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

1.10 Subd. 2. **Board of directors; organization.** (a) For purposes of this subdivision: (1) 1.11 "contributing member" means a contributing member or an eligible health carrier, as defined 1.12 in section 62E.22, subdivision 8; and (2) "plan enrollee" means a plan enrollee or an enrollee 1.13 in an individual health plan, as defined in section 62E.22, subdivision 9.

1.14 (b) The board of directors of the association shall be made up of eleven members as 1.15 follows: six directors selected by contributing members, subject to approval by the 1.16 commissioner, one of which must be a health actuary; five public directors selected by the 1.17 commissioner, at least two of whom must be plan enrollees, two of whom are covered under 1.18 an individual plan ~~subject to assessment under section 62E.11~~ or group plan offered by an 1.19 employer ~~subject to assessment under section 62E.11~~, and one of whom must be a licensed 1.20 insurance agent. At least two of the public directors must reside outside of the seven-county 1.21 metropolitan area. In determining voting rights at members' meetings, each member shall 1.22 be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the 1.23 member's cost of self-insurance, accident and health insurance premium, subscriber contract 1.24 charges, health maintenance contract payment, or community integrated service network 1.25 payment derived from or on behalf of Minnesota residents in the previous calendar year, 2.1 as determined by the commissioner. In approving directors of the board, the commissioner 2.2 shall consider, among other things, whether all types of members are fairly represented. 2.3 Directors selected by contributing members may be reimbursed from the money of the 2.4 association for expenses incurred by them as directors, but shall not otherwise be 2.5 compensated by the association for their services. The costs of conducting meetings of the 2.6 association and its board of directors shall be borne by members of the association.

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

2.8 Subd. 5. **Allocation of losses.** (a) For purposes of this subdivision: (1) "contributing 2.9 member" means a contributing member or an eligible health carrier, as defined in section 2.10 62E.22, subdivision 8; and (2) "plan enrollee" means a plan enrollee or an enrollee in an 2.11 individual health plan, as defined in section 62E.22, subdivision 9.

2.12 (b) Each contributing member of the association shall share the losses due to claims 2.13 expenses of the comprehensive health insurance plan for plans issued or approved for 2.14 issuance by the association~~, and~~.

2.15 (c) Each contributing member shall share in the operating and administrative expenses 2.16 incurred or estimated to be incurred by the association incident to the conduct of its affairs. 2.17 Claims expenses of the state plan which exceed the premium payments allocated to the

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

1.10 Subd. 2. **Board of directors; organization.** The board of directors of the association 1.11 shall be made up of ~~eleven~~ 13 members as follows: six directors selected by contributing 1.12 members, subject to approval by the commissioner, one of which must be a health actuary; 1.13 two directors selected by the commissioner of human services, one of whom must represent 1.14 hospitals and one of whom must represent health care providers; five public directors selected 1.15 by the commissioner, at least two of whom must be ~~plan enrollees, two of whom are covered~~ 1.16 ~~under an individual plan subject to assessment under section 62E.11 or group plan offered~~ 1.17 ~~by an employer subject to assessment under section 62E.11,~~ enrollees in the individual 1.18 market and one of whom must be a licensed insurance agent. At least two of the public 1.19 directors must reside outside of the seven-county metropolitan area. In determining voting 1.20 rights at members' meetings, each member shall be entitled to vote in person or proxy. ~~The~~ 1.21 ~~vote shall be a weighted vote based upon the member's cost of self-insurance, accident and~~ 1.22 ~~health insurance premium, subscriber contract charges, health maintenance contract payment,~~ 1.23 ~~or community integrated service network payment derived from or on behalf of Minnesota~~ 1.24 ~~residents in the previous calendar year, as determined by the commissioner.~~ In approving 1.25 directors of the board, the commissioner shall consider, among other things, whether all 2.1 types of members are fairly represented. Directors selected by contributing members may 2.2 be reimbursed from the money of the association for expenses incurred by them as directors, 2.3 but shall not otherwise be compensated by the association for their services. ~~The costs of~~ 2.4 ~~conducting meetings of the association and its board of directors shall be borne by members~~ 2.5 ~~of the association.~~

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2.18 payment of benefits shall be the liability of the contributing members. Contributing members
2.19 shall share in the claims expense of the state plan and operating and administrative expenses
2.20 of the association in an amount equal to the ratio of the contributing member's total accident
2.21 and health insurance premium, received from or on behalf of Minnesota residents as divided
2.22 by the total accident and health insurance premium, received by all contributing members
2.23 from or on behalf of Minnesota residents, as determined by the commissioner. Payments
2.24 made by the state to a contributing member for medical assistance or MinnesotaCare services
2.25 according to chapters 256 and 256B shall be excluded when determining a contributing
2.26 member's total premium.

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

2.28 Subd. 6. **Member assessments.** The association shall make an annual determination of
2.29 each contributing member's liability, if any, and may make an annual fiscal year end
2.30 assessment if necessary. The association may also, subject to the approval of the
2.31 commissioner, provide for interim assessments against the contributing members whose
2.32 aggregate assessments comprised a minimum of 90 percent of the most recent prior annual
2.33 assessment, in the event that the association deems that methodology to be the most
3.1 administratively efficient and cost-effective means of assessment, and as may be necessary
3.2 to assure the financial capability of the association in meeting the incurred or estimated
3.3 claims expenses of the state plan and operating and administrative expenses of the association
3.4 until the association's next annual fiscal year end assessment. Payment of an assessment
3.5 shall be due within 30 days of receipt by a contributing member of a written notice of a
3.6 fiscal year end or interim assessment. Failure by a contributing member to tender to the
3.7 association the assessment within 30 days shall be grounds for termination of the contributing
3.8 member's membership and ability to offer, issue, or renew policies of accident and health
3.9 or sickness insurance policies in this state. A contributing member which ceases to do
3.10 accident and health insurance business within the state shall remain liable for assessments
3.11 through the calendar year during which accident and health insurance business ceased. The
3.12 association may decline to levy an assessment against a contributing member if the
3.13 assessment, as determined herein, would not exceed ten dollars.

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

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

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

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

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2.6 Sec. 2. **[62E.21] DEFINITIONS.**

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

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3.19 Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal act as defined 3.20 in section 62A.011, subdivision 1a.	2.9 Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the Affordable Care Act 2.10 as defined in section 62A.011, subdivision 1a.
3.21 Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 3.22 62E.23, subdivision 2, paragraph (b).	2.11 Subd. 3. **Attachment point.** "Attachment point" means the threshold dollar amount for 2.12 claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits 2.13 in a plan year, after which threshold the claims costs for such benefits are eligible for 2.14 Minnesota premium security plan payments.
3.23 Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible 3.24 health carrier provides coverage through an individual health plan.	
3.25 Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive 3.26 Health Association created under section 62E.10.	2.15 Subd. 4. **Board.** "Board" means the board of directors of the Minnesota Comprehensive 2.16 Health Association established under section 62E.10.
3.27 Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 3.28 62E.23, subdivision 2, paragraph (c).	2.17 Subd. 5. **Coinsurance rate.** "Coinsurance rate" means the rate, established by the board 2.18 of the Minnesota Comprehensive Health Association, at which the association will reimburse 2.19 the eligible health carrier for claims costs incurred for an enrolled individual's covered 2.20 benefits in a plan year after the attachment point and before the reinsurance cap.
3.29 Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.	2.21 Subd. 6. **Commissioner.** "Commissioner" means the commissioner of commerce.
4.1 Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following 4.2 that offer individual health plans and incur claims costs for an individual enrollee's covered 4.3 benefits in the applicable benefit year:	2.22 Subd. 7. **Eligible health carrier.** "Eligible health carrier" means:
4.4 (1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of 4.5 accident and sickness insurance as defined in section 62A.01;	2.23 (1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of 2.24 accident and sickness insurance as defined in section 62A.01;
4.6 (2) a nonprofit health service plan corporation operating under chapter 62C; or	2.25 (2) a nonprofit health service plan corporation operating under chapter 62C; or
4.7 (3) a health maintenance organization operating under chapter 62D.	2.26 (3) a health maintenance organization operating under chapter 62D
	2.27 offering health plans in the individual market and incurring claims costs for an individual 2.28 enrollee's covered benefits in the applicable plan year that exceed the attachment point under 2.29 the Minnesota premium security plan.
4.8 Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined 4.9 in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 4.10 62A.011, subdivision 1b.	

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4.11 Subd. 10. **Individual market.** "Individual market" means the market for individual 4.12 health insurance coverage as defined in section 62A.011, subdivision 5.	2.30 Subd. 8. **Individual market.** "Individual market" has the meaning given in section 2.31 62A.011, subdivision 5.
4.13 Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota 4.14 Comprehensive Health Association" or "association" means the association as defined in 4.15 section 62E.02, subdivision 14.	3.1 Subd. 9. **Minnesota Comprehensive Health Association or association.** "Minnesota 3.2 Comprehensive Health Association" or "association" has the meaning given in section 3.3 62E.02, subdivision 14.
4.16 Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security 4.17 plan" or "plan" means the state-based reinsurance program created under this act.	3.4 Subd. 10. **Minnesota premium security plan.** The "Minnesota premium security plan" 3.5 means the state-based reinsurance program authorized under section 62E.23.
	3.6 Subd. 11. **Plan year.** "Plan year" means a calendar year for which an eligible health 3.7 carrier provides coverage under a health plan in the individual market.
4.18 Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, 4.19 reinsurance cap, and coinsurance rate for the plan.	
4.20 Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided 4.21 in section 62E.23, subdivision 2, paragraph (d).	3.8 Subd. 12. **Reinsurance cap.** "Reinsurance cap" means the threshold dollar amount for 3.9 claims costs incurred by an eligible health carrier for an enrolled individual's covered 3.10 benefits, after which threshold the claims costs for such benefits are no longer eligible for 3.11 Minnesota premium security plan payments, established by the board of the Minnesota 3.12 Comprehensive Health Association.
4.22 Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by 4.23 the association to an eligible health carrier under the plan.	
	3.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.
	3.14 Sec. 3. **[62E.22] DUTIES OF COMMISSIONER.**
	3.15 In the implementation and operation of the Minnesota premium security plan, established 3.16 under section 62E.23, the commissioner shall require eligible health carriers to calculate 3.17 the premium amount the eligible health carrier would have charged for the applicable plan 3.18 year had the Minnesota premium security plan not been established and to submit this 3.19 information as part of the rate filing.
	3.20 **EFFECTIVE DATE.** This section is effective the day following final enactment.
4.24 Sec. 6. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**	3.21 Sec. 4. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**

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4.25 Subdivision 1. **Administration of plan.** (a) The association shall administer the plan.	3.22 Subdivision 1. **The Minnesota premium security plan as state-based reinsurance.** 3.23 The association is Minnesota's reinsurance entity to administer the state-based reinsurance 3.24 program referred to as the Minnesota premium security plan. The Minnesota premium 3.25 security plan shall be designed to protect consumers by mitigating the impact of high-risk 3.26 individuals on rates in the individual market.
4.26 (b) The association may apply for any available federal funding for the plan. All funds 4.27 received by or appropriated to the association shall be deposited in the premium security 4.28 plan account in section 62E.25.	
4.29 (c) The association must collect data from an eligible health carrier that are necessary 4.30 to determine reinsurance payments, according to the data requirements under subdivision 4.31 5.	6.6 (1) collect or access data required to determine Minnesota premium security plan 6.7 payments from an eligible health carrier according to the data requirements under subdivision 6.8 5; and
5.1 (d) The board must not use any funds allocated to the plan for staff retreats, promotional 5.2 giveaways, excessive executive compensation, or promotion of federal or state legislative 5.3 or regulatory changes.	
5.4 (e) For each applicable benefit year, the association must notify eligible health carriers 5.5 of reinsurance payments to be made for the applicable benefit year no later than June 30 of 5.6 the year following the applicable benefit year.	5.26 Subd. 5. **Notification of Minnesota premium security plan payments.** (a) For each 5.27 applicable plan year, the association must notify eligible health carriers annually of Minnesota 5.28 premium security plan payments, if applicable, to be made for the applicable plan year no 5.29 later than June 30 of the year following the applicable plan year.
5.7 (f) On a quarterly basis during the applicable benefit year, the association must provide 5.8 each eligible health carrier with the calculation of total reinsurance payment requests.	6.1 (c) For each applicable plan year, the board must provide to each eligible health carrier 6.2 the calculation of total Minnesota premium security plan payment requests on a quarterly 6.3 basis during the applicable plan year.
6.9 (b) If the amount in the premium security plan account in section 62E.25 is not anticipated 6.10 to be adequate to fully fund the approved payment parameters as of July 1 of the year before 6.11 the applicable benefit year, the board, in consultation with the commissioner and the 6.12 commissioner of management and budget, shall propose payment parameters within the 6.13 available appropriations. The commissioner must permit an eligible health carrier to revise 6.14 an applicable rate filing based on the final payment parameters for the next benefit year.	6.4 Subd. 6. **Disbursement of Minnesota premium security plan payments.** (a) The 6.5 association must: 6.12 (b) If funding under section 62E.25 is not sufficient to pay all valid claims submitted 6.13 by eligible carriers for the premium security plan at the payment parameters, the board must, 6.14 in consultation with the commissioner and the commissioner of management and budget, 6.15 adopt revised payment parameters within the available funding.
5.9 (g) By August 15 of the year following the applicable benefit year, the association must 5.10 disburse all applicable reinsurance payments to an eligible health carrier.	6.9 (2) make Minnesota premium security plan payments to the eligible health carrier after 6.10 receiving a valid claim for payment from that eligible health carrier by August 15 of the 6.11 year following the applicable plan year.
5.11 Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment 5.12 parameters to ensure the payment parameters: 5.13 (1) will stabilize or reduce premium rates in the individual market;	4.3 (b) For plan year 2018, the Minnesota premium security plan parameters, including the 4.4 attachment point, reinsurance cap, and coinsurance rate, shall be established within the 4.5 parameters of the appropriated funds as follows:

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5.14 (2) will increase participation in the individual market;	
5.15 (3) mitigate the impact high-risk individuals have on premium rates in the individual 5.16 market;	
5.17 (4) take into account any federal funding available for the plan;	
5.18 (5) take into account the total amount available to fund the plan; and	
5.19 (6) for benefit year 2019 and thereafter, include cost savings mechanisms related to the 5.20 management of health care services.	
5.21 (b) The attachment point for the plan is the threshold amount for claims costs incurred 5.22 by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, 5.23 beyond which the claims costs for benefits are eligible for reinsurance payments. The 5.24 attachment point shall be set by the board at $50,000 or more, but not exceeding the 5.25 reinsurance cap.	4.6 (1) the attachment point is set at $45,000;
5.26 (c) The coinsurance rate for the plan is the rate at which the association will reimburse 5.27 an eligible health carrier for claims incurred for an enrolled individual's covered benefits 5.28 in a benefit year above the attachment point and below the reinsurance cap. The coinsurance 5.29 rate shall be set by the board at a rate between 50 and 70 percent.	4.8 (3) the coinsurance rate is set at 80 percent.
5.30 (d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible 5.31 health carrier for an enrolled individual's covered benefits, after which the claims costs for 6.1 benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set 6.2 by the board at $250,000 or less.	4.7 (2) the reinsurance cap is set at $250,000; and
6.3 Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment 6.4 parameters for the next benefit year by January 15 of the year before the applicable benefit 6.5 year. The commissioner shall review and approve the payment parameters no later than 14 6.6 days following the board's proposal. If the commissioner fails to approve the payment 6.7 parameters within 14 days following the board's proposal, the proposed payment parameters 6.8 are final and effective.	3.27 Subd. 2. **Minnesota premium security plan parameters.** (a) The board shall propose 3.28 to the commissioner the Minnesota premium security plan payment parameters for the next 3.29 plan year by January 15 of the calendar year prior to the applicable plan year. In developing 3.30 the proposed payment parameters, the board shall consider the anticipated impact on 3.31 premiums. The commissioner shall approve or reject the payment parameters no later than 3.32 14 calendar days following the board proposal. In developing the proposed payment 4.1 parameters for plan year 2019 and after, the board may develop methods to account for 4.2 variations in costs within the Minnesota premium security plan.
	4.9 (c) The board must apply the Minnesota premium security plan's parameters established 4.10 under paragraph (a) or (b), as applicable, when calculating reinsurance payments.
6.15 Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be 6.16 calculated with respect to an eligible health carrier's incurred claims costs for an individual 6.17 enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed 6.18 the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment	4.11 Subd. 3. **Payments under Minnesota premium security plan.** (a) Each Minnesota 4.12 premium security plan payment must be calculated with respect to an eligible health carrier's 4.13 incurred claims costs for an individual enrollee's covered benefits in the applicable plan 4.14 year. If such claims costs do not exceed the attachment point, payment will be zero dollars.

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6.19	point, the reinsurance payment shall be calculated as the product of the coinsurance rate	4.15	If such claims costs exceed the attachment point, payment will be calculated as the product
6.20	and the lesser of:	4.16	of the coinsurance rate multiplied by the lesser of:
6.21	(1) the claims costs minus the attachment point; or	4.17	(1) such claims costs minus the attachment point; or
6.22	(2) the reinsurance cap minus the attachment point.	4.18	(2) the reinsurance cap minus the attachment point.
6.23	(b) The board must ensure that reinsurance payments made to eligible health carriers do	4.19	(b) The board must ensure that the payments made to eligible health carriers must not
6.24	not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total	4.20	exceed the eligible health carrier's total paid amount for any eligible claim. For purposes
6.25	amount paid of an eligible claim" means the amount paid by the eligible health carrier based	4.21	of this paragraph, "total paid amount of an eligible claim" means the amount paid by the
6.26	upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time	4.22	eligible health carrier based upon the allowed amount less any deductible, coinsurance, or
6.27	the data are submitted or made accessible under subdivision 5, paragraph (e).	4.23	co-payment, as of the time the data is submitted or made accessible under subdivision 4,
		4.24	paragraph (b), clause (1).
6.28	Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health	4.25	Subd. 4. **Requests for Minnesota premium security plan payments.** (a) An eligible
6.29	carrier must request reinsurance payments when the eligible health carrier's claims costs	4.26	health carrier may make a request for payment when the eligible health carrier's claims costs
6.30	for an enrollee meet the criteria for reinsurance payments.	4.27	for an enrollee meet the criteria for payment under subdivision 3 and the requirements of
6.31	(b) An eligible health carrier must apply the payment parameters when calculating	4.28	this subdivision.
6.32	amounts the health carrier is eligible to receive from the plan.		
7.1	(c) An eligible health carrier must make requests for reinsurance payments in accordance	5.5	(c) An eligible health carrier must make requests for payment according to the
7.2	with any requirements established by the board.	5.6	requirements established by the board.
7.3	(d) An eligible health carrier must calculate the premium amount the health carrier would		
7.4	have charged for the applicable benefit year if the plan was not in effect and submit this		
7.5	information as part of its rate filing.		
7.6	(e) In order to receive reinsurance payments, an eligible health carrier must provide the	4.29	(b)(1) To be eligible for Minnesota premium security plan payments, an eligible health
7.7	association with access to the data within the dedicated data environment established by	4.30	carrier must provide to the association access to the data within the dedicated data
7.8	the eligible health carrier under the federal risk adjustment program under United States	4.31	environment established by the eligible health carrier under the federal Risk Adjustment
7.9	Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board	4.32	Program. Eligible health carriers must submit an attestation to the board asserting compliance
7.10	asserting compliance with the dedicated data environments, data requirements, establishment	5.1	with the dedicated data environments, data requirements, establishment and usage of masked
7.11	and usage of masked enrollee identification numbers, and data submission deadlines.	5.2	enrollee identification numbers, and data submission deadlines; and
7.12	(f) An eligible health carrier must provide the access described in paragraph (e) for the	5.3	(2) an eligible health carrier must provide the required access under clause (1) for the
7.13	applicable benefit year by April 30 of each year of the year following the end of the	5.4	applicable plan year by April 30 of the year following the end of the applicable plan year.
7.14	applicable benefit year.		
7.15	(g) An eligible health carrier must maintain documents and records, whether paper,	5.7	(d) An eligible health carrier must maintain documents and records, whether paper,
7.16	electronic, or in other media, sufficient to substantiate the requests for reinsurance payments	5.8	electronic, or in other media, sufficient to substantiate the requests for Minnesota premium
7.17	made pursuant to this section for a period of at least six years. An eligible health carrier	5.9	security plan payments made pursuant to this section for a period of at least ten years and
7.18	must also make those documents and records available upon request from the commissioner	5.10	must make those documents and records available upon request from the state or its designee

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7.19 for purposes of verification, investigation, audit, or other review of reinsurance payment 7.20 requests.	5.11 for purposes of verification, investigation, audit, or other review of Minnesota premium 5.12 security plan payment requests.
7.21 (h) An eligible health carrier may follow the appeals procedure under section 62E.10, 7.22 subdivision 2a.	5.30 (b) An eligible health carrier may follow the appeals procedure under section 62E.10, 5.31 subdivision 2a.
7.23 Subd. 6. **Audits and reports of eligible health carriers.** (a) The association may audit 7.24 an eligible health carrier to assess its compliance with the requirements of this act. The 7.25 eligible health carrier must cooperate with an audit. If an audit results in a proposed finding 7.26 of material weakness or significant deficiency with respect to compliance with any 7.27 requirement of this act, the eligible health carrier may respond to the draft audit report within 7.28 30 days of the draft audit report's issuance. 7.29 (b) Within 30 days of the issuance of the final audit report, if the final audit results in a 7.30 finding of material weakness or significant deficiency with respect to compliance with any 7.31 requirement of this act, the eligible health carrier must:	5.13 (e) The association or its designee may audit an eligible health carrier to assess the health 5.14 carrier's compliance with the requirements of this section. The eligible health carrier must 5.15 ensure that its contractors, subcontractors, or agents cooperate with any audit under this 5.16 section. If an audit results in a proposed finding of material weakness or significant deficiency 5.17 with respect to compliance with any requirement under this section, the eligible health 5.18 carrier may provide a response to the draft audit report within 30 calendar days. Within 30 5.19 calendar days of the issuance of the final audit report, the eligible health carrier must complete 5.20 the following:
7.32 (1) provide a written corrective action plan to the association for approval;	5.21 (1) provide a written corrective action plan to the association for approval if the final 5.22 audit results in a finding of material weakness or significant deficiency with respect to 5.23 compliance with any requirement under this section;
7.33 (2) upon association approval, implement the corrective action plan described; and	5.24 (2) implement the approved plan; and
8.1 (3) provide the association with documentation of the corrective actions taken.	5.25 (3) provide to the association written documentation of the corrective actions once taken.
8.2 Subd. 7. **Data.** Data collected, created, or maintained by the association for the purpose 8.3 of providing reinsurance payments to eligible health carriers is classified as private data on 8.4 individuals, as defined under section 13.02, subdivision 12; nonpublic data, as defined under 8.5 section 13.02, subdivision 9; or not public data, as defined under section 13.02, subdivision 8.6 8a.	6.16 Subd. 7. **Data.** Government data of the association under this section are private data 6.17 on individuals or nonpublic data as defined in section 13.02, subdivision 9 or 12. 6.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.
8.7 Sec. 7. **[62E.24] ACCOUNTING, REPORTS, AND AUDITS OF THE 8.8 ASSOCIATION.**	6.19 Sec. 5. **[62E.24] ACCOUNTING, REPORTING, AND AUDITING.**
8.9 Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year 8.10 of all:	6.20 Subdivision 1. **Accounting requirements.** For each plan year, the board must ensure 6.21 that it keeps an accounting of:
8.11 (1) funds appropriated for reinsurance payments and administrative and operational 8.12 expenses;	6.22 (1) all claims for Minnesota premium security plan payments received from eligible 6.23 health carriers;
8.13 (2) requests for reinsurance payments received from eligible health carriers;	6.24 (2) all Minnesota premium security plan payments made to eligible health carriers; and

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8.14 (3) reinsurance payments made to eligible health carriers; and	6.25 (3) all administrative expenses incurred for the Minnesota premium security plan.
8.15 (4) administrative and operational expenses incurred for the plan.	
8.16 Subd. 2. **Reports.** (a) The board must submit to the commissioner and make available 8.17 to the public a report summarizing the plan operations for each benefit year by posting the 8.18 summary on the Minnesota Comprehensive Health Association Web site and making the 8.19 summary otherwise available by November 1 of the year following the applicable benefit 8.20 year or 60 calendar days following the final disbursement of reinsurance payments for the 8.21 applicable benefit year, whichever is later.	6.26 Subd. 2. **Summary report.** The board must submit to the commissioner and make public 6.27 a report on the Minnesota premium security plan operations for each plan year by November 6.28 1 following the applicable year or 60 calendar days following the last disbursement of 6.29 Minnesota premium security plan payments for the applicable plan year.
8.22 (b) The board must submit a report to the standing committees of the legislature having 8.23 jurisdiction over health and human services and insurance within 60 days of the commissioner 8.24 making publicly available the final and approved premium rates, or by December 1, 8.25 whichever is later. The report must include information on what the premium increases in 8.26 the individual market will be for the next benefit year if the plan is not fully funded.	
	7.1 Subd. 3. **Audits.** The Minnesota premium security plan is subject to audit by the 7.2 legislative auditor. The board must ensure that its contractors, subcontractors, or agents 7.3 cooperate with the audit.
8.27 Subd. 3. **Independent external audit.** (a) The board must engage and cooperate with 8.28 an independent certified public accountant or CPA firm licensed or permitted under chapter 8.29 326A to perform an audit for each benefit year of the plan, in accordance with generally 8.30 accepted auditing standards. The audit must at a minimum:	7.4 Subd. 4. **External audit.** The board must engage an independent certified public 7.5 accountant firm licensed under chapter 326A to perform a financial audit and a programmatic 7.6 audit analyzing performance to determine whether the program is effectively accomplishing 7.7 its goals for each plan year of the Minnesota premium security plan in accordance with 7.8 generally accepted auditing standards. The board must:
8.31 (1) assess compliance with the requirements of sections 62E.21 to 62E.25; and	
9.1 (2) identify any material weaknesses or significant deficiencies and address manners in 9.2 which to correct any such material weaknesses or deficiencies.	
9.3 (b) The board, after receiving the completed audit, must:	
9.4 (1) provide the commissioner the results of the audit;	7.9 (1) provide to the commissioner the results of the audit, in the manner and time frame 7.10 to be specified by the commissioner;
9.5 (2) identify to the commissioner any material weakness or significant deficiency identified 9.6 in the audit and address in writing to the commissioner how the board intends to correct 9.7 any such material weakness or significant deficiency in compliance with subdivision 4; and	7.11 (2) identify to the commissioner any material weakness or significant deficiency identified 7.12 in the audit, and address in writing to the commissioner how the board intends to correct 7.13 any identified material weakness or significant deficiency; and

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9.8 (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.

9.12 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:

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

9.17 (2) implement the corrective action plan; and

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

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

9.20 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 shall be credited to the premium security plan account.

9.25 Sec. 9. Minnesota Statutes 2016, section 297I.05, subdivision 5, is amended to read:

9.26 Subd. 5. **Health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.** (a) A tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums on all direct business received by the organization, network, or corporation or its agents in Minnesota, in cash or otherwise, in the calendar year.

10.1 (b) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the ~~health care access fund~~ premium security plan account in section 62E.25. Refunds of overpayments of tax imposed by this subdivision must be paid from the ~~health care access fund~~ premium security plan account. There is annually appropriated from the ~~health care access fund~~ premium security plan account to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

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7.14 (3) make public the results of the audit, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency.

7.17 Subd. 5. **Action on audit findings.** If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement under this section, the commissioner of commerce must ensure the board:

7.20 (1) within 60 calendar days of the issuance of the final audit report, provides a written corrective action plan to the commissioner for approval;

7.22 (2) implements the approved plan; and

7.23 (3) provides to the commissioner written documentation of the corrective actions once taken.

7.25 Sec. 6. **[62E.25] FUNDING OF MINNESOTA PREMIUM SECURITY PLAN.**

7.26 (a) The reinsurance fund account is created in the special revenue fund of the state treasury. Funds in the account are appropriated to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the Minnesota premium security plan.

10.9 **EFFECTIVE DATE.** This section is effective July 1, 2017.

10.10 Sec. 10. Minnesota Statutes 2016, section 297I.05, subdivision 13, is amended to read:

10.11 Subd. 13. **Funds ~~deposited~~ credited into the premium security plan account and**
10.12 **into the general fund.** (a) Unless otherwise specified in this chapter, all amounts collected
10.13 by the commissioner under this chapter must be ~~deposited in the general fund.~~ credited as
10.14 follows:

10.15 (1) $70,000,000 in fiscal year 2018 and $70,000,000 in fiscal year 2019 and each fiscal
10.16 year thereafter must be credited to the premium security plan account in section 62E.25;
10.17 and

10.18 (2) the balance shall be credited to the general fund.

10.19 (b) The amount to be credited under paragraph (a), clause (1), is in addition to amounts
10.20 deposited in the premium security account in subdivision 5.

10.21 Sec. 11. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

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

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

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

8.16 Sec. 7. **LEGISLATIVE WORKING GROUP.**

8.17 A legislative working group is established consisting of the chairs and ranking minority
8.18 members of the senate committees with jurisdiction over commerce, health and human
8.19 services finance and policy, and human services reform finance and policy and the chairs
8.20 and ranking minority members of the house of representatives committees with jurisdiction
8.21 over commerce and regulatory reform, health and human services finance, and health and
8.22 human services reform. The purpose of the working group is to advise the board of the

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	8.23 Minnesota Comprehensive Health Association on the adoption of payment parameters and 8.24 other elements of a reinsurance plan for plan year 2019. The commissioner of commerce 8.25 must provide technical assistance for the working group, and must review and monitor the 8.26 following to serve as a resource for the working group:
	8.27 (1) the effectiveness of reinsurance models adopted in Alaska and other states in 8.28 stabilizing premiums in the individual market and the related costs thereof;
	8.29 (2) the effect of federal health reform legislation on the Minnesota premium security 8.30 plan, including but not limited to funding for the plan; and
	8.31 (3) the status of the health care access fund, and issues relating to its potential continued 8.32 use as a source of funding for the Minnesota premium security plan.
11.1 Sec. 12. **STATE INNOVATION WAIVER.**	9.1 Sec. 8. **STATE INNOVATION WAIVER.**
11.2 Subdivision 1. **Submission of waiver application.** The commissioner of commerce 11.3 shall apply to the secretary of Health and Human Services under United States Code, title 11.4 42, section 18052, for a state innovation waiver to implement the Minnesota premium 11.5 security plan for benefit years beginning on or after January 1, 2018, in a manner that 11.6 maximizes federal funding for the state. The waiver application submitted must ensure that, 11.7 upon implementation of the Minnesota premium security plan, eligible Minnesotans will 11.8 continue to receive advanced premium tax credits and cost-sharing reductions.	9.2 Subdivision 1. **Authority to submit a waiver application.** (a) The commissioner of 9.3 commerce shall apply to the United States Secretary of Health and Human Services under 9.4 United States Code, title 42, section 18052, for a waiver of applicable provisions of the 9.5 Affordable Care Act with respect to health insurance coverage in the state for a plan year 9.6 beginning on or after January 1, 2018, for the sole purpose of implementing the Minnesota 9.7 premium security plan in a manner that maximizes federal funding for Minnesota.
	9.8 (b) The waiver application submitted under paragraph (a) must request that:
	9.9 (1) the state receive federal funding in an amount equal to the amount the federal 9.10 government will not have to pay in advance premium tax credits under United States Code, 9.11 title 29, section 36B, to Minnesota residents due to reinsurance payments made by the 9.12 Minnesota Comprehensive Health Association;
	9.13 (2) the state receive federal funding in an amount equal to the amount the federal 9.14 government has not paid and continues not to pay in advance premium tax credits under 9.15 United States Code, title 29, section 36B, to Minnesota residents who are eligible for advance 9.16 premium tax credits under United States Code, title 29, section 36B, but have chosen not 9.17 to receive the credits; and
	9.18 (3) federal funding for MinnesotaCare, as Minnesota's basic health program, continues 9.19 to be based on the market premium and cost-sharing levels before the impact of reinsurance 9.20 under the Minnesota premium security plan established under Minnesota Statutes, section 9.21 62E.23.

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		9.22	(c) The commissioner shall implement a state plan for meeting the waiver requirements
		9.23	in a manner consistent with state and federal law, and as approved by the United States
		9.24	Secretary of Health and Human Services. Any federal funds received by the state due to
		9.25	the waiver application shall be deposited in the reinsurance fund account created under
		9.26	Minnesota Statutes, section 62E.25.
11.9	Subd. 2. **Consultation.** In developing the waiver application, the commissioner shall	9.27	Subd. 2. **Consultation.** In developing the waiver application, the commissioner shall
11.10	consult with the commissioner of human services, the commissioner of health, and the	9.28	consult with the Department of Human Services and MNsure.
11.11	MNsure board.		
11.12	Subd. 3. **Application timelines; notification.** The commissioner shall submit the waiver	9.29	Subd. 3. **Application deadline.** The commissioner shall submit the waiver application
11.13	application to the secretary of Health and Human Services on or before July 5, 2017. The	9.30	to the appropriate federal agency on or before July 5, 2017. The commissioner shall follow
11.14	commissioner shall make a draft application available for public review and comment by	9.31	all application instructions. The commissioner shall complete the draft waiver application
11.15	June 1, 2017. The commissioner shall notify the chairs and ranking minority members of	9.32	for public review and comment by June 1, 2017.
11.16	the legislative committees with jurisdiction over health and human services and insurance,		
11.17	and the board of directors of the Minnesota Comprehensive Health Association of any		
11.18	federal actions regarding the waiver request.		
11.19	Subd. 4. **Board review; contingent report.** The board of directors of the Minnesota		
11.20	Comprehensive Health Association shall review the decision of the secretary of Health and		
11.21	Human Services regarding the request for a state innovation waiver. If the waiver is rejected		
11.22	in whole or in part the board shall report to the chairs and ranking minority members of the		
11.23	legislative committees with jurisdiction over health and human services and insurance on		
11.24	the projected impact of the federal decision on the overall health insurance market and		
11.25	health plan affordability. The board shall submit this report within 60 calendar days of		
11.26	receipt of the federal decision.		
		10.1	Subd. 4. **Appropriation.** $155,000 in fiscal year 2018 is appropriated from the general
		10.2	fund to the commissioner of commerce to prepare and submit a state innovation waiver.
		10.3	**EFFECTIVE DATE.** This section is effective the day following final enactment.
11.27	Sec. 13. **COSTS RELATED TO IMPLEMENTATION OF THIS ACT.**		
11.28	A state agency that incurs administrative costs to implement any provision of this act		
11.29	and does not receive an appropriation for administrative costs of this act must implement		
11.30	the act within the limits of existing appropriations.		
12.1	Sec. 14. **PAYMENT PARAMETERS FOR 2018.**		

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12.2 Notwithstanding any law to the contrary, the board of directors of the Minnesota 12.3 Comprehensive Health Association shall set payment parameters for benefit year 2018 12.4 within the limits of available funds no later than 30 days following the enactment of this 12.5 act or 30 days following the appropriation of funds for the Minnesota premium security 12.6 plan, whichever is later.	
12.7 Sec. 15. **DEPOSIT OF FUNDS.**	
12.8 Within ten days of the effective date of this act, the Minnesota Comprehensive Health 12.9 Association shall deposit all money, including monetary reserves, the association holds into 12.10 the premium security plan account in section 62E.25.	
12.11 Sec. 16. **MINNESOTA PREMIUM SECURITY PLAN FUNDING; FISCAL YEAR 12.12 2018.**	
12.13 The Minnesota Comprehensive Health Association shall fund the operational and 12.14 administrative costs and reinsurance payments of the Minnesota premium security plan and 12.15 association, for fiscal year 2018, using the following amounts deposited in the premium 12.16 security plan account in section 62E.25, in the following order:	7.30 (b) The association shall pay claims for the Minnesota premium security plan using the 7.31 following sources, in the following order:
12.17 (1) any federal funds available, whether through grants or otherwise;	7.32 (1) any federal funds available;
12.18 (2) funds deposited under section 15;	8.1 (2) excess funds of the association;
12.19 (3) up to $50,000,000 of the transfer in section 18; and	8.2 (3) any state funds from the health care access fund; and
12.20 (4) funds deposited under sections 9 and 10.	8.3 (4) any state funds from the general fund.
	8.4 (c) The association shall return to the commissioner of commerce any general fund 8.5 amount not used to pay claims submitted by eligible health carriers under the Minnesota 8.6 premium security plan by June 30, 2021. Any amount returned to the commissioner of 8.7 commerce shall be transferred to the budget reserve account under section 16A.152, 8.8 subdivision 1a.
	8.9 (d) The association shall return to the commissioner of commerce any health care access 8.10 fund amount not used to pay claims submitted by eligible health carriers under the Minnesota 8.11 premium security plan by June 30, 2021. Any amount returned to the commissioner of 8.12 commerce shall be transferred to the health care access fund under section 16A.724.
	8.13 (e) The association may not pay more than $300,000,000 in claims for the premium 8.14 security plan for either plan year 2018 or 2019.
	8.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.

12.21 Sec. 17. **MINNESOTA PREMIUM SECURITY PLAN FUNDING; FISCAL YEAR**
12.22 **2019 AND THEREAFTER.**

12.23 (a) The Minnesota Comprehensive Health Association shall fund the operational and
12.24 administrative costs of the Minnesota premium security plan and association for fiscal year
12.25 2019 and every year thereafter through an assessment as provided by section 62E.11
12.26 deposited in the premium security plan account in section 62E.25.

12.27 (b) The Minnesota Comprehensive Health Association shall fund the reinsurance
12.28 payments and other plan costs of the Minnesota premium security plan and association for
12.29 fiscal year 2019 and every year thereafter using the following amounts deposited in the
12.30 premium security plan account, in the following order:

13.1 (1) any federal funds available, whether through grants or otherwise;

13.2 (2) the transfer in section 18; and

13.3 (3) funds deposited under sections 9 and 10.

13.4 Sec. 18. **TRANSFER.**

13.5 $80,000,000 in the 2018-2019 biennium is transferred from the health care access fund
13.6 to the premium security plan account in the special revenue fund. Up to $50,000,000 of this
13.7 amount must be transferred in fiscal year 2018. These are onetime transfers.

10.4 Sec. 9. **TRANSFERS.**

10.5 (a) The commissioner of management and budget shall transfer $180,000,000 in fiscal
10.6 year 2018 and $180,000,000 in fiscal year 2019 from the health care access fund to the
10.7 reinsurance fund account in the special revenue fund. This is a onetime transfer.

10.8 (b) The commissioner of management and budget shall transfer $120,000,000 in fiscal
10.9 year 2018 and $120,000,000 in fiscal year 2019 from the budget reserve account in Minnesota
10.10 Statutes, section 16A.152, subdivision 1a, to the general fund. This is a onetime transfer.

10.11 (c) The commissioner of management and budget shall transfer $120,000,000 in fiscal
10.12 year 2018 and $120,000,000 in fiscal year 2019 from the general fund to the reinsurance
10.13 fund account in the special revenue fund. This is a onetime transfer.

13.8 Sec. 19. **REPEALER.**

13.9 Laws 2013, chapter 9, section 15, is repealed.

13.10 Sec. 20. **EFFECTIVE DATE.**

13.11 Sections 1 to 8 and 10 to 19 are effective the day following final enactment.