual" means a resident of this state or a state that is a party to a regional exchange with West Virginia who is seeking to enroll in a qualified health plan offered to individuals through the exchange, who is not incarcerated due to a conviction, and who 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.

(o) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(p) "SHOP Exchange" means the Small Business Health Options Program established under this article.

(q) "Small employer" means an employer that employed an average of not more than fifty employees during the preceding calendar year. An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange and that would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this article as long as

it continuously makes enrollment through the SHOP Exchange available to its employees. The board created in section five of this article has the authority to modify the maximum number of employees that constitute a small employer up to one hundred employees pursuant to the provisions of section 1304(b)(2) of the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

§33-16G-3. Establishment of exchange.

(a) There is established within the Office of the Insurance Commissioner an entity known as the West Virginia Health Benefit Exchange. This is a governmental entity of the state.

(b) The exchange shall:

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

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this article and any emergency and legislative rules promulgated pursuant to this article.

(c) The exchange may accept gifts, grants and bequests, contract with other persons, and enter into memoranda of understanding with other governmental agencies to carry out any of its functions, including agreements with other states to perform joint administrative functions. The provisions of article three, chapter five-a of this code relating to the Purchasing Division of

the Department of Administration do not apply to these contracts. The exchange may not enter into contracts with any health insurance carrier or an affiliate of a health insurance carrier.

(d) The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this article, provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

§33-16G-4. Duties of exchange.

(a) The exchange shall begin to make qualified health plans available to qualified individuals and qualified employers beginning no later than January 1, 2014, and it may not make available any health benefit plan that is not a qualified health plan: *Provided,* That the exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the federal act.

(b) The exchange shall, consistent with any applicable guidelines issued by the secretary and under the supervision of the board:

(1) Implement procedures for the certification, recertification and decertification of health benefit 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;

(4) Maintain an Internet website and a toll-free telephone line through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(5) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary and determine each qualified health plan's level of coverage;

(6) Use a standardized format for presenting health benefit options in the exchange;

(7) Inform individuals of eligibility requirements for the Medicaid program, the Children's Health Insurance Program or any applicable state or local public program, and provide for the enrollment of any individual determined to be eligible for any such program;

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any applicable premium tax credit or cost-sharing reduction;

(9) Establish a SHOP Exchange through which qualified employers may access coverage for their employees;

(10) Grant a certification attesting that an individual is

exempt from the individual responsibility requirement or from the penalty imposed by federal law;

(11) Transfer to the United States Secretary of the Treasury the name and taxpayer identification number of each individual who:

(A) Was issued a certification under subdivision (10) of this subsection;

(B) Was an employee who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because either the employer did not provide minimum essential coverage or the employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value;

(C) Notifies the Exchange that he or she has changed employers; and

(D) Ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(12) Provide to each employer the name of each employee of the employer described in paragraph B, subdivision (11) of this subsection 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 or the 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 the Federal Act and standards developed by the secretary, and award grants to enable navigators to:

(A) Educate the public about the availability of qualified health plans and of premium tax credits and cost-sharing reductions;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the consumer services division of the West Virginia offices of the Insurance Commissioner or any other appropriate state agency for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(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 plan in which a qualified employee is enrolled, in accordance with the federal act, and collect the amount credited from the offering employer;

(17) Consult with stakeholders relevant to carrying out the activities required under this article; and

(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 Legislature a report concerning such accountings:

(B) Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the Federal Act and allow the secretary, in coordination with the Inspector General of the United States Department of Health and Humans Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(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.

(c) Prior to 2016, the requirements of this section are contingent with the availability of sufficient funding, and in the event of a decrease in anticipated funding from the federal government or other sources, the board may reassess the feasibility of meeting each of the requirements listed in this section and make

appropriate adjustments to the functions of the exchange as are deemed necessary.

§33-16G-5. Establishment of governing board of the exchange.

(a) The exchange shall operate subject to the supervision and control of a governing board. The powers conferred upon the board by this article and the carrying out of its purposes and duties shall be considered to be essential governmental functions and for a public purpose.

(b) The board shall be composed of the following members:

(1) Four voting *ex officio* members: The Commissioner, who shall serve as the board's chairperson; the Commissioner of the West Virginia Bureau for Medical Services; the Director of the West Virginia Children's Health Insurance Program; and the Chair of the West Virginia Health Care Authority. *Ex officio* members may designate a representative to serve in his or her place;

(2) Four persons appointed by the Governor with advice and consent of the Senate, each to represent the interests of one of the following groups: Individual health care consumers; small employers; organized labor; and insurance producers;

(3) One person to represent the interests of payers who is selected by majority vote of an advisory group comprising representatives of the ten carriers with the highest health insurance premium volume in this state in the preceding calendar year, as certified by the commissioner. Beginning in 2014, the advisory group shall be comprised only of representatives of those carriers that are offering qualified plans in the exchange

regardless of premium volume: *Provided,* That the member selected pursuant to this paragraph may not be an employee of a carrier or an affiliate of a carrier eligible to select such member; and

(4) One person to represent the interests of health care providers selected by the majority vote of an advisory group comprised of a representative of each of the following: West Virginia Association of Free Clinics, West Virginia Hospital Association, West Virginia State Medical Association, West Virginia Primary Care Association, West Virginia Nurses Association, West Virginia Society of Osteopathic Medicine, West Virginia Academy of Family Physicians, West Virginia Pharmacists Association, West Virginia Dental Association, West Virginia Behavioral Health Care Providers, West Virginia Chiropractic Society, West Virginia Optometric Association, West Virginia Podiatric Medical Association and a full-time director of a county or regional health department selected by all full-time directors of all county or regional health departments.

(5) Selection of board members pursuant to paragraphs (3) and (4) of this subdivision shall be conducted in a manner and at such times designated by the commissioner acting as chair of the board.

(6) Each member appointed pursuant to paragraph (2) of of this section or selected pursuant to paragraph (3) or (4) of this subsection shall serve a term of two years and is eligible to be reappointed. Any appointed or selected member whose term has expired may continue to serve until either he or she has been reappointed or his or her successor has been duly appointed or

selected.

(c) Board members may be removed by the Governor for cause.

(d) Members of the board are not entitled to compensation for services performed as members but are entitled to reimbursement for all reasonable and necessary expenses actually incurred in the performance of their duties.

(e) Seven members of the board constitute a quorum, and the affirmative vote of six members is necessary for any action taken by vote of the board. No vacancy in the membership of the board impairs the rights of a quorum by such vote to exercise all the rights and perform all the duties of the board.

(f) The board may employ an executive director who has overall management responsibility for the exchange and such employees as may be necessary. The executive director and employees of the exchange shall receive a salary as provided by the board. The executive director and all employees of the board are exempt from the classified service and not subject to the procedures and protections provided by article two, chapter six-c of this code and article six, chapter twenty-nine of this code;

(g) The board has the authority to modify the definition of a small employer as set forth in subsection (q), section two of this article to provide that a small employer may mean an employer that employed an average of not more than one hundred employees during the preceding calendar year consistent with section 1304(b)(2) of the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education

Reconciliation Act of 2010 (Public Law 111-152).

(h) The board shall make an annual report to the Governor and also file it with the Joint Legislative Committee on Government and Finance. The report shall summarize the activities of the exchange in the preceding calendar year.

(i) Neither the board nor its employees are liable for any obligations of the exchange. No member of the board or employee of the exchange is liable and no cause of action of any nature may arise against them for any act or omission related to the performance of their powers and duties under this article unless the act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

§33-16G-6. Health benefit plan certification.

(a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package of the federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans if;

(A) the exchange has determined that at least one qualified dental plan is available to supplement the plans's coverage; and

(B) the carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits, and 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 commissioner;

(3) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act and implementing rules for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under the federal act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under the federal act;

(5) The health carrier offering the plan:

(A) Is licensed and in good standing to offer health insurance coverage in this state;

(B) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the exchange for individual coverage;

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

(D) Does not charge any cancellation fees or penalties in

violation of subsection (c), section five of this article; and

(E) Complies with the regulations developed by the secretary under section 1311(d) of the Federal Act, implementing rules and such other requirements as the exchange may establish;

(6) The plan meets the requirements of certification as set forth in emergency and legislative rules promulgated pursuant to section eight of this article, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

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

(b) The exchange may not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

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

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

(c) The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently

post the information on its Internet website and through the toll-free telephone line. The exchange shall take this information, along with the information and the recommendations provided to the exchange by the commissioner, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

(2) Make available to the public and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of the following:

(A) Claims payment policies and practices;

(B) Periodic financial disclosures;

(C) Data on enrollment;

(D) Data on disenrollment;

(E) Data on the number of claims that are denied;

(F) Data on rating practices;

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

(H) Information on enrollee and participant rights under title I of the Federal Act; and

(I) Other information as determined appropriate by the secretary; and

(3) Permit individuals to learn, in a timely manner upon the request, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for with respect to the furnishing of a specific item or service by a participating

provider. At a minimum, this information shall be made available to the individual through an Internet website, a toll-free telephone line and through other means for individuals without access to the Internet.

(d) The exchange may not exempt any health 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 health carriers participating in the exchange.

(e) The provisions of this article that are applicable to qualified health plans also apply to the extent relevant to qualified dental plans except as modified as follows:

(1) the carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(2) the plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange or the Secretary shall prescribe in rules or regulations; and

(3) 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.

§33-16G-7. Funding; publication of costs.

(a) On and after July 1, 2011, the board is authorized to assess fees on health carriers licensed in this state, including health carriers that do not participate in the exchange, and shall establish the amount of such fees and the manner of the remittance and collection of such fees in legislative rules. Fees shall be based on premium volume of health insurance in this state and shall be for the purpose of operation of the exchange.

(b) The exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the exchange, and the administrative costs of the exchange, on an Internet website to educate consumers on such costs. This information shall include information on moneys lost to waste, fraud and abuse.

§33-16G-8. Rules.

The exchange may promulgate emergency and legislative rules for adoption by the Legislature pursuant to the provisions of article three, chapter twenty-nine-a of this code to implement the provisions of this article. Emergency or legislative rules promulgated under this section may not conflict with or prevent the application of the federal act or regulations promulgated by the secretary under such act.

§33-16G-9. Relation to other laws.

Nothing in this article, and no action taken by the exchange

pursuant to this article, preempts or supersedes the authority of the commissioner to regulate the business of insurance within this state and, except as expressly provided to the contrary in this article, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.

§33-16G-10. Special revenue account created.

(a) There is hereby created a special revenue account in the State Treasury, designated the "West Virginia Health Benefits Exchange Fund," which shall be an interest-bearing account and may be invested in the manner permitted by article six, chapter twelve of this code, with the interest income a proper credit to the fund, unless otherwise designated in law. The fund shall be administered by the board and used to pay all proper costs incurred in implementing the provisions of this article. Moneys deposited into this account are available for expenditure as the board may direct in accordance with the provisions of this article. Expenditures shall be for the purposes set forth in this article, are authorized from collections and do not revert to the General Fund.

(b) The following shall be paid into this account:

(1) All funds from the federal government received and dedicated to or otherwise able to be used for the purposes of this article;

(2) All other payments, gifts, grants, bequests or income from any source;

(3) Fees on health carriers established by the board; and

(4) Appropriations from the Legislature.

NOTE: The purpose of this bill is to provide for a health insurance exchange in accordance with the Patient Protection and Affordable Care Act.

This article is new; therefore, underscoring and strike-throughs have been omitted.