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Sixty-second
Legislative Assembly
of North Dakota

FIRST DRAFT:
Prepared by the Legislative Council staff for the
Health Care Reform Review Committee
September 2011

Introduced by

A BILL for an Act to provide for a North Dakota health benefit exchange; to provide for a contingent expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1.

Definitions.

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

1. "Commissioner" means the insurance commissioner.
2. "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.
3. "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.
4. "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.
5. "Essential health benefits" has the meaning provided under section 1302(b) of the federal act.

6. "Exchange" means the North Dakota health benefit exchange established under this Act.

7. "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].

8. "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.

9. "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.

10. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 9 of this Act.

11. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the exchange, and at the option of the employer, some or all of the employer's part-time employees, provided that the employer:

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

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

12. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described under section 1311(c) of the federal act and section 9 of this Act.

13. "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.

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

15. "Small employer" means an employer that employed an average of at least two but not more than fifty employees during the preceding calendar year; however, by rule the commissioner may revise this definition to provide for a maximum number of employees in excess of fifty employees. For purposes of this subsection:

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

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

c. All employees must be counted in accordance with state and federal law;

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

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

SECTION 2.

Establishment of exchange - Board of directors - Taxation.

1. The North Dakota health benefit exchange is established as a nonprofit corporation to facilitate access to qualified health plans. Neither the exchange nor the exchange's board of directors is an agency of this state. The laws applicable to state agencies do not apply to the exchange nor to the exchange's board unless otherwise specified in this chapter. The exchange may not duplicate or replace the duties of the commissioner established in chapter 26.1-01, including rate approval, except as directed by the federal act. All carriers authorized to conduct business in this state may be eligible to participate in the exchange.
2. The exchange is exempt from the taxes imposed under section 26.1-03-17 and any other tax law of this state. All property owned by the exchange is exempt from taxation.
3. A board of directors shall govern the operation of the exchange and shall determine and establish the development, governance, and operation of the exchange. The board of directors is not an agency of the state and therefore does not have the authority to adopt rules pursuant to chapter 28-32. The board shall implement and operate the exchange in accordance with this Act and take all actions necessary to ensure by January 1, 2013, or other date specified by the commissioner, consistent with federal law, that the exchange is determined by the federal government to be ready to operate by January 1, 2014, or later as otherwise specified by the commissioner and consistent with federal law.

NOTE: AARP does not take a position on what type of entity is chosen to administer the exchange.

SECTION 3.

Board of directors - Organization.

1. The board of directors of the exchange must be made up of ten directors, of whom seven are voting directors and three are nonvoting, ex officio directors consisting of the lieutenant governor, the department of human services director of medicaid, and the commissioner, or the ex officio directors' respective designees.
   a. Before January 2, 2012, the governor shall appoint the initial seven voting directors consisting of three representatives of leading health carriers and four consumer representatives who are not public employees. In appointing the voting directors, the governor shall ensure 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, health care finance, public health care delivery, health benefit plan law, consumer advocacy, and marketing.
   b. As the first term of each initial voting director expires, the voting directors of the board shall recommend to the governor two potential nominees to be considered by the governor for each open position. The governor shall select one of the two nominees for each open position based on consideration of the requirements for expertise established under subdivision a and the plan of operation and shall consider the geographic, demographic, economic, and other characteristics of the state when making the appointment.
2. The voting directors shall elect a voting director to serve as chairman.
3. The term for the voting director is three-years, except the term of two of the initial voting directors must be for two years and the initial term of two voting directors must be for four years in order to initiate stagger terms. Each director shall hold office until expiration of the director's term; until the director's successor is appointed; or until the director's death, resignation, or removal. An individual appointed to fill a midterm vacancy shall serve for the remainder of the unexpired term. A director may serve no more than two consecutive full terms, after which a lapse must occur before being reappointed.
4. In determining voting rights at board of director meetings, each voting director is entitled to vote in person or by proxy. The exchange may not compensate a director

for the director's services, except the exchange may reimburse a director from the money of the exchange for direct expenses incurred as a director.

5. A majority of the voting directors constitutes a quorum for the transaction of business. If a voting director vacancy exists, a majority of the remaining voting directors constitutes a quorum until the vacancy is filled.

6. A director 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. A director may be removed at any time, with cause, by a two-thirds approval of the other directors and the governor. If a vacancy occurs for a director, the governor shall appoint a new director for the duration of the unexpired term.

7. Approval by a majority of the voting directors present is required for any action of the board, unless two-thirds approval by all of the board members entitled to vote is otherwise required under this chapter.

8. A director may not participate in deliberations or vote on any matter before the board if the director has a conflict of interest. A conflict of interest means an association, including an economic interest or personal association, that has the potential to bias or have the appearance of biasing a director's decisions in matters related to the exchange or the conduct of activities under this Act. Each director 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 director is responsible for acting in the interest of the public in discharging the director's duties.

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

10. In the performance of their duties as directors of the exchange, the directors are exempt from the provisions of chapter 51-08.1.

NOTE: Blue Cross Blue Shield of North Dakota (BCBSND), Sanford, and Medica concur in this section. AARP suggests that the only restrictions on the Governor's appointments should be those contained in the federal regulations--at least a majority should represent consumers, a majority should have related experience, and insurers will be regulated and

financially impacted by the exchange and therefore should be excluded because of the conflict of interest.

SECTION 4.

Consumer advisory group.

1. No later than sixty days following the initial appointment of board members, the board of directors shall establish a consumer advisory group for the purpose of facilitating input from a variety of stakeholders on issues related to the duties and operation of the exchange and related issues.
2. Membership of the consumer advisory group must include:
   a. 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. Agents and brokers;
   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;
   j. Representatives of other relevant state agencies, such as the insurance department and the information technology department;
   k. Health care providers;
   l. Public health experts; and
   m. Representatives of large employers.

SECTION 5.

Technical advisory group.

1. No later than sixty days after the initial board members are appointed, 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 of directors 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.

SECTION 6.

Board of directors - Exchange - Duties.

1. The board of directors shall appoint and provide administrative services to the consumer advisory group and the technical advisory group. The board may establish other advisory groups as appropriate to carry out the activities required under this chapter.

2. The board of directors shall develop and the board and exchange shall operate in accordance with a plan of operation. The plan of operation must:

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

b. Provide the protocol for board of director nominees to the governor;

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

d. Establish the manner of board voting;

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

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

g. Establish document retention policies and procedures;

h. Establish a process for consulting with an appointed member of the attorney general's office for legal advice and interpretation with respect to the operations of the exchange; and

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

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

4. The exchange 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 exchange shall establish procedures and safeguards to protect the integrity and confidentiality of any data the exchange maintains.

SECTION 7.

Exchange requirements.

1. The exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates before January 2, 2014, or later as directed by the commissioner in compliance with federal law.

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

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

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

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

(1) The certification provided in subdivision a; and

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

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

NOTE: Subsections 2 and 3 are added at the request of Representative Keiser and all stakeholders are in support of the language. The stakeholders agree that the committee should consider applying the language of subsections 2 and 3 to the health insurance market outside the exchange. The stakeholders also agree that these subsections should not be interpreted to mean grant the exchange broader powers than already granted in the other portions of this Act.

4. The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the federal act.

5. Neither the exchange nor a carrier offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

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

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

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

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

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

NOTE: BCBSND, Medica, and Sanford concur in the language of subsection 10. AARP urges that the exchange be authorized to select insurers using the same competitive market forces that large employers use--using active purchasing methodologies to select insurers based on costs, value, quality, and consumer service--and that the exchange be granted the authority to limit the number of insurers as needed to ensure that all products meet minimum standards established by the exchange.

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

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

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

NOTE: Subsection 13 is Sanford's proposal. BCBSND provides that in order to minimize disruption to the small group market within the exchange and to guard against increased premiums, the Exchange Board of Directors should be authorized to consider the option of incorporating defined contribution models for small groups purchasing exchange products in multiple metallic levels only after input from the advisory committee and public input. Section 155.705b(2) of the federal regulations states that small groups must be allowed to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all qualified health plans within that level are made available to the qualified employees of the employer. Section 155.705b(3) of the federal regulations goes on to state that an exchange *may* choose to allow small groups to make one or more qualified health plans available to qualified employees by a method other than the method described in paragraph (b)(2) of that regulation.

SECTION 8.

Exchange - Duties.

The exchange shall:

1. Implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311(c) of the federal act and section 9 of this Act, of health benefit plans as qualified health plans.

2. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

3. Provide for enrollment periods, as provided under section 1311(c)(6) of the federal act.

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

5. Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311(c)(3) of

the federal act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the federal act.

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

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

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

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

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

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

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

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

   a. A list of the individuals who are issued a certification under subsection 9, 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 that he or she has changed employers; and

(2) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

12. Provide to each employer the name of each employee of the employer described in subdivision b of subsection 11 who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

13. Perform duties required of the exchange by the secretary or the secretary of the treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions.

14. Select entities qualified to serve as navigators in accordance with section 1311(i) of the federal act and with standards developed by the secretary and award grants to enable navigators to:

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

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

c. Facilitate enrollment in qualified health plans;

d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of

the federal Public Health Service Act, or any other appropriate state agency for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan, coverage, or a determination under that plan or coverage; and

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

15. 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.

16. Meet the following financial integrity requirements:

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

b. Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the federal act and allow the secretary, in coordination with the inspector general of the federal department of health and human services, to:

(1) Investigate the affairs of the exchange;

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

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

c. In carrying out the exchange's activities under this Act, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

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

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

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

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

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

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

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

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

b. Other 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.

SECTION 9.

Health benefit plan certification.

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

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

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

(2) In a form approved by the exchange, the carrier makes prominent disclosure at the time the carrier offers the plan that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

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

c. The health benefit plan provides at least a bronze level of coverage, as determined pursuant to subsection 5 of section 8 of this Act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the federal act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

d. The health benefit plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the federal act, and if the plan is offered to a qualified employer, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the federal act;

e. The health carrier offering the health benefit plan:

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

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

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

(4) Does not charge any cancellation fees or penalties in violation of subsection 5 of section 7 of this Act; and

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

f. The health benefit plan meets the requirements of certification as promulgated by the secretary under section 1311(c)(1) of the federal act, which include minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance; and

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

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

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

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

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

3. Notwithstanding subsection 2, a health carrier that does not offer a qualified health plan in the exchange during the initial and subsequent annual open enrollment periods, is prohibited from offering a qualified health plan in the exchange before the following annual open enrollment period. The exchange may permit a health carrier that did not offer a qualified health plan in the exchange during the initial and subsequent annual open enrollment periods to begin offering a qualified health plan before the following annual open enrollment period if the exchange determines that it is in the interest of qualified individuals and qualified employers in this state.

4. Except as otherwise provided in subsections 2 and 3, a health carrier that ceases to offer any qualified health plans in the exchange after January first of a plan year is prohibited from offering a new qualified health plan in the exchange for a period of two years from the date of the health carrier's exit from the exchange. This subsection does not prohibit an affiliated health carrier from continuing to offer a qualified health

plan in the exchange. The exchange may permit a health carrier that ceases to offer any qualified health plans in the exchange after January first of a plan year to begin offering a new qualified health plan in the exchange if the exchange determines that making the qualified health plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

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

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

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

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

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

(6) Data on rating practices;

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

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

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

c. Provide in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance under the individual's health benefit plan or coverage that the individual would be

responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information must be made available to the individual through an internet website and through other means for individuals without access to the internet.

6. The exchange may not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures parity between or among health carriers participating in the exchange.

7. The exchange shall give each health carrier the opportunity to appeal the denial of certification by the exchange of a health benefit plan. The appeal must include the opportunity for submission and consideration of facts, arguments, or proposals for necessary adjustments to health benefit plan or plans that were denied certification. To the extent that the exchange and the health carrier are unable to reach an agreement following the submission of such information, a hearing must be conducted by an administrative law judge, in accordance with state administrative hearing requirements under chapter 28-32, who must render a final decision.

SECTION 10.

Qualified dental plans.

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

SECTION 11.

Funding - Publication of costs.

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

SECTION 12.

Rules - Policies.

The board of directors may develop policies and procedures to implement the provisions of this Act. Policies and procedures developed under this section may not conflict with or prevent the application of regulations promulgated by the secretary under the federal act or exceed the rules enforced by the commissioner.

SECTION 13.

Application.

This Act and actions taken by the exchange pursuant to this Act do not preempt or supersede the authority of the commissioner to regulate the business of insurance within this state. Except as expressly provided to the contrary in this Act, 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 14. 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 or invalidated by the courts or otherwise rendered invalid by a final judicial decree or if the state is granted a federal waiver before or after the establishment of the North Dakota health benefit exchange, this Act expires August 1 following the next regular legislative session after the effective date of the repeal, invalidation, or federal waiver unless the legislative assembly takes specific action to extend the Act.

SECTION 15. EMERGENCY. This Act is declared to be an emergency measure.