..... moves to amend H.F. No. 99 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

PREMIUM SUBSIDY PROGRAM

Section 1. **DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 1 to 5, the following terms have the meanings given.

Subd. 2. **Eligible individual.** "Eligible individual" means a Minnesota resident who is not receiving a premium tax credit under Code of Federal Regulations and is not receiving public program coverage under Minnesota Statutes, section 256B.055, or 256L.04.

Subd. 3. **Gross premium.** "Gross premium" means the amount billed for a health plan purchased by an eligible individual prior to a state premium subsidy, as defined in subdivision 5, in a calendar year.

Subd. 4. **Net premium.** "Net premium" means the gross premium less the subsidy defined in subdivision 5.

Subd. 5. **Premium subsidy.** "Premium subsidy":

(1) is a payment made on behalf of eligible individuals for the promotion of general welfare, and is not compensation for any services;

(2) is equal to 25 percent of the monthly gross premium otherwise paid by or on behalf of the eligible individual that covers the eligible individual and the eligible individual's spouse and dependents; and

(3) is excluded from any calculation used to determine eligibility within any of the Department of Human Services programs.

Subd. 6. **Health carrier.** "Health carrier" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 2.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of management and budget.

Subd. 8. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan, as defined in Minnesota Statutes, section 62A.011, subdivision 5.

Sec. 2. **PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE INDIVIDUALS.**

Payments to health carriers are based upon the premium subsidy available to eligible individuals in the individual market, regardless of the cost of coverage purchased. Health carriers seeking reimbursement from the state must submit an invoice and supporting information to the commissioner in a form prescribed by the commissioner in order to be eligible for payment. Payments are made on behalf of eligible individuals effectuating coverage for calendar year 2017 and for the months in that year that the net premium amount has been received by the health carriers for that individual. Total state payments to health carriers are to be made within the scope of the available appropriation in section 3.

Sec. 3. **FUNDING.**

$311,645,000 in fiscal year 2017 is appropriated to Minnesota Management and Budget from the health care access fund for the purposes of making payments as defined in section 2. The commissioner shall prorate payments to the health carriers if necessary so as not to exceed the appropriation available. The appropriation is onetime and is available through June 30, 2018.

Sec. 4. **AUDIT.**

The Department of Commerce shall conduct audits of the health carriers' supporting data, as prescribed by the commissioner, to determine whether payments align with criteria established in sections 1 and 2. The Department of Human Services shall provide data as necessary to the Department of Commerce to complete the audit. All data collected for that purpose will be held as confidential and nonpublic. The commissioner shall withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 1 and 2, as determined by the Department of Commerce. $300,000 in fiscal year 2017 is appropriated from the health care access fund to the Department of

Commerce for purposes of this section, and to facilitate payments to health carriers. The appropriation is available until expended.

Sec. 5. **GROSS PREMIUM EXEMPTIONS.**

This gross premium is not exempt under Minnesota Statutes, section 297I.15, or 62V.05, subdivision 2.

Sec. 6. **EFFECTIVE DATE.**

Sections 1 to 5 are effective the day following final enactment.

ARTICLE 2

TRANSITION OF CARE COVERAGE

Section 1. **TRANSITION OF CARE COVERAGE FOR CALENDAR YEAR 2017; INVOLUNTARY TERMINATION OF COVERAGE.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Enrollee" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 2b.

(c) "Health plan" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 3.

(d) "Health plan company" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 4.

(e) "Individual market" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 5.

(f) "Involuntary termination of coverage" means the termination of a health plan due to a health plan company's refusal to renew the health plan in the individual market because the health plan company elects to cease offering individual market health plans in all or some geographic rating areas of the state.

Subd. 2. **Application.** This section applies to an enrollee who is subject to a change in health plans in the individual market due to an involuntary termination of coverage from a health plan in the individual market after October 31, 2016, and before January 1, 2017, and who enrolls in a new health plan in the individual market for all or a portion of calendar year 2017 that goes into effect after December 31, 2016, and before March 2, 2017.

Subd. 3. **Change in health plans; transition of care coverage.** (a) If an enrollee satisfies the criteria in subdivision 2, the enrollee's new health plan company must provide, upon request of the enrollee or the enrollee's health care provider, authorization to receive services that are otherwise covered under the terms of the enrollee's calendar year 2017 health plan from a provider who provided care on an in-network basis to the enrollee during calendar year 2016 but who is out of network in the enrollee's calendar year 2017 health plan:

(1) for up to 120 days if the enrollee has received a diagnosis of, or is engaged in a current course of treatment for, one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

(b) For all requests for authorization under this subdivision, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria in paragraph (a) or subdivision 2.

(c) The commissioner of Minnesota Management and Budget must reimburse the enrollee's new health plan company for costs attributed to services authorized under this subdivision. Costs eligible for reimbursement under this paragraph are the difference between the health plan company's reimbursement rate for in-network providers for a service authorized under this subdivision and its rate for out-of-network providers for the service. The health plan company must seek reimbursement from the commissioner for costs attributed to services authorized under this subdivision, in a form and manner mutually agreed upon by the commissioner and the affected health plan companies. Total state reimbursements to health plan companies under this paragraph are subject to the limits of the available appropriation. In the event that funding for reimbursements to health plan companies is not sufficient to fully reimburse health plan companies for the costs attributed to services authorized under this subdivision, health plan companies must continue to cover services authorized under this subdivision.

Subd. 4. **Limitations.** (a) Subdivision 3 applies only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of:

(i) the health plan company's reimbursement rate for in-network providers for the same or similar service; or

(ii) the provider's regular fee for that service;

(2) request authorization for services in the form and manner specified by the enrollee's new health plan company, if the provider chooses to request authorization; and

(3) provide the enrollee's new health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 5. **Request for authorization.** The enrollee's health plan company may require medical records and other supporting documentation to be submitted with a request for authorization under subdivision 3. If authorization is denied, the health plan company must explain the criteria used to make its decision on the request for authorization and must explain the enrollee's right to appeal the decision. If an enrollee chooses to appeal a denial, the enrollee must appeal the denial within five business days of the date on which the enrollee receives the denial. If authorization is granted, the health plan company must provide the enrollee, within five business days of granting the authorization, with an explanation of how transition of care will be provided.

EFFECTIVE DATE. This section is effective for health plans issued after December 31, 2016, and before March 2, 2017, and that are in effect for all or a portion of calendar year 2017. This section expires June 30, 2018.

Sec. 2. **APPROPRIATION; COVERAGE FOR TRANSITION OF CARE.**

$15,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of Minnesota Management and Budget to reimburse health plan companies for costs attributed to coverage of transition of care services under section 1. No more than three percent of this appropriation is available to the commissioner for administrative costs. This is a onetime appropriation and is available until expended.

EFFECTIVE DATE. This section is effective the day following final enactment."

Amend the title accordingly