..... moves to amend H.F. No. 468 as follows:

Page 1, after line 4, insert:

"Section 1. **[62V.01] CITATION.**

This chapter must be known and may be cited as the Minnesota Exchange Act.

Sec. 2. **[62V.02] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Act.** "Act" means the Minnesota Exchange Act.

Subd. 3. **Affordable Care Act of 2010.** "Affordable Care Act of 2010" 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 all amendments thereto from time to time, or implementing regulations issued thereunder.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 5. **Dental organization.** "Dental organization" has the meaning as defined in section 62Q.76, subdivision 7.

Subd. 6. **Health plan.** "Health plan," for purposes of this act, means a health benefit policy, contract, certificate, or agreement as defined in section 62A.011, subdivision 3, and a dental plan as defined in section 62Q.76, subdivision 3.

Subd. 7. **Health plan company.** "Health plan company" means a health carrier or community integrated service network as defined in section 62Q.01, subdivision 4.

Subd. 8. **Insurance producer.** "Insurance producer" has the meaning as defined in section 60K.31, subdivision 6.

Subd. 9. **Minnesota exchange or exchange.** "Minnesota exchange" or "exchange" means the exchange established pursuant to this act.

Subd. 10. **Qualified employer.** "Qualified employer" means a small employer as defined in section 62L.02, subdivision 26, that elects to make its eligible employees, as defined in section 62L.02, subdivision 13, eligible for one or more qualified health plans offered through the exchange.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Affordable Care Act of 2010 and section 62V.07.

Subd. 12. **Qualified individual.** "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.

Subd. 13. **Secretary.** "Secretary" means the secretary of the United States Department of Health and Human Services.

Subd. 14. **Small employer.** "Small employer" means a small employer as defined in section 62L.02, subdivision 26.

Sec. 3. **[62V.03] EXCHANGE.**

Subdivision 1. **Creation; tax exemption.** There is established an exchange to facilitate access to qualified health plans available to qualified individuals and qualified employers, effective January 1, 2014. The exchange is exempt from the taxes imposed under chapter 297I and any other tax law of this state, and all property owned by the association is exempt from taxation.

Subd. 2. **Board of directors; organization.** The board of directors of the exchange must be made up of nine directors, consisting of three appointed by each of the Subcommittee on Committees of the Senate Rules Committee, the speaker of the house, and the governor. Subsequent directors are elected by the board members. In appointing the board of directors, the persons making the appointments must ensure the board has expertise in the following areas: individual health plans; small employer health plans; health plan administration and infrastructure; health care actuary; health care finance; public health care delivery system; health plan law; and marketing. Of the directors

appointed by the house of representatives and senate, at least one, but not more than two, appointed by each body must reside outside of the seven-county metropolitan area.

In determining voting rights at director meetings, each director must be entitled to vote in person or proxy. Directors may be reimbursed from the money of the exchange for expenses incurred by them as directors, but must not otherwise be compensated by the exchange for their services.

Subd. 3. **Election of board.** On or before January 1, 2012, the persons authorized in subdivision 1 must appoint an initial board of directors of the exchange who must serve until the annual meeting in 2014. Thereafter, sitting directors of the exchange must elect the board of directors in accordance with this act and the plan of operation.

Subd. 4. **Term of office.** After the annual meeting in 2014, each director must serve 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. Directors are limited to serving two terms, not including service on the initial board.

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

Subd. 6. **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.

Subd. 7. **Approval by the board.** Approval by a majority of the 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.

Subd. 8. **Open meetings.** All meetings of the exchange board, its advisory group, and any board committees must comply with chapter 13D. Notwithstanding this requirement, meetings must be closed to review or discuss nonpublic data on individuals as described in section 62V.04, subdivision 6, nonpublic data as described in section 62V.07, subdivision 4, and premium rate information submitted by health plan companies before the rates are approved by the commissioner.

Subd. 9. **Antitrust exemption.** In the performance of their duties as directors of the exchange, the directors must be exempt from the provisions of sections 325D.49 to 325D.66.

Subd. 10. **Conflict of interest.** Directors must recuse themselves from discussion of and voting on an official matter if the director has a conflict of interest. A conflict of interest means an association including a financial 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.

Subd. 11. **Advisory group.** The board must convene an advisory group that is charged with advising the board on actuarial, financial, access to coverage, risk adjustment, and risk corridors as required under the Affordable Care Act of 2010. The board or a representative of the board shall regularly meet and consult with the advisory group. The advisory group must be comprised solely of those with expertise in these topics.

Sec. 4. **[62V.04] ESTABLISHMENT OF EXCHANGE; POWERS.**

Subdivision 1. **Establishment of exchange.** The exchange is established as a nonprofit entity organized under this act that has the following powers, subject to limitations provided under applicable federal or state law or in its articles or plan of operation:

(1) to exist in perpetuity;

(2) to sue and be sued, and participate in a legal, administrative, or arbitration proceeding in its corporate name;

(3) to buy, lease, acquire, own, hold, improve, use, and deal in and with, real or personal property, or an interest in property, wherever located;

(4) to sell, convey, mortgage, create a security interest in, lease, exchange, transfer, or dispose of all or a part of its real or personal property, or an interest in property, wherever located;

(5) to make contracts with any entity to carry out functions of the exchange under this act 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 plan company or an affiliate of a health plan company is not eligible;

(6) to incur liabilities, borrow money, and secure its obligations by mortgage of or creation of a security interest in its property and income;

(7) to invest and reinvest its funds;

(8) to conduct its business, carry on its operations, have offices, and exercise the powers granted by this chapter anywhere in the United States;

(9) to employ and retain persons necessary to carry out the duties of the exchange;

(10) to pay pensions, retirement allowances, and compensation for past services and establish employee or incentive benefit plans, trusts, and provisions for employees and their families, dependents, and beneficiaries, and to indemnify and buy insurance for a fiduciary of an employee benefit and incentive plan, trust, or provision;

(11) to participate in the promotion, organization, management, and operation of an organization or in a transaction, undertaking, or arrangement that the participating corporation would have power to conduct by itself, whether or not the participation involves sharing or delegation of control;

(12) to participate with others in a corporation, partnership, limited partnership, joint venture, trust, or other association of any kind that the participating corporation would have power to conduct by itself, whether or not the participation involves sharing or delegation of control upon two-thirds approval of all board members entitled to vote;

(13) to provide for its benefit life insurance and other insurance with respect to the services of its officers, directors, employees, and agents;

(14) to have, alter, and use a corporate seal;

(15) to adopt, amend, and repeal the plan of operation relating to the management of the business or the regulation of the affairs of the corporation subject to a two-thirds approval of all board members entitled to vote;

(16) to establish committees of the board of directors, elect or appoint persons to the committees, and define their duties;

(17) to elect or appoint officers, employees, and agents of the corporation, define their duties, and fix their compensation;

(18) to indemnify persons acting on behalf of the exchange;

(19) to dissolve and wind up upon two-thirds approval of all board members entitled to vote;

(20) to file applications and take other action as necessary to establish and maintain the exchange as tax exempt pursuant to the federal income tax code;

(21) to recommend to the commissioner revisions to state law relating to the regulation of accident and health insurance in order to improve the efficiency and effectiveness of that regulation; and

(22) to take other actions reasonably required to implement the provisions of this act.

Subd. 2. **Exempt from Administrative Procedure Act.** The exchange is exempt from chapter 14 and the Administrative Procedure Act, except as otherwise provided in this act.

Subd. 3. **Plan of operation.** (a) The exchange must develop 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 officers, including an executive director of the exchange;

(4) establish the manner of voting; and

(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, except that any expenses related to advertising of exchange programs must not exceed 0.2 percent of the total premiums collected for qualified health plans sold through the exchange.

(b) The plan of operation must 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 made available to the public.

(c) The plan of operation and any amendments to the plan of operation must be submitted to the commissioner and must be effective upon approval in writing by the commissioner. The commissioner's approval must be made within 60 days and must be based solely on meeting the requirements of this act. The exchange must comply with the plan of operation or any amendments to it.

(d) If the interim board of directors fails to submit a suitable plan of operation within 60 days following the creation of the interim 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 commissioner or superseded by a plan of operation or amendment submitted 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.

Subd. 4. **Purpose of exchange.** The exchange must:

(1) facilitate access to qualified health plans;

(2) assist qualified small employers in this state in facilitating the enrollment of their employees of qualified employers in qualified health plans; and

(3) meet the requirements of this act and any rules implemented under this act.

Subd. 5. **Data sharing.** 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 the 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 that it maintains.

Notwithstanding any other law to the contrary, employers and health plan companies are permitted to share the applicable information needed by the exchange to carry out the purposes of this act, without obtaining consent from employees or enrollees. As provided elsewhere in this act, the exchange must assist qualified employers in this state in facilitating the enrollment of their employees in qualified health plans and nothing in this section prohibits the exchange from sharing information between qualified employers and their employees to carry out its responsibilities under this act.

Subd. 6. **Data on individuals.** Data on individuals who seek access to qualified health plans through the exchange and data on qualified individuals are classified as private data on individuals or nonpublic data, as defined in section 13.02. Summary data, as defined in section 13.02, subdivision 19, may be prepared under this subdivision.

Sec. 5. **[62V.05] GENERAL REQUIREMENTS.**

(a) The exchange must provide access to qualified health plans to qualified individuals and qualified employers beginning with effective dates on or after January 1, 2014.

(1) The exchange must not make available access to any health plan that is not a qualified health plan.

(2) The exchange must allow a health plan company to offer a health 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 Affordable Care Act of 2010.

(b) Neither the exchange nor a health plan company 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.

(c) Any standard or requirement adopted by the state pursuant to title I of the Affordable Care Act of 2010, or any amendment to state legislation made by title I of the Affordable Care Act of 2010, must be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. Nothing in the Affordable Care Act of 2010 precludes the sale of health plans through mechanisms outside the exchange.

(d) Health plan companies offering qualified health plans in the exchange must pay licensed insurance producers consideration commensurate with consideration paid by health plan companies for identical plans sold outside the exchange. Nothing in this act is intended to limit the consideration paid to licensed insurance producers on other plans not sold inside the exchange.

(e) Health plan companies offering individual or small group qualified health plans through the exchange must be limited to no more than one bronze, one gold, one silver, and one platinum plan, as defined under section 1302 of the Affordable Care Act of 2010.

(f) All qualified health plans offered in the exchange must be offered outside the exchange.

Sec. 6. **[62V.06] DUTIES OF EXCHANGE.**

Subdivision 1. **Certification of health plans.** The exchange must implement procedures for the certification, recertification, and decertification of health plans as qualified health plans, consistent with guidelines developed by the secretary under section 1311(c) of the Affordable Care Act of 2010, state rules adopted by the commissioner pursuant to section 62V.09, and the requirements of section 62V.07.

Subd. 2. **Individuals.** The exchange must:

(1) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(2) provide for enrollment periods, as provided under section 1311(c)(6) of the Affordable Care Act of 2010;

(3) maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(4) use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the federal Public Health Services Act;

(5) in accordance with section 1413 of the Affordable Care Act of 2010, inform individuals of eligibility requirements for the medical assistance program under chapter 256B or any applicable state or local public health care program, including any program

funded by the children's health insurance program under title XXI of the Social Security Act and, if available, any basic health program under section 1331 of the Affordable Care Act of 2010, screen applications for any such program, and facilitate enrollment of individuals in that program if screening indicates eligibility; and

(6) 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 Affordable Care Act of 2010.

Subd. 3. **Employers.** The exchange must:

(1) credit the amount of any free choice voucher to the monthly premium of the plan in which an employee of a qualified employer is enrolled, in accordance with section 10108 of the Affordable Care Act of 2010, and collect the amount credited from the offering employer; and

(2) provide to each employer the name of each employee of the employer described under subdivision 5, clause (3), who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation.

Subd. 4. **Plan ratings; benefit levels.** The exchange must:

(1) 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 Affordable Care Act of 2010;

(2) determine each qualified health plan's status as a bronze, silver, gold, or platinum level of coverage in accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the Affordable Care Act of 2010;

(3) establish a process through which qualified employers may access coverage for their employees in the exchange, which must 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 exchange at the specified level of coverage; and

(4) subject to section 1411 of the Affordable Care Act of 2010, 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:

(i) there is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.

Subd. 5. **Tax matters.** (a) The exchange must transfer to the secretary of the United States Treasury the following:

(1) a list of the individuals who are issued a certification under clause (3), 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:

(i) the employer did not provide minimum essential coverage; or

(ii) 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:

(i) each individual who notifies the exchange under section 1411(b)(4) of the Affordable Care Act of 2010 that the individual has changed employers; and

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

(b) The exchange must 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.

Subd. 6. **Navigators.** (a) In order to be considered an entity qualified to be a navigator, all individuals employed by or affiliated with the entity that is facilitating enrollment in qualified health plans must be health insurance agents licensed and regulated by the commissioner. Navigators shall perform the duties as prescribed in section 1311(s) of the Affordable Care Act of 2010. As required by the Affordable Care Act of 2010, the exchange may award grants to enable navigators to perform their duties. Any grant must be funded by the operating expenses of the exchange. The exchange must select entities qualified to serve as navigators in accordance with section 1311(i) of the Affordable Care Act of 2010, 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 Affordable Care Act of 2010;

(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 Services Act, 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.

(b) No navigator grant under this section may be made to any state, county, city, township, or other governmental subdivision.

Subd. 7. **Group market definitions.** No later than January 15, 2016, the exchange must develop recommendations on whether to expand eligible group size beyond small employer. As part of that recommendation, the exchange must compare premium growth rates inside and outside the exchange.

Subd. 8. **Stakeholders.** The exchange must consult with stakeholders relevant to carrying out the activities required under this act including, but not limited to:

(1) 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 commissioner of human services;

(5) health plan companies offering qualified health plans through the exchange; and

(6) advocates for enrolling hard-to-reach populations.

Subd. 9. **Financial integrity.** To demonstrate financial integrity, the exchange must meet the following oversight requirements:

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

(2) fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the Affordable Care Act of 2010 and allow the secretary, in coordination with the inspector general of the United States Department of Health and Human Services, to:

(i) investigate the affairs of the exchange;

(ii) examine the properties and records of the exchange; and

(iii) require periodic reports in relation to the activities undertaken by the exchange;

(3) fully cooperate with the monitoring and oversight activities of the commissioner under section 62V.09; and

(4) 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.

Subd. 10. **Records of exchange.** The exchange must maintain appropriate records and documentation relating to the activities of the exchange. All records, documents, and work product prepared by the exchange are the property of the exchange. The commissioner must have access to the data for the purposes of carrying out the supervisory functions provided for in this act.

Subd. 11. **Enrollment through insurance producers.** (a) As authorized under section 1312(e) of the Affordable Care Act of 2010, the exchange must allow agents or brokers:

(1) to 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) to assist qualified individuals in applying for premium tax credits and cost-sharing reductions for plans sold through the exchange.

(b) If an individual sells, negotiates, or solicits insurance as defined in section 60K.31 in enrolling a qualified individual in a qualified health plan, the individual must be licensed as an insurance producer under chapter 60K.

Sec. 7. **[62V.07] HEALTH PLAN CERTIFICATION.**

Subdivision 1. **Qualified health plan.** The exchange may certify a health plan as a qualified health plan if:

(1) the health plan provides the essential health benefits package described in section 1302(a) of the Affordable Care Act of 2010, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of dental plans, as provided in subdivision 6, if:

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

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

(2) the premium rates and policy forms have been approved by the commissioner;

(3) the health plan provides at least a bronze level of coverage, as determined pursuant to section 62V.06, subdivision 4, clause (2), unless the health plan is certified as a qualified catastrophic plan, meets the requirements of section 1302(e) of the Affordable Care Act of 2010 for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) the health plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Affordable Care Act of 2010, and if the health plan is offered to a qualified employer, the health plan's deductible does not exceed the limits established under section 1302(c)(2) of the Affordable Care Act of 2010;

(5) the health plan company offering the health plan:

(i) is licensed and in good standing as a health plan company;

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

(iii) 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 health plan is offered directly from the health plan company or through an insurance producer;

(iv) does not charge any cancellation fees or penalties in violation of section 62V.05, paragraph (b); and

(v) complies with the regulations developed by the secretary under section 1311(d) of the Affordable Care Act of 2010 and such other requirements as the exchange may establish;

(6) the health plan meets the requirements of certification as adopted by rule by the commissioner pursuant to section 62V.09 and by the secretary under section 1311(c) of the Affordable Care Act of 2010; and

(7) the exchange determines that making the health plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

Subd. 2. **Health plan exclusion.** (a) The exchange must not exclude a health 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 plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

(b) Notwithstanding paragraph (a), a health plan company 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 plan company that did not offer a qualified health plan in the exchange on January 1, 2014, to begin offering a qualified health plan in the exchange prior to January 1, 2015,

if the exchange determines that it is in the interest of qualified individuals and qualified employers in this state.

Subd. 3. **Reentry prohibition.** (a) Except as otherwise provided in subdivision 2, a health plan company 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 plan company's exit from the exchange. Nothing in this subdivision prohibits an affiliated health plan company from continuing to offer a qualified health plan in the exchange.

(b) The exchange may permit a health plan company that ceases to offer any qualified health plans in the exchange after January 1, 2014, to begin offering a new qualified health plan in the exchange if the exchange determines that making the qualified health plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

Subd. 4. **Data required.** The exchange must require each health plan company seeking certification of a health plan as a qualified health plan to:

(1) submit verification that any premium increase was approved by the commissioner prior to implementation of that increase. The health plan company must prominently post the information on its Internet Web site. The exchange must take this information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the Public Health Services Act, into consideration when determining whether to allow the health plan company to make health plans available through the exchange. Data provided by health plan companies to the exchange for purposes of this clause is classified as private or nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data;

(2)(i) make available to the public, in the format described in item (ii) and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of the following:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment;

(D) data on disenrollment;

(E) data on the number of claims that are denied;

(F) data on rating practices;

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

(H) information on enrollee and participant rights under title I of the Affordable Care Act of 2010; and

(I) other information as determined appropriate by the secretary;

(ii) provide the information required in clause (1) in plain language, as that term is defined in section 1311(e)(3)(B) of the Affordable Care Act of 2010; and

(iii) permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, co-payments, and coinsurance under the individual's health plan or coverage, that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information must be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

Subd. 5. **State licensure.** The exchange must not exempt any health plan company seeking certification of a qualified health plan from state licensure or solvency requirements, regardless of the type or size of the health plan company. The exchange must apply the criteria of section 62V.07 in a manner that ensures a level playing field between or among health plan companies participating in the exchange.

Subd. 6. **Dental plans.** (a) The provisions of this act that are applicable to qualified health plans must also allow for and apply to the extent relevant to dental plans except as modified in accordance with paragraphs (b) to (d).

(b) The dental organization must be licensed to offer dental plans but need not be licensed to offer other health plans.

(c) The dental plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health plans without dental coverage and must include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the Affordable Care Act of 2010, and such other minimum dental benefits as the exchange or the secretary may specify by regulation.

(d) A health plan company and a dental organization may jointly offer a comprehensive health plan through the exchange in which the essential pediatric dental benefits are provided by the dental organization and the other benefits are provided by the health plan company.

Subd. 7. **Administrative Procedure Act.** Actions by the exchange under this section that are adverse to a health plan company seeking to offer, or to continue to offer, a qualified health plan are subject to the contested case procedures under chapter 14.

Sec. 8. **[62V.08] FUNDING; PUBLICATION OF COSTS.**

(a) The exchange may generate funding necessary to support its operations provided under this act. Any user fees must be collected by the exchange directly from each qualified individual or employee of a qualified employer purchasing a qualified health plan through the exchange.

(b) The exchange must publish the administrative and operational costs of the exchange on an Internet Web site to educate consumers on such costs. The information published must include the amount of premiums and federal premium subsidies collected by the exchange; the amount and source of any other fees collected by the exchange for purposes of supporting its operations; and any money lost to fraud, waste, and abuse.

Sec. 9. **[62V.09] DUTIES OF THE COMMISSIONER.**

Subdivision 1. **Duties.** The commissioner may:

(1) supervise the creation of the exchange within the limits described in this act;

(2) monitor compliance of the exchange with the requirements of this act, which may include investigating the activities of the exchange, examining the records and property of the exchange, and requiring periodic reporting by the exchange; and

(3) in conjunction with the commissioner of health, monitor 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 plan performance.

Subd. 2. **Consistent and uniform regulation.** In exercising the duties described under subdivision 1, the commissioner, and the commissioner of health with respect to health maintenance organizations, must ensure consistent and uniform regulation of qualified health plans and same or similar health plans offered outside of the exchange unless contrary to other provisions of this act or the Affordable Care Act of 2010.

Subd. 3. **Licensure.** The commissioner must not require as a condition of licensure that a health plan company offer a qualified health plan in the exchange.

Sec. 10. **[62V.10] RELATION TO OTHER LAWS.**

Nothing in this act, and no action taken by the exchange pursuant to this act, may 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 plan companies offering qualified health plans in this state must comply fully with all applicable health plan company laws of this state and rules adopted and orders issued by the commissioner.

Sec. 11. **[62V.11] SUNSET.**

If section 1311 of the Affordable Care Act of 2010 is either repealed or invalidated by the courts or otherwise rendered invalid by judicial decree, or if the federal premium tax credits under sections 1401 to 1415 of the Affordable Care Act of 2010 are terminated, prior to or after the establishment of the exchange as described in section 62V.04, this act must sunset no later than 30 days following the effective date of the repeal or invalidation unless the legislature takes specific action to extend the act. "

Page 1, delete line 12 and insert:

"Sec. 12. **EFFECTIVE DATE.**

Sections 1 to 11 are effective the day following final enactment."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly