..... moves to amend H.F. No. 1693 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2016, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **Board of directors; organization.** (a) For purposes of this subdivision: (1) "contributing member" means a contributing member or an eligible health carrier, as defined in section 62E.22, subdivision 8; and (2) "plan enrollees" means a plan enrollee or an enrollee in an individual health plan, as defined in section 62E.22, subdivision 9.

(b) The board of directors of the association shall be made up of eleven members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; five public directors selected by the commissioner, at least two of whom must be plan enrollees, two of whom are covered under an individual plan ~~subject to assessment under section 62E.11~~ or group plan offered by an employer ~~subject to assessment under section 62E.11~~, and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 2. Minnesota Statutes 2016, section 62E.11, subdivision 5, is amended to read:

Subd. 5. **Allocation of losses.** (a) For purposes of this subdivision: (1) "contributing member" means a contributing member or an eligible health carrier, as defined in section 62E.22, subdivision 8; and (2) "plan enrollees" means a plan enrollee or an enrollee in an individual health plan, as defined in section 62E.22, subdivision 9.

(b) Each contributing member of the association shall share the losses due to claims expenses of: (1) the comprehensive health insurance plan for plans issued or approved for issuance by the association~~, and~~; or (2) the Minnesota premium security plan, as defined in section 62E.22, subdivision 12.

(c) Each contributing member shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan which exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Claims expenses of the Minnesota premium security plan which exceed funding allocated to reinsurance payments shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plan and Minnesota premium security plan and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total accident and health insurance premium, received from or on behalf of Minnesota residents as divided by the total accident and health insurance premium, received by all contributing members from or on behalf of Minnesota residents, as determined by the commissioner. Payments made by the state to a contributing member for medical assistance or MinnesotaCare services according to chapters 256 and 256B shall be excluded when determining a contributing member's total premium.

Sec. 3. Minnesota Statutes 2016, section 62E.11, subdivision 6, is amended to read:

Subd. 6. **Member assessments.** The association shall make an annual determination of each contributing member's liability for the state plan or the Minnesota premium security plan, as defined in section 62E.22, subdivision 12, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the contributing members whose aggregate assessments comprised a minimum of 90 percent of the most recent prior annual assessment, in the event that the association deems that methodology to be the most administratively efficient and cost-effective means of assessment, and as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plan or Minnesota premium security plan and operating and

administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment shall be due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership and ability to offer, issue, or renew policies of accident and health or sickness insurance policies in this state. A contributing member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment, as determined herein, would not exceed ten dollars.

Sec. 4. **[62E.21] TITLE.**

Sections 62E.21 to 62E.25 may be cited as the "Minnesota Premium Security Plan Act."

Sec. 5. **[62E.22] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incurs claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D.

Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" means the market for individual health insurance coverage as defined in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" means the association as defined in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program created under this act.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

Sec. 6. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**

Subdivision 1. **Administration of plan.** (a) The association shall administer the plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account.

(c) The association must collect data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5.

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disperse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) mitigate the impact high-risk individuals have on premium rates in the individual market;

(4) take into account any federal funding available for the plan;

(5) take into account the total amount available to fund the plan; and

(6) for benefit year 2019 and thereafter, include cost savings mechanisms related to the management of health care services.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 70 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit

year. The commissioner shall review and approve the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the approved payment parameters are not fully funded by the legislature by July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, reinsurance payment is $0. If the claims costs exceed the attachment point, reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. Total amount paid of an eligible claim means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (e).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier must request reinsurance payments when the eligible health carrier's claims costs for an enrollee meet the criteria for reinsurance payments.

(b) An eligible health carrier must apply the payment parameters when calculating amounts the health carrier is eligible to receive from the plan.

(c) An eligible health carrier must make requests for reinsurance payments in accordance with any requirements established by the board.

(d) An eligible health carrier must calculate the premium amount the health carrier would have charged for the applicable benefit year if the plan was not in effect and submit this information as part of their rate filing.

(e) In order to receive reinsurance payments, an eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(f) An eligible health carrier must provide the access described in paragraph (e) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(g) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(h) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

Subd. 6. **Audits and reports of eligible health carriers.** (a) The association may audit an eligible health carrier to assess its compliance with the requirements this act. The eligible health carrier must cooperate with any audit. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this act, the eligible health carrier may respond to the draft audit report within 30 days of the draft audit report's issuance.

(b) Within 30 days of the issuance of the final audit report, if the final audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement of this act, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) upon association approval, implement the corrective action plan described; and

(3) provide the association with documentation of the corrective actions taken.

Subd. 7. **Data.** Data collected, created, or maintained by the association for the purpose of providing reinsurance payments to eligible health carriers is classified as private data on individuals, as defined under section 13.02, subdivision 12; nonpublic data, as defined under

section 13.02, subdivision 9; or not public data, as defined under section 13.02, subdivision 8a.

Sec. 7. **[62E.24] ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.**

Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year of all:

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

(3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** (a) The board must submit to the commissioner and make available to the public a report summarizing the plan operations for each benefit year, by posting the summary on the Minnesota Comprehensive Health Association Web site and making the summary otherwise available, by November 1 of the year following the applicable benefit year, or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

(b) The board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance within 60 days of the commissioner making publicly available the final and approved premium rates, or by December 1, whichever is later. The report must include information on what the premium increases in the individual market will be for the next benefit year if the plan is not fully funded.

Subd. 3. **Independent external audit.** (a) The board must engage and cooperate with an independent qualified auditor to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 4; and

(3) make available to the public a summary of the results of the audit, by posting the summary on the Minnesota Comprehensive Health Association Web site and making the summary otherwise available, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency.

Subd. 4. **Actions on audit findings.** If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

Sec. 8. **[62E.25] PREMIUM SECURITY PLAN ACCOUNT.**

The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the association for the operation of the plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account not currently needed, shall be credited to the premium security plan account.

Sec. 9. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

(c) Notwithstanding Minnesota Statutes, section 138.17, government data on an enrollee or health carrier under this section must be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later. This paragraph does not apply to data maintained by the legislative auditor."

Amend the title accordingly