Testimony
Interim Health Care Reform Review Committee
Friday, August 5, 2011
Provided by Marlowe Kro, Associate State Director
AARP North Dakota

Chairman Keiser and members of the Health Care Reform Review Committee, my name is Marlowe Kro, Associate State Director for Community Outreach, AARP North Dakota.

Thank you for the opportunity to provide AARP's redlined edition of the National Association of Insurance Commissioners (NAIC) Health Benefit Model Act. As we testified at your last meeting on July 7th, AARP strongly believes that regardless of where the exchange is placed, it is critical that the entity be accountable, its actions transparent, and its governing board act in the best interest of consumers.

As the ultimate beneficiaries of the exchange, consumers should be well represented in its governance and management. While others have a role, the governing structure should assure that the consumer voice is central and not secondary to others. The governing body's deliberations and decisions should be transparent, and should provide ample opportunity for public input.

Ms. Clark has provided you a copy of the AARP redlined NAIC Model Act and we trust this committee will have opportunity to review AARP's recommendations for consideration of inclusion in North Dakota's Health Benefit Exchange.

As planning for North Dakota's health insurance exchange continues, AARP stands ready to provide continuing input. If you have any questions of me today, I will be happy to respond.

~~AMERICAN~~ HEALTH BENEFIT EXCHANGE ~~MODEL~~ ACT OF NORTH DAKOTA

Table of Contents

Section 1. Title
Section 2. Purpose and Intent
Section 3. Definitions
Section 4. Establishment of Exchange
Section 5. General Requirements
Section 6. Duties of Exchange
Section 7. Health Benefit Plan Certification
Section 8. Consumer assistance tools and programs.
Section 9. Funding; Publication of Costs
Section ~~9~~10. Regulations
Section ~~10~~11. Relation to Other Laws
Section ~~11~~12. Effective Date

Section 1. Title

This Act shall be known and may be cited as the ~~American~~ Health Benefit Exchange Act of North Dakota.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Drafting Note: States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the references to "small" employers and the "small" group market.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "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.

C. "Essential health benefits" ahs the meaning provided under section 1302(b) of the Federal Act.

D. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

~~D~~E. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

~~E~~F. (1) "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.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or 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 on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

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

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include 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:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

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

~~F~~G. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

~~G~~H. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7E of this Act.

~~H~~I. "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 SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

~~I~~J. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

~~J~~K. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) 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.

~~K~~L. "Secretary" means the Secretary of the federal Department of Health and Human Services.

~~L~~M. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

~~M~~N. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

(2) 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 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that 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 available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an

increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. The ~~[insert official title of the Exchange]~~Health Benefit Exchange of North Dakota is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

B. Governance

1. The State must ensure that the Exchange has in place a clearly-defined governing board that:

(a) Is administered under a formal, publicly-adopted operating charter or by-laws;

(b) Holds regular public governing board meetings that are announced in advance;

(c) Represents consumer interests by ensuring that overall governing board membership is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and

(d) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

2. Governance principles.

(a) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.

(c) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

3. A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.

(a) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange.

~~B~~C. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

~~C~~D. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity is not a health insurance issuer or a member of the same controlled group of corporations (or under common control with) as a health insurance issuer, and

(1) is defined as the State Medicaid agency or an entity incorporated under and subject to the laws of one or more states, and

(2).has demonstrated experience on a state or regional basis ~~includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience~~ in the individual and small group health insurance markets and in benefits coverage.~~, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.~~

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act 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.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) 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.

C. 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.

Section 6. Duties of Exchange

The Exchange shall:

A. 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 7 of this Act, of health benefit plans as qualified health plans;

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

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information, including health plan quality and performance, for ~~on~~ such plans;

E. 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;

F. 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 PHSA;

G. 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 (CHIP) 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;

H. 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;

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

J. 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:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) 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:

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

(b) 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

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

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

L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. 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;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary~~, and award grants to enable Navigators to:(1)~~

1. Entities eligible to be a Navigator.

(a) To receive a Navigator grant, an entity must

(i) Be capable of carrying out at least those duties described in paragraph (d) of this section;

(ii) Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(iii) Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable; and

(iv) Not have a conflict of interest during the term as Navigator.

(b) The Exchange must include entities from at least two of the following categories for receipt of a Navigator grant:

(i) Community and consumer-focused nonprofit groups;

(ii) Trade, industry, and professional associations;

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

(iv) Chambers of commerce;

(v) Unions;
(vi) Resource partners of the Small Business Administration;
(vii) Licensed agents and brokers; and
(viii) Other public or private entities that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.

2. The Exchange must ensure that a Navigator must not
(a) Be a health insurance issuer; or
(b) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP.

3. An entity that serves as a Navigator must carry out at least the following duties:
(a) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;
(b) Provide information and services in a fair, accurate and impartial manner.
(c) 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 QHPs;
(d) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such 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, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

4. Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange.

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

~~(2) 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;~~

~~(3) Facilitate enrollment in qualified health plans;~~

~~(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and~~

~~(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;~~

O. ~~Review~~ consider the rate of premium growth within the Exchange and outside the Exchange~~, and consider the information~~ in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. ~~Consult with~~Establish advisory panels of stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

1. Educated health care consumers who are enrollees in QHPs;
2. Individuals and entities with experience in facilitating enrollment in health coverage;
3. Advocates for enrolling hard-to-reach populations, which includes individuals with a mental health or substance abuse disorder. This includes advocates for individuals with disabilities and those who need culturally and linguistically appropriate services;
4. Small businesses and self-employed individuals;
5. State Medicaid and CHIP agencies.
6. Consumers or consumer advocates who are Medicaid or CHIP beneficiaries;
7. Federally-recognized tribe(s) as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. §479a, located within the Exchange's geographic area;
8. Public health experts;
9. Health care providers;
10. Large employers;
11. Health insurance issuers; and
12. Agents and brokers~~(1) Educated health care consumers who are enrollees in qualified health plans;~~

~~(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;~~

~~(3) Representatives of small businesses and self-employed individuals;~~

~~(4) The [insert name of State Medicaid office]; and~~

~~(5) Advocates for enrolling hard to reach populations~~; and

R. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) 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 U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;

(b) Examine the properties and records of the Exchange; and

(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its 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.

(4). Fiduciary Duties and Liability

(a). Any person who acts on behalf of an Exchange shall act as a fiduciary. Such person shall ensure that the Exchange is operated

(i) solely in the interests of qualified individuals and qualified employers participating in qualified health plans offered through the Exchange, and

(ii) for the exclusive purpose of facilitating the purchase of qualified health plans.

(b) Any person who acts as afiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable tomake 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 shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The 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 E, if:

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

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, 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;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The 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 through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health 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;

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) 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;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, 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

(7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) 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.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its 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 PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

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

(vi) Data on rating practices;

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

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's 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 shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

D. The Exchange shall 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 assures a level playing field between or among health carriers participating in the Exchange.

E. Decertification of QHP
(a) Decertification means the termination by the Exchange of the certification status and offering of a QHP.
(b) The Exchange must establish a process for the decertification of QHPs which, at a minimum, meet the requirements in this section.

(c) The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria.
(d) The Exchange must establish a process for the appeal of a decertification of a QHP.
(e) Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:
(1) The QHP issuer;
(2) Exchange enrollees in the QHP who must receive information about a special enrollment period;
(3) HHS; and
(4) The State department of insurance.

F. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, 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

(4) 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 8. Funding; Publication of Costs

A. ~~A.~~ Funding
a. As required by section 1311(d)(5)(A) of the Federal Act, the State shall ensure that the Exchange is self-sustaining by January 1, 2015.
b. The Exchange may charge assessments or user fees to health carriers or otherwise may receive funding necessary to support its operations provided under this Act.
c. Any unspent funding by an Exchange shall be used for future state operation of its Exchange.

B. Disclosure. Taxes, fees, or assessments used to finance the Exchange must be clearly disclosed by the Exchange as such, including publishing the average cost of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs.

C. Treatment of Taxes or Fees for Medical Loss Ratio Purposes. Taxes, fees, or assessment used to finance the Exchange shall be considered a state tax or assessment as defined in section 2718(a) of the PHSA and its implementing regulations, and must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

Section 9. Consumer assistance tools and programs.

A. Call center. The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance.
B. Internet website. The Exchange must maintain an up-to-date Internet website that:
(1) Provides standardized comparative information on each available QHP, including at a minimum:
(i) Premium and cost-sharing information;
(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;
(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;
(iv) The results of enrollee satisfaction survey, described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned pursuant to section 1311(c)(3) of the Affordable Care Act;
(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR 158;
(vii) Transparency of coverage measures reported to the Exchange during certification; and
(viii) The provider directory made available to the Exchange.

(2) Is accessible to people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons with limited English proficiency.

(3) Publishes the following financial information:
(i) The average costs of licensing required by the Exchange;
(ii) Any regulatory fees required by the Exchange;
(iii) Any payments required by the Exchange in addition to fees under (i) and (ii) of this paragraph;
(iv) Administrative costs of such Exchange; and
(v) Monies lost to waste, fraud, and abuse.

(4) Provides applicants with information about Navigators and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

(5) Allows for an eligibility determination to be made.

(6) Allows for enrollment in coverage in accordance with subpart E of this part.

C. Exchange calculator. The Exchange must establish and make available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.

D. Consumer assistance. The Exchange must have a consumer assistance function, including the Navigator program and must refer consumers to consumer assistance programs in the State when available and appropriate.

E. Outreach and education. The Exchange must conduct outreach and education activities to educate consumers about the Exchange and to encourage participation.

Section ~~9~~10. Regulations

The ~~Exchange~~ State may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

Section ~~10~~11. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to 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 fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Section ~~11~~12. Effective Date

This Act shall be effective [insert date].

~~AMERICAN~~ HEALTH BENEFIT EXCHANGE ~~MODEL~~ ACT OF NORTH DAKOTA

Table of Contents

Section 1. Title
Section 2. Purpose and Intent
Section 3. Definitions
Section 4. Establishment of Exchange
Section 5. General Requirements
Section 6. Duties of Exchange
Section 7. Health Benefit Plan Certification
Section 8. Choice
Section ~~8~~9. Funding; Publication of Costs
Section ~~9~~10. Regulations
~~Section 10. Relation to Other Laws~~
Section 11. Effective Date

Section 1. Title

This Act shall be known and may be cited as the ~~American~~ Health Benefit Exchange Act of North Dakota.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

B. "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.

C. "Essential health benefits" has the meaning provided under section 1302(b) of the Federal Act.

D~~C~~. "Exchange" means the ~~[insert name of~~North Dakota State Exchange~~]~~ established pursuant to section 4 of this Act and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

E~~D~~. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

F. "Individual Exchange" means the Exchange through which qualified individuals may purchase coverage established under Section 6 of this Act.

G~~E~~.

(1) "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.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or 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 on-site medical clinics; or
(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;
(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include 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:

(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
(c) Similar supplemental coverage provided to coverage under a group health plan.

H~~F~~. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

I~~G~~. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7G~~E~~ of this Act.

JH. "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 SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed.; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

K. "Principal place of business" is defined as the location in a state where an employer has its headquarters or significant place of business and where the person with direction and control authority over the business are employed.

LI. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

MJ. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) 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.

NK. "Secretary" means the Secretary of the federal Department of Health and Human Services.

OL. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

PM.

(1) "Small employer" means an employer that employed an average of 2 to not more than 50100 employees during the preceding calendar year unless and until such time as Federal law or regulations may require.

(2) 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 shall be treated as a single employer.

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All eEmployees shall be counted in accordance with state law, including part-time employees and employees who are not eligible for coverage through the employer;

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that 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 available to its employees through the SHOP Exchange, and would cease to be a small

employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

~~A.~~ The ~~[insert official title of the Exchange]~~Health Benefit Exchange of North Dakota is hereby established by the State as a ~~[insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity]~~nonprofit entity.

A. -Board of Directors: The nonprofit entity shall be governed by a board, with duties and powers as established by this section. The Board shall consist of 8 members; 5 voting members appointed by the Governor who are not public employees and 3 non-voting, ex officio members.

(1) The term for the voting members of the Board shall be a three year term, except that a person appointed to fill a vacancy shall serve only for the unexpired term.

(2) Of the voting members first appointed, in order to ensure staggered terms, two of the Governor's appointees shall serve for a term of two years and the remaining Governor's appointees shall serve for a term of three years.

(3) The Board's ex officio members shall include the Lieutenant Governor, the State director of Medicaid and the Commissioner of the Department of Insurance or their respective designees.

(4) The Governor shall appoint one voting member in good standing of the American Academy of Actuaries, two voting members from the consumer community who are familiar with the purchase of individual or group insurance, and two voting members from leading North Dakota health insurance carriers.

(5) The Governor shall designate one voting member of the Board to serve as chairperson.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans to qualified individuals and qualified employers;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in a qualified health plan or qualified health plans; and

(3) Meet the requirements of the Federal Act, this Act and any regulations implemented under this Act~~.~~; and

(4) Select an Executive Director to lead operations and hire necessary staff; and

(5) Consult with an appointed member of the Attorney General's office regarding legal interpretation and advice.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. ~~An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.~~

(1) An eligible entity is not a health carrier and is defined as:

a. A person –

i. Incorporated under, and subject to the laws, of 1 or more states;

ii. That has demonstrated experience on a state or regional basis in the individual or small group health insurance markets, or in benefits coverage.

(2) Any eligible entity that enters into an agreement to carry out 1 or more responsibilities of the Exchange shall have the same fiduciary duties and liability as provided for in Section 6.R. of this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act 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.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates ~~on or before January 1, 2014~~as established by Federal law or regulation.

B.

(1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) 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.

C. 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.

D. 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.

(1) Additional Benefits-

(a) Nothing in this section shall preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits, including wellness programs.

(b) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that state law or regulation requires that a qualified health plan offer benefits in addition to the essential health benefits, the state shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a qualified health plan or on behalf of an individual directly to the qualified health plan in which such individual is enrolled.

(c) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that funding to defray the cost for such additional benefits is not provided, the qualified health plan shall not be required to provide such additional benefits.

Section 6. Duties of Exchange

The Exchange shall:

A. 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 7 of this Act, of health benefit plans as qualified health plans;

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

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

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

E. 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;

F. 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 PHSA;

G. 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 (CHIP) 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;

H. 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;

I. Establish an Individual Exchange, through which qualified individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

J~~I~~. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

K~~J~~. 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:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

L~~K~~. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) 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:
(a) The employer did not provide minimum essential coverage; or
(b) 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

(3) The name and taxpayer identification number of:
(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

ML. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

NM. 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;

ON. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) 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;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

PO. Review Consider the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

QP. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer, and remit the amount of the free choice voucher to the appropriate health carrier;

RQ. ~~Consult with~~Establish an advisory panel of stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) Representatives of health carriers that offer qualified health plans through the Exchange;

(5) Representatives of health carriers that are not offering qualified plans through the Exchange;

(6) The Department of Insurance;

(~~4~~7) The ~~[insert name of State Medicaid office]~~Department of Human Services;

(8) The Information Technology Department

(9) Representatives of health care providers; and

(~~5~~10) Advocates for enrolling hard to reach populations~~; and~~.

SR. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit, to the Secretary, the Governor, the commissioner and the Legislature, a report concerning such accountings;

(2) 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 U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;
(b) Examine the properties and records of the Exchange; and
(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its 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.

(4) Fiduciary Duties and Liability -

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

(b) Any person who acts as a fiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations, or duties imposed by this section shall be 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 shall be subject to such

other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary

Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The 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 ~~E~~G, if:

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

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, 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;

(2) The premium rates and contract language have been approved by the ~~e~~Commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The 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 through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health 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;

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) 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;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act~~, which include, but are not limited to, 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~~ unless

(7) The Exchange determines that making the plan available through the Exchange is not in the interest of qualified individuals and qualified employers in this State, in accordance with section 7.C of this Act.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) 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.

C. Presumption of Best Interest:

(1) In order to foster a competitive Exchange marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the Exchange to certify all health plans meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange.

(2) The Exchange shall certify all health plans meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange. The Exchange shall establish and publish a transparent, objective process for decertifying qualified health plans that are determined to be not in the public interest to be offered through the Exchange.

D~~C~~. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its 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 PHSA, into consideration when determining whether to continue to allow the carrier to make plans available through the Exchange~~;~~. In no case shall an Exchange impose any premium price controls or restrict premium that otherwise meets the requirements of State Law.

(2)

(a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;
(ii) Periodic financial disclosures;
(iii) Data on enrollment;
(iv) Data on disenrollment;
(v) Data on the number of claims that are denied;
(vi) Data on rating practices;
(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
(viii) Information on enrollee and participant rights under title I of the Federal Act; and
(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's 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 shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

E. Appeal of Decertification or Denial of Certification:

(1) The Exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan.

(2) The Exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

(a) the submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue; and

(b) a hearing and a decision on the record, to the extent that the Exchange and the health carrier are unable to reach agreement following the submission of the information in subparagraph (a).

(3) Any hearing held pursuant to paragraph (2) of this subsection shall be conducted by an [impartial party or an administrative law judge with appropriate legal training] and in accordance with [state administrative hearing requirements or APA hearing requirements (5 U.S.C. § 556)].

F~~D~~. The Exchange shall 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 assures a level playing field between or among health carriers participating in the Exchange.

G~~E~~.

(1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, 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

(4) 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 8. Choice

A. In accordance with section 1312(b) of the Federal Act, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing such qualified health plan.

B. Risk Pooling - In accordance with section 1312(c) of the Federal Act

(1) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, members of a single risk pool.

(2) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

C. Empowering Consumer Choice - In accordance with section 1312(d) of the Federal Act

(1) This section shall not prohibit --

(a) a health carrier from offering outside of an Exchange a health plan to a qualified individual or qualified employer; or

(b) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) This section shall not limit the operation of any requirement under state law or regulation with respect to any policy or plan that is offered outside of the Exchange with respect to any requirement to offer benefits.

(3) Voluntary Nature of an Exchange-

(a) Nothing in this section shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(b) Nothing in this section shall compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(c) A qualified individual may enroll 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 plan only if the individual is eligible to enroll in the plan under section 1302(e)(2) of the Federal Act.

D. Enrollment through Agents or Brokers - In accordance with section 1312(e) of the Federal Act, the Exchange may allow agents or brokers

(1) to enroll qualified individuals and qualified employers in any qualified health plan offered through the Exchange for which the individual or employer is eligible; and

(2) to assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the Exchange.

Section 9. Funding; Publication of Costs

A. Funding -

(1) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange shall be self-sustaining by January 1, 2015. A budget for the Exchange shall be prepared by the governor and submitted to the Legislature annually for approval.

(2) The Exchange may charge assessments or user fees to health carriers or otherwise may ~~generate~~ receive funding necessary to support its operations provided under this Act, such as from the State's general fund revenue, tobacco taxes, premium taxes and from grants.

(3) Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding.

(4) Services performed by the Exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers.

(5) Any unspent funding by an Exchange shall be used for future state operation of its Exchange or returned to health carriers as a credit if a state charges fees to carriers.

B. Disclosure - Taxes, fees or assessments used to finance the Exchange must be clearly disclosed by the Exchange as such, including publishing the average cost of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs.

C. Treatment of Taxes or Fees for Medical Loss Ratio Purposes - Taxes, fees or assessment used to finance the Exchange shall be considered a state tax or assessment as defined in section 2718(a) of the PHSA and its implementing regulations, and must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

D. Publication - ~~B.~~ The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9~~10~~. Regulations

The Exchange may promulgate ~~regulations~~ rules to implement the provisions of this Act. ~~Regulations~~ Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act or exceed the rules enforced by the Department of Insurance.

~~**Section 10. Relation to Other Laws**~~

~~Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to 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 fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.~~

Section 11. Effective Date

This Act shall be effective [insert date].

~~AMERICAN~~ HEALTH BENEFIT EXCHANGE ~~MODEL~~ ACT OF NORTH DAKOTA

Table of Contents

Section 1. Title
Section 2. Purpose and Intent
Section 3. Definitions
Section 4. Establishment of Exchange
Section 5. General Requirements
Section 6. Duties of Exchange
Section 7. Health Benefit Plan Certification
Section 8. Choice
Section ~~8~~9. Funding; Publication of Costs
Section ~~9~~10. Regulations
~~Section 10. Relation to Other Laws~~
Section 11. Effective Date

Section 1. Title

This Act shall be known and may be cited as the ~~American~~ Health Benefit Exchange Act of North Dakota.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

B. "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.

C. "Essential health benefits" has the meaning provided under section 1302(b) of the Federal Act.

D~~C~~. "Exchange" means the ~~[insert name of~~North Dakota State Exchange~~]~~ established pursuant to section 4 of this Act and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

E~~D~~. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

F. "Individual Exchange" means the Exchange through which qualified individuals may purchase coverage established under Section 6 of this Act.

G~~E~~.

(1) "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.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or 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 on-site medical clinics; or
(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;
(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include 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:

(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
(c) Similar supplemental coverage provided to coverage under a group health plan.

H~~F~~. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

I~~G~~. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7G~~E~~ of this Act.

JH. "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 SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed.; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

K. "Principal place of business" is defined as the location in a state where an employer has its headquarters or significant place of business and where the person with direction and control authority over the business are employed.

LI. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

MJ. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) 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.

NK. "Secretary" means the Secretary of the federal Department of Health and Human Services.

OL. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

PM.

(1) "Small employer" means an employer that employed an average of 2 to not more than 50100 employees during the preceding calendar year unless and until such time as Federal law or regulations may require.

(2) 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 shall be treated as a single employer.

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All eEmployees shall be counted in accordance with state law, including part-time employees and employees who are not eligible for coverage through the employer;

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that 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 available to its employees through the SHOP Exchange, and would cease to be a small

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employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. The ~~[insert official title of the Exchange]~~Health Benefit Exchange of North Dakota is hereby established by the State as a ~~[insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity]~~nonprofit entity.

A. Board of Directors. The nonprofit entity shall be governed by a board, with duties and powers as established by this section. The Board shall consist of 8 members; 5 voting members appointed by the Governor who are not public employees and 3 non-voting, ex officio members.

(1) The term for the voting members of the Board shall be a three year term, except that a person appointed to fill a vacancy shall serve only for the unexpired term.

(2) Of the voting members first appointed, in order to ensure staggered terms, two of the Governor's appointees shall serve for a term of two years and the remaining Governor's appointees shall serve for a term of three years.

(3) The Board's ex officio members shall include the Lieutenant Governor, the State director of Medicaid and the Commissioner of the Department of Insurance or their respective designees.

(4) The Governor shall appoint one voting member in good standing of the American Academy of Actuaries, two voting members from the consumer community who are familiar with the purchase of individual or group insurance, and two voting members from leading North Dakota health insurance carriers.

(5) The Governor shall designate one voting member of the Board to serve as chairperson.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans to qualified individuals and qualified employers;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in a qualified health plan or qualified health plans; and

(3) Meet the requirements of the Federal Act, this Act and any regulations implemented under this Act~~.~~; and

(4) Select an Executive Director to lead operations and hire necessary staff; and

(5) Consult with an appointed member of the Attorney General's office regarding legal interpretation and advice.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. ~~An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.~~

(1) An eligible entity is not a health carrier and is defined as:

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a. A person –

i. Incorporated under, and subject to the laws, of 1 or more states;

ii. That has demonstrated experience on a state or regional basis in the individual or small group health insurance markets, or in benefits coverage.

(2) Any eligible entity that enters into an agreement to carry out 1 or more responsibilities of the Exchange shall have the same fiduciary duties and liability as provided for in Section 6.R. of this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act 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.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates ~~on or before January 1, 2014~~as established by Federal law or regulation.

B.

(1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange shall not make available any health plan for which product language and premium rates have not been approved by the Commissioner.

(3) The Exchange shall be provided by the Commissioner 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:

(i) The certification provided in subsection B(3)(a) above by the Commissioner's actuary, and;

(ii) a statement by the Commisioner's actuary identifying calculations and/or assumptions underlying the carrier's filed rates which were unreasonable to the actuary and which necessitated modification of the premium rates;

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

~~(2)~~(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.

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C. 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.

D. 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.

(1) Additional Benefits-

(a) Nothing in this section shall preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits, including wellness programs.

(b) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that state law or regulation requires that a qualified health plan offer benefits in addition to the essential health benefits, the state shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a qualified health plan or on behalf of an individual directly to the qualified health plan in which such individual is enrolled.

(c) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that funding to defray the cost for such additional benefits is not provided, the qualified health plan shall not be required to provide such additional benefits.

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Section 6. Duties of Exchange

The Exchange shall:

A. 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 7 of this Act, of health benefit plans as qualified health plans;

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

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

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

E. 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;

F. 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 PHSA;

G. 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 (CHIP) 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;

H. 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;

I. Establish an Individual Exchange, through which qualified individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible,

J~~H~~. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

K~~J~~. 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:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

L~~K~~. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) 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:
(a) The employer did not provide minimum essential coverage; or
(b) 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

(3) The name and taxpayer identification number of:
(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

M~~L~~. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

N~~M~~. 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;

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ON. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) 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;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the ~~Public Health Service Act (~~PHSA~~)~~, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

PO. ~~Review~~ Consider the rate of premium growth within the Exchange and outside the Exchange~~, and consider the information~~ in developing recommendations on whether to continue limiting qualified employer status to small employers;

QP. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, ~~and~~ collect the amount credited from the offering employer, and remit the amount of the free choice voucher to the appropriate health carrier;

RQ. ~~Consult with~~Establish an advisory panel of stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

~~(3)~~ (3) Representatives of small businesses and self-employed individuals;

(4) Representatives of health carriers that offer qualified health plans through the Exchange;

(5) Representatives of health carriers that are not offering qualified plans through the Exchange;

(6) The Department of Insurance;

(47) The ~~[insert name of State Medicaid office]~~Department of Human Services; and

(~~5~~8) Advocates for enrolling hard to reach populations~~; and~~.

SR. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit, to the Secretary, the Governor, the commissioner and the Legislature, a report concerning such accountings;

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(2) 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 U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;
(b) Examine the properties and records of the Exchange; and
(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its 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.

(4) Fiduciary Duties and Liability -

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

(b) Any person who acts as a fiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations, or duties imposed by this section shall be 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 shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary

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Section 7. Health Benefit Plan Certification

A. The Exchange ~~may~~ shall certify a health benefit plan as a qualified health plan if:

(1) The 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 ~~E~~G, if:

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

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, 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;

(2) The premium rates and contract language have been approved by the ~~e~~Commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The 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 through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health 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;

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) 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;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act~~, which include, but are not limited to, 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~~ unless

(7) The Exchange determines that making the plan available through the Exchange is not in the interest of qualified individuals and qualified employers in this State, in accordance with section 7.C of this Act.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) 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.

C. Presumption of Best Interest:

(1) In order to foster a competitive Exchange marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the Exchange to certify all health plans meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange.

(2) The Exchange shall certify all health plans meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange. The Exchange shall establish and publish a transparent, objective process for decertifying qualified health plans that are determined to be not in the public interest to be offered through the Exchange.

D~~C~~. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its 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 PHSA, into consideration when determining whether to continue to allow the carrier to make plans

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available through the Exchange~~;~~. In no case shall an Exchange impose any premium price controls or restrict premium that otherwise meets the requirements of State Law.

(2)

(a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;
(ii) Periodic financial disclosures;
(iii) Data on enrollment;
(iv) Data on disenrollment;
(v) Data on the number of claims that are denied;
(vi) Data on rating practices;
(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
(viii) Information on enrollee and participant rights under title I of the Federal Act; and
(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's 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 shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

E. Appeal of Decertification or Denial of Certification:

(1) The Exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan.

(2) The Exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

(a) the submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue; and

(b) a hearing and a decision on the record, to the extent that the Exchange and the health carrier are unable to reach agreement following the submission of the information in subparagraph (a).

(3) Any hearing held pursuant to paragraph (2) of this subsection shall be conducted by an [impartial party or an administrative law judge with appropriate legal training] and in accordance with [state administrative hearing requirements or APA hearing requirements (5 U.S.C. § 556)].

F~~D~~. The Exchange shall 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 assures a level playing field between or among health carriers participating in the Exchange.

G~~E~~.

(1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the

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provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, 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

(4) 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 8. **Choice**

A. In accordance with section 1312(b) of the Federal Act, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing such qualified health plan.

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B. Risk Pooling - In accordance with section 1312(c) of the Federal Act

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(1) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, members of a single risk pool.

(2) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

C. Empowering Consumer Choice - In accordance with section 1312(d) of the Federal Act

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(1) This section shall not prohibit --

(a) a health carrier from offering outside of an Exchange a health plan to a qualified individual or qualified employer; or

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(b) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

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(2) This section shall not limit the operation of any requirement under state law or regulation with respect to any policy or plan that is offered outside of the Exchange with respect to any requirement to offer benefits.

(3) Voluntary Nature of an Exchange-

(a) Nothing in this section shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(b) Nothing in this section shall compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(c) A qualified individual may enroll 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 plan only if the individual is eligible to enroll in the plan under section 1302(e)(2) of the Federal Act.

D. Enrollment through Agents or Brokers - In accordance with section 1312(e) of the Federal Act, the Exchange may allow agents or brokers

(1) to enroll qualified individuals and qualified employers in any qualified health plan offered through the Exchange for which the individual or employer is eligible; and

(2) to assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the Exchange.

Section 9. Funding; Publication of Costs

A. Funding -

(1) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange shall be self-sustaining by January 1, 2015. A budget for the Exchange shall be prepared by the governor and submitted to the Legislature annually for approval.

(2) The Exchange may charge assessments or user fees to health carriers or otherwise may ~~generate~~ receive funding necessary to support its operations provided under this Act, such as from the State's general fund revenue, tobacco taxes, premium taxes and from grants.

(3) Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding.

(4) Services performed by the Exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers.

(5) Any unspent funding by an Exchange shall be used for future state operation of its Exchange or returned to health carriers as a credit if a state charges fees to carriers.

B. Disclosure - Taxes, fees or assessments used to finance the Exchange must be clearly disclosed by the Exchange as such, including publishing the average cost of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs.

C. Treatment of Taxes or Fees for Medical Loss Ratio Purposes - Taxes, fees or assessment used to finance the Exchange shall be considered a state tax or assessment as defined in section 2718(a) of the PHSA and its implementing regulations, and must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

D. Publication - ~~B.~~ The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an

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Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section ~~9~~10. Regulations

The Exchange may promulgate ~~regulations~~ rules to implement the provisions of this Act. ~~Regulations~~ Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act or exceed the rules enforced by the Department of Insurance.

~~**Section 10. Relation to Other Laws**~~

~~Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to 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 fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.~~

Section 11. Effective Date

This Act shall be effective [insert date].

~~AMERICAN~~ HEALTH BENEFIT EXCHANGE ~~MODEL~~ ACT OF NORTH DAKOTA

Table of Contents

Section 1. Title
Section 2. Purpose and Intent
Section 3. Definitions
Section 4. Establishment of Exchange
Section 5. General Requirements
Section 6. Duties of Exchange
Section 7. Health Benefit Plan Certification
Section 8. Funding; Publication of Costs
Section 9. ~~Regulations~~
~~Section 10.~~ Relation to Other Laws
~~Section11~~Section10. Sunset
Section 11. Effective Date

Section 1. Title

This Act shall be known and may be cited as the ~~American~~ Health Benefit Exchange Act of North Dakota.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to ~~provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to~~ assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

B. "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.

C. "Exchange" means the ~~[insert name of State Exchange]~~ North Dakota Health Benefit Exchange established pursuant to ~~section 4 of~~ this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and ~~any~~ all amendments thereto from time to time, or implementing regulations ~~or guidance~~ issued under, those Acts.

E. (1) "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.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or 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 on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

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

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include 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:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

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

F. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this Sstate, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

G. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section ~~7E~~ 7I of this Act.

H. "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 ~~SHOP~~ Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the ~~SHOP~~ Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the ~~SHOP~~ Exchange to all of its eligible employees who are principally employed in this State.

I. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

J. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) 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.

K. "Secretary" means the Secretary of the federal Department of Health and Human Services.

~~L. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.~~

~~M~~L. (1) "Small employer" means an employer that employed an average of at least two but not more than ~~100~~ 50 employees during the preceding calendar year unless and until such time as federal law or regulations specify another upper limit.

(2) 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 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) ~~All e~~Employees shall be counted in accordance with state and federal law~~, including part-time employees and employees who are not eligible for coverage through the employer~~;

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

(d) 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 its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment in qualified health plans available to its employees.

Section 4. Establishment of Exchange

A. ~~A.~~ The ~~[insert official title of the Exchange]~~North Dakota Health Benefit Exchange is hereby established as a ~~[insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a~~ nonprofit entity~~]~~ to facilitate access to qualified health plans, effective January 1, 2014. Neither the Exchange nor its board of directors is an agency of this State, and the laws applicable to state agencies do not apply to the Exchange or its board unless otherwise specified in this Act. The Exchange shall neither duplicate nor replace the duties of the commissioner established in chapter 26.1-01 of title 26.1 of the North Dakota Century Code, 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

B. The Exchange is exempt from the taxes imposed under section 26.1-03-17 and any other tax law of this State and all property owned by the Exchange is exempt from taxation.

~~A.~~C. 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 this State and therefore does not have the authority to promulgate rules pursuant to the Administrative Agencies Practice Act, chapter 28-32 of title 28 of the North Dakota Century Code. The board shall implement and operate the Exchange in accordance with this Act and take all actions necessary to ensure by January 1, 2013 that the North Dakota Health Benefit Exchange is determined by the federal government to be ready to operate no later than January 1, 2014.

(1) **Organization.** The board of directors of the Exchange must be made up of 12 directors, of whom nine are voting directors and three are nonvoting, ex-officio directors consisting of the Lieutenant Governor, the State Director of Medicaid and the commissioner of the Department of Insurance, or their respective designees. The commissioner shall appoint two consumer representatives as initial voting directors. The remaining seven voting directors shall consist of two appointed by each the Senate and the House of Representatives, and three appointed by the Governor. In appointing the voting directors, the person making the appointments must ensure the board has expertise in all of 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. In determining voting rights at director meetings, each voting director must be entitled to vote in person or proxy. Directors must not be compensated by the exchange for their services, except that directors may be reimbursed from the money of the exchange solely for expenses incurred by them as directors.

(2) **Election of board.** On or before January 1, 2012, the initial board of directors must be appointed as provided in clause (1). The board must serve at least until January 1, 2014. Thereafter, voting members shall be elected by the sitting directors of the exchange in accordance with the requirements for expertise and the plan of operation, and shall consider the geographic, demographic, economic, and other characteristics of the State when making the appointments. The board must elect a board chair from among the nine voting directors.

(3) **Term of office.** The term for the voting members of the board of directors shall be a three-year term, except that the board must make appropriate arrangements to stagger the terms of the directors so that approximately one-third of the terms expire each year. Each director must hold office until expiration of the director's term or until the director's successor is duly elected or appointed and qualified, or until the director's death, resignation, or removal. A person appointed to fill a vacancy shall serve only for the unexpired term. Directors are limited to serving two terms.

(4) **Quorum**. A majority of the directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining directors constitutes a quorum.

(5) **Resignation and removal**. A director may resign at any time by giving written notice to the board chair. The 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 commissioner. If a vacancy occurs for a director, the board must appoint a new director for the duration of the unexpired term.

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

(7) **Conflict of interest.** No director may participate in deliberations or vote on any matter before the exchange 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. Directors must file with the Secretary of State a Statement of Interest in a manner as prescribed by section 16.01-09-03 of the North Dakota Century Code. Failure to disclose a Statement of Interest will constitute cause for removal from the board. Each director is responsible for acting in the interest of the public in discharging his or her duties.

(8) **Open Meetings.** All meetings of the board of directors, its advisory group, and any board committees must comply with section 44-04-19 of the North Dakota Century Code. Notwithstanding the above, meetings must be closed in order to review or discuss data on individuals and premium rate information submitted by health carriers before such rates are approved by the commissioner.

(9) **Antitrust Exemption**. In the performance of their duties as directors of the Exchange, the directors are exempt from the provisions of sections 51-08.1-01 to 51-08.1-12 of the North Dakota Century Code.

(10) **Consumer Advisory Group.** No later than 60 days after the board members are appointed, the board must 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. Membership of the group must include, but is not limited to:

(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) The Department of Human Services;
(j) Representatives of other relevant State agencies, such as the Department of Insurance or the Information Technology Department;
(k) Health care providers;
(l) Public health experts; and
(m) Large employers.

(11) **Technical Advisory Group**. No later than 60 days after the board members are appointed, the board must convene 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.

In addition, the Technical Advisory Group must 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. Moreover, it must make recommendations on issues related to consumers who may move between state public health care programs and qualified health plans offered in the Exchange.

D. The Exchange ~~shall~~must develop, and operate in accordance with, a plan of operation. The plan of operation must:

(1) Provide for the operation and governance of the Exchange;
(2) Provide for the election of a board of directors by the sitting directors of the exchange;
(3) Establish the procedure for the board of directors to elect or appoint officers, including an executive director of the Exchange;
(4) Establish the manner of voting;
(5) Establish a program to publicize the existence of the Exchange; the eligibility requirements for purchasing qualified health plans through the exchange; for subsidies offered for purchasing qualified health plans offered through the Exchange; enrollment procedures; and to foster public awareness of the Exchange;
(6) Establish criteria and procedures for certifying qualified health plans in conformity with, and not to exceed the requirements of, the Federal Act;
(7) Establish document retention policies and procedures;
(8) 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
(9) 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.

If the initial board of directors fails to submit a suitable plan of operation within 60 days following the creation of the initial board, or if at any time thereafter the exchange fails to submit required amendments to the plan, the commissioner may submit to the Exchange a plan of operation or amendments to the plan, which the Exchange must follow. The plan of operation or amendments submitted by the commissioner must continue in force until amended by the Exchange and approved by the commissioner. A plan of operation or an amendment submitted by the commissioner constitutes an order of the commissioner.

~~(1) Facilitate the purchase and sale of qualified health plans;~~

~~(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and~~

~~(3) Meet the requirements of this Act and any regulations implemented under this Act.~~

E. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the ~~[insert name of State Medicaid agency]~~ Department of Human Services or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

F. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act 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 must establish procedures and safeguards to protect the integrity and confidentiality of any data it maintains.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) 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.

C. 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.

D. In accordance with section 1312(b) of the Federal Act, the Exchange must 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.

~~B.~~E. 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

(1) Nothing in this section shall preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits specified under section 1302(b), including wellness programs.

(2) 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 payments to defray the cost of any additional benefits directly to an individual enrolled in a qualified health benefit plan or on behalf of an individual directly to the qualified health beneft plan in which such individual is enrolled.

(3) To the extent that funding to defray the cost for such additional benefits is not provided, the qualified health plan shall not be required to provide such additional benefits.

F. 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.

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

H. Nothing in the Federal Act precludes the sale of health benefit plans through mechanisms outside the Exchange, nor does anything in the Federal Act preclude a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health benefit plan offered outside of the Exchange.

~~C.~~I. The Exchange must 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.

Section 6. Duties of Exchange

The Exchange shall:

A. 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 7 of this Act, of health benefit plans as qualified health plans;

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

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

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

E. 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;

F. 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 PHSA;

G. 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 (CHIP) 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;

H. 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;

I. Establish a ~~SHOP Exchange~~process through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the ~~SHOP~~ Exchange at the specified level of coverage.

J. 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:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection I, including the name and taxpayer identification number of each individual;

(2) 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:

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

(b) 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

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

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

L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. 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;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) 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;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the ~~Public Health Service Act (~~PHSA~~)~~, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. ~~Review~~ Consider the rate of premium growth within the Exchange and outside the Exchange~~, and consider the information~~ in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, ~~and~~ collect the amount credited from the offering employer, and remit the amount of the free choice voucher to the appropriate health carrier;

~~Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:~~

~~(1) Educated health care consumers who are enrollees in qualified health plans;~~

~~(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;~~

~~(3) Representatives of small businesses and self-employed individuals;~~

~~(4) The [insert name of State Medicaid office]; and~~

~~(5) Advocates for enrolling hard to reach populations; and~~

~~R~~Q. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) 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 U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;

(b) Examine the properties and records of the Exchange; and
(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its 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.

R. As authorized under section 1312(e) of the Federal Act, the Exchange must allow agents or brokers to:

(1) 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

(2) Assist qualified individuals in apply for premium tax credits and cost-sharing reductions for plans sold through the Exchange.

If an individual sells, negotiates, or solitics insurance as defined in section 26.1-26-02 of the North Dakota Century Code in enrolling a qualified individual in a qualified health plan, the individual must be licensed as an insurance producer under chapter 26.1-26.

Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) 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 E, if:
(a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and
(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, 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;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The health benefit plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of ~~the Federal Act~~section 1302(e) of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) 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 ~~through the SHOP Exchange~~to a qualified employer, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act.

(5) The health carrier offering the health benefit plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers through the Exchange at least one qualified health plan in the silver level and at least one plan in the gold level ~~through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage.~~;

(c) Charges the same premium rate for each ~~qualified~~ 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;

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) 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.

(6) The health benefit plan meets the requirements of certification as promulgated by ~~regulation pursuant to section 9 of this Act and by~~ the Secretary under section 1311(c)(1) of the Federal Act, which include, but are not limited to, 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

(7) 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.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) 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.

C. Notwithstanding subsection B, a health carrier that does not offer a qualified health plan in the Exchange on January 1, 2014, is prohibited from offering a qualified health plan in the Exchange prior to January 1, 2015. The Exchange may permit a health carrier that did not offer a qualified health plan in the Exchange on January 1, 2014 to begin offering a qualified health plan prior to January 1, 2015 if the Exchange determines that it is in the interest of qualified individuals and qualified employers in this State.

D. Except as otherwise provided in subsections B and C, a health carrier that ceases to offer any qualified health plans in the Exchange after January 1, 2014 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. Nothing in this subdivision prohibits 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 1, 2014 to being 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.

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

(1) Submit ~~a justification for~~verification that any premium increase ~~before~~ was approved by the commissioner prior to implementation of that increase. The carrier shall prominently post the information on its 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 ~~PHSA~~Public Health Service Act, into consideration when determining whether to allow the carrier to make health benefit plans available through the Exchange;

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

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

(vi) Data on rating practices;

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

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; ~~and~~

(b) ~~The~~ Provide the information required in subparagraph (a) of this paragraph ~~shall be provided~~ in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) ~~Permit individuals to learn~~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 shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

~~D~~F. The Exchange shall 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 ~~assures~~ ensures ~~a level playing field~~parity between or among health carriers participating in the Exchange.

~~E~~G. 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, who must render a final decision.

I (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection ~~or by regulations adopted by the Exchange~~;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, 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

(4) 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 8. Funding; Publication of Costs

A. ~~A.~~ As required by section 1311(d)(5)(a) of the Federal Act, the Exchange shall be self-sustaining by January 1, 2015. A budget for the Exchange shall be prepared by the governor and submitted to the Legislature annually for approval.

~~A.~~B. The Exchange may charge assessments or user fees ~~to health carriers~~ or otherwise may generate funding necessary to support its operations provided under this Act.

~~B.~~C. ~~B.~~ The Exchange shall publish the ~~average costs of licensing, regulatory fees and any other payments required by the Exchange, and the~~ administrative and operational costs of the Exchange, on an Internet website to educate consumers on such costs. ~~This~~ The information published shall 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 ~~information on monies~~any money lost to waste, fraud and abuse.

~~**Section 9. Regulations**~~

~~The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.~~

Section ~~10~~9. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to 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 fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Section 10. Sunset

If section 1311 of the Federal Act is either repealed or invalidated by the courts or otherwise rendered invalid by judicial decree, or if the State is granted a federal waiver prior to or after the establishment of the Health Benefit Exchange of North Dakota, this Act must sunset no later than 30 days following the effective date of the repeal, invalidation, or federal waiver unless the legislature takes specific action to extend the Act.

Section 11. Effective Date

This Act shall be effective ~~[insert date]~~the day following final enactment.

~~AMERICAN~~ HEALTH BENEFIT EXCHANGE ~~MODEL~~ ACT OF NORTH DAKOTA

Table of Contents

Section 1. Title
Section 2. Purpose and Intent
Section 3. Definitions
Section 4. Establishment of Exchange
Section 5. General Requirements
Section 6. Duties of Exchange
Section 7. Health Benefit Plan Certification
Section 8. Choice
Section ~~8~~9. Funding; Publication of Costs
Section ~~9~~10. Regulations
~~Section 10. Relation to Other Laws~~
Section 11. Effective Date

Section 1. Title

This Act shall be known and may be cited as the ~~American~~ Health Benefit Exchange Act of North Dakota.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

B. "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.

C. "Essential health benefits" has the meaning provided under section 1302(b) of the Federal Act.

D~~C~~. "Exchange" means the ~~{insert name of~~North Dakota State Exchange~~}~~ established pursuant to section 4 of this Act and includes the Individual Exchange and the SHOP Exchange, unless otherwise specified.

E~~D~~. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

F. "Individual Exchange" means the Exchange through which qualified individuals may purchase coverage established under Section 6 of this Act.

G~~E~~.

(1) "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.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or 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 on-site medical clinics; or
(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;
(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include 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:

(a) Coverage only for a specified disease or illness; or
(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
(c) Similar supplemental coverage provided to coverage under a group health plan.

H~~F~~. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

I~~G~~. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7G~~E~~ of this Act.

JH. "Qualified employer" means a small employer as defined in 26.1-36.3-01.32 that elects to make its ~~full-time~~ eligible employees as defined in 26.1-36.3-01.12 eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

~~(1) Has~~ has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, if the majority of its eligible employees reside in North Dakota~~wherever employed,; or~~

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

K. "Principal place of business" is defined as the location in a state where an employer has its headquarters or significant place of business and where the person with direction and control authority over the business are employed.

LI. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

MJ. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) 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.

NK. "Secretary" means the Secretary of the federal Department of Health and Human Services.

OL. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

PM.

(1) "Small employer" as defined in 26.1-36.3-01.32 means an employer that employed an average of 2 to not more than 50~~100~~ employees during the preceding calendar year unless and until such time as Federal law or regulations may require.

(2) 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 shall be treated as a single employer.

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) ~~All e~~Employees shall be counted in accordance with state law~~, including part-time employees and employees who are not eligible for coverage through the employer~~;

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

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

Section 4. Establishment of Exchange

~~A.~~ The ~~[insert official title of the Exchange]~~Health Benefit Exchange of North Dakota is hereby established by the State as a ~~[insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity]~~nonprofit entity.

A. ~~-~~Board of Directors: The nonprofit entity shall be governed by a board, with duties and powers as established by this section. The Board shall consist of ~~9~~8 members; ~~6~~5 voting members appointed by the Governor who are not public employees and 3 non-voting, ex officio members.

(1) The term for the voting members of the Board shall be a three year term, except that a person appointed to fill a vacancy shall serve only for the unexpired term.

(2) Of the voting members first appointed, in order to ensure staggered terms, two of the Governor's appointees shall serve for a term of two years and the remaining Governor's appointees shall serve for a term of three years.

(3) The Board's ex officio members shall include the Lieutenant Governor, the State director of Medicaid and the Commissioner of the Department of Insurance or their respective designees.

(4) The Governor shall appoint one voting member in good standing of the American Academy of Actuaries, two voting members from the consumer community who are familiar with the purchase of individual or group insurance, and three~~two~~ voting members from leading North Dakota health insurance carriers.

(5) The Governor shall designate one voting member of the Board to serve as chairperson.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans to qualified individuals and ~~qualified employers~~;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in a qualified health plan or qualified health plans; and

(3) Meet the requirements of the Federal Act, this Act and any regulations implemented under this Act~~-~~; and

(4) Select an Executive Director to lead operations and hire necessary staff; and

(5) Consult with an appointed member of the Attorney General's office regarding legal interpretation and advice.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. ~~An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.~~

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(1) An eligible entity is not a health carrier and is defined as:

a. A person –

i. Incorporated under, and subject to the laws, of 1 or more states;

ii. That has demonstrated experience on a state or regional basis in the individual or small group health insurance markets, or in benefits coverage.

(2) Any eligible entity that enters into an agreement to carry out 1 or more responsibilities of the Exchange shall have the same fiduciary duties and liability as provided for in Section 6.R. of this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act 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.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates ~~on or before January 1, 2014~~as established by Federal law or regulation.

B.

(1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) 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.

C. 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.

D. 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.

(1) Additional Benefits-

(a) Nothing in this section shall preclude a qualified health plan from voluntarily offering benefits in addition to essential health benefits, including wellness programs.

(b) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that state law or regulation requires that a qualified health plan offer benefits in addition to the essential health benefits, the state shall make payments to defray the cost of any additional benefits directly to an individual enrolled in a qualified health plan or on behalf of an individual directly to the qualified health plan in which such individual is enrolled.

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(c) As required by section 1311(d)(B)(ii) of the Federal Act, to the extent that funding to defray the cost for such additional benefits is not provided, the qualified health plan shall not be required to provide such additional benefits.

Section 6. Duties of Exchange

The Exchange shall:

A. 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 7 of this Act, of health benefit plans as qualified health plans;

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

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

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

E. 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;

F. 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 PHSA;

G. 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 (CHIP) 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;

H. 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;

I. Establish an Individual Exchange, through which qualified individuals may enroll in any qualified plan offered through the Individual Exchange for which they are eligible.

J~~I~~. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify either a defined benefit~~a~~ level of coverage or a defined contribution level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage or, the employer may offer a selection of qualified health plans for the employee to choose from;

K~~J~~. 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:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

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(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

LK. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) 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:
(a) The employer did not provide minimum essential coverage; or
(b) 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

(3) The name and taxpayer identification number of:
(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and
(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

ML. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

NM. 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;

ON. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) 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;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the ~~Public Health Service Act (~~PHSA~~)~~, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

PO. ~~Review Consider~~ Analyze the rate of premium growth within the Exchange and outside the Exchange~~, and consider the information~~ in developing recommendations on whether to continue limiting qualified employer status to small employers;

~~Q.~~ ~~Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer, and remit the amount of the free choice voucher to the appropriate health carrier;~~

Comment [lmc1]: Isn't this a moot clause since the voucher provision was repealed as part of appropriations measure, H.R. 1473, that the president signed?

R~~Q~~. ~~Consult with~~Establish an advisory panel of stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) Representatives of health carriers that offer qualified health plans through the Exchange;

(5) Representatives of health carriers that are not offering qualified plans through the Exchange;

(6) The Department of Insurance;

(47) The ~~[insert name of State Medicaid office]~~Department of Human Services;

(8) The Information Technology Department

(9) Representatives of health care providers; and

(~~5~~10) Advocates for enrolling hard to reach populations~~; and~~.

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S~~R~~. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit, to the Secretary, the Governor, the commissioner and the Legislature, a report concerning such accountings;

(2) 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 U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;
(b) Examine the properties and records of the Exchange; and
(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its 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.

(4) Fiduciary Duties and Liability -

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

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(b) Any person who acts as a fiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations, or duties imposed by this section shall be 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 shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary

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Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The 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 ~~E~~G, if:

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

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, 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;

(2) The premium rates and contract language have been approved by the ~~e~~Commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The 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 through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health 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;

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) 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;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act~~, which include, but are not limited to, 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~~ unless

(7) The Exchange determines that making the plan available through the Exchange is not in the interest of qualified individuals and qualified employers in this State, in accordance with section 7.C of this Act.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) 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.

C. Presumption of Best Interest:

(1) In order to foster a competitive Exchange marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the Exchange to certify all health plans and consider consumer choice, network selection and cost. ~~meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange.~~

(2) The Exchange shall certify all health plans ~~meeting the requirements of section 1311(c) of the Federal Act for participation in the Exchange. The Exchange~~ and shall establish and publish a transparent, objective process for decertifying qualified health plans that are determined to be not in the public interest to be offered through the Exchange.

D~~C~~. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Have State Division of Insurance approval of ~~Submit a justification for~~ any premium increase before implementation of that increase. Rates approved by the Division of Insurance shall be deemed approved by the Exchange and ~~The carrier shall prominently~~ posted ~~the information~~ on its 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 PHSA, into consideration when determining whether to continue to allow the carrier to make plans available through the Exchange~~:~~. In no case shall an Exchange impose any premium price controls or restrict premium that otherwise meets the requirements of State Law.

(2)

(a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;
(ii) Periodic financial disclosures;
(iii) Data on enrollment;
(iv) Data on disenrollment;
(v) Data on the number of claims that are denied;
(vi) Data on rating practices;
(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;
(viii) Information on enrollee and participant rights under title I of the Federal Act; and
(ix) Other information as determined appropriate by the Secretary; and

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(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's 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 shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

E. Appeal of Decertification or Denial of Certification:

(1) The Exchange shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan.

(2) The Exchange shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

(a) the submission and consideration of facts, arguments, or proposals of adjustment of the health plan or plans at issue; and

(b) a hearing and a decision on the record, to the extent that the Exchange and the health carrier are unable to reach agreement following the submission of the information in subparagraph (a).

(3) Any hearing held pursuant to paragraph (2) of this subsection shall be conducted by an [impartial party or an administrative law judge with appropriate legal training] and in accordance with [state administrative hearing requirements or APA hearing requirements (5 U.S.C. § 556)].

F~~D~~. The Exchange shall 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 assures a level playing field between or among health carriers participating in the Exchange.

G~~E~~.

(1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, 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

(4) 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.

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Section 8. **Choice**

A. In accordance with section 1312(b) of the Federal Act, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing such qualified health plan.

B. Risk Pooling - In accordance with section 1312(c) of the Federal Act

(1) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Individual Exchange, members of a single risk pool.

(2) A health carrier shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the SHOP Exchange, to be members of a single risk pool.

C. Empowering Consumer Choice - In accordance with section 1312(d) of the Federal Act

(1) This section shall not prohibit --

(a) a health carrier from offering outside of an Exchange a health plan to a qualified individual or qualified employer; or

(b) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) This section shall not limit the operation of any requirement under state law or regulation with respect to any policy or plan that is offered outside of the Exchange with respect to any requirement to offer benefits.

(3) Voluntary Nature of an Exchange-

(a) Nothing in this section shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(b) Nothing in this section shall compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(c) A qualified individual may enroll 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 plan only if the individual is eligible to enroll in the plan under section 1302(e)(2) of the Federal Act.

D. Enrollment through Agents or Brokers - In accordance with section 1312(e) of the Federal Act, the Exchange may allow agents or brokers

(1) to enroll qualified individuals and qualified employers in any qualified health plan offered through the Exchange for which the individual or employer is eligible; and

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(2) to assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the Exchange.

Section 9. Funding; Publication of Costs

A. Funding -

(1) As required by section 1311(d)(5)(A) of the Federal Act, the Exchange shall be self-sustaining by January 1, 2015. A budget for the Exchange shall be prepared by the governor and submitted to the Legislature annually for approval.

(2) The Exchange may charge assessments or user fees to health carriers or otherwise may ~~generate~~ receive funding necessary to support its operations provided under this Act, such as from the State's general fund revenue, tobacco taxes, premium taxes and from grants.

(3) Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding.

(4) Services performed by the Exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers.

(5) Any unspent funding by an Exchange shall be used for future state operation of its Exchange or returned to health carriers as a credit if a state charges fees to carriers.

B. Disclosure - Taxes, fees or assessments used to finance the Exchange must be clearly disclosed by the Exchange as such, including publishing the average cost of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs.

C. Treatment of Taxes or Fees for Medical Loss Ratio Purposes - Taxes, fees or assessment used to finance the Exchange shall be considered a state tax or assessment as defined in section 2718(a) of the PHSA and its implementing regulations, and must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

D. Publication - ~~B.~~ The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section ~~9~~10. Regulations

The Exchange may promulgate ~~regulations~~ rules to implement the provisions of this Act. ~~Regulations~~ Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act or exceed the rules enforced by the Department of Insurance.

~~**Section 10. Relation to Other Laws**~~

~~Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to 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 fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.~~

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Section 11. Effective Date

This Act shall be effective [insert date].

Prepared by the North Dakota Legislative Council staff for the Health Care Reform Review Committee

August 4, 2011

HEALTH CARE REFORM REVIEW COMMITTEE

Representative Eliot Glassheim submitted the following health benefit exchange governance proposal for committee consideration:

GOVERNANCE

New State Agency

New state agency governed by a board:

- Insurance Commissioner, chairman;
- Information Technology Department;
- Department of Human Services;
- State Department of Health;
- Governor;
- Office of Management and Budget; and
- Chairman of the Joint Health Care Reform standing committee.

Advisory Committee

Advisory committee made up of stakeholders:

- Senior citizens;
- Blue Cross Blue Shield of North Dakota;
- Two additional health insurers;
- North Dakota Chamber of Commerce;
- North Dakota Hospital Association;
- North Dakota Medical Association;
- Two physicians;
- Two Medicaid recipients; and
- Representatives of nonprofit organizations.

Standing Committee

Joint Health Care Reform standing committee with members appointed by majority leaders and minority leaders of each chamber.

Clark, Jennifer S.

From: Deb.Knuth@cancer.org
Sent: Monday, August 01, 2011 1:02 PM
To: Clark, Jennifer S.
Cc: ktupa@aptnd.com
Subject: Legislative Management's Health Care Reform Review Committee
Attachments: ACS-CAN-AHA-Exchange-Document1.pdf

Thank you for allowing ACS CAN an opportunity to reply to your request. We have been following the Legislative Management's Health Care Reform Review Committee as it studies the impact of the federal Affordable Care Act (ACA).

The American Cancer Society Cancer Action Network is interested in the health benefit exchange provisions of the ACA. Please see the attachment to this email that reviews threshold questions for state insurance exchanges.

In a best world, we'd like to see a quasi-agency (so it's not bound by all the rules of a regular state agency). There should definitely be a Governance Board, or Board of Directors that is subject to open meeting laws and strict conflict of interests restrictions for members.

The exchange should be funded by a common fee on all insurers that operate in the state (inside and outside the exchange). It's not possible to have comments on essential benefits just yet because that interim reg has yet to be declared by HHS. While we'd like to see no special interest groups serve on the Governance Board, in many states, insurers are indeed on the Board. In that case, we absolutely think that a consumer counter balance is necessary.

One final note....there is a common belief that insurers bring an "expertise" that can't be found anywhere else about this process and therefore are a necessary presence.

That's just not true. Many academic institutions have insurance/eco experts who could bring a real knowledge without a conflict of interest to the process. If you have any questions, please contact me. Thanks again. Deb

Deborah Knuth, Director-- Government Relations

American Cancer Society Cancer Action Network (ACS CAN)

Great West Division

2401 46th Ave. SE, Ste. 102, Mandan, ND 58554

t) 701.250.1022, ext. 106 f)701.250.9145 c)701.471.2859

We need your help. Take Action at http://www.cancer.org/takeaction

"For all those whose cares have been our concern, the work goes on, the cause endures, the hope still lives and the dreams shall never die." Ted Kennedy

Cancer Action Network™ American Cancer Society®

American Heart Association | American Stroke Association®

Threshold Questions for State Exchanges

The Affordable Care Act (ACA) creates state health benefit exchanges that will be the central marketplace for many people to compare and buy insurance plans in the individual or small-group markets. As states consider how to create and implement an exchange, these are the most important questions for them to address.

1. Is the exchange governance board properly structured to ensure that its decisions serve the best interest of consumers, patients, workers, and small employers?

Rationale: The governance board will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that the members have appropriate management to successfully make the many critical administrative decisions that must be made by 2014. It is imperative that board members not have a conflict with their business or professional interests. Other stakeholders, including patients and consumers, are best involved through advisory boards. Finally, the governance board must be held publicly accountable through open meeting laws and solicitation of public comments.

2. Do the rules for the insurance market outside the exchange complement those inside the exchange to mitigate "adverse selection"?

Rationale: It is essential that the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.

3. Is the Medicaid program well integrated with the exchange?

Rationale: Under the ACA, all individuals with incomes under 133 percent of the federal poverty level are eligible for coverage under Medicaid. The exchanges are responsible for screening and enrolling eligible people in the program. It will be critical that the exchange is well integrated with the state Medicaid program to ensure seamless enrollment. Further, because many individuals will move between Medicaid and the exchange over time due to fluctuation in income, it is crucial that exchange rules allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.

4. Is the exchange structured to emphasize administrative simplicity for consumers?

Rationale: A major goal of the ACA is to make information about insurance more accessible. Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information, such as each plan's benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.

5. Does the exchange have a continuous and stable source of funding?

Rationale: To facilitate good management and planning, it is important that the exchanges have a predictable and steady source of funding. Otherwise, there is a risk that funding will become vulnerable to the often unpredictable legislative appropriations process. One option is to establish fees on insurers, which should be assessed on plans inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

6. Does the exchange have the authority to be an active purchaser?

Rationale: To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, exchanges should have the authority to be "active purchasers" when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.

Clark, Jennifer S.

From: Ken Dykes [kdykes@bismarckcancercenter.com]
Sent: Thursday, July 28, 2011 4:05 PM
To: Clark, Jennifer S.
Subject: HIX

Jennifer, I just wanted you to know that we'd be interested in being kept informed of developments with the exchange concept here in ND...we'd be happy to help in any way we can, but, as a small non-profit provider, don't have any expertise in this nor a lot of human or financial resources to help out...
Thanks.
Ken

Ken Dykes
Executive Director
BISMARCK
CANCER CENTER
500 North 8th Street
Bismarck, ND 58501
(701) 222-6100
(701) 222-6150 (Fax)
bismarckcancercenter.com

"Run when you can, walk when you have to, crawl if you must: just never give up." --Dean Kamazes

Clark, Jennifer S.

From: Rod St. Aubyn [Rod.St.Aubyn@bcbsnd.com]
Sent: Monday, August 01, 2011 5:08 PM
To: Clark, Jennifer S.
Subject: RE: Health Care Reform Review Committee - Request for Input

Jennifer, in your e-mail dated July 21, 2011, you inquired if our company (Noridian Mutual Insurance Company dba Blue Cross Blue Shield of North Dakota) would be "interested in administering, governing, or participating in some manner in all or a portion of a North Dakota-administered health benefit exchange that meets the requirements of the ACA." The laws governing the ACA restrict insurers from carrying out "1 or more responsibilities of the Exchange." (Section 1311 of PPACA). As a result, based on current laws and regulations for the ACA, Noridian appears to be precluded from administering any components of the Exchange. However, Noridian or its subsidiaries may be interested in providing technological solutions for building the information technology portions of the Exchange, without having any control over administration.

In regards to governing of the exchange, as per our proposed mark-ups of the NAIC model exchange bill, we feel that insurers should be on the governing board and we would welcome the opportunity to serve in that capacity. As per recent HHS rules, the role of insurers on the governing board is recognized, but insurers may not comprise a majority on the governing board.

I hope this clarifies our answers to your questions. Rod

Rod St. Aubyn
Manager - Government Relations
4510 13th Avenue S.
Fargo, ND 58121-0001
701-282-1847

Clark, Jennifer S.

From: Dell Horn [dhorn@daktel.com]
Sent: Monday, July 25, 2011 10:36 AM
To: Clark, Jennifer S.
Subject: state health insurance exchange

Our participation is dependent on whether or not failing to participate has negative consequences. I did not see any mention of negative consequences so I am reluctant to give input. I hope my response helps your committee.

Dell Horn, Director
Jamestown Community Corrections
701 952-2038

Clark, Jennifer S.

From: Mathern-Jacobson, Rebecca [RMathern-Jacobson@marchofdimes.com]
Sent: Monday, July 18, 2011 10:41 AM
To: Berry, Spencer D.; Dever, Dick D.; Klein, Jerry J.; Lee, Judy E.; Mathern, Tim; Clark, Donald L.; Frantsvog, Robert; Glassheim, Eliot A.; Johnson, Nancy; Kaldor, Lee A.; Kasper, Jim M.; Keiser, George J.; Kreidt, Gary L.; Meier, Lisa M.; Metcalf, Ralph E.; Nelson, Marvin E.; Rohr, Karen M.; Weisz, Robin L.; Winrich, Lonny B.
Cc: Clark, Jennifer S.; Roseland, Karin
Subject: Health Exchange governance
Attachments: Exchange governance.pdf; Health Insurance Exchange ND.pdf

Greetings members of the Health Care Reform Review Committee,

The mission of the March of Dimes is to improve maternal and child heath by preventing birth defects, premature birth, and infant mortality. Attached you will find our position on the health exchange in North Dakota.

Regarding your recent committee discussion related to matters of governance, we ask that the governing board of directors include a representative with maternal child health experience.

Thank you for your consideration and for your service,
Reba Mathern-Jacobson

[illegible] Mathern-Jacobson, MSW
[illegible] Director of Program Services

[illegible] of Dimes
[illegible] Dakota Chapter
[illegible] Drive Suite 102
[illegible]
[illegible] (701 [illegible] 5530)
[illegible] 235 [illegible]

March of Dimes is the champion for babies.

[illegible]dimes.com

March of Dimes Foundation
North Dakota Chapter

1330 Page Dr., Suite 102
Fargo, ND 58103
Telephone (701) 235-5530
1(800) 393-4637
Fax (701) 235-8725
Email:
ND407@marchofdimes.com

Karin Roseland
State Director

July 14, 2011

Dear Health Care Reform Review Committee,

The mission of the March of Dimes is to improve maternal and child health by preventing birth defects, premature birth, and infant mortality. March of Dimes recognizes that health exchanges being established across the country will impact access and quality of care for infants and pregnant women. Attached you will find our position on the health exchange in North Dakota.

This letter is in response to your July 7 meeting and discussion regarding governance of the health exchange. The March of Dimes asks that legislation to establish a health insurance exchange in North Dakota include language that requires the governing board of directors to include a representative with maternal child health experience.

On another note, we applaud the live web cast of your committee meetings.

On behalf of children in North Dakota,

Karin Roseland, State Director

cc: Jennifer S. N. Clark, Committee Counsel

Health Insurance Exchange

At Issue

States will play a crucial role in health reform implementation at the state level, particularly with regard to establishing the new health insurance exchanges. The health insurance exchange is essentially a marketplace where individuals and small employers can purchase health insurance.

March of Dimes believes that every woman of childbearing age, infant and child should have access to comprehensive affordable health insurance that meets their needs. March of Dimes focuses on coverage of preventive services for women and children, as well as coverage of specialty services for women at risk of complicated pregnancies, and children with special healthcare needs, such as those born preterm or with birth defects.

Importance

According to the Institute of Medicine (IOM), health insurance status is the most important factor in determining whether a child receives health services when they are needed. In addition, the IOM has also found that health insurance plays a key role in access to maternity care for pregnant women.

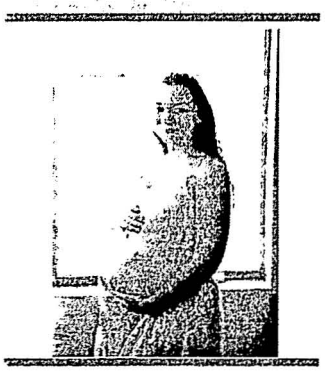
Recommendation

March of Dimes asks that ND legislation to establish health insurance exchanges:

- Include language that requires the health insurance exchange's board of directors to include a representative with Maternal Child Health experience due to the unique insurance needs of pregnant women, infants and children.
- Include language that requires the health insurance exchange to coordinate with the state's Medicaid and CHIP programs. This is important for a variety of reasons, including fluctuating income and eligibility that could cause pregnant women, infants and children to qualify for various programs from one year to the next (to ensure there is no gap in coverage). This is also important for families in which parents may be eligible for coverage through the health insurance exchange but their children are eligible for Medicaid or CHIP due to differing eligibility levels for different populations.
- Include language that requires the health insurance exchange (which are required by federal law to engage in a quality improvement activity) to report on the same quality measures on which North Dakota's CHIP and Medicaid programs report. Using the same measures should be administratively simpler for the state, and provides a larger data set allowing policymakers, advocates, etc. to compare the quality of care provided in Medicaid, CHIP and the exchanges.

March of Dimes Mission

The mission of the March of Dimes is to improve the health of women of childbearing age, infants, and children by preventing birth defects, premature birth and infant mortality. And if something goes wrong, we offer information and comfort to families. We also research the problems that threaten the health of babies and work on preventing them.



The March of Dimes Urges North Dakota to ensure the state's health insurance exchange

(1) has a member on the governing board with MCH experience,

(2) coordinates with North Dakota's Medicaid and CHIP programs and

(3) requires reporting on the same quality measures on which North Dakota's CHIP and Medicaid programs report.

For more information, please contact
Reba Mathern-Jacobson, Associate Director of Program Services and Public Affairs, at rmathern-jacobson@marchofdimes.com or (701)-235-5530.

march of dimes

North Dakota
Chiropractic Association

August 1st, 2011

Representative George Keiser
Heath Care Reform Review Committee
ND State Legislature

Dear Mr. Keiser:

Thank you for the opportunity of allowing the North Dakota Chiropractic Association to provide comment in the process of developing our ND State Health Insurance Exchange. We truly value this opportunity and we hope that you find the information we provide a value to your committee. We have discussed this topic on a state and national level and some of the key points are contained below.

The proposed rule release by HHS on July 15th allows entities to be hired to carry out exchange activities. HHS precludes insurers from being hired to carry out any exchange activities. NDCA supports this preclusion and supports "conflict of interest" information being disclosed by groups who are hired to carry out exchange activities.

The NDCA also supports HHS' proposal that the Exchange governing body have a majority of members that have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. The NDCA would like greater assurance that healthcare providers (and not limited to MDs) be included on the governing board. The NDCA would be glad to provide a seat on the governing board if given the opportunity. We also support the provision in the proposal that exchanges consult with certain groups of stakeholders (including healthcare providers) as they establish their programs and throughout ongoing operations. Ideally the board should be comprised of 9 members, 5 of those from the healthcare industry and 4 from the private sector. This would allow different healthcare groups to be represented while keeping it "well rounded" by including members from the private sector.

The NDCA supports HHS' concerns regarding provider access and support the need for patient choice with regard to providers. Here, the proposed rule explicitly states that HHS recognizes that primary care access is a challenge however we support broadly defining the types of providers that furnish primary care services. This is especially important in a rural state like North Dakota. Chiropractic care has proven itself to be a cost-effective form of health care that is widely used across our state. Inclusion of chiropractic care is essential not only from cost-effective standpoint but also as a clinical treatment standpoint, meaning that we get patients better, faster and for less money than other forms of care.

As the definition of minimum essential benefits and the formation of health insurance exchanges intersect in 2014, it is imperative that a variety of stakeholders have representation on committees or task forces charged with overseeing health insurance exchange actions and their regulation of coverage for minimum essential benefits. The broad intent of this legislation is to lower costs while providing for increased competition and freedom of choice. This cannot be achieved without ensuring increased access to a variety of health care providers as intended. Insurance exchange responsibilities should not

be left to one individual, but rather a panel of individuals who represent a variety of citizen interests, including the healthcare provider community. Anti-discrimination language in Section 2706 of Section 1201 "Amendment to the Public Health Service Act" of the Patient Protection and Affordable Care Act (PPACA) ensures broad inclusion of these providers, including doctors of chiropractic. The chiropractic profession has an important perspective and it is critical that doctors of chiropractic be included on advisory panels and boards established for the implementation of Health Insurance Exchanges at the state level.

Again, I would like to thank you and your committee for allowing us to comment in this process. We look forward to hearing from you and if there is anything that we can clarify or expand upon please do not hesitate to contact Ken Tupa or myself and we will be happy to assist you.

With kindest regards,

Dr. Steve Pederson
President North Dakota Chiropractic Association

July 30, 2011

Representative George Keiser
Health Care Reform Review Committee

Re: Committee Hearing on August 5th

Representative Keiser,

I will not be able to attend the Health Care Reform Review Committee meeting in Fargo on August 5th. However, I do want to respond to your question regarding our thoughts from the Hospital Association.

In regards to structure:

I believe that there should be one pool for all the citizens of North Dakota. I believe having two groups for individuals and small groups would create a perceived class system. I believe the pool should be structured to have several levels, i.e. bronze, silver, gold and platinum and each level then limited to 3 to 5 options within that level. I believe one program with multiple levels will give both the insurers and the consumers enough options to choose from.

I believe anyone wishing to sell health insurance in the state should be part of the exchange; there should not be any exclusion's. The exchange should operate like "Expedia" one stop shopping for health insurance and interfaced with state programs.

Governance:

I believe this is the most important issue of the exchange. I have included my options from the July 7th meeting. I believe either of these options is viable. I believe whichever option is selected that hospitals need to be at the table. I believe that the governing board should be made up of healthcare providers: insurance representatives, physicians, hospital leaders and state representation, i.e. Insurance Commissioner's office and Human Services. Again below are the options that I presented in July.

Option #1:

- Free standing quasi-governmental agency
- Board make-up:
  - Seven to nine members
    - Governor selects - 3 to 5
    - Senate/House Majority leaders – 1
    - Senate/House Minority leaders – 1

        - Department of Human Services – 1
        - Insurance Department – 1

Option #2:

- Non-profit private board:
- Board make-up:
    - Seven to nine members
        - Governor selects – 3
        - Department of Human Services – 1
        - Insurance Department – 1
        - Private Ins. Representation – 2 to 4

Again I am out of state on August 5th and unable to attend. If you have questions that you would like me to address please let me know. I find this process very exciting and do want to remain part of the process.

Respectfully,

Jerry E. Jurena, President
North Dakota Hospital Association

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NORTH DAKOTA MEDICAL ASSOCIATION

1622 East Interstate Avenue
Post Office Box 1198
Bismarck, North Dakota
58502-1198

(701) 223-9475
Fax (701) 223-9476
www.ndmed.org

August 3, 2011

Representative George Keiser
Chairman, Health Care Reform Review Committee
600 E. Boulevard
Bismarck ND 58505

Dear Chairman Keiser:

As I indicated to you at the pre-planning meeting, due to a previous professional commitment, I am unable to attend the Health Care Review Committee hearing set for August 5, 2011, in Fargo.

I have reviewed the agenda and do not have any further comments separate from those presented to the Committee on July 7, 2011. I would like to reiterate that NDMA feels strongly that actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

Exchanges will be best served with patients and practicing physicians in their governance structures. Giving physicians a voice in the establishment and operation of an exchange will lead to a more positive reception in the physician community and will help to identify problems with the exchanges, allowing them to be rectified as quickly as possible.

I look forward to participating in the next committee meeting. Thank you and please let me know if you have any questions.

Sincerely,

Courtney Koebele
Executive Director
North Dakota Medical Association

C: Jennifer Clark
Adam Hamm
Jerry Jurena

North Dakota Women's Network
222 N 4th Street, Suite 215
Bismarck, ND 58501
701-223-6985
renee@ndwomen.org

August 4, 2011

Re: State Implementation of Healthcare Benefits Exchange Provision of ACA

Dear Chairman Keiser and members of Legislative Management's Healthcare Reform Review Committee,

Thank you for the opportunity to provide input for the discussion of the healthcare benefits exchange provision and the model National Association of Insurance Commissioners (NAIC) model language. The Affordable Care Act includes standards that all exchanges must meet. However, the law also leaves a great deal of flexibility and work to the states when it comes to the design and implementation of health insurance exchanges that meet these standards. Therefore, the ability of exchanges to function as marketplaces for high-value coverage—marketplaces that are user-friendly, transparent, and stable—largely depends on the policy choices made by states.

A few points of importance for the exchange program from the perspective of the North Dakota Women's Network:

- The governing body of the exchange should include consumer representatives as official members. The governing body should not include members who may have conflicts of interest due to affiliations with health care industries. Additionally, the exchange operating entity should be subject to state laws regarding transparency and public input for decision-making bodies, along with other measures that seek to ensure the accountability and integrity of the entity.

- The North Dakota Women's Network is invested in ensuring the program established meets the needs of women by equalizing insurance rules inside and outside the exchanges. For example, older women will presumably be looking for comprehensive plans and, if eligible, may receive a tax credit to make that coverage more affordable. Meanwhile, if plans outside the exchange only offer less comprehensive coverage that is marketed to younger healthy individuals, they will gravitate toward the plans outside the exchange leaving the exchange with individuals with great health needs. This process could drive up premiums for plans offered in the exchange and undermine its capacity to

offer affordable coverage. It is important for insurance companies to offer similar products inside and outside the exchange.

- North Dakota does provide prohibition of gender rating (women are charged a higher rate than men) in the individual market, although not the small group market. Prohibition of gender rating should be maintained and expanded to all markets and be part of the exchange program.

- When establishing the contracted entities, or Navigators, designed to help consumers learn about their coverage options and enroll in a plan, a wide range of entities should serve in this role. It is important to keep in mind that a diversity of entities may be best suited for effective outreach to low-income communities, people with limited English proficiency and people with limited access to the internet and web-based tools.

- As required by the ACA, consumers must be able to go to a single website and use one application to find out whether they and their family members are eligible for premium credits, Medicaid, or the Children's Health Insurance Program (CHIP), and then to easily enroll in coverage. Consumers should be able to apply for coverage (and to be assisted in doing so) at community health centers, grocery stores, churches, fairs, and other community locations.

- Life changes such as losing a job, taking part-time employment or having a child are some factors that can cause changes in a person's income and insurance coverage. The exchange program policies should create a guaranteed eligibility period to address coverage gaps due to life circumstances. We have the opportunity to create a State Basic Health Program which would pool together individuals eligible from 133%-200% of the federal poverty level into one program. This option could reduce the frequent coverage disruptions that happen between those thresholds. The Basic Health Program could streamline administrative procedures, benefit designs, and eligibility rules across programs.

Again, thank you for the opportunity to provide input in the discussion and establishment of a health insurance exchange program. The establishment of this exchange is extremely important for the North Dakota Women's Network and the citizens of North Dakota. I am happy to respond to any questions and provide further information.

Sincerely,

Renee Stromme
Executive Director