Bill Summary Comparison of

Health and Human Services

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| Senate File No. 800-3 | House File No. UES0800-1 |
| Article 5: Health Insurance  | *Senate-only article* |

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| Article 5: Health Insurance |  |  |
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| **Section 1 (62A.04, subd. 1)** specifies that certain required standard policy provisions when referenced in other sections do not apply to accident and sickness or accident and health insurance that are health plans. | Senate only |  |
| **Section 2 (62A.21, subd. 2a)** specifies that continuation of coverage only applies to a former spouse who was covered on the insured’s health plan on the day before entry of a valid divorce decree. | Senate only |  |
| **Section 3 (62A.3075)** requires a health plan company that provides coverage for cancer chemotherapy treatment to indicate the level of coverage for orally administered anticancer medication in its pharmacy benefit filing with the commissioner. | Senate only\*See H.F. 1832, on the general register. |  |
| **Section 4 (62D.105, subd. 1)** specifies that an health maintenance organization (HMO) only has to provide coverage to an enrollee’s dependent children and former spouse who was covered on the day before the entry of a valid divorce decree. | Senate only |  |
| **Section 5 (62D.105, subd. 2)** clarifies the definition of dependent children. | Senate only |  |
| **Section 6 (62E.04, subd. 11)** clarifies that any policy of accident and health insurance subject to the requirements of the ACA, the requirements of this section do not apply. | Senate only |  |
| **Section 7 (62E.05, subd. 1)** clarifies that any policy of accident and health insurance subject to the requirements of the ACA do not have to certify whether the plan is a #1, #2, or #3 coverage plan. | Senate only |  |
| **Section 8 (62E.06, subd. 5)** clarifies that the requirements for qualified plans do not apply to any policy of accident and health insurance subject to the requirements of the ACA. | Senate only |  |
| **Section 9 (62K.16)** requires health carriers issuing individual health plans to permit enrollees to terminate coverage by directly contacting either the health carrier or MNsure if the enrollee purchased coverage through MNsure.  Requires health carriers and MNsure to develop a form for terminating coverage online. | Senate only |  |
| **Section 10 (62M.07) Paragraph (d)** specifies that any authorization for a prescription drug must remain valid for the duration of an enrollee’s contract term so long as the drug continues to be prescribed to the patient, the drug remains safe, has not been withdrawn from use by the FDA or the manufacturer, and no drug warnings or recommended changes in drug usage has occurred.  Excludes public health care programs from this paragraph. | Senate only |  |
| **Section 11 (62Q.575, subd. 1)** requires a health plan company to contract with a primary care provider as an in- network provider if the provider is certified as a health care home or is in the process of becoming certified as a health care home. | Senate only |  |
| **Subd. 2** prohibits a health plan company from imposing a co-payment or fee or other cost-sharing requirement for selecting or designating a primary care provider of the enrollee’s choosing, unless the health plan company imposes the same cost-sharing requirements or fees upon an enrollee’s selection or designation on any of the health plan company’s primary care providers. |  |  |
| **Subd. 3** requires the provider contract to include a care coordination payment in addition to the payment rate for the covered services provided by the primary care provider, and prohibits the health care company from imposing a co-payment, fee, or other cost-sharing requirement on care coordination services. |  |  |
| **Section 12 (62Q.678**) requires a health plan company that actively markets an individual health plan to offer in each county at least one individual health plan with a provider network that includes in network access to more than a single health care provider system or a health plan that includes more than one primary care location in each county. | Senate only (Similar to article 2, section 1, enacted in H.F. 5) |  |
| **Section 13 (62Q.83)** creates prescription drug benefit transparency and management requirements.**Subd. 1** defines the following terms:  drug; enrollee contract year; formulary; health plan company; and prescription.**Subd. 2** requires a health plan company that cover prescription drugs and uses a formulary to make its formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days prior to annual renewal dates.**Subd. 3. Paragraph (a),**specifies that once a formulary has been established a health plan company, may at any time during an enrollee’s contract year, expand its formulary by adding drugs to the formulary; reduce the copayments or coinsurance; or move a drug to a benefit category that reduces the enrollee’s cost.**Paragraph (b)** states that a health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee’s cost only if a generic or multisource brand name drug rated as therapeutically equivalent or a biological drug rated as interchangeable is added to the formulary at a lower cost to the enrollee and upon 60 notice to prescribers, pharmacists, and affected enrollees.**Paragraph (c)** permits a health plan company to change utilization review requirements or move drugs to a benefit category that increases an enrollee’s cost during the enrollee’s contract year upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided that the changes do not apply to enrollees who are currently taking the drugs affected by the changes for the duration of the enrollee's contract year.  **Paragraph (d)** permits a health plan company to remove drugs from its formulary that have been deemed unsafe by the FDA, or that have been withdrawn by the FDA or the product manufacturer, or when an independent source has issued drug-specific warnings or recommended changes in drug usage.**Subdivision 4** excludes public health care programs from this section. | Senate only |  |
| **Section 14 (317A.811, subd.1)** specifies that a health maintenance organization (HMO) and a service plan corporation  are required to notify the attorney general of their intent to dissolve, merge, or consolidate or to transfer all or substantially all of their assets. | Senate only |  |
| **Section 15 (317A.811, subd.1a)** specifies that a HMO and a service plan corporation are subject to notice and approval requirements for certain transactions under section 317A.814. | Senate only |  |
| **Section 16 (317A.814)** establishes nonprofit health care entity conversion notification and approval requirements.**Subdivision 1** defines the following terms:  commissioner; conversion benefit entity; conversion transaction; family member; nonprofit health care entity; public benefit assets; and related organization.**Subdivision 2** prohibits a nonprofit entity from entering into a conversion transaction if a person who has been an officer, director or other executive of the nonprofit health care entity, or a related organization or a family member of that person; (1) has or will receive any compensation or other financial benefit in connection with the conversion transaction; (2) has or will hold an ownership stake, stock, securities or other financial interest in or receive any type of financial benefit from any entity in which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction; or (3) has or will hold an ownership stake or other financial interest in or receive any financial benefit  from any entity that has or will have a business relationship with an entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction.**Subdivision 3** requires a nonprofit health care entity to notify the Attorney General before entering into a conversion transaction and include as part of the notification, an itemization of the entity’s public benefit assets and the valuation the entity attributes to those assets, a proposed plan for distribution of those assets to a conversion benefit entity, and other information the Attorney General considers necessary for review of the proposed transaction. Requires the Attorney General to approve the transaction.  Requires a copy of the notice and the information required with the notice to be provided to either the Commissioner of Health or commerce.**Subdivision 4** outlines the elements that the Attorney General must consider in making a decision to approve or disapprove a conversion transaction.  Requires the Attorney General to consult with either the Commissioner of Health or commerce in making this decision.**Subdivision 5** specifies the requirements that an entity must meet to be considered a conversion benefit entity for purposes of accepting assets from a nonprofit health care entity as part of a conversion transaction.**Subdivision 6** authorizes the attorney general to solicit public comment regarding the proposed conversion transaction.**Subdivision 7** requires the Attorney General to notify the nonprofit health care entity in writing of its decision to approve or disapprove the transaction within 150 days of receiving notice of the transaction.  Requires the Attorney General to include the reason for a decision not to approve the transaction, and permits the Attorney General to extend the period for an additional 90 days if needed to obtain additional information.**Subdivision 8** requires the nonprofit health care entity to transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction if the proposed conversion transaction is approved or conditionally approved.**Subdivision 9** requires the nonprofit health care entity or conversion benefit entity to reimburse the attorney general or a state agency for all reasonable and actual costs incurred by the attorney general or a state agency in reviewing a proposed conversion transaction.**Subdivision 10** requires a conversion benefit entity to submit an annual report to the Attorney General that contains a description of its charitable activities related to the use of the public benefit assets received under an approved transaction.**Subdivision 11** states that a conversion transaction entered into in violation of this section is null and void and the attorney general has the authority to bring an action to unwind a conversion transaction entered into in violation of subdivision 2.**Subdivision 12** states that this section does not affect any power or responsibility of a health maintenance organization, service plan corporation, a conversion benefit entity, the attorney general, or the commissioner under chapter 62C, 62D, 317A, 501B or other law. | Senate only |  |
| **Section 17** clarifies the definition of an eligible individual in SF1as a Minnesota resident who is not receiving an advanced premium tax credit in a month in which their overage is effective. | Senate only (Enacted in HF5) |  |
| **Section 18** clarifies in SF1 that the legislative auditor may maintain not public government data on an enrollee or health carrier required for the audits may be maintained for a longer period of time then stated in order to comply with generally accepted government auditing standards. | Senate only (Enacted in HF5) |  |
| **Section 19** adds a data sharing subdivision to SF1 that requires the commissioner of human services and the executive director of MNsure to disclose to the commissioner of management and budget data on public program coverage enrollment and data on an enrollee’s receipt of an advanced premium tax credit.  This subdivision also requires the commissioner of management and budget to disclose data to health carriers on enrollees’ enrollment in public program coverage to the extent it is necessary to determine eligibility for the premium subsidy program.   Specifies that the data disclosed may only be used for the purpose of the administration of the premium subsidy program. | Senate only (Enacted in HF5) |  |
| **Section 20** clarifies in SF1 that the commissioner of management and budget must consult with the commissioners of health and commerce and human services to develop and implement a process to recover from health carriers the amount of premium subsidies received by an enrollee determined to be ineligible for the subsidy. | Senate only (Enacted in H.F. 5) |  |
| **Section 21** clarifies the sunset date for SF1 article 1. | Senate only |  |
| **Section 22** clarifies in SF1 the dates in which the appropriations are available. | Senate only |  |
| **Section 23** clarifies that the unauthorized provider services section passed in SF1 does not apply to the public health care programs. | Senate only |  |
| **Section 24** modifies the effective date for the unauthorized provider services section passed in SF1 to January 1, 2019. | Senate only (H.F. 5 also amended this effective date to January 1, 2018.) |  |
| **Section 25** requires MNsure to seek any federal waiver necessary to implement section 62K.16 permitting an enrollee to terminate individual health coverage by directly contacting the carrier, even when the coverage was purchased through MNsure. | Senate only |  |