State of North Dakota
Interim Health Care Reform Review Committee
Rep. George Keiser, Chairman

Health care reform timeline
2010–2018

Presented by Rebecca Ternes
June 14, 2011

North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
ADAM HAMM, COMMISSIONER

2010

Issue	What law will do	Effective date
Health insurance consumer assistance offices and ombudsmen	States may establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to: • Assist with the filing of complaints and appeals • Collect, track and quantify problems and inquiries • Educate consumers on their rights and responsibilities • Assist consumers with enrollment in plans • Resolve problems with obtaining subsidies States may be required to collect and report data of all the types of problems and inquiries encountered by consumers.[1]	Effective as of date of enactment (3/23/2010)
Preservation of right to maintain existing coverage	The following provisions will apply to grandfathered plans: • Excessive waiting periods • Lifetime limits only • Rescissions • Extension of dependent coverage • Uniform summary of benefits and coverage and standardized definitions • Medical loss ratios[1]	Effective as of date of enactment (3/23/2010)
$250 Medicare Part D rebate	A $250 rebate will be available to seniors reaching the Medicare Part D donut hole.[1]	June 2010
Temporary high-risk pool program	The Secretary of Health and Human Services (HHS) is required to establish a temporary high-risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least six months. Pools must: • Have no preexisting condition exclusions • Cover at least 65% of total allowed costs • Have an out-of-pocket limit no greater than the limit for high deductible health plans ($5,950 for individuals and $11,900 for families) • Utilize adjusted community rating with maximum variation for age of 4:1 • Have premiums established at a standard rate for a standard population The state's current high risk pool, the Comprehensive Health Association of North Dakota (CHAND), does not meet the requirements.[1]	Effective 90 days after enactment (June 23, 2010)

Issue	What law will do	Effective date
Temporary reinsurance program for early retirees	The Secretary of HHS shall establish a temporary reinsurance program to reimburse employment-based plans for 80% of costs incurred by early retirees age 55 and over but not eligible for Medicare between $15,000 and $90,000 annually.[1]	Effective 90 days after enactment (June 23, 2010)
Web portal to identify affordable coverage options	The Secretary of HHS shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage.[1]	07/01/ 2010
Annual and lifetime limits	Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to Jan. 1, 2014 on essential benefits.[1]	09/23/2010
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions- effective six months after enactment for under age 19.[1]	Effective Sept. 23, 2010 for individuals 19 and under. Effective Jan. 1, 2014 for all others.
Rescissions	Insurers cannot rescind coverage after a sickness. Coverage may be rescinded only for fraud or intentional misrepresentation of material fact.[1]	09/23/2010
Coverage of preventative health services	Plans must provide coverage without cost-sharing for: • Services recommended by the U.S. Preventive Services Task Force • Immunizations recommended by the Advisory Committee on enactment Immunization Practices of the Centers for Disease Control • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered.[1]	09/23/2010
Extension of adult dependent coverage	Plans that provide dependent coverage must extend coverage to adult children up to age 26.[1]	09/23/2010
Provision of additional information	All plans must submit to the Secretary of Health and Human Services (HHS)and state insurance commissioners and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage[1]	09/23/2010

Issue	What law will do	Effective date
Appeals process	Internal claims appeal process: • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: • All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) with minimum standards established by the Secretary of HHS that is similar to the NAIC model.[1]	09/23/2010
Patient protections	A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider.[1]	09/23/2010
Ensuring that consumers get value for their dollars	The Secretary of HHS, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online. The Secretary shall award $250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services. Amounts of grants to states are to be determined by the Secretary.	Effective 2010 plan year
Small business tax credit	Available to small businesses offering coverage to employees[1]	Tax credits of up to 35 percent of the cost of premiums will be available in 2010 and will reach 50 percent in 2014.

2011

Issue	What law will do	Effective date
Loss ratio	Medical loss ratios of 80 and 85 percent, respectively, are required for individual/small group and large group plans. Loss ratio is the fraction of revenue from a plan's premiums that goes to pay for medical services.[2]	01/01/2011
Bringing down the cost of health care	Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups.[1]	01/01/2011
Long-term care	A voluntary long-term care program will begin, financed through payroll deductions.[2]	01/01/2011
Study of large group market	The Secretary of HHS shall conduct a study of self-insured and fully-insured plans to compare the characteristics of employers, plan benefits, plan reserves and solvency and determine the extent to which the bill's market reforms will cause adverse selection in the large group market and prompt small and mid-size employers to self insure.[1]	Due no later than one year after enactment (3/23/2011)
GAO study regarding the rate of denial of coverage and enrollment by health insurance and group health plans	The GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of application to enroll in health insurance plans by group health plans and health insurance issuers.[1]	One year after enactment (3/23/2011)

2012

Issue	What law will do	Effective date
Ensuring quality of care	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management • Implement activities to prevent hospital readmission • Implement activities to improve patient safety and reduce medical errors Implement wellness and health promotion activities[1]	2 years after enactment (3/23/2012)
Uniform explanation of coverage documents and standardized definitions	The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees.[1]	Standards must be developed by March 2011; implementation by March 2012

2013

Issue	What law will do	Effective date
Health benefit exchange	The Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges.	01/01/ 2013
Administrative simplification requirements	The Secretary of HHS will develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions.[1]	Rules adopted by July 1, 2011 to become effective by January 1, 2013
Employer requirement to inform employees of coverage option	Employers must provide employees with written notice at the time of hiring informing them of the existence of the Exchange and the availability of subsidies through the Exchange if the plan covers less than 60% of the cost of covered benefits.[1]	03/01/2013

2014

Issue	What law will do	Effective date
Health benefit exchange	The Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges. If a state does not create a qualified exchange, the Secretary must create one. There must be two exchanges: a non-group market exchange and an exchange for small businesses. States may choose to operate only one exchange serving both groups. Some functions to be performed by an exchange include: • Certify qualified plans to be sold in the exchange • Maintain a website • Provide for initial, annual and special open enrollment periods • Maintain a toll-free number • Create a rating system for plans and perform satisfaction survey • Provide a calculator to determine enrollee premiums and subsidies • Identify those individuals exempt from the individual mandate and notify treasury • Require participating plans to provide justification for rate increases[1]	State exchanges must be operational by Jan. 1, 2014.
Free choice vouchers	Employers must provide a voucher in the amount of the employer's contribution towards the group health plan to each employee whose household income is below 400% FPL if the employees' cost of coverage under the group health plan is between 8% and 9.8% of household income and the employee does not enroll in the employer's group health plan. Employees may use these vouchers to purchase coverage through the Exchange.[1]	01/01/2014
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions on anyone.[1]	01/01/2014
Requirement to maintain minimum essential coverage	U.S. citizens and legal residents are required to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.	01/01/2014

	Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).[3]	
Issue	**What law will do**	**Effective date**
Guaranteed issue and renewability in all markets	The law requires guaranteed issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the exchanges.[3]	Plan years beginning 01/01/2014
Employers must offer coverage	Imposes a mandate on employers with 50+ workers: offer coverage by 2014 or pay $2,000/full time worker (excluding the first 30); if offer unaffordable coverage, pay $3,000/employee receiving taxpayer assistance to buy it or a total of $2,000/employee, whichever is more. Employers of 50 or fewer workers are exempt.[2]	01/01/2014
Guaranteed availability of coverage	Insurers must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods.[1]	Plan years beginning 01/01/2014
Prohibiting discrimination against individual participants and beneficiaries based on health status	A plan may not establish rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, generic information, evidence of insurability (including conditions arising out of domestic violence), disability, any other health-status related factor deemed appropriate by the Secretary.[1]	Plan years beginning 01/01/2014
Non-discrimination in health care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks.[1]	Plan years beginning 01/01/2014
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges.[1]	Plan years beginning 01/01/2014
Prohibition on excessive waiting periods	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.[1]	Plan years beginning 01/01/2014
Coverage for individuals participating in approved clinical trials	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.[1]	Plan years beginning 01/01/2014
Rating reforms must apply uniformly to all health insurance issuers and group health plans	Any standard or requirement adopted by a State must be applied uniformly to all health plans in each market to which the standards or requirements apply.[1]	Plan years beginning 01/01/2014

2016

Issue	What law will do	Effective date
Provisions relating to offering of plans in more than one state	Two or more states may enter into a "health care choice compact" under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where it was written or issued. Plans must be licensed in each state in which they sell coverage or must submit to the jurisdiction of the states with regard to the above laws.[1]	01/01/2016

2017

Issue	What law will do	Effective date
Waiver for State Innovation	A state may apply for waivers of the following requirements: • Requirements for Qualified Health Benefits Plans • Requirements for Health Insurance Exchanges • Requirements for reduced cost-sharing in qualified health benefits plans • Requirements for premium subsidies • Requirements for the employer mandate • Requirements for the individuals mandate The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver.[1]	Plan years beginning 01/01/ 2017

2018

Issue	What law will do	Effective date
Tax on "Cadillac" plans	Imposes new taxes on so-called "Cadillac" health insurance policies;[2] 40% tax on health insurance plans worth more than $27,500 for a family plan, $10,200 for an individual plan (family coverage now averages $13,375) [3]	01/01/2018

Sources:
1 National Association of Insurance Commissioners
2 National Conference of Insurance Legislators
3 Kaiser Health News

HEALTH CARE REFORM
NAIC/COMMISSIONER RESPONSIBILITIES
Progress Report – May 2011

Issue	Responsibility	Citation	NAIC Activities
Medical Loss Ratio	NAIC to develop report establishing uniform definitions and standardized methodologies for calculating the MLR.	Section 2718 of PHSA Sec 10101 of PPACA	Sent definitions and methodologies to HHS before deadline – they were accepted by the Secretary. Developed Supplemental Blank to collect data – data collected for 2010. Analyzing impact of MLR on agents/ brokers and possible legislative changes. Considering amendments to Supplemental Blank for 2011; working with HHS on 2011 rebate reporting form.
Rate Review	Grants provided to states that meet minimum federal rate review procedures. Commissioner must report on authority.	Sec 2794 of PHSA Sec 1003 of PPACA	Provided recommendation to HHS on rate review via conference calls and comment letters. Developed draft rate review form for HHS. Worked with HHS and states on the Rate Review Grants – SERFF collecting data for states and receiving grant funds. Commented on the Proposed Regulation and the Draft HHS Rate Review Form. Working with HHS as state laws are reviewed and state-based thresholds are established.
Standard Definitions, Disclosures and Uniform Summary of Benefits	NAIC to develop standards and in conjunction with consumer and industry reps and submit to the Sec.	Sec 2715 of PHSA Sec 1001 of PPACA	Standard Definitions developed by the statutory subgroup sent to HHS. Uniform Summary of Benefits developed by the statutory subgroup sent to HHS. Working on Coverage Fact Labels – current drafts being tested for readability and helpfulness to consumers. Awaiting proposed regulation.
Uniform Enrollment	NAIC to submit criteria for uniform enrollment form to be used in Exchanges.	Sec 1311 of PPACA	Statutory subgroup developing recommendations to HHS.
Individual and Group Market Reforms	NAIC to provide assistance to Sec and models for states. NAIC to consult on definition of age bands and rating areas.	Sec 2701 of the PHSA Sec 1201 of PPACA	Updated Model Laws and Regulations to reflect minimum federal requirements that are effective prior to January 1, 2014. Reg Framework (B) TF working on Model Law and Regulation updates necessary to reflect the minimum federal requirements that are effective January 1, 2014. Consulting with HHS and DOL on NAIC External Review Model, which is referenced in

Issue	Responsibility	Citation	NAIC Activities
			the federal law Tracking state implementation and enforcement of the new laws and regulations. No action yet on age bands and rating areas.
Exchanges	NAIC to consult on regulations establishing Exchanges.	Sec 1321 of PPACA	Created new NAIC Model Law that meets minimum standards of the federal law – some key decisions left to the states. Drafting White Papers to assist states as they consider Exchange design options and address key issues. Drafting Technical Papers on other reforms that will impact Exchange operations. Providing technical assistance to HHS on the federal regulations. Working with other state organizations to share information and provide assistance.
Data Collection	Data to be submitted to the Secretary and Insurance Commissioners by all insurers (including self-insured). Info can be collected by the NAIC.	Sec 2715A of PHSA Sec 10101 of PPACA	Worked with HHS on Ombudsman Grants and the data to be collected by the states. Continuing to work with HHS on an MOU to share data and on future data collection efforts.
Medigap Reforms	NAIC to amend Medigap model to add cost-sharing to Plans C and F	Sec 3201 of PPACA	Medigap Subgroup has held a hearing and begun the process of reviewing the current Model.
Interim Reinsurance Program and Risk Adjustment Mechanism	NAIC to consult on establishment of risk adjustment and interim reinsurance program. Reinsurance assessments to be based on NAIC estimates.	Sec 1341 of PPACA	Actuary and Reinsurance regulators have had initial conversations with HHS on reinsurance and risk adjustment. NAIC to soon begin developing recommendations.
Uniform Fraud Reporting Form	NAIC to develop model standards and forms for private insurers to report fraud and abuse to insurance commissioners and other state officials.	Sec 2794 of PHSA Sec 6603 of PPACA	A letter from the Secretary requesting that the NAIC begin development of the form is expected soon. A new group has also been created to look at the role of limited benefit plans after 2013.
Interstate Compact Standards	NAIC to develop standards for voluntary interstate compacts..	Sec 1333 of PPACA	No action yet.

Federal Exchange grants

Planning grants

These grants give states the resources to conduct the research and planning needed to determine how their Exchanges will be operated and governed. States can use these funds for a variety of initial planning activities. Funds up to $1 million are available for each state and the District of Columbia. Released July 2010.

Forty-nine states and the District of Columbia received $1 million Exchange planning grants. Alaska did not apply for this grant. The following states have since returned the funds: Florida, Louisiana and Oklahoma.

Innovator grants

Early Innovator states will develop Exchange IT models that can be adopted and tailored by other states. All Early Innovator states have committed to assuring that the technology they develop is reusable and transferable. Released October 2010.

Grantee: Kansas Insurance Department
Award amount: $31,537,465

Procured and implemented by the Kansas Health Policy Authority (KHPA), Kansas is extending the new Kansas Medicaid/CHIP eligibility system (K-MED) and integrating K-MED with the Kansas Health Insurance Exchange. The State of Kansas is in preliminary discussions with the State of Missouri to partner on an Exchange and other aspects of this initiative.

Grantee: Maryland Dept of Health and Mental Hygiene
Award amount: $6,227,454

Maryland proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with Maryland legacy systems and the federal portal systems, and Maryland's consumption of planned federal web services (e.g. verification and rules). The technology foundation used by Maryland in its Healthy Maryland initiative is currently being used by several other states. This “point” solution will extend the existing Healthy Maryland platform, which was recently implemented.

Grantee: University of Massachusetts Medical School
Award amount: $35,591,333

This is a multi-state consortia proposal led by the University of Massachusetts Medical School and will include individuals and small businesses in Connecticut, Maine, Massachusetts, Rhode Island and Vermont. These consumers will be able to shop for, select and purchase affordable and high-quality health plans consistent with national reform goals for 2014. The proposed

project approach will be to create and build a flexible Exchange information technology framework in Massachusetts and share those products with other New England states.

Grantee: New York Department of Health
Award amount: $27,431,432

New York proposes to build off its eMedNY Medicaid Management Information System (MMIS) system to build products for the Exchange. It is the primary source of Medicaid data used for financial reporting, program analysis, auditing and quality measurement. The Department plans to use MMIS' assets as the basis for designing and developing an Exchange to serve all New York State health insurance consumers.

Grantee: Oregon Health Authority
Award amount: $48,096,307

Oregon is using commercially available, off-the-shelf software to create the Exchange. The Exchange Early Information Technology Innovation Grant will help Oregon create a modular, reusable IT solution that will provide the Exchange's customers with seamless access to information, financial assistance and easy health insurance enrollment, with no gaps in coverage or assistance cliffs for anyone up to 400% of the federal poverty level. The OHA estimates that 516,000 Medicaid clients and 277,000 commercial insurance consumers will use the Health Insurance Exchange to shop for and enroll in health coverage.

Grantee: Wisconsin Department of Health Services
Award amount: $37,757,266

Wisconsin's proposal envisions a single, intuitive portal through which residents can access subsidized and non-subsidized health care and other state-based programs (e.g. Medicaid, CHIP, child care). The Exchange will integrate across health and human services programs to promote efficiency and lower overall administrative cost.

Grantee: Oklahoma Health Care Authority
Award amount: $54,582,269
Award returned

Establishment grants

These grants are intended to help states continue their work to implement Exchanges. States may initially apply for either level one or level two establishment grants, based on their progress. Level one grants provide up to one year of funding to states that have made some progress under their planning grant. Level two grants are designed to provide funding through December 2014 to applicants that are further along in the establishment of an Exchange. Awards are uncapped. Released January 2011.

Grantee: Indiana
Administrator: Indiana Family and Social Services Administration
Award amount: $6,895,126
Level of funding: Level one
Summary: Indiana will strengthen the health information technology systems that will be integral to its Exchange. Additional funding will support project management, legal, actuarial and financial expertise and general policy support.

Grantee: Rhode Island
Administrator: Rhode Island Department of Business Regulation
Intended award amount: $5,240,668
Level of funding: Level one
Summary: Rhode Island will strengthen health information technology systems, develop an integrated consumer support program to provide support to individuals and small businesses, and strengthen its business operations

Grantee: Washington
Administrator: Washington State Health Care Authority
Intended award amount: $22,942,671
Level of funding: Level one
Summary: Washington will develop options and recommendations on policy decisions that will have a significant impact on the Exchange. The grant will also provide funds to develop a health information technology system that will support its Exchange.

State exchange status

State	Law passed	Details
California	SB 900 (2010)	SB 900 establishes the California Health Benefit Exchange within state government as an independent public entity to be governed by a board.
Indiana	Executive order issued 1/3/11	The Executive Order structures the Exchange as a nonprofit corporation. Forms the Indiana Insurance Market, Inc. to serve as the Exchange.
Maryland	SB 182 (2011)	SB 182 tracks the NAIC model. Provides that the Exchange be established a public corporation and as an independent unit of State government.
Massachusetts		Had an existing Exchange prior to PPACA's enactment, but may need to revise for compliance with PPACA.
Oregon	SB 99 (2011) *not yet signed by Governor*	Consistent with NAIC model. Requires Exchange to be public corporation.
Utah	HB 128 (2011)	Had existing Exchange prior to PPACA's enactment, but may need to revise to comply with PPACA. HB 128 makes a number of changes to the existing statute related to Utah Health Exchange.
Vermont	H 202 (2011)	Consistent with NAIC model. Establishes Exchange as a division in the Department of Vermont Health Access.
Virginia	HB 2434 (2011)	HB 2434 expresses the intent to develop a Virginia Exchange in the Commonwealth. Recommendations are due Oct. 1, 2011.
Washington	SB 5445 (2011)	Establishes Exchange development board. Establishes Exchange as public-private partnership separate from the state.
West Virginia	SB 408 (2011)	SB 408 is consistent with the NAIC model. Includes other provisions related to the governance, functions and operation of the Exchange. Exchange is established as a governmental entity of the state.
Wisconsin		Exchange demo being tested
Wyoming	HB 50	Creates steering committee to study state exchange vs. regional exchange. Report by Oct. 1, 2011.

As of June 7, 26 states and the District of Columbia have pending Exchanges legislation (AL, AK, AR, CO, CT, HI, IL, IA, ME, MD, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NC, OK, OR, PA, RI, SC and TX).

Information courtesy of the NAIC as of 6/7/11