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Sixty-second
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED HOUSE BILL NO. 1474

Introduced by

Legislative Management

(Health Care Reform Review Committee)

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 repeal chapter 26.1-54 of the North Dakota Century Code and section 3 of chapter 225 of the 2011 Session Laws, relating to the insurance commissioner's and department of human services' duties to establish a health benefit exchange and provide updates to the legislative management; to provide a statement of legislative intent; to provide for reports to the legislative management; to provide an appropriation; to provide a continuing appropriation; to provide a transfer; 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 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. "Director" means the director of the office of management and budget.

6. "Division" means the office of management and budget health benefit exchange division.

7. "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.

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

9. "Exchange" means the North Dakota health benefit exchange established under this chapter.

10. "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].

11. "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.

12. "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.

13. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 54-66-12.

14. "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 exchange to the employer's eligible employees, wherever employed; or

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

15. "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 54-66-12.

16. "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.

17. "Secretary" means the secretary of the federal department of health and human services.

18. "Small employer" means an employer that employed an average of at least one but not more than fifty employees during the preceding calendar year and which employs at least one employee on the first day of the plan year. For purposes of this subsection all employees must be counted in accordance with section 1304(b) of the federal act.

54-66-02. Establishment of health benefit exchange division - North Dakota health benefit exchange board - 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 an agency for purposes of chapter 28-82. The director shall appoint an executive director of the division. The position of executive director is not a classified position and the executive director serves at the pleasure of the director.
2. The division shall administer the North Dakota health benefit exchange. In accordance with this chapter, the board shall establish the policy for the administration of the exchange. The division shall implement the policy established by the board and administer the exchange according to this chapter, the policy established by the board, and the federal act. The purpose of the exchange is to facilitate the purchase of qualified health plans, assist small employers in facilitating the enrollment of their employees in qualified health benefit plans offered in the small group market, and apply eligibility and enrollment standards of individuals in the state's medical assistance program and the state's children's health insurance program. Except as provided under this chapter or directed by the federal act, the exchange may not duplicate or replace the duties of the commissioner established under chapter 26.1-01 or the duties of the executive director of the department of human services established under chapter 54-24.1 or 50-29. All carriers authorized to conduct business in this state may be eligible to participate in the exchange.
3. The board shall establish policy and the division shall administer the exchange in accordance with this chapter and take all actions necessary to ensure by January 1, 2013, or later as otherwise specified by the director and consistent with federal law, that the exchange is determined by the federal government to be ready to operate by October 1, 2013, or later as otherwise specified by the director and consistent with federal law. The division shall provide administrative services for the board.
4. The department of human services shall take the steps necessary to create and coordinate with the division those portions of the exchange relating to eligibility determination and enrollment of individuals in the state's medical assistance program

and the state's children's health insurance program in order to meet the requirements of the federal act.

5. The division and department of human services shall collaborate with the information technology department as necessary and appropriate in establishing and administering the exchange. State agencies shall cooperate with the board, the division, and the department of human services to ensure the success of the exchange.

54-66-03. Board - Organization.

1. The board is made up of nine voting members and four nonvoting ex officio members. The commissioner or the commissioner's designee; the executive director of the department of human services or the executive director's designee; and one member of the house of representatives and one member of the senate, appointed by the chairman of the legislative management, are the ex officio nonvoting members. By January 1, 2012, the governor shall appoint the following nine voting members:
   a. Two members who represent the health insurance industry;
   b. One member who represents small employers;
   c. One member who represents licensed insurance producers;
   d. One member who is a health care professional;
   e. One member as determined by the governor; and
   f. Three members who represent consumers.
2. When the governor appoints each of the board members, the governor shall ensure that no single business entity employs or is otherwise represented by more than one board member.
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 ensure that in considering the experience of the voting members of the board in the aggregate, 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.

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

5. Except for the initial board member appointments, which must be staggered so no more than three 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 being reappointed.

6. In determining voting rights at board meetings, each member may vote in person or by proxy. Each voting member and legislator member is entitled to receive per diem compensation in the amount established by subsection 1 of section 54-03-20 plus reimbursement for mileage and travel as specified in section 54-06-09 and expenses as specified in section 44-08-04 for attending board meetings. The compensation and reimbursement provided for in this subsection may not be paid to any board member who receives a salary or other compensation as an employee or official of this state if the individual is serving on the commission by virtue of the individual's state office or state employment. Costs incurred under this subsection must be paid from the money of the health benefit exchange fund.

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.

8. A voting 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 may remove a voting board member for cause.

9. 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.

10. 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 or confidential premium rate information is discussed must be closed.

11. In the performance of their duties as board members, the voting board members are exempt from the provisions of chapter 51-08.1.

54-66-04. Board - Duties.

1. Based on the policy established by the board, the division shall adopt rules to address how the board will deal with board member conflict of interest issues when these issues arise. The 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 an actual or possible 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.

2. In recognition of the government-to-government relationship between the state and the federally recognized tribes in the state, the board shall regularly consult on an ongoing basis with each of the federally recognized tribes located in the state, consult with the Indian affairs commission, and invite the executive director of the Indian affairs commission to board meetings.

3. The board shall establish a health benefit exchange advisory group and technical advisory group. The board may establish temporary advisory groups as appropriate to carry out the board's duties. The board may provide the members of the health benefit exchange advisory group and of the technical advisory group per diem compensation in an amount that may not exceed the amount established by subsection 1 of section 54-03-20 plus the board may provide reimbursement for mileage and travel as specified in section 54-06-09 and expenses as specified in section 44-08-04 for attending advisory group meetings. The compensation and reimbursement provided for in this subsection may not be paid to any advisory group member who receives a

salary or other compensation as an employee or official of this state if the individual is serving on the commission by virtue of the individual's state office or state employment. Costs incurred under this subsection must be paid from the money of the health benefit exchange fund.

54-66-05. Health benefit exchange advisory group.

1. Within ninety days following the initial appointment of board members, the board shall establish a health benefit exchange 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 health benefit exchange advisory group may include:
   a. Educated health care consumers who are enrollees in qualified health plans, including individuals with disabilities;
   b. Individuals and entities with experience in facilitating enrollment in qualified health plans;
   c. Licensed insurance producers;
   d. Advocates for enrolling hard-to-reach populations;
   e. Advocates for consumers with disabilities, mental illness, and chronic conditions;
   f. Representatives of small businesses and self-employed individuals;
   g. Representatives of health carriers that offer qualified health plans through the exchange;
   h. Representatives of health carriers that do not offer qualified health plans through the exchange;
   i. Representatives of the department of human services and other relevant state agencies, such as the insurance department and the information technology department;
   j. Representatives of labor;
   k. Health care providers;
   l. Public health experts;
   m. Representatives of large employers; and
   n. Other stakeholders.

54-66-06. Technical advisory group.

1. Within ninety days following the initial appointment of board members, the board shall establish a technical advisory group that is charged with advising the board on actuarial, financial, and risk matters related to:
   a. The transitional reinsurance program for the individual market;
   b. Risk adjustment;
   c. Risk corridors;
   d. Measures to mitigate adverse selection;
   e. Maintaining separate risk pools for the individual and small group markets or merging the risk pools, and the implications for the small group and individual markets both inside and outside the exchange; and
   f. Whether to expand exchange eligibility to large employers.
2. The technical advisory group shall advise the board on requirements, options, and waivers, if appropriate, to ensure that the board is informed of technical requirements under the federal act. Additionally, the technical advisory group shall make recommendations on issues related to consumers who may move between state public health care programs and qualified health plans offered in the exchange.

54-66-07. Board policies and procedures - Division authority.

1. In consultation with the division, the board shall establish policies and procedures as provided under this subsection and the board, division, and exchange shall operate in accordance with these policies and procedures. The policies and procedures must:
   a. Provide for the operation of the exchange;
   b. Establish the procedure for the board to elect or appoint officers;
   c. Establish the manner of board voting;
   d. Establish a program for the division to foster public awareness of the exchange and to publicize the eligibility requirements for purchasing qualified health plans through the exchange, subsidies offered for purchasing qualified health plans offered through the exchange, enrollment procedures, and use of the exchange to apply eligibility for and enrollment standards of individuals in the state's medical assistance program and the state's children's health insurance program;

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 provide that the independent financial audit report must be available to the public.

2. The division may contract with one or more eligible entities to carry out one or more of the exchange's functions. For purposes of this subsection, an eligible entity has the same meaning as under the federal act.

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

54-66-08. Operation of the exchange.

1. By October 1, 2013, or later as directed by the director in compliance with federal law, the exchange must be capable of beginning operations to support the initial open enrollment period and to be fully operational by January 1, 2014.

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 filed, the certification by the health carrier's qualified actuary which was provided to the insurance department as part of the rate request.

b. For premium rates modified or disapproved through the rate review process the insurance department shall identify the factors affecting the decision to modify or disapprove the rate.

4. The exchange must allow for 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 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 must be applied uniformly to all health benefit plans in each insurance market to which the standard and requirements apply.

10. The exchange must be designed to 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 must 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 must 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.

14. The division shall 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.

15. In order to meet the following financial integrity requirements, the division shall:

    a. Keep an accurate accounting of all exchange activities, receipts, and expenditures and annually submit to the secretary, the governor, the commissioner, and the legislative management a report concerning such accountings; and

    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.

54-66-09. Exchange requirements.

The exchange must:

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 54-66-12, 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 state's medical assistance program under chapter 50-24.1, the state's children's health insurance program under chapter 50-29, 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. Provide 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. Include 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, issue 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. Provide for the transfer to the federal secretary of the treasury the following:
    a. A list of the individuals who are issued a certification under subsection 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 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. Comply with requirements of the exchange required 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. As authorized under section 1312(e) of the federal act, allow for licensed insurance producers 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.

54-66-10. Navigation office - Grants - Regulation.

1. The navigation office is established within the division. The navigation office shall provide services designed to directly or indirectly assist consumers in navigating the exchange. The navigation office:
    a. Shall maintain expertise in eligibility, enrollment, and program specifications.
    b. Shall conduct public education activities to raise awareness about the exchange.
    c. Shall 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 entity for any enrollee with a grievance, complaint, or question regarding the enrollee's health plan, coverage, or a determination under such plan or coverage.
    d. Shall provide training and education services to individuals and entities that have existing relationships or could readily establish such relationships with employers; employees; consumers, including uninsured and underinsured individuals; and self-employed individuals likely to be eligible for enrollment in a qualified health plan. The training and education must:
        (1) Address how to facilitate enrollment in qualified health plans;
        (2) Address how to provide information and services in a fair, accurate, and impartial manner;
        (3) Address how to provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange, including individuals with limited English proficiency; and
        (4) Address how to ensure accessibility and usability of navigator tools and functions for individuals with disabilities in accordance with the federal

Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 327; 42 U.S.C. 12101 et seq.] and section 504 of the federal Rehabilitation Act of 1973 [Pub. L. 93-112; 87 Stat. 394; 29 U.S.C. 701 et seq.].

2. The navigation office shall provide navigator grants to the Indian affairs commission to provide navigation services targeted primarily to Indian individuals and groups in the state. The Indian affairs commission shall take the steps necessary to comply with the terms of the grants, including:

a. Maintaining expertise in eligibility, enrollment, and program specifications;

b. Conducting public education activities to raise awareness about the exchange;

c. Providing information and services in a fair, accurate, and impartial manner;

d. Facilitating enrollment in qualified health plans;

e. Providing 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 entity for any enrollee with a grievance, complaint, or question regarding the enrollee's health plan, coverage, or a determination under such plan or coverage;

f. Providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange, including individuals with limited English proficiency; and

g. Ensuring accessibility and usability of navigator tools and functions for individuals with disabilities in accordance with the federal Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 327; 42 U.S.C. 12101 et seq.] and section 504 of the federal Rehabilitation Act of 1973 [Pub. L. 93-112; 87 Stat. 394; 29 U.S.C. 701 et seq.].

3. The board, through the navigation office, shall regulate who may charge a fee to or otherwise receive consideration to assist employers, employees, or consumers in making health coverage decisions through use of the exchange. This regulation must include a requirement that an individual must be certified by the navigation office if that individual charges a fee or receives consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individual or qualified employees in a qualified health plan. For purposes of this subsection, wages

do not constitute consideration if the wages are not based on enrollment. The navigation office shall provide for at least the following two levels of certification: certification to allow a certificate holder to assist in navigating the entire exchange and certification limited to allowing a certificate holder to assist in navigating the medical assistance and children's health insurance program elements of the exchange. A person that does not charge a fee or otherwise receive consideration may assist employers, employees, and consumers in making health coverage decisions through use of the exchange without being certified under this subsection. The certification requirements must include successful completion of an education program provided by the navigation office.

a. In order to be certified under this subsection, an individual must be:

(1) A licensed insurance producer; or

(2) An individual identified by the department of human services as being knowledgeable regarding the state's medical assistance program and children's health insurance program.

b. The exchange may provide information regarding such certified individuals on the exchange website for the convenience of consumers seeking insurance through the exchange.

c. A certificate holder may not in a single transaction charge a fee and receive consideration from a health insurance issuer in connection with the enrollment of a qualified individual or qualified employees in a qualified health plan.

54-66-11. Risk pools.

In accordance with section 1312(c) of the federal act, 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 exchange 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.

54-66-12. Health benefit plan certification.

1. The division 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 division 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 division, 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 54-66-09, 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 a licensed insurance producer;

(4) Does not charge any cancellation fees or penalties in violation of subsection 5 of section 54-66-08; and

(5) Complies with the regulations developed by the secretary under section 1311(d) of the federal act and such other requirements as the division 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 division 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 division may not exclude a health benefit plan from the exchange:

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

b. Through the imposition of premium price controls by the division; 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 division 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 in the exchange before the following annual open enrollment period if the division 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 division 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 division 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 division 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 division shall take this information, along with the information and the recommendations provided to the division 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 division, 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 division 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.

54-66-13. Qualified dental plans.

Except as otherwise provided under this section, to the extent relevant, the provisions of this 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.

54-66-14. Funding - Publication of costs - Health benefit exchange fund - Reports to legislative management.

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 specified by the director and consistent with federal law. Until January 1, 2015, the division, the information technology department, and the department of human services shall use grant funds to finance the establishment of the exchange.

2. Under section 54-44.1-06, the governor shall submit a separate appropriations request for the division. Before August first of each year, the division shall submit a proposal to the board outlining how to raise the funds necessary to fund the board, division, and exchange. To the extent the division's proposal includes the collection of funds that are based on insurance, the division shall consult with the commissioner in designing the proposal. Before October first of each year, the board shall establish a plan for funding the board, division, and exchange. To the extent the board's plan includes the collection of funds that are based on insurance, the board shall consult with the commissioner. Annually, the board shall report to the legislative management the board's plan for funding the board, division, and exchange. Annually, the department of human services shall report to the legislative management the department's plan for funding the medical assistance-related and children's health insurance program-related exchange activities of the department.

3. To the extent the board's funding plan is based on the collection of funds that are based on insurance, the funding plan is limited to collecting such funds from hospital, surgical, medical expense, and major medical insurance and the funding plan must be applied universally to plans inside and outside the exchange.

4. The board may charge assessments or user fees or otherwise may generate funding necessary to support board, division, and exchange operations provided under this chapter, including collection of exchange website advertisement revenues. If the board's funding plan includes the collection of funds that are based on insurance, upon request of the board the commissioner shall charge and collect such funds and shall deposit such funds in the health benefit exchange fund.

5. Services performed by the exchange on behalf of other state or federal programs may not be funded with premium taxes, assessments, or user fees collected from health carriers under this chapter.

6. Any funding unspent by the division may be used for future state operation of the exchange or returned to health carriers as a credit if the division charges fees to carriers.

7. There is created in the state treasury the health benefit exchange fund. Any moneys appropriated to the division; received or generated by assessments or user fees; or

otherwise generated to support the board, division, or exchange operations must be deposited in this fund. Interest earned on moneys in the fund must be credited to the fund.

8. The division 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 board for purposes of supporting the exchange's operations; and any money lost to waste, fraud, and abuse.

54-66-15. Adjudicative proceedings - Final orders - Attorney's fees and costs.

1. Every adjudicative proceeding arising under this chapter must be conducted as provided under chapter 28-32. The division may adopt rules to implement the provision of adjudicative proceedings arising under this chapter.
2. Notwithstanding contrary provisions of chapter 28-32, in a hearing conducted by a hearing officer under chapter 28-32, the hearing officer shall issue final findings of fact and conclusions of law and issue a final order.
3. Notwithstanding contrary provisions of chapter 28-32, in a hearing conducted by a hearing officer under chapter 28-32 which involves as adverse parties the division and a party not an administrative agency or an agent of an administrative agency, the hearing officer shall award the party not an administrative agency reasonable attorney's fees and costs if the hearing officer finds in favor of that party and determines that the division acted without substantial justification. Any attorney's fees and costs awarded under this subsection must be paid from funds in the health benefit exchange fund. The hearing officer may withhold all or part of the attorney's fees from any award if the hearing officer finds the division's action was substantially justified or that special circumstances exist which make the award of all or a portion of the attorney's fees unjust. This subsection does not affect any fees under other applicable law.

54-66-16. Records.

Notwithstanding any provision of this code making records confidential, the division and the department of human services may receive from and provide to federal and state agencies

information gathered in the administration of the exchange, including social security numbers, if the disclosure is necessary for the division, the department of human services, or the receiving entity to perform its duties and responsibilities.

54-66-17. Rules.

The division, in consultation with the board, shall adopt rules to implement this chapter. Rules adopted under this chapter may not conflict with or prevent the application of regulations promulgated by the secretary under the federal act or except as specified under this chapter exceed the rules enforced by the commissioner or by the director of the department of human services.

54-66-18. Application.

This chapter and actions taken by the board and division pursuant to this 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 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. REPEAL. Chapter 26.1-54 of the North Dakota Century Code and section 3 of chapter 225 of the 2011 Session Laws are repealed.

SECTION 3. APPLICATION - REPORTS TO THE LEGISLATIVE MANAGEMENT. In carrying out the requirements of this Act, the insurance commissioner, department of human services, and information technology department shall provide regular updates to the legislative management during the 2011-12 interim which must include monthly written reports on the status of state and federal funds received and the status of state and federal funds expended. In determining, planning, and implementing the North Dakota health benefit exchange, collectively the office of management and budget health benefit exchange division, the department of human services, and the information technology department may submit proposed legislation to the legislative management before October 1, 2012.

SECTION 4. LEGISLATIVE INTENT - HEALTH BENEFIT EXCHANGE ESTABLISHMENT GRANTS - REPORT TO THE LEGISLATIVE MANAGEMENT. It is the intent of the sixty-second legislative assembly that the office of management and budget shall apply for 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 sixty-second legislative assembly that the office of management and budget health benefit exchange division, the information technology department, and the department of human services explore any additional grant opportunities that may become available for the health benefit exchange.

It is also the intent of the sixty-second legislative assembly that, except as expressly authorized by the legislative assembly, state entities may not use state funds to fund the planning activities related to, the development of, and the operation of the health benefit exchange.

Upon approval of health benefit exchange grants, the receiving department or division shall notify the office of management and budget and report to the legislative management on any grants awarded.

SECTION 5. FEDERAL GRANTS - CONTINUING APPROPRIATION - REPORT TO THE LEGISLATIVE MANAGEMENT. 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 health benefit exchange division, the information technology department, and the department of human services for the purposes of establishing a state health insurance exchange, for the period beginning November 14, 2011, and ending June 30, 2013. Upon approval of health insurance exchange grants, the receiving department or division shall notify the office of management and budget and report to the legislative management any increased federal appropriation authority.

SECTION 6. APPROPRIATION - EXEMPTION. There is appropriated from special funds derived from federal funds and other income, the sum of $2,060,378, or so much of the sum as may be necessary, to the office of management and budget health benefit exchange division for the purpose of defraying the expenses of establishing and operating the health benefit exchange, for the period beginning November 14, 2011, and ending June 30, 2013. The office of management and budget health benefit exchange division is authorized nine full-time equivalent positions for operations of the health benefit exchange. The appropriation provided in this section is not subject to section 54-44.1-11 and any unexpended funds from this

appropriation are available for defraying the expenses of establishing and operating the health benefit exchange, for the biennium beginning July 1, 2013, and ending June 30, 2015.

SECTION 7. APPROPRIATION. There is appropriated from special funds derived from federal funds and other income, the sum of $35,964,750, or so much of the sum as may be necessary, to the information technology department for the purpose of defraying the expenses of establishing and implementing the health benefit exchange, for the period beginning November 14, 2011, and ending June 30, 2013. The information technology department is authorized nineteen full-time equivalent positions for implementation of the health benefit exchange. The appropriation provided in this section is not subject to section 54-44.1-11 and any unexpended funds from this appropriation are available for defraying the expenses of establishing and implementing the health benefit exchange, for the biennium beginning July 1, 2013, and ending June 30, 2015.

SECTION 8. APPROPRIATION. There is appropriated out of any moneys in the health benefit exchange fund in the state treasury, not otherwise appropriated, the sum of $500,000, or so much of the sum as may be necessary, to the office of management and budget health benefit exchange division for the purpose of funding the operation and activities of the division's navigation office, for the period beginning November 14, 2011, and ending June 30, 2013.

SECTION 9. INSURANCE COMMISSIONER - HEALTH BENEFIT EXCHANGE FUND - TRANSFER - APPROPRIATION. Up to $750,000 of the amount appropriated to the insurance commissioner from federal funds as provided in section 2 of chapter 225 of the 2011 Session Laws for the purpose of planning for implementation of a health benefit exchange and not spent or obligated as of December 1, 2011, must be transferred by the director of the office of management and budget and the insurance commissioner to the health benefit exchange fund by December 31, 2011. There is appropriated out of any moneys in the health benefit exchange fund in the state treasury, not otherwise appropriated, the sum of $750,000, or so much of the sum as may be necessary, to the office of management and budget health benefit exchange division for the purpose of planning, establishing, and administering the North Dakota health benefit exchange, for the period beginning November 14, 2011, and ending June 30, 2013. The health benefit exchange division may transfer these funds to the department of human services or the information technology department for the purpose of planning and establishing the North Dakota health benefit exchange.

SECTION 10. LEGISLATIVE INTENT. Creation of a state-administered health benefit exchange is not intended to express the sixty-second legislative assembly's support of the federal Patient Protection and Affordable Care Act, but instead is intended to express its support of state control.

SECTION 11. 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 federal-administered or state-administered health benefit exchange.

SECTION 12. EFFECTIVE DATE. This Act becomes effective on November 14, 2011.

SECTION 13. 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 or otherwise rendered invalid, in whole or in part, by a final judicial decree or if the state is granted a federal waiver for the health benefit exchange requirement before or after the establishment of the North Dakota health benefit exchange, section 1 of this Act expires as of 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 that section of the Act.