11.0806.02000

Sixty-second
Legislative Assembly
of North Dakota

SECOND DRAFT:
Prepared by the Legislative Council staff for the
Health Care Reform Review Committee
October 2011

Introduced by

A BILL for an Act to create and enact chapter 54-66 of the North Dakota Century Code, relating to creation of a North Dakota health benefit exchange; to provide a statement of legislative intent; to provide an appropriation; to provide a continuing appropriation; to provide an effective date; and to provide for a contingent expiration date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 54-66 of the North Dakota Century Code is created and enacted as follows:

54-66-01. Definitions.

As used in this ~~Act~~chapter, unless the context otherwise requires:

1. "Board" means the North Dakota health benefit exchange board.
2. "Commissioner" means the insurance commissioner.
3. "Defined benefit plan" means a health benefit plan through which a qualified employer provides a fixed percentage of contribution toward the employee or dependent premium and the qualified employer designates one or more benefit plans from which employees may choose. An employer contribution may vary based upon premium increases and based upon the employer's choice of plan design.
4. "Defined contribution plan" means a health benefit plan through which a qualified employer provides a fixed monetary contribution toward the employee or dependent premium and the employee chooses to enroll in one or more benefit plans of the employee's choice from the carrier of the employee's choice offered on the exchange. Any premiums with the chosen benefit plan which exceed the fixed monetary contribution are costs borne by the employee.
5. "Division" means the office of management and budget health benefit exchange division.

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

~~6.~~7. "Essential health benefits" has the meaning provided under section 1302(b) of the federal act.

~~7.~~8. "Exchange" means the North Dakota health benefit exchange established under this ~~Act~~chapter.

~~8.~~9. "Federal act" means the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the federal Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

~~9.~~10. "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. The term does not include:

a. Coverage limited to accident or disability income insurance or for 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 onsite medical clinics;

h. Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.], under which benefits for health care services are secondary or incidental to other insurance benefits;

i. The following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof; or

(3) Other similar, limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.];

j. 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:

(1) Coverage limited to a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance; or

k. The following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)];

(2) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services [10 U.S.C. ch. 55]; or

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

~~10.~~11. "Health carrier" or "carrier" means an entity subject to the insurance laws and rules of this state or which is subject to the jurisdiction of the commissioner which contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term may include a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, and any other entity providing a plan of health insurance, health benefits, or health services.

~~11.~~12. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section ~~9 of this Act~~54-66-10.

~~12.~~13. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the

exchange, and at the option of the employer, some or all of the employer's part-time employees, provided that the employer:

a. Has the employer's principal place of business in North Dakota and elects to provide coverage through the ~~small business health options programs~~ exchange to the employer's eligible employees, wherever employed; or

b. Elects to provide coverage through the ~~small business health options~~ exchange to all of the employer's eligible employees who are principally employed in North Dakota.

~~13.~~14. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described under section 1311(c) of the federal act and section ~~9 of this Act~~54-66-10.

~~14.~~15. "Qualified individual" means an individual, including a minor, who:

a. Is seeking to enroll in a qualified health plan offered to individuals through the exchange;

b. Resides in this state;

c. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

d. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

~~15.~~16. "Secretary" means the secretary of the federal department of health and human services.

~~16.~~17. "Small employer" means an employer that employed an average of at least ~~two~~one but not more than fifty employees during the preceding calendar year~~; however, by rule the commissioner may revise this definition to provide for a maximum number of employees in excess of fifty employees~~ and which employs at least one employee on the first day of the plan year. For purposes of this subsection~~:~~

~~a. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 must be treated as a single employer;~~

~~b. An employer and any predecessor employer must be treated as a single employer;~~

~~c. All~~all employees must be counted in accordance with ~~state and~~section 1304(b) of the federal ~~law~~ act~~;~~

~~d. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees which is reasonably expected that employer will employ on business days in the current calendar year; and~~

~~e. An employer that makes enrollment in qualified health plans offered in the small group market available to its employees through the exchange, and would cease to be a small employer by reason of an increase in the number of employees, shall continue to be treated as a small employer for purposes of this Act as long as the employer continuously makes enrollment in qualified health plans available to its employees~~.

NOTE: Revisions to the definition of "small employer" are made per the recommendation of the Insurance Department. Although the ACA defines "small employer" as groups from 1 to 100 employees; the ACA also provides that for plan years beginning before January 1, 2016, states may treat 50 employees as small employees. As revised, this definition follows the ACA definition; however, limits the small group to no more than 50 employees.

NOTE: Additional research may be required to determine whether the state may increase the small employer definition to two employees.

NOTE: The committee may wish to consider whether this definition should be consistent with the "small employer" definition in the small employer employee health insurance law--Section 26.1-36.3(32).

NOTE: This definition will need to be amended by January 1, 2016, to increase from 50 employees to 100 employees.

54-66-02. Establishment of health benefit exchange division - ~~Board~~North Dakota health benefit exchange board - ~~Taxation~~North Dakota health benefit exchange.

1. The health benefit exchange division is created as a division of the office of management and budget. The division is under the control of the North Dakota health benefit exchange board. The board members are appointed by the governor and the board is under the supervision of the director of the office of management and budget. The board is an agency under chapter 28-82. The board shall appoint an executive director. The position of executive director is not a classified position and the executive director serves at the pleasure of the board.

2. The ~~North Dakota health benefit exchange~~ board shall establish and administer the ~~North Dakota health benefit~~ exchange. The exchange is established to facilitate access to qualified health plans. Except as provided under this chapter or directed by the federal act, neither the board nor the exchange may duplicate or replace the duties of the commissioner established under chapter 26.1-01~~, including rate approval~~. All carriers authorized to conduct business in this state may be eligible to participate in the exchange.

~~2.~~3. ~~The office of management and budget shall provide the board with administrative and personnel services.~~ The board shall govern the operation of the exchange and shall determine and establish the development~~,~~ and governance~~, and operation~~ of the exchange. ~~The board is an agency under chapter 28-32.~~ The board shall implement and operate the exchange in accordance with this ~~Act~~chapter and take all actions necessary to ensure by January 1, 2013, or other date specified by the commissioner, consistent with federal law, that the exchange is determined by the federal government to be ready to operate by January 1, 2014, or later as otherwise specified by the commissioner and consistent with federal law.

NOTE: Revise section per committee directive and discussions with the Office of Management and Budget (OMB) to provide for creation of a new division to OMB, clarification of chain of command, and clarification of appointment of executive director.

54-66-03. Board - Organization.

1. The board is made up of five voting members and two nonvoting ex officio members. The commissioner or the commissioner's designee and the executive director of the department of human services or the executive director's designee are the ex officio nonvoting members. By January 1, 2012, the governor shall appoint ~~a board member who represents~~the five voting members, one of whom must represent the health insurance industry, ~~a board member who represents~~one of whom must represent small group employer interests, and ~~a board member who represents~~three of whom must represent consumer interests.

2. When the governor appoints each of the board members who represent consumer interests, the governor shall select the member from a list of at least three nominees created by submission of a single nominee from at least three statewide consumer entities identified by the governor, such as the community action association, Catholic

family services, and Lutheran social services. If the names submitted are unacceptable because the nominees do not meet the requirements of subsection 3, the governor shall clarify the missing qualification, shall request additional nominees, and shall select the member from the list of qualified nominees.

3. In appointing the board members the governor shall consider whether the board has expertise in the following areas: individual health benefit plans, small employer health benefit plans, health benefit plan administration and infrastructure, health care actuarial science, health care finance, public health care delivery, health benefit plan law, consumer advocacy, and marketing. In appointing board members the governor shall assure that a majority of the board's voting members have relevant experience in health benefit administration, health care finance, health plan purchasing, health care delivery system administration, health policy issues related to the small group and individual markets, health policy issues related to the uninsured, and public health.

~~2.~~4. The board members shall elect a voting member to serve as chairman.

~~3.~~5. Except for the initial board member appointments, which must be staggered so no more than ~~one term expires~~two terms expire each year and no more than one consumer representative's term expires each year, the term for a board member is three years. Each board member shall hold office until expiration of the member's term; until the member's successor is appointed; or until the member's death, resignation, or removal. An individual appointed to fill a midterm vacancy shall serve for the remainder of the unexpired term. A board member may serve no more than two consecutive full terms, after which a lapse must occur before reappointed.

~~4.~~6. In determining voting rights at board meetings, each member~~, including an ex officio member, is entitled to~~ may vote in person or by proxy. The ~~exchange~~division may not compensate a board member, except the ~~exchange~~division may reimburse a voting board member from the money of the exchange for direct expenses incurred as a board member.

~~5.~~7. A majority of the voting board members constitutes a quorum for the transaction of business. If a vacancy exists, a majority of the remaining voting board members constitutes a quorum until the vacancy is filled.

~~6.~~8. A board member may resign at any time by giving written notice to the board chairman. A resignation takes effect at the time the resignation is received unless the resignation specifies a later date. The governor, in consultation with the director of the office of management and budget, may remove a board member for cause. ~~If a vacancy occurs for a board member, the governor shall appoint a new board member for the duration of the unexpired term.~~

~~7.~~9. ALTERNATIVE A - The governor may not appoint a board member if that individual's participation in deliberations before or voting of the board would constitute a conflict of interest. A board member may not participate in deliberations or vote on any matter before the board if ~~the board member has a~~to do so would result in a conflict of interest. A conflict of interest means an association, including an economic interest or personal association, that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to the exchange or the conduct of activities under this ~~Act~~chapter.

NOTE: This new language is based on Senator Tim Mathern's bill draft [11.0802.02000] which was based on Washington's health benefit exchange law. This approach would prohibit all voting board members from having conflicts.

9. ALTERNATIVE B - The governor may not appoint a board member representing consumers if that individual's participation in deliberations before or voting of the board would constitute a conflict of interest. A conflict of interest means an association, including an economic interest or personal association, that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to the exchange or the conduct of activities under this chapter.

NOTE: This new language is limited to the board members representing consumer interests. The proposed Department of Health and Human Services (HHS) rules [Section 155.110(c)(3)] requires that a governing board "represents consumer interests by ensuring that overall governing board membership is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance." This federal regulation implies it may be acceptable for each of the nonconsumer representatives to have a conflict of interest.

9. ALTERNATIVE C - The board shall adopt rules to address how the board will deal with board member conflict of interest issues when they arise. These rules must include a definition of what constitutes a conflict of interest; a board member duty to disclose a conflict of interest, possible conflict of interest, or circumstances that the public may

perceive to be a conflict of interest; and a protocol the board will follow if a conflict of interest arises. The rules may allow, limit, or prohibit participation in board deliberation or voting by a board member with a disclosed conflict of interest.

NOTE: The approach to this option is based upon the actions the Comprehensive Health Association of North Dakota (CHAND) has taken to address conflict of interest issues for its board.

10. Each voting board member shall file with the secretary of state a statement of interest in a manner as prescribed by section 16.1-09-03. Failure to disclose a statement of interest constitutes cause for removal from the board. Each board member is responsible for acting in the interest of the public in discharging the board member's duties.

~~8.~~11. All meetings of the board, its advisory groups, and any board committees must comply with section 44-04-19, except those portions of meetings at which the review or discussion of data on individuals ~~and~~or confidential premium rate information ~~submitted by health carriers before such rates are approved by the commissioner~~ is discussed, must be closed.

NOTE: The revision addresses concerns the Insurance Department raised.

~~9.~~12. In the performance of their duties as board members, the board members are exempt from the provisions of chapter 51-08.1.

NOTE: Revisions to this section increase the board from five members to seven members, adding two additional consumer representatives; provide the two ex officio members are nonvoting members; clarify the employer representative represents small group employer interests; provide a nominee mechanism for the Governor to appoint the members who represent consumer interests; revise reference from "actuarial" to "actuarial science"; include board requirements included in Section 155.110(c) of the HHS proposed rules; and provide the voting members are to select a board chairman from among the voting board members.

54-66-04. Consumer advisory group.

1. Within sixty days following the initial appointment of board members, the board shall establish an eleven-member consumer advisory group for the purpose of facilitating input from a variety of stakeholders on issues related to the duties and operation of the exchange and related issues.

2. Membership of the consumer advisory group must include:

   a. An educated health care consumer who is or will be an enrollee in a qualified health plan;

b. An agent or broker;

c. A representative of large businesses, a representative of small businesses, and a representative of self-employed individuals;

d. A representative of a health carrier that offers or will offer a qualified health plan through the exchange;

e. A representative of a health carrier that does not offer a qualified health plan through the exchange;

f. Representatives of health care providers; and

g. A representative of labor.

NOTE: Section 155.130 of the HHS proposed rules provides the exchange shall "regularly consult on an ongoing basis" with a specified list of stakeholders. The stakeholders included in the federal rule is broader than the list provided for under this section. It may be necessary to expand this list to comply with the federal rules. Additionally, the committee may wish to consider changing the name of this advisory group from "consumer" to "stakeholder" in order to avoid confusion with the board members who represent consumer interests.

54-66-05. Board - Exchange - Duties.

1. The board may establish temporary advisory groups as appropriate to carry out the activities required under this ~~Act~~chapter.

2. The board shall ~~develop and the board~~adopt rules as provided under this subsection and the board, division, and exchange shall operate in accordance with ~~a plan of operation~~these rules. The ~~plan of operation~~rules must:

a. Provide for the operation and governance of the exchange;

b. Establish the procedure for the board to elect or appoint officers, including ~~hiring~~appointment of an executive director ~~of the exchange~~;

c. Establish the manner of board voting;

d. Establish a program to publicize the existence of the exchange, eligibility requirements for purchasing qualified health plans through the exchange, subsidies offered for purchasing qualified health plans offered through the exchange, and enrollment procedures and establish a program to foster public awareness of the exchange;

e. Establish criteria and procedures for certifying qualified health plans in conformity with, and not to exceed the requirements of, the federal act;

f. Establish document retention policies and procedures; and

g. Provide for an annual, independent financial audit of all the books and records of the exchange and a report of the independent audit must be available to the public.

3. The ~~exchange~~division may contract with ~~an eligible entity for any~~one or more eligible entities to carry out one or more of the exchange's functions ~~described in this Act~~. For purposes of this subsection, an eligible entity has the same meaning as under the federal act ~~may not be a health carrier and must be a person that is incorporated under, and subject to the laws of one or more states which has demonstrated experience on a state or regional basis in the individual or small group health insurance markets, or in benefits administration or which has demonstrated experience in particular functions necessary in the specific operation of the exchange that is being contracted for~~.

NOTE: The Insurance Department raised concern regarding the definition of "eligible entity." This revision should make the definition consistent with Section 155.110(a) of the HHS proposed rules.

4. The ~~exchange~~division may enter information sharing agreements with federal and state agencies and other state exchanges to carry out the exchange's responsibilities under this ~~Act~~chapter 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. The ~~exchange~~board shall establish procedures and safeguards to protect the integrity and confidentiality of any data the exchange maintains.

5. In recognition of the government-to-government relationship between the state and the federally recognized tribes in the state, the board shall consult with the Indian affairs commission and shall invite the executive director of the Indian affairs commission to board meetings.

NOTE: This subsection is revised to add the language from Senator Mathern's bill draft regarding the Indian Affairs Commission.

54-66-06. Exchange requirements.

1. ~~The~~By January 1, 2014, or later as directed by the commissioner in compliance with federal law, the exchange shall make qualified health plans available to qualified individuals and qualified employers ~~beginning with effective dates by January 1, 2014, or later as directed by the commissioner in compliance with federal law.~~

2. The exchange may not make available any health benefit plan that is not a qualified health plan and may not make available any health plan for which product language and premium rates have not been approved by the commissioner.

3. The commissioner shall provide the exchange the following related to all premium rate filings by health carriers offering qualified health plans:

a. For premium rates approved as filed, the following certification by the health carrier's qualified actuary: "In my opinion, the premium rates to which this certification applies have been calculated according to generally accepted actuarial practices and are neither excessive, inadequate, nor unfairly discriminatory".

b. For premium rates modified through the rate approval process:

(1) The ~~certification provided in subdivision a~~following certification by the commissioner's qualified actuary: "In my opinion, the premium rates to which this certification applies have been calculated according to generally accepted actuarial practices and are neither excessive, inadequate, nor unfairly discriminatory"; and

(2) A statement by the commissioner's actuary identifying calculations or assumptions or both underlying the carrier's filed rates that were unreasonable to the actuary and which necessitated modification of the premium rates.

c. For premium rates disapproved, a statement by the commissioner's actuary identifying calculations or assumptions or both underlying the carrier's filed rates that were unreasonable to the actuary and which necessitated disapproval.

NOTE: The Insurance Department raised concerns regarding subsection 3, and these issues have not been addressed in this revision.

4. 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.

5. Neither the exchange nor a carrier offering health benefit plans through the exchange may 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.

6. In accordance with section 1312(b) of the federal act, the exchange may not prohibit a qualified individual enrolled in a qualified health plan offered through the exchange from paying any applicable premium owed by the qualified individual to the health carrier issuing the qualified health plan.

7. The exchange may make a qualified health plan available notwithstanding any provision of state law that may require benefits other than the essential health benefits specified under section 1302(b) of the federal act. This section does not preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits specified under section 1302(b), including wellness programs.

8. As required by section 1311(d)(3)(B)(ii) of the federal act, to the extent ~~that~~ state law or regulation requires that a qualified health benefit plan offer benefits in addition to the essential health benefits specified under section 1302(b), the state shall make direct payments to an individual enrolled in a qualified health benefit plan or on behalf of an individual in order to defray the cost of any additional benefits directly to the qualified health benefit plan in which such individual is enrolled. To the extent that such funding to defray the cost for such additional benefits is not provided by the state, the qualified health plan is not required to provide such additional benefits.

9. Any standard or requirement adopted by the state pursuant to title I of the federal act~~, or any amendment to state legislation made by title I of the federal act,~~ must be applied uniformly to all health benefit plans in each insurance market to which the standard and requirements apply.

NOTE: This revision is made at the recommendation of the Insurance Department.

10. The exchange shall foster a competitive marketplace for insurance and may not solicit bids or engage in the active purchasing of insurance.

11. The exchange may not preclude the sale of health benefit plans through mechanisms outside the exchange, nor may the exchange preclude a qualified individual from enrolling in, or a qualified employer from selecting for the qualified employer's employees, a health benefit plan offered outside of the exchange.

12. The exchange may not prohibit a qualified individual from enrolling in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e) of the federal act, a qualified individual may enroll in the catastrophic plan only if the individual is eligible to enroll under section 1302(e)(2) of the federal act.

13. For employers that choose to offer defined contribution plans to qualified individuals, the exchange shall provide the option of choosing either an employee choice or an employer choice method of enrollment into the exchange. For employers that choose to offer defined benefit plans, the exchange shall allow the employer to designate the health benefit plans available for the employees. Designated health benefit plans may be limited by the employer to a specific carrier or one or more specific qualified health plans.

54-66-07. Exchange - Duties.

The exchange shall:

1. Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311(c) of the federal act and section ~~9 of this Act~~54-66-10, 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, as provided under section 1311(c)(6) of the federal act.

4. Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.

5. Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311(c)(3) of the federal act~~,~~ and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the federal act.

6. Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the federal Public Health Service Act.

7. In accordance with section 1413 of the federal act, inform individuals of eligibility requirements for the medicaid program under title XIX of the Social Security Act, the children's health insurance program under title XXI of the Social Security Act, or any applicable state or local public program and if through screening of the application by the exchange the exchange determines that any individual is eligible for any such program, enroll that individual in that program.

8. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the federal act.

9. Establish a process through which qualified employers may access coverage for their employees, to enable any qualified employer to specify a level of coverage so that any of the qualified employer's employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage.

10. Subject to section 1411 of the federal act, grant a certification attesting that for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

a. There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

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

11. Transfer to the federal secretary of the treasury the following:

a. A list of the individuals who are issued a certification under subsection ~~9~~10, including the name and taxpayer identification number of each individual;

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(1) The employer did not provide minimum essential coverage; or

(2) 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; and

c. The name and taxpayer identification number of:

(1) Each individual who notifies the exchange under section 1411(b)(4) of the federal act of the fact that ~~he or she~~the employee has changed employers; and

(2) Each individual who 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 subdivision b of subsection 11 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 section 1311(i) of the federal act and with standards developed by the secretary. The minimum qualifications to be a navigator must include the requirement that the navigator be an insurance producer licensed under chapter 26.1-26 and comply with continuing education requirements established by the commissioner which specifically address the provision of services as a navigator.~~

~~15. Award grants to enable navigators to:~~

~~a. Conduct public education activities to raise awareness of the availability of qualified health plans;~~

~~b. Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the federal act;~~

~~c. Facilitate enrollment in qualified health plans;~~

~~d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the federal Public Health Service Act, or any other appropriate state agency for~~

~~any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan or coverage or regarding 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.~~

NOTE: The text of subsections 4 and 5 has been moved to Section 54-66-08.

~~16.~~14. Consider the rate of premium growth within the exchange and outside the exchange in developing recommendations on whether to continue limiting qualified employer status to small employers.

~~17.~~15. 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 legislative management 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 federal department of health and human services, to:

(1) Investigate the affairs of the exchange;

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

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

c. In carrying out the exchange's activities under this ~~Act~~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.

NOTE: As a state agency, the language of this subdivision may not be necessary.

~~18.~~16. As authorized under section 1312(e) of the federal act, allow agents or brokers to:

a. Enroll qualified individuals and qualified employers in any qualified health plans in the individual or small group market as soon as the plan is offered through the exchange in the state; and

b. Assist qualified individuals applying for premium tax credits and cost-sharing reductions for plans sold through the exchange.

54-66-08. Navigators.

1. The board shall determine what entities are qualified to serve as navigators in accordance with section 1311(i) of the federal act, in accordance with standards developed by the secretary, and as provided under this section. The board shall include entities from at least two of the categories as required under the federal act. The board's minimum qualifications to be a navigator must include:
   a. The navigator must be an insurance producer licensed under chapter 26.1-26 and comply with continuing education requirements established by the commissioner which specifically address the provision of services as a navigator;
   b. The navigator may not have a conflict of interest during the term as navigator;
   c. The navigator may not be a health insurance issuer; and
   d. The navigator may not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a qualified health plan.

NOTE: Subdivisions b, c, and d reflect the language of HHS proposed rule Section 155.210.

2. The board shall award grants to enable navigators to:
   a. Conduct public education activities to raise awareness of the availability of qualified health plans;
   b. Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the federal act;
   c. Facilitate enrollment in qualified health plans;
   d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the federal Public Health Service Act, or any other appropriate state agency for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan or coverage or regarding 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.

NOTE: This is a newly created section. Based on the language of the previous version of the bill draft, it retains the requirement that a navigator be a licensed producer and is also revised to include language from Section 155.210 of the HHS proposed rules. Section 155.210(b)(2) provides at least two of the following categories must receive a "navigator grant:

(i) Community and consumer-focused nonprofit groups;

(ii) Trade, industry, and professional associations;

(iii) Commercial fishing industry organizations, ranching and farming organizations;

(iv) Chambers of commerce;

(v) Unions;

(vi) Resource partners of the Small Business Administration;

(vii) Licensed agents and brokers; and

(viii) Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies."

54-66-09. ~~Fiduciary duties - Licensure -~~ Risk pool.

~~1. Any person that acts on behalf of the exchange shall act as a fiduciary. Such person shall ensure that the exchange is operated solely in the interests of qualified individuals and qualified employers participating in qualified health plans offered through the exchange, and operated for the exclusive purpose of facilitating the purchase of qualified health plans.~~

~~2. Any person that acts as a fiduciary on behalf of the exchange which breaches any of that person's responsibilities, obligations, or duties imposed by this section is liable to make good to the exchange, the qualified health plans offered through the exchange, or participants of qualified health plans offered through the exchange, any losses resulting from each breach, and is subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.~~

~~3. If an individual sells, negotiates, or solicits insurance as defined in section 26.1-26-02, in enrolling a qualified individual in a qualified health plan, the individual must be licensed as an insurance producer under chapter 26.1-26.~~

~~4.~~ In accordance with section 1312(c) of the federal act~~:~~

~~a.~~ ~~Except~~, except for grandfathered health plans, a health carrier shall consider all enrollees in all health plans members of a single risk pool offered by such carrier in the individual market, including those enrollees who do not enroll in such plans through the individual exchange~~.~~

~~b. Other~~ and other than grandfathered health plans, a health carrier shall consider all enrollees in all health plans offered by such carrier in the small group market, including those enrollees who do not enroll in such plans through the exchange, to be members of a single risk pool.

NOTE: This revision is in response to the concern raised by the Insurance Department. If this fiduciary language is retained in the bill draft, additional information will be required regarding exactly who is bound by this duty, what would occur if there are two or more conflicting duties, and how this duty coexists with other duties state employees may have.

54-66-10. Health benefit plan certification.

1. The exchange shall certify a health benefit plan as a qualified health plan if:

a. The health benefit plan provides the essential health benefits package described in section 1302(a) of the federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection 5, if:

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

(2) In a form approved by the exchange, the carrier makes prominent disclosure at the time the carrier offers the plan 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;

b. The premium rates and contract language have been approved by the commissioner;

c. The health benefit plan provides at least a bronze level of coverage, as determined pursuant to subsection 5 of section ~~7 of this Act~~54-66-07, unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the federal act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

d. The health benefit 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 to a qualified employer, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the federal act;

e. The health carrier offering the health benefit plan:

(1) Is licensed and in good standing to offer health insurance coverage in North Dakota;

(2) Offers through the exchange at least one qualified health plan in the silver level and at least one plan in the gold level;

(3) Charges the same premium rate for each health benefit 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;

(4) Does not charge any cancellation fees or penalties in violation of subsection 5 of section ~~6 of this Act~~54-66-06; and

(5) Complies with the regulations developed by the secretary under section 1311(d) of the federal act and such other requirements as the exchange may establish;

f. The health benefit plan meets the requirements of certification as promulgated by the secretary under section 1311(c)(1) of the federal act, which include 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

g. The exchange determines that making the health benefit plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

2. The exchange may not exclude a health benefit plan:

a. On the basis that the plan is a fee-for-service plan;

b. Through the imposition of premium price controls by the exchange; or

c. 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.

3. Notwithstanding subsection 2, a health carrier that does not offer a qualified health plan in the exchange during the initial and subsequent annual open enrollment periods, is prohibited from offering a qualified health plan in the exchange before the

following annual open enrollment period. The exchange may permit a health carrier that did not offer a qualified health plan in the exchange during the initial and subsequent annual open enrollment periods to begin offering a qualified health plan before the following annual open enrollment period if the exchange determines that it is in the interest of qualified individuals and qualified employers in this state.

4. Except as otherwise provided in subsections 2 and 3, a health carrier that ceases to offer any qualified health plans in the exchange after January first of a plan year is prohibited from offering a new qualified health plan in the exchange for a period of two years from the date of the health carrier's exit from the exchange. This subsection does not prohibit an affiliated health carrier from continuing to offer a qualified health plan in the exchange. The exchange may permit a health carrier that ceases to offer any qualified health plans in the exchange after January first of a plan year to begin offering a new qualified health plan in the exchange if the exchange determines that making the qualified health plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

5. The exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to:

   a. Submit verification that any premium increase was approved by the commissioner before implementation of that increase. The carrier shall post prominently the information on the carrier's internet website. The exchange shall take this information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the federal Public Health Service Act, into consideration when determining whether to allow the carrier to make health benefit plans available through the exchange;

   b. In plain language, as that term is defined in section 1311(e)(3)(B) of the federal act, make available to the public and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of the following:

      (1) Claims payment policies and practices;

      (2) Periodic financial disclosures;

      (3) Data on enrollment;

      (4) Data on disenrollment;

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

(6) Data on rating practices;

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

(8) Information on enrollee and participant rights under title I of the federal act; and

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

c. Provide in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance under the individual's health benefit 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 must be made available to the individual through an internet website and through other means for individuals without access to the internet.

6. 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 ensures parity between or among health carriers participating in the exchange.

54-66-11. Qualified dental plans.

Except as otherwise provided under this section, to the extent relevant, the provisions of this ~~Act~~chapter which are applicable to qualified health plans also apply to qualified dental plans. The carrier must be licensed to offer dental coverage, but need not be licensed to offer other health benefits; the plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and at a minimum must include the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange or the secretary may specify by regulation; and 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.

54-66-12. Funding - Publication of costs - Fund.

1. As required by section 1311(d)(5)(a) of the federal act, the exchange must be self-sustaining by January 1, 2015, or later as otherwise required by federal law. The governor shall prepare a budget for the exchange and shall submit the budget to the legislative assembly for approval.
2. ~~The~~In addition to premium tax funds collected under [insert section], the exchange may charge assessments or user fees or otherwise may generate funding necessary to support exchange operations provided under this ~~Act~~chapter.
3. Services performed by the exchange on behalf of other state or federal programs may not be funded with assessments or user fees collected from health carriers.
4. Any funding unspent by the exchange must be used for future state operation of the exchange or returned to health carriers as a credit if the state charges fees to carriers.
5. There is created in the state treasury the health benefit exchange fund. Any moneys received or generated by premium taxes, assessments, user fees, or otherwise generated to support the exchange operations must be deposited in this fund.
6. The exchange shall publish the administrative and operational costs of the exchange, on an internet website to educate consumers on such costs. The information published must include the amount of premiums and federal premium subsidies collected by the exchange; the amount and source of any other fees collected by the exchange for purposes of supporting ~~its~~the exchange's operations; and any money lost to waste, fraud, and abuse.

NOTE: The revision to this section includes the provision the exchange will be funded through a premium tax and creation of a fund that will receive the premium tax funds.

NOTE: Additional language will need to be added to the bill draft to create the additional premium tax funds. In order to provide navigator grants in 2013, it is likely the increase in premium tax would need to be effective January 1, 2012.

NOTE: The committee may wish to consider whether there may be retaliatory issues related to an increase in premium tax versus implementation of an assessment or other fee.

54-66-13. Rules.

The board shall adopt rules to implement this ~~Act~~chapter. Rules adopted under this ~~Act~~chapter may not conflict with or prevent the application of regulations promulgated by the secretary under the federal act or exceed the rules enforced by the commissioner.

54-66-14. Application.

This ~~Act~~chapter and actions taken by the exchange pursuant to this ~~Act~~chapter do not preempt or supersede the authority of the commissioner to regulate the business of insurance within this state. Except as expressly provided to the contrary in this ~~Act~~chapter, all health carriers offering qualified health plans in this state shall comply with all applicable health insurance laws of this state and rules adopted and orders issued by the commissioner.

SECTION 2. LEGISLATIVE INTENT - HEALTH BENEFIT EXCHANGE ESTABLISHMENT GRANTS - REPORT. It is the intent of the sixty-second legislative assembly that the office of management and budget shall apply for available federal exchange establishment grants to be used for the purposes of health benefit exchange planning activities to include developing an information technology system for the health benefit exchange. Health benefit exchange establishment grants include level one and level two establishment grants. It is also the intent of the legislative assembly that the office of management and budget, the information technology department, the department of human services, and the insurance department explore any additional grant opportunities that may become available for the health benefit exchange. Upon approval of health benefit exchange grants, the departments shall notify the office of management and budget and report to the legislative management on any grants awarded.

NOTE: Added at the request of the committee and OMB. If the language of this section is not included in the bill draft, the last sentence in the section should be revised to remove the reference to increased federal appropriation authority.

SECTION 3. FEDERAL GRANTS - CONTINUING APPROPRIATION. Any federal funds received from federal health insurance exchange grants is appropriated out of special funds derived from federal funds, not otherwise appropriated to the office of management and budget, the information technology department, the department of human services, and the insurance department for the purposes of establishing a state health insurance exchange for the period beginning December 1, 2011, and ending June 30, 2013. Upon approval of health insurance exchange grants, the departments shall notify the office of management and budget and report to the budget section any increased federal appropriation authority.

NOTE: Added at the request of the committee and OMB. Without this section, agencies would use the current provisions in law to request and receive additional appropriation authority from the Emergency Commission and the Budget Section.

SECTION 4. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $8,736,675, or so much of the

sum as may be necessary, and from special funds derived from federal funds and other income, the sum of $33,881,250, or so much of the sum as may be necessary, to the department of human services for the purpose of defraying the expenses of incorporating the medicaid and children's health insurance program eligibility determination functionality into the state's health benefit exchange created under this Act, and for the purpose of defraying the corresponding costs related to the modification of the department's economic assistance eligibility system, for the period beginning December 1, 2011, and ending June 30, 2013. The department of human services is authorized one full-time equivalent position for this initiative.

NOTE: Added at the request of the committee and OMB.

SECTION 5. APPROPRIATION. There is appropriated from special funds derived from federal funds and other income, the sum of $19,346,077, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the costs of the department of human services eligibility system, for the fiscal period beginning December 1, 2011, and ending June 30, 2013. The information technology department is authorized ten additional full-time equivalent positions for the project; however, the positions are only authorized until the development and implementation of the system is completed.

NOTE: Added at the request of the committee and OMB.

SECTION 6. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $214,123, or so much of the sum as may be necessary, and from special funds derived from federal funds and other income, the sum of $290,156, or so much of the sum as may be necessary, to the department of human services for the purpose of defraying the expenses of implementation of the federal Affordable Care Act, for the period beginning December 1, 2011, and ending June 30, 2013. The department of human services is authorized seven full-time equivalent positions for this implementation.

NOTE: Added at the request of the committee and OMB.

SECTION 7. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of , or so much of the sum as may be necessary, to the for the purpose of , for the biennium beginning December 1, 2011, and ending June 30, 2013. The office of management and budget and the information technology department are authorized [insert number] full-time equivalent positions for implementation of the health benefit exchange.

NOTE: The appropriation amount for the navigator grants and for any other state financial obligations and the number of full-time equivalent positions required to develop, implement, and maintain the health benefit exchange will need to be addressed.

SECTION 8. LIMITATIONS ON STATE AGENCIES - LEGISLATIVE INTENT. Absent legislative authorization, an executive branch state agency may not enter any agreement, contract, or other relationship with the federal government for the state or federal government to establish, manage, operate, or form a relationship to provide a health benefit exchange under the federal Affordable Care Act. It is the intent of the sixty-second legislative assembly that executive branch state agencies not work with the federal government to evade or otherwise circumvent legislative authority to establish, manage, operate, or form a state-administered health benefit exchange.

NOTE: Section created per committee directive.

SECTION 9. EFFECTIVE DATE. This Act becomes effective December 1, 2011.

SECTION 10. CONTINGENT EXPIRATION DATE. If section 1311 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the federal Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], is repealed by Congress, repealed or invalidated by the courts, or otherwise rendered invalid by a final judicial decree or if the state is granted a federal waiver before or after the establishment of the North Dakota health benefit exchange, this Act expires August first following the next regular legislative session after the effective date of the repeal, invalidation, or federal waiver unless the legislative assembly takes specific action to extend the Act.

NOTE: Section revised per committee directive to include repeal by Congress.

DISCUSSION: This bill draft should continue to be reviewed for "timeline issues" such as the date by which navigators need to be functioning, the date by which the exchange needs to be functioning for selection of coverage, and other dates that may be applicable.