Sixty-first
Legislative Assembly
of North Dakota

SENATE BILL NO.

Introduced by

Senator Mathern

A BILL for an Act to provide for establishment of the healthy North Dakota health insurance plan; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Definitions. As used in this Act:

1. "Authority" means the healthy North Dakota authority.
2. "Board" means the board of trustees of the authority.
3. "Health care network" means a provider-driven, coordinated group of health care providers comprised of primary care physicians, medical specialists, physician assistants, nurses, clinics, one or more hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment.
4. "Medical inflation" means changes in the consumer price index for all consumers, United States city average, for the medical care group, including medical care commodities and medical care services, as determined by the United States department of labor.
5. "Plan" means the healthy North Dakota plan.
6. "Primary care provider" means a health care provider that is identified as the key professional responsible for coordinating all medical care for a given participant, including referral to a specialist. The term includes a general practice physician, family practitioner, internist, pediatrician, obstetrician and gynecologist, advanced practice nurse, certified nurse midwife, and physician assistant. The term also may include a specialist who is treating a person with a chronic medical condition or special health care needs for which regular treatment by a specialist is medically necessary or a specialist who is treating a disabled individual.

SECTION 2. Creation and organization of authority.

1. There is created a public body corporate and politic to be known as the "healthy North Dakota authority". The nonvoting members of the board consist of the executive director of the public employees retirement system and four representatives from the advisory committee under section 11 of this Act who are health care personnel and administrators, selected by the advisory committee. The executive director of the public employees retirement system shall serve as the initial chairman of the board until such time as the board elects a chairman from its voting membership. The board also consists of the following voting members, appointed by the governor for staggered six-year terms:
   a. Four members selected from a list of names submitted by statewide labor or union coalitions. One of these members must be a public employee.
   b. Four members selected from a list of names submitted by statewide business and employer organizations. One of these members must be a public employer.
   c. One member selected from a list of names submitted by statewide public schoolteacher organizations.
   d. One member selected from a list of names submitted by statewide small business organizations.
   e. Two members who are farmers, selected from a list of names submitted by statewide general farm organizations.
   f. One member who is a self-employed individual.
   g. Three members selected from a list of names submitted by statewide health care consumer organizations.
2. a. The terms of all members of the board expire on July first.
   b. Each member of the board holds office until a successor is appointed and qualified unless the member vacates or is removed from office. A member who serves as a result of holding another office or position vacates office as a member when the member vacates the other office or position. A member who ceases to qualify for office vacates the member's office. A vacancy on

the board must be filled in the same manner as the original appointment to the board for the remainder of the unexpired term, if any.

c. A majority of the members of the board constitutes a quorum for the purpose of conducting its business and exercising its powers and for all other purposes, notwithstanding the existence of any vacancies. Action may be taken by the board upon a vote of a majority of the members present. Meetings of the members of the board may be held anywhere within or without the state.

3. Each member of the board is responsible for taking care that the highest level of independence and judgment is exercised at all times in administering the plan and overseeing the individuals and organizations selected to implement the plan.

4. The board shall:

a. Establish and administer a health care system in this state that ensures that all eligible persons have access to high-quality, timely, and affordable health care. In establishing and administering the health care system, except as otherwise provided by law, the board shall seek to attain all of the following goals:

(1) Every resident of this state must have access to affordable, comprehensive health care services.

(2) Health care reform must maintain and improve choice of health care providers and high-quality health care services in this state.

(3) Health care reform must implement cost-containment strategies that retain and assure affordable coverage for all residents of this state.

b. Establish, fund, and manage the plan as provided in this Act.

c. Appoint an executive director, who serves at the pleasure of the board. The board may delegate to one or more of its members or its executive director any power and duty the board considers proper. The executive director shall receive such compensation as may be determined by the board.

d. Provide for mechanisms to enroll every eligible resident in this state under the plan. Any contract entered by the board with providers must include

provisions to enroll all eligible individuals at the point of service, and outreach programs to assure every eligible individual becomes enrolled in the plan.

e. Create a program for consumer protection and a process to resolve disputes with providers.

f. Establish an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the board. An individual who is adversely affected by a board eligibility determination or other determination is entitled to judicial review of the determination.

g. Submit an annual report on its activities to the governor.

h. Contract for annual, independent, program evaluations and financial audits that measure the extent to which the plan is achieving the goals under paragraphs 1, 2, and 3 of subdivision a. The board may not enter into a contract with the same auditor for more than six years.

i. Accept bids from health care networks in accordance with the criteria set out in section 7 of this Act or make payments to fee-for-service providers in accordance with section 7 of this Act. The board shall consult with the public employees retirement system in determining the most effective and efficient way of purchasing health care benefits.

j. Audit health care networks and providers to determine if their services meet the plan objectives and criteria under this Act.

5. The board shall have all the powers necessary or convenient to carry out this Act. In addition to all other powers granted the board under this Act, the board may:

a. Adopt, amend, and repeal bylaws and policies and procedures for the regulation of its affairs and the conduct of its business.

b. Maintain an office.

c. Sue and be sued.

d. Accept gifts, grants, loans, or other contributions from private or public sources.

e. Establish the authority's budget and monitor the fiscal management of the authority.

f. Execute contracts and other instruments, including contracts for any professional services required for the authority.

g. Employ officers, agents, and employees that it may require and determine their qualifications and compensation.

h. Procure liability insurance.

i. Contract for studies on issues, as identified by the board or by the advisory committee under section 11 of this Act, that relate to the plan.

j. Borrow money, as necessary on a short-term basis, to address cashflow issues.

k. Compel witnesses to attend meetings and to testify upon any necessary matter concerning the plan.

6. The members of the board are entitled to receive sixty-two dollars and fifty cents per day compensation and necessary mileage and travel expenses as provided in sections 44-08-04 and 54-06-09.

SECTION 3. Eligibility.

1. Except as provided in subsections 2, 3, 4, and 5 and subject to subsection 6 an individual is eligible to participate in the plan if the individual satisfies all of the following criteria:

a. The individual has maintained that individual's place of permanent abode, as defined by the board, in this state for at least twelve months.

b. The individual maintains a substantial presence in this state, as defined by the board.

c. The individual is under sixty-five years of age.

d. The individual is not eligible for health care coverage from the federal government or a foreign government, is not an inmate of a penal facility, and is not placed or confined in, or committed to, an institution for the mentally ill or developmentally disabled.

2. If an individual and the members of the individual's immediate family do not meet the criteria under subdivisions a and b of subsection 1, but do meet the criteria under subdivisions c and d of subsection 1 and the individual is gainfully employed

in this state, as defined by the board, the individual and the members of the individual's immediate family are eligible to participate in the plan.

3. If a child under age eighteen resides with the child's parent in this state but the parent does not yet meet the residency requirement under subdivision a of subsection 1, the child is eligible to participate in the plan regardless of the length of time the child has resided in this state.

4. A pregnant woman who resides in this state who does not yet meet the residency requirement under subdivision a of subsection 1 is eligible to participate in the plan regardless of the length of time the pregnant woman has resided in this state.

5. An individual who is eligible to participate in the plan under subsection 1, 2, 3, or 4 and who receives health care coverage under a collective bargaining agreement that is in effect on January 1, 2010, is not eligible to participate in the plan until the day on which the collective bargaining agreement expires or the day on which the collective bargaining agreement is extended, modified, or renewed.

6. The department of human services may develop waiver requests to the appropriate federal agencies to permit funds from federal health care services programs to be used for health care coverage for individuals under the plan.

7. For purposes of this Act, the board shall define the following terms:

   a. Place of permanent abode.

   b. Substantial presence in this state. In defining "substantial presence in this state", the board shall consider such factors as the amount of time per year that an individual is actually present in the state and the amount of taxes that an individual pays in this state, except that, if the individual attends school outside of this state and is under twenty-three years of age, the factors must include the amount of time that the individual's parent or guardian is actually present in the state and the amount of taxes that the individual's parent or guardian pays in this state, and if the individual is in active service with the United States armed forces outside of this state, the factors must include the amount of time that the individual's parent, guardian, or spouse is actually present in the state and the amount of taxes that the individual's parent, guardian, or spouse pays in this state.

c. Immediate family.

d. Gainfully employed. The definition must include employment by individuals who are self-employed and individuals who work on farms.

SECTION 4. Office of outreach, enrollment, and advocacy.

1. The board shall establish an office of outreach, enrollment, and advocacy. The office shall contract with nonprofit organizations to perform the outreach, enrollment, and advocacy functions specified in this section, and to review the health care payment and services records of individuals who are participating, or who are eligible to participate, in the plan and who have provided the office with informed consent for the review. The office may not contract with any organization under this subsection that provides services under the plan or that has any other conflict of interest, as described in subsection 3.

2. The office of outreach, enrollment, and advocacy shall:

   a. Engage in aggressive outreach to enroll eligible individuals and participants in their choice of health care coverage under the plan.

   b. Assist eligible individuals in choosing health care coverage by examining cost, quality, and geographic coverage information regarding their choice of available networks or providers.

   c. Inform plan participants of the role they can play in holding down health care costs by taking advantage of preventive care, enrolling in chronic disease management programs if appropriate, responsibly utilizing medical services, and engaging in healthy lifestyles. The office shall inform participants of networks or workplaces where healthy lifestyle incentives are in place.

   d. At the direction of the board, establish a process for resolving disputes with providers.

   e. Act as an advocate for plan participants having questions, difficulties, or complaints about their health care services or coverage, including investigating and attempting to resolve the complaint. Investigation should include, when appropriate, consulting with the health care advisory committee under section 11 of this Act regarding best practice guidelines.

f. If a participant's complaint cannot be successfully resolved, inform the participant of any legal or other means of recourse for the participant's complaint. If the complaint involves a dispute over eligibility or other determinations made by the board, the participant must be directed to the appeals process for board decisions.

g. Provide information to the public, agencies, legislators, and others regarding problems and concerns of plan participants and, in consultation with the health care advisory committee under section 11 of this Act, make recommendations for resolving those problems and concerns.

h. Ensure that plan participants have timely access to the services provided by the office.

3. The office and its employees and contractors may not have any conflict of interest relating to the performance of their duties. There is a conflict of interest if, with respect to the office's director, employees, or contractors, or a person affiliated with the office's director, employees, or contractors, any of the following exists:

a. Direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or health care provider.

b. Direct ownership interest or investment interest in a health care facility, health insurer, or health care provider.

c. Employment by, or participation in, the management of a health care facility, health insurer, or health care provider.

d. Receipt of, or having the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

SECTION 5. Benefits.

1. The board shall establish a health care plan that will take effect on January 1, 2010. The plan must provide the same benefits as those that were in effect as of January 1, 2009, under the state employee uniform group health insurance plan under chapter 54-52.1. The board may adjust the plan benefits to provide additional cost-effective treatment options if there is evidence-based research that

the options are likely to reduce health care costs, avoid health risks, or result in better health outcomes.

2. In addition to the benefit requirements under subsection 1, the plan must provide coverage for mental health services and alcohol or other drug abuse treatment to the same extent as the plan covers treatment for physical conditions and coverage for preventive dental care for children up to eighteen years of age.

SECTION 6. Cost-sharing.

1. The plan must cover the following preventive services without any cost-sharing requirement:
   a. Prenatal care for pregnant women.
   b. Well-baby care.
   c. Medically appropriate examinations and immunizations for children up to eighteen years of age.
   d. Medically appropriate gynecological examinations, papanicolaou tests, and mammograms.
   e. Medically appropriate regular medical examinations for adults, as determined by best practices.
   f. Medically appropriate colonoscopies.
   g. Preventive dental care for children up to eighteen years of age.
   h. Other preventive services or procedures, as determined by the board, for which there is scientific evidence that exemption from cost-sharing is likely to reduce health care costs or avoid health risks.
   i. Chronic care services, provided that the participant receiving the services is participating in, and complying with, a chronic disease management program as defined by the board.

2. a. (1) Subject to paragraph 2, during any year, a participant who is eighteen years of age or older on January first of that year shall pay a deductible of three hundred dollars, which applies to all covered services and articles.

(2) During any year, a family consisting of two or more participants who are eighteen years of age or older on January first of that year shall pay a

deductible of six hundred dollars, which shall apply to all covered services and articles.

(3) During any year, a participant who is under eighteen years of age on January first of that year may not be required to pay a deductible.

(4) Except for copayments and coinsurance, the plan must provide a participant with full coverage for all covered services and articles after the participant has received covered services and articles totaling the applicable deductible amount under this subsection, regardless of whether the participant has paid the deductible amount.

b. (1) A provider that provides to a participant a covered service or article to which a deductible applies shall charge for the service or article the payment rate established by the board under paragraph 1 of subdivision b of subsection 7 of section 7 of this Act if the participant's coverage is under the fee-for-service option under subdivision a of subsection 2 of section 7 of this Act or the applicable network rate for the service or article, as determined by the board, if the participant's coverage is under the health care network option under subdivision b of subsection 2 of section 7 of this Act. Except as provided in paragraph 3, a provider of a covered service or article to which a deductible applies shall accept as payment in full for the covered service or article the payment rate specified in this paragraph and may not bill a participant who receives the service or article for any amount by which the charge for the service or article is reduced under this paragraph.

(2) Except for prescription drugs, a provider may not refuse to provide to a participant a covered service or article to which a deductible applies on the basis that the participant does not pay, or has not paid, any applicable deductible amount before the service or article is provided.

(3) A provider may not charge any interest, penalty, or late fee on any deductible amount owed by a participant unless the deductible amount owed is at least six months past due and the provider has provided the

participant with notice of the interest, penalty, or late fee at least ninety days before the interest, penalty, or late fee payment is due. Interest may not exceed one percent per month, and any penalty or late fee may not exceed the provider's reasonable cost of administering the unpaid bill.

c. Notwithstanding paragraphs 1 and 2 of subdivision a, the board may adjust the deductible amounts specified in paragraphs 1 and 2 of subdivision a, but only to reduce those amounts.

3. a. During any year, a participant who is eighteen years of age or older on January first of that year shall pay a copayment of twenty dollars for medical, hospital, and related health care services, as determined by the board.

b. A participant, regardless of age, who receives health care services from a specialist provider without a referral from the participant's primary care provider under the plan shall be required to pay twenty-five percent of the cost of the services provided.

c. Notwithstanding subdivision a, a participant who is eighteen years of age or older shall pay a copayment of sixty dollars for inappropriate emergency room use, as determined by the board.

d. (1) All participants, regardless of age, shall pay five dollars for each prescription of a generic drug that is on the formulary determined by the board.

(2) All participants, regardless of age, shall pay fifteen dollars for each prescription of a brand name drug that is on the formulary determined by the board.

(3) All participants, regardless of age, shall pay forty dollars for each prescription of a brand name drug that is not on the formulary determined by the board.

(4) Notwithstanding paragraphs 1, 2, and 3, a participant may not be required to pay more for a prescription drug than the actual cost of the prescription drug plus the negotiated dispensing fee.

e. Notwithstanding subdivisions a, b, c, and d, the board may adjust the copayment and coinsurance amounts specified in subdivisions a, b, c, and d.

4. Notwithstanding the deductible, coinsurance, and copayment amounts in subsections 2 and 3, all of the following apply:

a. Subject to subdivision b, a participant who is eighteen years of age or older on January first of a year may not be required to pay more than two thousand dollars during that year in total cost-sharing under subsections 2 and 3.

b. A family consisting of two or more participants may not be required to pay more than three thousand dollars during a year in total cost-sharing under subsections 2 and 3.

SECTION 7. Service areas - Selection and payment of health care providers and health care networks.

1. The board may establish areas in the state, which may be counties, multicounty regions, or other areas, for the purpose of receiving bids from health care networks. These areas must be established so as to maximize the level and quality of competition among health care networks or to increase the number of provider choices available to eligible persons and participants in the areas.

2. In each area designated by the board under subsection 1, the board shall offer both of the following options for delivery of health care services under the plan:

a. An option, known as the "fee-for-service option", under which participants must choose a primary care provider, may be referred by the primary care provider to any medical specialist, and may be admitted by the primary care provider or specialist to any hospital or other facility, for the purpose of receiving the benefits provided under this Act. Under this option, the board, with the assistance of one or more administrators chosen by a competitive bidding process and with whom the board has contracted, shall pay directly, at the provider payment rates established by the board under paragraph 1 of subdivision b of subsection 7, for all health care services and articles that are covered under the plan.

b. An option under which one or more health care networks that meet the qualifying criteria in subsection 4 and are certified under subsection 5 provide

health care services to participants. The board is required to offer this option in each area designated by the board to the extent that qualifying health care networks exist in the area.

3. The board shall annually solicit sealed risk-adjusted premium bids from competing health care networks for the purpose of offering health care coverage to participants. The board shall request each bidder to submit information pertaining to whether the bidder is a qualifying health care network, as described in subsection 4.

4. A health care network is qualifying if it does all of the following:

a. Demonstrates to the satisfaction of the board that the fixed monthly risk-adjusted amount that it bids to provide participants with the health care benefits specified in this Act reasonably reflects its estimated actual costs for providing participants with such benefits in light of its underlying efficiency as a network, and has not been artificially underbid for the predatory purpose of gaining market share.

b. Will spend at least ninety-two percent of the revenue it receives under this Act on one of the following:

(1) Payments to health care providers in order to provide the health care benefits specified in this Act to participants who choose the health care network.

(2) Investments that the health care network has reasonably determined will improve the overall quality or lower the overall cost of patient care.

c. Ensures:

(1) That participants living in an area that a health care network serves are not required to drive more than thirty minutes, or, in a metropolitan area served by mass transit, spend more than sixty minutes using mass transit facilities, in order to reach the offices of at least two primary care providers, as defined by the board; and

(2) That physicians, physician assistants, nurses, clinics, hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other

drug abuse treatment, are conveniently available, as defined by the board, to participants living in every part of the area that the health care network serves.

d. Ensures that participants have access, twenty-four hours a day seven days a week, to a toll-free hotline and help desk that is staffed by persons who live in the area and who have been fully trained to communicate the benefits provided under this Act and the choices of providers that participants have in using the health care network.

e. Ensures that each participant who chooses the health care network selects a primary care provider who is responsible for overseeing all of the participant's care.

f. Will provide each participant with medically appropriate and high-quality health care, including mental health services and alcohol or other drug abuse treatment, in a highly coordinated manner.

g. Emphasizes, in its policies and operations, the promotion of healthy lifestyles; preventive care, including early identification of and response to high-risk individuals and groups, early identification of and response to health disorders, disease management, including chronic care management, and best practices, including the appropriate use of primary care, medical specialists, medications, and hospital emergency rooms; and the utilization of continuous quality improvement standards and practices that are generally accepted in the medical field.

h. Has developed and is implementing a program, including providing incentives to providers when appropriate, to promote health care quality, increase the transparency of health care cost and quality information, ensure the confidentiality of medical information, and advance the appropriate use of technology.

i. Has entered shared service agreements with out-of-network medical specialists, hospitals, and other facilities, including medical centers of excellence in the state, through which participants can obtain, at no additional expense to participants beyond the normally required level of cost-sharing,

the services of out-of-network providers that the network's primary care physicians selected by participants have determined is necessary to ensure medically appropriate and high-quality health care, to facilitate the best outcome, or, without reducing the quality of care, to lower costs.

j. Has in place a comprehensive, shared, electronic patient records and treatment tracking system and an electronic provider payment system.

k. Has adopted and implemented a strong policy to safeguard against conflicts of interest.

l. Has been organized by physicians or other health care providers, a cooperative, or an entity whose mission includes improving the quality and lowering the cost of health care, including the avoidance of unnecessary operating and capital costs arising from inappropriate utilization or inefficient delivery of health care services, unwarranted duplication of services and infrastructure, or creation of excess capacity.

m. Agrees to enroll and provide the benefits specified in this Act to all participants who choose the network, regardless of the participant's age, sex, race, religion, national origin, sexual orientation, health status, marital status, disability status, or employment status, except that a health care network may:

(1) Limit the number of new enrollees it accepts if the health care network certifies to the board that accepting more than a specified number of enrollees would make it impossible to provide all enrollees with the benefits specified in this Act at the level of quality that the network is committed to maintaining, provided that the health care network uses a random method for deciding which new enrollees it accepts; or

(2) Limit the participants that it serves to a specific affinity group, such as farmers or teachers, that the health care network has certified to the board, provided that the limitation does not involve discrimination based on any of the factors described in this subdivision and has neither been created for the purpose, nor will have the effect, of screening out

higher-risk enrollees. This paragraph applies only to affinity groups that are in existence as of December 31, 2009.

5. a. The board shall review the bids submitted under subsection 3, the information submitted by bidders pertaining to whether the bidders are qualifying health care networks, and other evidence provided to the board as to whether a particular bidder is a qualifying health care network.

b. Based on the information about bidder qualifications submitted or otherwise provided under subdivision a, the board shall certify which health care networks are qualifying health care networks.

c. With respect to all health care networks that the board certifies under subdivision b, the board shall open the submitted, sealed bids at a predetermined time. The board shall classify the certified health care networks according to price and quality measures after comparing their risk-adjusted per month bids and assessing their quality. The board shall classify the network that bid the lowest price as the lowest-cost network, and shall classify as a low-cost network any network that has bid a price that is close to the price bid by the lowest-cost network. Any other network must be classified as a higher-cost network.

6. The board shall provide an annual open enrollment period during which each participant may select a certified health care network from among those offered, or a fee-for-service option. Coverage is effective on the following January first. A participant who does not select a certified health care network or the fee-for-service option will be assigned randomly to one of the networks that have been classified under subsection 5 as having submitted the lowest or a low bid and as performing well on quality measures, or to the fee-for-service option if that is the lowest-cost option. A participant who selects the fee-for-service option or a certified health care network that has been classified as a higher-cost network, but who fails to pay the additional payment under paragraph 2 of subdivision a of subsection 7, must be assigned randomly to one of the networks that has been classified under subsection 5 as the lowest-cost network or as a low-cost network

and as performing well on quality measures, or to the fee-for-service option if that is the lowest-cost option.

7. a. (1) On behalf of each participant who selects or has been assigned to a certified health care network that has been classified under subdivision c of subsection 5 as the lowest-cost network or a low-cost network and as performing well on quality measures, the board shall pay monthly to the health care network the full risk-adjusted per member per month amount that was bid by the network. The dollar amount must be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who selects or is assigned to the lowest-cost network or a low-cost network may not be required to pay any additional amount to the network.

(2) If a participant chooses instead to enroll in a certified health care network that has been classified under subdivision c of subsection 5 as a higher-cost network, the board shall pay monthly to the chosen health care network an amount equal to the bid submitted by the network that the board classified under subdivision c of subsection 5 as the lowest-cost network and as having performed well on quality measures. The dollar amount must be actuarially adjusted for the participant based on age, sex, and other appropriate risk factors determined by the board. A participant who chooses to enroll in a higher-cost network must pay monthly, in addition to the amount paid by the board, an additional payment sufficient to ensure that the chosen network receives the full price bid by that network.

(3) The board may retain a percentage of the dollar amounts established for each participant under paragraphs 1 and 2 to pay to certified health care networks that have incurred disproportionate risk not fully compensated for by the actuarial adjustment in the amount established for each eligible person. A payment to a certified health care network

under this subdivision must reflect the disproportionate risk incurred by the health care network.

b. (1) The board shall establish provider payment rates that will be paid to providers of covered services and articles that are provided to participants who choose the fee-for-service option under subdivision a of subsection 2. The payment rates must be fair and adequate to ensure that this state is able to retain the highest quality of medical practitioners. The board shall limit increases in the provider payment rate for each service or article such that any increase in per person spending under the plan does not exceed the national rate of medical inflation.

(2) Except for deductibles, copayments, coinsurance, and any other cost-sharing required or authorized under the plan, a provider of a covered service or article shall accept as payment in full for the covered service or article the payment rate determined under paragraph 1 and may not bill a participant who receives the service or article for any amount by which the charge for the service or article is reduced under paragraph 1.

(3) The board, with the assistance of its actuarial consultants, shall establish the monthly risk-adjusted cost of the fee-for-service option offered to participants under subdivision a of subsection 2. The board shall classify the fee-for-service option in the same manner that the board classifies certified health care networks under subdivision c of subsection 5.

(4) If the board has determined under subdivision c of subsection 5 that there is at least one certified low-cost health care network in an area, which may be the lowest-cost health care network, and if the fee-for-service option offered in that area has been classified as a higher-cost choice under paragraph 3, the cost to a participant enrolling in the fee-for-service option must be determined as follows:

(a) If there are available to the participant three or more certified health care networks classified under subdivision c of subsection 5 as low-cost networks, or as the lowest-cost network and two or more low-cost networks, the participant shall pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established under paragraph 3 for the fee-for-service option, except that the amount paid may not exceed one hundred dollars per month for an individual, or two hundred dollars per month for a family, as adjusted for medical inflation.

(b) If there are available to the participant two certified health care networks classified under subdivision c of subsection 5 as low-cost networks, or as the lowest-cost network and one low-cost network, the participant shall pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established under paragraph 3 for the fee-for-service option, except that the amount paid may not exceed sixty-five dollars per month for an individual, or one hundred twenty-five dollars per month for a family, as adjusted for medical inflation.

(c) If there is available to the participant only one certified health care network classified under subdivision c of subsection 5 as a low-cost network, or as the lowest-cost network, the person shall pay the difference between the cost of the lowest-cost health care network and the monthly risk-adjusted cost established under paragraph 3 for the fee-for-service option, except that the amount paid may not exceed twenty-five dollars per month for an individual, and fifty dollars per month for a family, as adjusted for medical inflation.

(6) If the board has determined, under subdivision c of subsection 5, that there is no certified lowest-cost health care network or low-cost health

care network in the area, there is no extra cost to the participant enrolling in the fee-for-service option.

8. Health care providers and facilities providing services under the fee-for-service option under subdivision a of subsection 2 must be encouraged to collaborate with each other through financial incentives established by the board. Providers shall work with facilities to pool infrastructure and resources; to implement the use of best practices and quality measures; and to establish organized processes that result in high-quality, low-cost medical care. The board shall establish an incentive payment system to providers and facilities that comply with this subsection, in accordance with criteria established by the board.

9. Except for prescription drugs to which a deductible applies, the board shall assume the risk for, and pay directly for, prescription drugs provided to participants. In implementing this requirement, the board shall replicate the prescription drug buying system developed by the retirement board for prescription drug coverage under the state employee uniform group insurance plan under chapter 54-52.1, unless the board determines that another approach would be more cost-effective. The board may join the prescription drug purchasing arrangement under this Act with similar arrangements or programs in other states to form a multistate purchasing group to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices, or to contract with a third party, such as a private pharmacy benefits manager, to negotiate with prescription drug manufacturers and distributors for reduced prescription drug prices.

SECTION 8. Subrogation. The board and authority are entitled to the right of subrogation for reimbursement to the extent that a participant may recover reimbursement for health care services and items in an action or claim against any third party.

SECTION 9. Employer-provided health care benefits. This Act does not prevent an employer, or a Taft-Hartley trust on behalf of an employer, from paying all or part of any cost-sharing under section 6 or 7 of this Act, or from providing any health care benefits not provided under the plan, for any of the employer's employees.

SECTION 10. Assessments, individuals, and businesses.

1. In this section:

a. "Commissioner" means the tax commissioner.

b. "Dependent" means a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full-time student under the age of twenty-one years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

c. "Eligible individual" means an individual who is eligible to participate in the plan, other than an employee or a self-employed individual.

d. "Employee" means an individual who has an employer.

e. "Employer" means a person who is required under the Internal Revenue Code to file form 941.

f. "Medical inflation" means the percentage change between the United States consumer price index for all urban consumers, United States city average, for the medical care group only, including medical care commodities and medical care services, for the month of August of the previous year and the United States consumer price index for all urban consumers, United States city average, for the medical care group only, including medical care commodities and medical care services, for the month of August 2009, as determined by the United States department of labor.

g. "Poverty line" means the federal poverty line, as defined under 42 U.S.C. 9902(2), for a family the size of the individual's family.

h. "Self-employed individual" means an individual who is required under the Internal Revenue Code to file schedule SE.

i. "Social security wages" means:

(1) For purposes of subdivision a of subsection 2, the amount of wages, as defined in section 3121(a) of the Internal Revenue Code, paid to an employee by an employer in a taxable year, up to a maximum amount that is equal to the social security wage base.

(2) For purposes of subdivision b of subsection 2, the amount of net earnings from self-employment, as defined in section 1402(a) of the

Internal Revenue Code, received by an individual in a taxable year, up to a maximum amount that is equal to the social security wage base.

(3) For purposes of subsection 3, the amount of wages, as defined in section 3121(a) of the Internal Revenue Code, paid by an employer in a taxable year with respect to employment, as defined in section 3121(b) of the Internal Revenue Code, up to a maximum amount that is equal to the social security wage base multiplied by the number of the employer's employees.

2. Subject to subsection 4, the board shall calculate the following assessments, based on its anticipated revenue needs:

a. For an employee who is under the age of sixty-five, a percent of social security wages that is at least two percent and not more than four percent, subject to the following:

(1) If the employee has social security wages that are one hundred fifty percent or less of the poverty line, the employee may not be assessed.

(2) If the employee has no dependents and the employee's social security wages are more than one hundred fifty percent and two hundred percent or less of the poverty line the assessment must be in an amount, as determined by the board on a sliding scale based on the employee's social security wages, that is between zero percent and four percent of the employee's social security wages.

(3) If the employee has one or more dependents, or is a single individual who is pregnant, and the employee's social security wages are more than one hundred fifty percent and three hundred percent or less of the poverty line the assessment must be in an amount, as determined by the board on a sliding scale based on the employee's social security wages, that is between zero percent and four percent of the employee's social security wages.

b. For a self-employed individual who is under the age of sixty-five, a percent of social security wages that is at least nine percent and not more than ten percent.

c. For an eligible individual who has no social security wages under paragraph 1 or 2 of subdivision i of subsection 1 or, from an employer, under paragraph 3 of subdivision i of subsection 1, ten percent of federal adjusted gross income, up to the maximum amount of income that is subject to social security tax.

3. Subject to subsection 4, the board shall calculate an assessment, based on its anticipated revenue needs, that is a percentage of aggregate social security wages that is at least nine percent and not more than twelve percent.

4. Collection and calculation of assessments.

a. For taxable years beginning after December 31, 2009, the commissioner shall impose on, and collect from, individuals the assessment amounts that the board calculates under subsection 2, either through an assessment that is collected as part of the income tax due, or through another method devised by the commissioner. For taxable years beginning after December 31, 2009, the commissioner shall impose on, and collect from, employers the assessment amounts that the board calculates under subsection 3, either through an assessment that is collected as part of the tax due, or through another method devised by the commissioner.

b. The amounts that the commissioner collects under subdivision a must be deposited into a special fund in the state treasury known as the healthy North Dakota trust fund.

c. The board may annually increase or decrease the amounts that may be assessed under subsections 2 and 3. No annual increase under this subdivision may exceed the percentage increase for medical inflation unless a greater increase is provided for by law.

SECTION 11. Advisory committee.

1. The board shall establish a health care advisory committee to advise the board on all of the following:

a. Matters related to promoting healthier lifestyles.

b. Promoting health care quality.

c. Increasing the transparency of health care cost and quality information.

d. Preventive care.

e. Early identification of health disorders.

f. Disease management.

g. Appropriate use of primary care, medical specialists, prescription drugs, and hospital emergency rooms.

h. Confidentiality of medical information.

i. Appropriate use of technology.

j. Benefit design.

k. Availability of physicians, hospitals, and other providers.

l. Reduction of health care costs.

m. Any subject assigned to it by the board.

n. Any subject determined appropriate by the committee.

2. The board shall appoint as members of the committee all of the following individuals:

a. At least one member designated by the North Dakota medical association.

b. At least one member designated by the North Dakota academy of family physicians.

c. At least one member designated by the North Dakota healthcare association.

d. One member designated by the president of the state board of higher education who is knowledgeable in the field of medicine and public health.

e. One member designated by the dean of the university of North Dakota school of medicine and health sciences.

f. Two members designated by the North Dakota nurses association.

g. One member designated by the North Dakota dental association.

h. One member designated by statewide organizations interested in mental health issues.

i. One member representing health care administrators.

j. Other members representing health care professionals.

SECTION 12. EFFECTIVE DATE. Section 10 of this Act is effective for taxable years beginning after December 31, 2008.