

Sixty-second
Legislative Assembly
of North Dakota

ENGROSSED HOUSE BILL NO. 1474

Introduced by

Legislative Management

(Health Care Reform Review Committee)

1 A BILL for an Act to create and enact chapter 54-66 of the North Dakota Century Code, relating
2 to creation of a North Dakota health benefit exchange; to repeal chapter 26.1-54 of the North
3 Dakota Century Code and section 3 of chapter 225 of the 2011 Session Laws, relating to the
4 insurance commissioner's and department of human services' duties to establish a health
5 benefit exchange and provide updates to the legislative management; to provide a statement of
6 legislative intent; to provide for reports to the legislative management; to provide an
7 appropriation; to provide a continuing appropriation; to provide a transfer; to provide an effective
8 date; and to provide for a contingent expiration date.

9 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

10 **SECTION 1.** Chapter 54-66 of the North Dakota Century Code is created and enacted as
11 follows:

12 **54-66-01. Definitions.**

13 As used in this chapter, unless the context otherwise requires:

- 14 1. "Board" means the North Dakota health benefit exchange board.
- 15 2. "Commissioner" means the insurance commissioner.
- 16 3. "Defined benefit plan" means a health benefit plan through which a qualified employer
17 provides a fixed percentage of contribution toward the employee or dependent
18 premium and the qualified employer designates one or more benefit plans from which
19 employees may choose. An employer contribution may vary based upon premium
20 increases and based upon the employer's choice of plan design.
- 21 4. "Defined contribution plan" means a health benefit plan through which a qualified
22 employer provides a fixed monetary contribution toward the employee or dependent
23 premium and the employee chooses to enroll in one or more benefit plans of the
24 employee's choice from the carrier of the employee's choice offered on the exchange.

- 1 Any premiums with the chosen benefit plan which exceed the fixed monetary
2 contribution are costs borne by the employee.
- 3 5. "Director" means the director of the office of management and budget.
- 4 6. "Division" means the office of management and budget health benefit exchange
5 division.
- 6 7. "Educated health care consumer" means an individual who is knowledgeable about
7 the health care system and has background or experience in making informed
8 decisions regarding health, medical, and scientific matters.
- 9 8. "Essential health benefits" has the meaning provided under section 1302(b) of the
10 federal act.
- 11 9. "Exchange" means the North Dakota health benefit exchange established under this
12 chapter.
- 13 10. "Federal act" means the federal Patient Protection and Affordable Care Act
14 [Pub. L. 111-148], as amended by the federal Health Care and Education
15 Reconciliation Act of 2010 [Pub. L. 111-152].
- 16 11. "Health benefit plan" means a policy, contract, certificate, or agreement offered or
17 issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of
18 the costs of health care services. The term does not include:
- 19 a. Coverage limited to accident or disability income insurance or for any
20 combination thereof;
- 21 b. Coverage issued as a supplement to liability insurance;
- 22 c. Liability insurance, including general liability insurance and automobile liability
23 insurance;
- 24 d. Workers' compensation or similar insurance;
- 25 e. Automobile medical payment insurance;
- 26 f. Credit-only insurance;
- 27 g. Coverage for onsite medical clinics;
- 28 h. Other similar insurance coverage, specified in federal regulations issued under
29 the Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191;
30 110 Stat. 1936; 29 U.S.C. 1181 et seq.], under which benefits for health care
31 services are secondary or incidental to other insurance benefits;

- 1 i. The following benefits if the benefits are provided under a separate policy,
2 certificate, or contract of insurance or are otherwise not an integral part of the
3 plan:
- 4 (1) Limited scope dental or vision benefits;
5 (2) Benefits for long-term care, nursing home care, home health care, or
6 community-based care, or any combination thereof; or
7 (3) Other similar, limited benefits specified in federal regulations issued under
8 the Health Insurance Portability and Accountability Act of 1996
9 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.];
- 10 j. The following benefits if the benefits are provided under a separate policy,
11 certificate, or contract of insurance; there is no coordination between the
12 provision of the benefits and any exclusion of benefits under any group health
13 plan maintained by the same plan sponsor; and the benefits are paid with respect
14 to an event without regard to whether benefits are provided with respect to such
15 an event under any group health plan maintained by the same plan sponsor:
- 16 (1) Coverage limited to a specified disease or illness; or
17 (2) Hospital indemnity or other fixed indemnity insurance; or
- 18 k. The following if offered as a separate policy, certificate, or contract of insurance:
- 19 (1) Medicare supplemental health insurance as defined under section 1882(g)
20 (1) of the federal Social Security Act [42 U.S.C. 1395ss(g)(1)];
- 21 (2) Coverage supplemental to the coverage provided under the Civilian Health
22 and Medical Program of the Uniformed Services [10 U.S.C. ch. 55]; or
23 (3) Similar supplemental coverage provided to coverage under a group health
24 plan.
- 25 12. "Health carrier" or "carrier" means an entity subject to the insurance laws and rules of
26 this state or which is subject to the jurisdiction of the commissioner which contracts or
27 offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs
28 of health care services. The term may include a sickness and accident insurance
29 company, a health maintenance organization, a nonprofit hospital and health service
30 corporation, and any other entity providing a plan of health insurance, health benefits,
31 or health services.

- 1 13. "Qualified dental plan" means a limited scope dental plan that has been certified in
2 accordance with section 54-66-12.
- 3 14. "Qualified employer" means a small employer that elects to make its full-time
4 employees eligible for one or more qualified health plans offered through the
5 exchange, and at the option of the employer, some or all of the employer's part-time
6 employees, provided that the employer:
- 7 a. Has the employer's principal place of business in North Dakota and elects to
8 provide coverage through the exchange to the employer's eligible employees,
9 wherever employed; or
- 10 b. Elects to provide coverage through the exchange to all of the employer's eligible
11 employees who are principally employed in North Dakota.
- 12 15. "Qualified health plan" means a health benefit plan that has in effect a certification that
13 the plan meets the criteria for certification described under section 1311(c) of the
14 federal act and section 54-66-12.
- 15 16. "Qualified individual" means an individual, including a minor, who:
- 16 a. Is seeking to enroll in a qualified health plan offered to individuals through the
17 exchange;
- 18 b. Resides in this state;
- 19 c. At the time of enrollment, is not incarcerated, other than incarceration pending
20 the disposition of charges; and
- 21 d. Is, and is reasonably expected to be, for the entire period for which enrollment is
22 sought, a citizen or national of the United States or an alien lawfully present in
23 the United States.
- 24 17. "Secretary" means the secretary of the federal department of health and human
25 services.
- 26 18. "Small employer" means an employer that employed an average of at least one but
27 not more than fifty employees during the preceding calendar year and which employs
28 at least one employee on the first day of the plan year. For purposes of this subsection
29 all employees must be counted in accordance with section 1304(b) of the federal act.

1 **54-66-02. Establishment of health benefit exchange division - North Dakota health**
2 **benefit exchange board - North Dakota health benefit exchange.**

3 1. The health benefit exchange division is created as a division of the office of
4 management and budget. The division is an agency for purposes of chapter 28-82.
5 The director shall appoint an executive director of the division. The position of
6 executive director is not a classified position and the executive director serves at the
7 pleasure of the director.

8 2. The division shall administer the North Dakota health benefit exchange. In accordance
9 with this chapter, the board shall establish the policy for the administration of the
10 exchange. The division shall implement the policy established by the board and
11 administer the exchange according to this chapter, the policy established by the board,
12 and the federal act. The purpose of the exchange is to facilitate the purchase of
13 qualified health plans, assist small employers in facilitating the enrollment of their
14 employees in qualified health benefit plans offered in the small group market, and
15 apply eligibility and enrollment standards of individuals in the state's medical
16 assistance program and the state's children's health insurance program. Except as
17 provided under this chapter or directed by the federal act, the exchange may not
18 duplicate or replace the duties of the commissioner established under chapter 26.1-01
19 or the duties of the executive director of the department of human services established
20 under chapter 54-24.1 or 50-29. All carriers authorized to conduct business in this
21 state may be eligible to participate in the exchange.

22 3. The board shall establish policy and the division shall administer the exchange in
23 accordance with this chapter and take all actions necessary to ensure by January 1,
24 2013, or later as otherwise specified by the director and consistent with federal law,
25 that the exchange is determined by the federal government to be ready to operate by
26 October 1, 2013, or later as otherwise specified by the director and consistent with
27 federal law. The division shall provide administrative services for the board.

28 4. The department of human services shall take the steps necessary to create and
29 coordinate with the division those portions of the exchange relating to eligibility
30 determination and enrollment of individuals in the state's medical assistance program

1 and the state's children's health insurance program in order to meet the requirements
2 of the federal act.

3 5. The division and department of human services shall collaborate with the information
4 technology department as necessary and appropriate in establishing and
5 administering the exchange. State agencies shall cooperate with the board, the
6 division, and the department of human services to ensure the success of the
7 exchange.

8 **54-66-03. Board - Organization.**

9 1. The board is made up of nine voting members and four nonvoting ex officio members.
10 The commissioner or the commissioner's designee; the executive director of the
11 department of human services or the executive director's designee; and one member
12 of the house of representatives and one member of the senate, appointed by the
13 chairman of the legislative management, are the ex officio nonvoting members. By
14 January 1, 2012, the governor shall appoint the following nine voting members:

- 15 a. Two members who represent the health insurance industry;
16 b. One member who represents small employers;
17 c. One member who represents licensed insurance producers;
18 d. One member who is a health care professional;
19 e. One member as determined by the governor; and
20 f. Three members who represent consumers.

21 2. When the governor appoints each of the board members, the governor shall ensure
22 that no single business entity employs or is otherwise represented by more than one
23 board member.

24 3. In appointing the board members the governor shall consider whether the board has
25 expertise in the following areas: individual health benefit plans, small employer health
26 benefit plans, health benefit plan administration and infrastructure, health care
27 actuarial science, health care finance, public health care delivery, health benefit plan
28 law, consumer advocacy, and marketing. In appointing board members the governor
29 shall ensure that in considering the experience of the voting members of the board in
30 the aggregate, a majority of the board's voting members have relevant experience in
31 health benefit administration, health care finance, health plan purchasing, health care

1 delivery system administration, health policy issues related to the small group and
2 individual markets, health policy issues related to the uninsured, and public health.

3 4. The board members shall elect a voting member to serve as chairman.

4 5. Except for the initial board member appointments, which must be staggered so no
5 more than three terms expire each year and no more than one consumer
6 representative's term expires each year, the term for a board member is three years.

7 Each board member shall hold office until expiration of the member's term; until the
8 member's successor is appointed; or until the member's death, resignation, or
9 removal. An individual appointed to fill a midterm vacancy shall serve for the
10 remainder of the unexpired term. A board member may serve no more than two
11 consecutive full terms, after which a lapse must occur before being reappointed.

12 6. In determining voting rights at board meetings, each member may vote in person or by
13 proxy. Each voting member and legislator member is entitled to receive per diem
14 compensation in the amount established by subsection 1 of section 54-03-20 plus
15 reimbursement for mileage and travel as specified in section 54-06-09 and expenses
16 as specified in section 44-08-04 for attending board meetings. The compensation and
17 reimbursement provided for in this subsection may not be paid to any board member
18 who receives a salary or other compensation as an employee or official of this state if
19 the individual is serving on the commission by virtue of the individual's state office or
20 state employment. Costs incurred under this subsection must be paid from the money
21 of the health benefit exchange fund.

22 7. A majority of the voting board members constitutes a quorum for the transaction of
23 business. If a vacancy exists, a majority of the remaining voting board members
24 constitutes a quorum until the vacancy is filled.

25 8. A voting board member may resign at any time by giving written notice to the board
26 chairman. A resignation takes effect at the time the resignation is received unless the
27 resignation specifies a later date. The governor may remove a voting board member
28 for cause.

29 9. Each voting board member shall file with the secretary of state a statement of interest
30 in a manner as prescribed by section 16.1-09-03. Failure to disclose a statement of
31 interest constitutes cause for removal from the board. Each board member is

1 responsible for acting in the interest of the public in discharging the board member's
2 duties.

3 10. All meetings of the board, its advisory groups, and any board committees must comply
4 with section 44-04-19, except those portions of meetings at which the review or
5 discussion of data on individuals or confidential premium rate information is discussed
6 must be closed.

7 11. In the performance of their duties as board members, the voting board members are
8 exempt from the provisions of chapter 51-08.1.

9 **54-66-04. Board - Duties.**

10 1. Based on the policy established by the board, the division shall adopt rules to address
11 how the board will deal with board member conflict of interest issues when these
12 issues arise. The rules must include a definition of what constitutes a conflict of
13 interest; a board member duty to disclose a conflict of interest, possible conflict of
14 interest, or circumstances that the public may perceive to be a conflict of interest; and
15 a protocol the board will follow if an actual or possible conflict of interest arises. The
16 rules may allow, limit, or prohibit participation in board deliberation or voting by a board
17 member with a disclosed conflict of interest.

18 2. In recognition of the government-to-government relationship between the state and the
19 federally recognized tribes in the state, the board shall regularly consult on an ongoing
20 basis with each of the federally recognized tribes located in the state, consult with the
21 Indian affairs commission, and invite the executive director of the Indian affairs
22 commission to board meetings.

23 3. The board shall establish a health benefit exchange advisory group and technical
24 advisory group. The board may establish temporary advisory groups as appropriate to
25 carry out the board's duties. The board may provide the members of the health benefit
26 exchange advisory group and of the technical advisory group per diem compensation
27 in an amount that may not exceed the amount established by subsection 1 of section
28 54-03-20 plus the board may provide reimbursement for mileage and travel as
29 specified in section 54-06-09 and expenses as specified in section 44-08-04 for
30 attending advisory group meetings. The compensation and reimbursement provided
31 for in this subsection may not be paid to any advisory group member who receives a

1 salary or other compensation as an employee or official of this state if the individual is
2 serving on the commission by virtue of the individual's state office or state
3 employment. Costs incurred under this subsection must be paid from the money of the
4 health benefit exchange fund.

5 **54-66-05. Health benefit exchange advisory group.**

6 1. Within ninety days following the initial appointment of board members, the board shall
7 establish a health benefit exchange advisory group for the purpose of facilitating input
8 from a variety of stakeholders on issues related to the duties and operation of the
9 exchange and related issues.

10 2. Membership of the health benefit exchange advisory group may include:

11 a. Educated health care consumers who are enrollees in qualified health plans,
12 including individuals with disabilities;

13 b. Individuals and entities with experience in facilitating enrollment in qualified
14 health plans;

15 c. Licensed insurance producers;

16 d. Advocates for enrolling hard-to-reach populations;

17 e. Advocates for consumers with disabilities, mental illness, and chronic conditions;

18 f. Representatives of small businesses and self-employed individuals;

19 g. Representatives of health carriers that offer qualified health plans through the
20 exchange;

21 h. Representatives of health carriers that do not offer qualified health plans through
22 the exchange;

23 i. Representatives of the department of human services and other relevant state
24 agencies, such as the insurance department and the information technology
25 department;

26 j. Representatives of labor;

27 k. Health care providers;

28 l. Public health experts;

29 m. Representatives of large employers; and

30 n. Other stakeholders.

1 **54-66-06. Technical advisory group.**

- 2 1. Within ninety days following the initial appointment of board members, the board shall
3 establish a technical advisory group that is charged with advising the board on
4 actuarial, financial, and risk matters related to:
- 5 a. The transitional reinsurance program for the individual market;
 - 6 b. Risk adjustment;
 - 7 c. Risk corridors;
 - 8 d. Measures to mitigate adverse selection;
 - 9 e. Maintaining separate risk pools for the individual and small group markets or
10 merging the risk pools, and the implications for the small group and individual
11 markets both inside and outside the exchange; and
 - 12 f. Whether to expand exchange eligibility to large employers.
- 13 2. The technical advisory group shall advise the board on requirements, options, and
14 waivers, if appropriate, to ensure that the board is informed of technical requirements
15 under the federal act. Additionally, the technical advisory group shall make
16 recommendations on issues related to consumers who may move between state
17 public health care programs and qualified health plans offered in the exchange.

18 **54-66-07. Board policies and procedures - Division authority.**

- 19 1. In consultation with the division, the board shall establish policies and procedures as
20 provided under this subsection and the board, division, and exchange shall operate in
21 accordance with these policies and procedures. The policies and procedures must:
- 22 a. Provide for the operation of the exchange;
 - 23 b. Establish the procedure for the board to elect or appoint officers;
 - 24 c. Establish the manner of board voting;
 - 25 d. Establish a program for the division to foster public awareness of the exchange
26 and to publicize the eligibility requirements for purchasing qualified health plans
27 through the exchange, subsidies offered for purchasing qualified health plans
28 offered through the exchange, enrollment procedures, and use of the exchange
29 to apply eligibility for and enrollment standards of individuals in the state's
30 medical assistance program and the state's children's health insurance program;

- 1 e. Establish criteria and procedures for certifying qualified health plans in conformity
- 2 with, and not to exceed the requirements of, the federal act;
- 3 f. Establish document retention policies and procedures; and
- 4 g. Provide for an annual, independent financial audit of all the books and records of
- 5 the exchange and provide that the independent financial audit report must be
- 6 available to the public.
- 7 2. The division may contract with one or more eligible entities to carry out one or more of
- 8 the exchange's functions. For purposes of this subsection, an eligible entity has the
- 9 same meaning as under the federal act.
- 10 3. The division may enter information sharing agreements with federal and state
- 11 agencies and other state exchanges to carry out the exchange's responsibilities under
- 12 this chapter provided such agreements include adequate protections with respect to
- 13 the confidentiality of the information to be shared and comply with all state and federal
- 14 laws and regulations. The division shall establish procedures and safeguards to
- 15 protect the integrity and confidentiality of any data the exchange maintains.

16 **54-66-08. Operation of the exchange.**

- 17 1. By October 1, 2013, or later as directed by the director in compliance with federal law,
- 18 the exchange must be capable of beginning operations to support the initial open
- 19 enrollment period and to be fully operational by January 1, 2014.
- 20 2. The exchange may not make available any health benefit plan that is not a qualified
- 21 health plan and may not make available any health plan for which product language
- 22 and premium rates have not been approved by the commissioner.
- 23 3. The commissioner shall provide the exchange the following related to all premium rate
- 24 filings by health carriers offering qualified health plans:
 - 25 a. For premium rates filed, the certification by the health carrier's qualified actuary
 - 26 which was provided to the insurance department as part of the rate request.
 - 27 b. For premium rates modified or disapproved through the rate review process the
 - 28 insurance department shall identify the factors affecting the decision to modify or
 - 29 disapprove the rate.
- 30 4. The exchange must allow for a health carrier to offer a plan that provides limited scope
- 31 dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal

- 1 Revenue Code of 1986 through the exchange, either separately or in conjunction with
2 a qualified health plan, if the plan provides pediatric dental benefits meeting the
3 requirements of section 1302(b)(1)(J) of the federal act.
- 4 5. Neither the exchange nor a carrier offering health benefit plans through the exchange
5 may charge an individual a fee or penalty for termination of coverage if the individual
6 enrolls in another type of minimum essential coverage because the individual has
7 become newly eligible for that coverage or because the individual's
8 employer-sponsored coverage has become affordable under the standards of section
9 36B(c)(2)(C) of the Internal Revenue Code of 1986.
- 10 6. In accordance with section 1312(b) of the federal act, the exchange may not prohibit a
11 qualified individual enrolled in a qualified health plan offered through the exchange
12 from paying any applicable premium owed by the qualified individual to the health
13 carrier issuing the qualified health plan.
- 14 7. The exchange may make a qualified health plan available notwithstanding any
15 provision of state law that may require benefits other than the essential health benefits
16 specified under section 1302(b) of the federal act. This section does not preclude a
17 qualified health plan from voluntarily offering benefits in addition to essential health
18 benefits specified under section 1302(b), including wellness programs.
- 19 8. As required by section 1311(d)(3)(B)(ii) of the federal act, to the extent state law or
20 regulation requires that a qualified health benefit plan offer benefits in addition to the
21 essential health benefits specified under section 1302(b), the state shall make direct
22 payments to an individual enrolled in a qualified health benefit plan or on behalf of an
23 individual in order to defray the cost of any additional benefits directly to the qualified
24 health benefit plan in which such individual is enrolled. To the extent that such funding
25 to defray the cost for such additional benefits is not provided by the state, the qualified
26 health plan is not required to provide such additional benefits.
- 27 9. Any standard or requirement adopted by the state pursuant to title I of the federal act
28 must be applied uniformly to all health benefit plans in each insurance market to which
29 the standard and requirements apply.
- 30 10. The exchange must be designed to foster a competitive marketplace for insurance and
31 may not solicit bids or engage in the active purchasing of insurance.

- 1 11. The exchange may not preclude the sale of health benefit plans through mechanisms
2 outside the exchange, nor may the exchange preclude a qualified individual from
3 enrolling in, or a qualified employer from selecting for the qualified employer's
4 employees, a health benefit plan offered outside of the exchange.
- 5 12. The exchange may not prohibit a qualified individual from enrolling in any qualified
6 health plan, except that in the case of a catastrophic plan described in section 1302(e)
7 of the federal act, a qualified individual may enroll in the catastrophic plan only if the
8 individual is eligible to enroll under section 1302(e)(2) of the federal act.
- 9 13. For employers that choose to offer defined contribution plans to qualified individuals,
10 the exchange must provide the option of choosing either an employee choice or an
11 employer choice method of enrollment into the exchange. For employers that choose
12 to offer defined benefit plans, the exchange must allow the employer to designate the
13 health benefit plans available for the employees. Designated health benefit plans may
14 be limited by the employer to a specific carrier or one or more specific qualified health
15 plans.
- 16 14. The division shall consider the rate of premium growth within the exchange and
17 outside the exchange in developing recommendations on whether to continue limiting
18 qualified employer status to small employers.
- 19 15. In order to meet the following financial integrity requirements, the division shall:
20 a. Keep an accurate accounting of all exchange activities, receipts, and
21 expenditures and annually submit to the secretary, the governor, the
22 commissioner, and the legislative management a report concerning such
23 accountings; and
- 24 b. Fully cooperate with any investigation conducted by the secretary pursuant to the
25 secretary's authority under the federal act and allow the secretary, in coordination
26 with the inspector general of the federal department of health and human
27 services, to:
- 28 (1) Investigate the affairs of the exchange;
29 (2) Examine the properties and records of the exchange; and
30 (3) Require periodic reports in relation to the activities undertaken by the
31 exchange.

1 **54-66-09. Exchange requirements.**

2 The exchange must:

- 3 1. Implement procedures for the certification, recertification, and decertification,
4 consistent with guidelines developed by the secretary under section 1311(c) of the
5 federal act and section 54-66-12, of health benefit plans as qualified health plans.
- 6 2. Provide for the operation of a toll-free telephone hotline to respond to requests for
7 assistance.
- 8 3. Provide for enrollment periods, as provided under section 1311(c)(6) of the federal act.
- 9 4. Maintain an internet website through which enrollees and prospective enrollees of
10 qualified health plans may obtain standardized comparative information on such plans.
- 11 5. Assign a rating to each qualified health plan offered through the exchange in
12 accordance with the criteria developed by the secretary under section 1311(c)(3) of
13 the federal act and determine each qualified health plan's level of coverage in
14 accordance with regulations issued by the secretary under section 1302(d)(2)(A) of the
15 federal act.
- 16 6. Use a standardized format for presenting health benefit options in the exchange,
17 including the use of the uniform outline of coverage established under section 2715 of
18 the federal Public Health Service Act.
- 19 7. In accordance with section 1413 of the federal act, inform individuals of eligibility
20 requirements for the state's medical assistance program under chapter 50-24.1, the
21 state's children's health insurance program under chapter 50-29, or any applicable
22 state or local public program and if through screening of the application by the
23 exchange the exchange determines that any individual is eligible for any such
24 program, enroll that individual in that program.
- 25 8. Provide by electronic means a calculator to determine the actual cost of coverage after
26 application of any premium tax credit under section 36B of the Internal Revenue Code
27 of 1986 and any cost-sharing reduction under section 1402 of the federal act.
- 28 9. Include a process through which qualified employers may access coverage for their
29 employees, to enable any qualified employer to specify a level of coverage so that any
30 of the qualified employer's employees may enroll in any qualified health plan offered
31 through the exchange at the specified level of coverage.

- 1 10. Subject to section 1411 of the federal act, issue a certification attesting that for
2 purposes of the individual responsibility penalty under section 5000A of the Internal
3 Revenue Code of 1986, an individual is exempt from the individual responsibility
4 requirement or from the penalty imposed by that section because:
- 5 a. There is no affordable qualified health plan available through the exchange, or
6 the individual's employer, covering the individual; or
- 7 b. The individual meets the requirements for any other such exemption from the
8 individual responsibility requirement or penalty.
- 9 11. Provide for the transfer to the federal secretary of the treasury the following:
- 10 a. A list of the individuals who are issued a certification under subsection 10,
11 including the name and taxpayer identification number of each individual;
- 12 b. The name and taxpayer identification number of each individual who was an
13 employee of an employer but who was determined to be eligible for the premium
14 tax credit under section 36B of the Internal Revenue Code of 1986 because:
- 15 (1) The employer did not provide minimum essential coverage; or
16 (2) The employer provided the minimum essential coverage, but it was
17 determined under section 36B(c)(2)(C) of the Internal Revenue Code to
18 either be unaffordable to the employee or not provide the required minimum
19 actuarial value; and
- 20 c. The name and taxpayer identification number of:
- 21 (1) Each individual who notifies the exchange under section 1411(b)(4) of the
22 federal act of the fact that the employee has changed employers; and
- 23 (2) Each individual who ceases coverage under a qualified health plan during a
24 plan year and the effective date of that cessation.
- 25 12. Provide to each employer the name of each employee of the employer described in
26 subdivision b of subsection 11 who ceases coverage under a qualified health plan
27 during a plan year and the effective date of the cessation.
- 28 13. Comply with requirements of the exchange required by the secretary or the secretary
29 of the treasury related to determining eligibility for premium tax credits, reduced cost-
30 sharing, or individual responsibility requirement exemptions.

- 1 14. As authorized under section 1312(e) of the federal act, allow for licensed insurance
2 producers to:
- 3 a. Enroll qualified individuals and qualified employers in any qualified health plans in
4 the individual or small group market as soon as the plan is offered through the
5 exchange in the state; and
- 6 b. Assist qualified individuals applying for premium tax credits and cost-sharing
7 reductions for plans sold through the exchange.

8 **54-66-10. Navigation office - Grants - Regulation.**

- 9 1. The navigation office is established within the division. The navigation office shall
10 provide services designed to directly or indirectly assist consumers in navigating the
11 exchange. The navigation office:
- 12 a. Shall maintain expertise in eligibility, enrollment, and program specifications.
- 13 b. Shall conduct public education activities to raise awareness about the exchange.
- 14 c. Shall provide referrals to any applicable office of health insurance consumer
15 assistance or health insurance ombudsman established under section 2793 of
16 the federal Public Health Service Act, or any other appropriate state entity for any
17 enrollee with a grievance, complaint, or question regarding the enrollee's health
18 plan, coverage, or a determination under such plan or coverage.
- 19 d. Shall provide training and education services to individuals and entities that have
20 existing relationships or could readily establish such relationships with
21 employers; employees; consumers, including uninsured and underinsured
22 individuals; and self-employed individuals likely to be eligible for enrollment in a
23 qualified health plan. The training and education must:
- 24 (1) Address how to facilitate enrollment in qualified health plans;
- 25 (2) Address how to provide information and services in a fair, accurate, and
26 impartial manner;
- 27 (3) Address how to provide information in a manner that is culturally and
28 linguistically appropriate to the needs of the population being served by the
29 exchange, including individuals with limited English proficiency; and
- 30 (4) Address how to ensure accessibility and usability of navigator tools and
31 functions for individuals with disabilities in accordance with the federal

1 Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 327;
2 42 U.S.C. 12101 et seq.] and section 504 of the federal Rehabilitation Act of
3 1973 [Pub. L. 93-112; 87 Stat. 394; 29 U.S.C. 701 et seq.].

4 2. The navigation office shall provide navigator grants to the Indian affairs commission to
5 provide navigation services targeted primarily to Indian individuals and groups in the
6 state. The Indian affairs commission shall take the steps necessary to comply with the
7 terms of the grants, including:

- 8 a. Maintaining expertise in eligibility, enrollment, and program specifications;
9 b. Conducting public education activities to raise awareness about the exchange;
10 c. Providing information and services in a fair, accurate, and impartial manner;
11 d. Facilitating enrollment in qualified health plans;
12 e. Providing referrals to any applicable office of health insurance consumer
13 assistance or health insurance ombudsman established under section 2793 of
14 the federal Public Health Service Act, or any other appropriate state entity for any
15 enrollee with a grievance, complaint, or question regarding the enrollee's health
16 plan, coverage, or a determination under such plan or coverage;
17 f. Providing information in a manner that is culturally and linguistically appropriate
18 to the needs of the population being served by the exchange, including
19 individuals with limited English proficiency; and
20 g. Ensuring accessibility and usability of navigator tools and functions for individuals
21 with disabilities in accordance with the federal Americans with Disabilities Act
22 of 1990 [Pub. L. 101-336; 104 Stat. 327; 42 U.S.C. 12101 et seq.] and section
23 504 of the federal Rehabilitation Act of 1973 [Pub. L. 93-112; 87 Stat. 394; 29
24 U.S.C. 701 et seq.].

25 3. The board, through the navigation office, shall regulate who may charge a fee to or
26 otherwise receive consideration to assist employers, employees, or consumers in
27 making health coverage decisions through use of the exchange. This regulation must
28 include a requirement that an individual must be certified by the navigation office if that
29 individual charges a fee or receives consideration directly or indirectly from any health
30 insurance issuer in connection with the enrollment of any qualified individual or
31 qualified employees in a qualified health plan. For purposes of this subsection, wages

1 do not constitute consideration if the wages are not based on enrollment. The
2 navigation office shall provide for at least the following two levels of certification:
3 certification to allow a certificate holder to assist in navigating the entire exchange and
4 certification limited to allowing a certificate holder to assist in navigating the medical
5 assistance and children's health insurance program elements of the exchange. A
6 person that does not charge a fee or otherwise receive consideration may assist
7 employers, employees, and consumers in making health coverage decisions through
8 use of the exchange without being certified under this subsection. The certification
9 requirements must include successful completion of an education program provided
10 by the navigation office.

11 a. In order to be certified under this subsection, an individual must be:

12 (1) A licensed insurance producer; or

13 (2) An individual identified by the department of human services as being
14 knowledgeable regarding the state's medical assistance program and
15 children's health insurance program.

16 b. The exchange may provide information regarding such certified individuals on the
17 exchange website for the convenience of consumers seeking insurance through
18 the exchange.

19 c. A certificate holder may not in a single transaction charge a fee and receive
20 consideration from a health insurance issuer in connection with the enrollment of
21 a qualified individual or qualified employees in a qualified health plan.

22 **54-66-11. Risk pools.**

23 In accordance with section 1312(c) of the federal act, except for grandfathered health plans,
24 a health carrier shall consider all enrollees in all health plans members of a single risk pool
25 offered by such carrier in the individual market, including those enrollees who do not enroll in
26 such plans through the exchange and other than grandfathered health plans, a health carrier
27 shall consider all enrollees in all health plans offered by such carrier in the small group market,
28 including those enrollees who do not enroll in such plans through the exchange, to be members
29 of a single risk pool.

30 **54-66-12. Health benefit plan certification.**

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

- 1 a. The health benefit plan provides the essential health benefits package described
2 in section 1302(a) of the federal act, except that the plan is not required to
3 provide essential benefits that duplicate the minimum benefits of qualified dental
4 plans, as provided in subsection 5, if:
- 5 (1) The division has determined that at least one qualified dental plan is
6 available to supplement the plan's coverage; and
- 7 (2) In a form approved by the division, the carrier makes prominent disclosure
8 at the time the carrier offers the plan that the plan does not provide the full
9 range of essential pediatric benefits and that qualified dental plans providing
10 those benefits and other dental benefits not covered by the plan are offered
11 through the exchange;
- 12 b. The premium rates and contract language have been approved by the
13 commissioner;
- 14 c. The health benefit plan provides at least a bronze level of coverage, as
15 determined pursuant to subsection 5 of section 54-66-09, unless the plan is
16 certified as a qualified catastrophic plan, meets the requirements of section
17 1302(e) of the federal act for catastrophic plans, and will only be offered to
18 individuals eligible for catastrophic coverage;
- 19 d. The health benefit plan's cost-sharing requirements do not exceed the limits
20 established under section 1302(c)(1) of the federal act, and if the plan is offered
21 to a qualified employer, the plan's deductible does not exceed the limits
22 established under section 1302(c)(2) of the federal act;
- 23 e. The health carrier offering the health benefit plan:
- 24 (1) Is licensed and in good standing to offer health insurance coverage in North
25 Dakota;
- 26 (2) Offers through the exchange at least one qualified health plan in the silver
27 level and at least one plan in the gold level;
- 28 (3) Charges the same premium rate for each health benefit plan without regard
29 to whether the plan is offered through the exchange and without regard to
30 whether the plan is offered directly from the carrier or through a licensed
31 insurance producer;

- 1 (4) Does not charge any cancellation fees or penalties in violation of
2 subsection 5 of section 54-66-08; and
- 3 (5) Complies with the regulations developed by the secretary under section
4 1311(d) of the federal act and such other requirements as the division may
5 establish;
- 6 f. The health benefit plan meets the requirements of certification as promulgated by
7 the secretary under section 1311(c)(1) of the federal act, which include minimum
8 standards in the areas of marketing practices, network adequacy, essential
9 community providers in underserved areas, accreditation, quality improvement,
10 uniform enrollment forms and descriptions of coverage, and information on
11 quality measures for health benefit plan performance; and
- 12 g. The division determines that making the health benefit plan available through the
13 exchange is in the interest of qualified individuals and qualified employers in this
14 state.
- 15 2. The division may not exclude a health benefit plan from the exchange:
- 16 a. On the basis that the plan is a fee-for-service plan;
- 17 b. Through the imposition of premium price controls by the division; or
- 18 c. On the basis that the health benefit plan provides treatments necessary to
19 prevent patients' deaths in circumstances the exchange determines are
20 inappropriate or too costly.
- 21 3. Notwithstanding subsection 2, a health carrier that does not offer a qualified health
22 plan in the exchange during the initial and subsequent annual open enrollment
23 periods, is prohibited from offering a qualified health plan in the exchange before the
24 following annual open enrollment period. The division may permit a health carrier that
25 did not offer a qualified health plan in the exchange during the initial and subsequent
26 annual open enrollment periods to begin offering a qualified health plan in the
27 exchange before the following annual open enrollment period if the division
28 determines that it is in the interest of qualified individuals and qualified employers in
29 this state.
- 30 4. Except as otherwise provided in subsections 2 and 3, a health carrier that ceases to
31 offer any qualified health plans in the exchange after January first of a plan year is

1 prohibited from offering a new qualified health plan in the exchange for a period of two
2 years from the date of the health carrier's exit from the exchange. This subsection
3 does not prohibit an affiliated health carrier from continuing to offer a qualified health
4 plan in the exchange. The division may permit a health carrier that ceases to offer any
5 qualified health plans in the exchange after January first of a plan year to begin
6 offering a new qualified health plan in the exchange if the division determines that
7 making the qualified health plan available through the exchange is in the interest of
8 qualified individuals and qualified employers in this state.

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

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

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

21 (1) Claims payment policies and practices;

22 (2) Periodic financial disclosures;

23 (3) Data on enrollment;

24 (4) Data on disenrollment;

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

26 (6) Data on rating practices;

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

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

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

1 c. Provide in a timely manner upon the request of the individual, the amount of
2 cost-sharing, including deductibles, copayments, and coinsurance under the
3 individual's health benefit plan or coverage that the individual would be
4 responsible for paying with respect to the furnishing of a specific item or service
5 by a participating provider. At a minimum, this information must be made
6 available to the individual through an internet website and through other means
7 for individuals without access to the internet.

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

12 **54-66-13. Qualified dental plans.**

13 Except as otherwise provided under this section, to the extent relevant, the provisions of
14 this chapter which are applicable to qualified health plans also apply to qualified dental plans.
15 The carrier must be licensed to offer dental coverage, but need not be licensed to offer other
16 health benefits; the plan must be limited to dental and oral health benefits, without substantially
17 duplicating the benefits typically offered by health benefit plans without dental coverage and at a
18 minimum must include the essential pediatric dental benefits prescribed by the secretary
19 pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the
20 exchange or the secretary may specify by regulation; and carriers may jointly offer a
21 comprehensive plan through the exchange in which the dental benefits are provided by a carrier
22 through a qualified dental plan and the other benefits are provided by a carrier through a
23 qualified health plan, provided that the plans are priced separately and are also made available
24 for purchase separately at the same price.

25 **54-66-14. Funding - Publication of costs - Health benefit exchange fund - Reports to**
26 **legislative management.**

27 1. As required by section 1311(d)(5)(a) of the federal act, the exchange must be
28 self-sustaining by January 1, 2015, or later as otherwise specified by the director and
29 consistent with federal law. Until January 1, 2015, the division, the information
30 technology department, and the department of human services shall use grant funds
31 to finance the establishment of the exchange.

- 1 2. Under section 54-44.1-06, the governor shall submit a separate appropriations request
2 for the division. Before August first of each year, the division shall submit a proposal to
3 the board outlining how to raise the funds necessary to fund the board, division, and
4 exchange. To the extent the division's proposal includes the collection of funds that are
5 based on insurance, the division shall consult with the commissioner in designing the
6 proposal. Before October first of each year, the board shall establish a plan for funding
7 the board, division, and exchange. To the extent the board's plan includes the
8 collection of funds that are based on insurance, the board shall consult with the
9 commissioner. Annually, the board shall report to the legislative management the
10 board's plan for funding the board, division, and exchange. Annually, the department
11 of human services shall report to the legislative management the department's plan for
12 funding the medical assistance-related and children's health insurance program-
13 related exchange activities of the department.
- 14 3. To the extent the board's funding plan is based on the collection of funds that are
15 based on insurance, the funding plan is limited to collecting such funds from hospital,
16 surgical, medical expense, and major medical insurance and the funding plan must be
17 applied universally to plans inside and outside the exchange.
- 18 4. The board may charge assessments or user fees or otherwise may generate funding
19 necessary to support board, division, and exchange operations provided under this
20 chapter, including collection of exchange website advertisement revenues. If the
21 board's funding plan includes the collection of funds that are based on insurance,
22 upon request of the board the commissioner shall charge and collect such funds and
23 shall deposit such funds in the health benefit exchange fund.
- 24 5. Services performed by the exchange on behalf of other state or federal programs may
25 not be funded with premium taxes, assessments, or user fees collected from health
26 carriers under this chapter.
- 27 6. Any funding unspent by the division may be used for future state operation of the
28 exchange or returned to health carriers as a credit if the division charges fees to
29 carriers.
- 30 7. There is created in the state treasury the health benefit exchange fund. Any moneys
31 appropriated to the division; received or generated by assessments or user fees; or

1 otherwise generated to support the board, division, or exchange operations must be
2 deposited in this fund. Interest earned on moneys in the fund must be credited to the
3 fund.

4 8. The division shall publish the administrative and operational costs of the exchange, on
5 an internet website to educate consumers on such costs. The information published
6 must include the amount of premiums and federal premium subsidies collected by the
7 exchange; the amount and source of any other fees collected by the board for
8 purposes of supporting the exchange's operations; and any money lost to waste,
9 fraud, and abuse.

10 **54-66-15. Adjudicative proceedings - Final orders - Attorney's fees and costs.**

11 1. Every adjudicative proceeding arising under this chapter must be conducted as
12 provided under chapter 28-32. The division may adopt rules to implement the
13 provision of adjudicative proceedings arising under this chapter.

14 2. Notwithstanding contrary provisions of chapter 28-32, in a hearing conducted by a
15 hearing officer under chapter 28-32, the hearing officer shall issue final findings of fact
16 and conclusions of law and issue a final order.

17 3. Notwithstanding contrary provisions of chapter 28-32, in a hearing conducted by a
18 hearing officer under chapter 28-32 which involves as adverse parties the division and
19 a party not an administrative agency or an agent of an administrative agency, the
20 hearing officer shall award the party not an administrative agency reasonable
21 attorney's fees and costs if the hearing officer finds in favor of that party and
22 determines that the division acted without substantial justification. Any attorney's fees
23 and costs awarded under this subsection must be paid from funds in the health benefit
24 exchange fund. The hearing officer may withhold all or part of the attorney's fees from
25 any award if the hearing officer finds the division's action was substantially justified or
26 that special circumstances exist which make the award of all or a portion of the
27 attorney's fees unjust. This subsection does not affect any fees under other applicable
28 law.

29 **54-66-16. Records.**

30 Notwithstanding any provision of this code making records confidential, the division and the
31 department of human services may receive from and provide to federal and state agencies

1 information gathered in the administration of the exchange, including social security numbers, if
2 the disclosure is necessary for the division, the department of human services, or the receiving
3 entity to perform its duties and responsibilities.

4 **54-66-17. Rules.**

5 The division, in consultation with the board, shall adopt rules to implement this chapter.
6 Rules adopted under this chapter may not conflict with or prevent the application of regulations
7 promulgated by the secretary under the federal act or except as specified under this chapter
8 exceed the rules enforced by the commissioner or by the director of the department of human
9 services.

10 **54-66-18. Application.**

11 This chapter and actions taken by the board and division pursuant to this chapter do not
12 preempt or supersede the authority of the commissioner to regulate the business of insurance
13 within this state. Except as expressly provided to the contrary in this chapter, all health carriers
14 offering qualified health plans in this state shall comply with all applicable health insurance laws
15 of this state and rules adopted and orders issued by the commissioner.

16 **SECTION 2. REPEAL.** Chapter 26.1-54 of the North Dakota Century Code and section 3 of
17 chapter 225 of the 2011 Session Laws are repealed.

18 **SECTION 3. APPLICATION - REPORTS TO THE LEGISLATIVE MANAGEMENT.** In
19 carrying out the requirements of this Act, the insurance commissioner, department of human
20 services, and information technology department shall provide regular updates to the legislative
21 management during the 2011-12 interim which must include monthly written reports on the
22 status of state and federal funds received and the status of state and federal funds expended.

23 In determining, planning, and implementing the North Dakota health benefit exchange,
24 collectively the office of management and budget health benefit exchange division, the
25 department of human services, and the information technology department may submit
26 proposed legislation to the legislative management before October 1, 2012.

27 **SECTION 4. LEGISLATIVE INTENT - HEALTH BENEFIT EXCHANGE ESTABLISHMENT**
28 **GRANTS - REPORT TO THE LEGISLATIVE MANAGEMENT.** It is the intent of the
29 sixty-second legislative assembly that the office of management and budget shall apply for
30 federal exchange establishment grants to be used for the purposes of health benefit exchange
31 planning activities to include developing an information technology system for the health benefit

1 exchange. Health benefit exchange establishment grants include level one and level two
2 establishment grants.

3 It is also the intent of the sixty-second legislative assembly that the office of management
4 and budget health benefit exchange division, the information technology department, and the
5 department of human services explore any additional grant opportunities that may become
6 available for the health benefit exchange.

7 It is also the intent of the sixty-second legislative assembly that, except as expressly
8 authorized by the legislative assembly, state entities may not use state funds to fund the
9 planning activities related to, the development of, and the operation of the health benefit
10 exchange.

11 Upon approval of health benefit exchange grants, the receiving department or division shall
12 notify the office of management and budget and report to the legislative management on any
13 grants awarded.

14 **SECTION 5. FEDERAL GRANTS - CONTINUING APPROPRIATION - REPORT TO THE**
15 **LEGISLATIVE MANAGEMENT.** Any federal funds received from federal health insurance
16 exchange grants is appropriated out of special funds derived from federal funds, not otherwise
17 appropriated, to the office of management and budget health benefit exchange division, the
18 information technology department, and the department of human services for the purposes of
19 establishing a state health insurance exchange, for the period beginning November 14, 2011,
20 and ending June 30, 2013. Upon approval of health insurance exchange grants, the receiving
21 department or division shall notify the office of management and budget and report to the
22 legislative management any increased federal appropriation authority.

23 **SECTION 6. APPROPRIATION - EXEMPTION.** There is appropriated from special funds
24 derived from federal funds and other income, the sum of \$2,060,378, or so much of the sum as
25 may be necessary, to the office of management and budget health benefit exchange division for
26 the purpose of defraying the expenses of establishing and operating the health benefit
27 exchange, for the period beginning November 14, 2011, and ending June 30, 2013. The office
28 of management and budget health benefit exchange division is authorized nine full-time
29 equivalent positions for operations of the health benefit exchange. The appropriation provided in
30 this section is not subject to section 54-44.1-11 and any unexpended funds from this

1 appropriation are available for defraying the expenses of establishing and operating the health
2 benefit exchange, for the biennium beginning July 1, 2013, and ending June 30, 2015.

3 **SECTION 7. APPROPRIATION.** There is appropriated from special funds derived from
4 federal funds and other income, the sum of \$35,964,750, or so much of the sum as may be
5 necessary, to the information technology department for the purpose of defraying the expenses
6 of establishing and implementing the health benefit exchange, for the period beginning
7 November 14, 2011, and ending June 30, 2013. The information technology department is
8 authorized nineteen full-time equivalent positions for implementation of the health benefit
9 exchange. The appropriation provided in this section is not subject to section 54-44.1-11 and
10 any unexpended funds from this appropriation are available for defraying the expenses of
11 establishing and implementing the health benefit exchange, for the biennium beginning July 1,
12 2013, and ending June 30, 2015.

13 **SECTION 8. APPROPRIATION.** There is appropriated out of any moneys in the health
14 benefit exchange fund in the state treasury, not otherwise appropriated, the sum of \$500,000, or
15 so much of the sum as may be necessary, to the office of management and budget health
16 benefit exchange division for the purpose of funding the operation and activities of the division's
17 navigation office, for the period beginning November 14, 2011, and ending June 30, 2013.

18 **SECTION 9. INSURANCE COMMISSIONER - HEALTH BENEFIT EXCHANGE FUND -**
19 **TRANSFER - APPROPRIATION.** Up to \$750,000 of the amount appropriated to the insurance
20 commissioner from federal funds as provided in section 2 of chapter 225 of the 2011 Session
21 Laws for the purpose of planning for implementation of a health benefit exchange and not spent
22 or obligated as of December 1, 2011, must be transferred by the director of the office of
23 management and budget and the insurance commissioner to the health benefit exchange fund
24 by December 31, 2011. There is appropriated out of any moneys in the health benefit exchange
25 fund in the state treasury, not otherwise appropriated, the sum of \$750,000, or so much of the
26 sum as may be necessary, to the office of management and budget health benefit exchange
27 division for the purpose of planning, establishing, and administering the North Dakota health
28 benefit exchange, for the period beginning November 14, 2011, and ending June 30, 2013. The
29 health benefit exchange division may transfer these funds to the department of human services
30 or the information technology department for the purpose of planning and establishing the North
31 Dakota health benefit exchange.

1 **SECTION 10. LEGISLATIVE INTENT.** Creation of a state-administered health benefit
2 exchange is not intended to express the sixty-second legislative assembly's support of the
3 federal Patient Protection and Affordable Care Act, but instead is intended to express its support
4 of state control.

5 **SECTION 11. LIMITATIONS ON STATE AGENCIES - LEGISLATIVE INTENT.** Absent
6 legislative authorization, an executive branch state agency may not enter any agreement,
7 contract, or other relationship with the federal government for the state or federal government to
8 establish, manage, operate, or form a relationship to provide a health benefit exchange under
9 the federal Affordable Care Act. It is the intent of the sixty-second legislative assembly that
10 executive branch state agencies not work with the federal government to evade or otherwise
11 circumvent legislative authority to establish, manage, operate, or form a federal-administered or
12 state-administered health benefit exchange.

13 **SECTION 12. EFFECTIVE DATE.** This Act becomes effective on November 14, 2011.

14 **SECTION 13. CONTINGENT EXPIRATION DATE.** If section 1311 of the federal Patient
15 Protection and Affordable Care Act [Pub. L. 111-148], as amended by the federal Health Care
16 and Education Reconciliation Act of 2010 [Pub. L. 111-152], is repealed by Congress or
17 otherwise rendered invalid, in whole or in part, by a final judicial decree or if the state is granted
18 a federal waiver for the health benefit exchange requirement before or after the establishment
19 of the North Dakota health benefit exchange, section 1 of this Act expires as of August first
20 following the next regular legislative session after the effective date of the repeal, invalidation, or
21 federal waiver unless the legislative assembly takes specific action to extend that section of the
22 Act.