HOUSE RESEARCH

Act Summary

Chapter: 2 **Session:** 2017 Regular Session

Topic: Premium Subsidy Program and Insurance Market Reforms

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Article 1: Premium Subsidy Program

Overview

This article establishes a premium subsidy program administered by the commissioner of Minnesota Management and Budget, to assist persons in paying for individual health coverage in 2017. The premium subsidy is provided as a 25 percent reduction in the premium paid by an eligible person to a health carrier. Health carriers receive payments from the commissioner based on the premium subsidies provided. The article requires the commissioner to reduce the premium subsidy percentage for the period September 1, 2017, through December 31, 2017, if the commissioner determines this is necessary to remain within the limits of the appropriation. The article requires the Legislative Auditor to audit health carrier data to determine whether subsidy payments align with the criteria, and to audit the extent to which health carriers provided subsidies to persons meeting the residency and other eligibility requirements, and allows the commissioner to withhold or recover payments made to health carriers.

1 **Definitions.** Defines the following terms: commissioner, eligible individual, gross premium, health carrier, individual health plan, individual market, net premium, and premium subsidy.

"Eligible individual" is defined as a Minnesota resident who is not receiving a premium tax credit, is not enrolled in MA or MinnesotaCare, and has purchased an individual health plan from a health carrier in the individual market.

"Premium subsidy" is in part defined as a payment made on behalf of an eligible individual that is equal to 25 percent of the gross premium for individual coverage.

Section

2 Payment to health carriers on behalf of eligible individuals.

Subd. 1. Program established. Requires the commissioner of Minnesota Management and Budget, in consultation with the commissioners of commerce and human services, to establish and administer the premium subsidy program to help individuals pay for coverage in the individual market in 2017.

Subd. 2. Premium subsidy provided. Requires health carriers, as soon as practicable but no later than April 30, 2017, to begin paying premium subsidies to eligible individuals, for all the months for which the net premium is paid. Requires eligible individuals to pay the net premium to the health carrier.

Subd. 3. Payments to health carriers. (a) Requires the commissioner to make payments to health carriers on behalf of eligible individuals effectuating coverage for calendar year 2017, for those months in which the eligible individual has paid the net premium to the health carrier. Requires payments to health carriers to be based on the premium subsidy available to eligible individuals, regardless of the cost of coverage purchased. Prohibits the commissioner from withholding payments because a health carrier cannot prove that a person is an eligible individual.

(b) Requires health carriers seeking reimbursement to submit an invoice and supporting information, using a form developed by the commissioner. Requires the commissioner to finalize the form by March 1, 2017.

(c) Requires payments to be made within the limits of the appropriation. Requires the commissioner to reimburse health carriers for the full requested amount, up to the level of the appropriation. Requires the commissioner, by July 15, 2017, to determine whether the available appropriation will be sufficient to provide subsidies equal to 25 percent of the gross premium for the period September 1, 2017, through December 31, 2017. If the commissioner determines that the appropriation is not sufficient, requires the commissioner to reduce the premium subsidy percentage for that period by an amount sufficient to remain within the appropriation. Specifies notice requirements for health carriers and enrollees.

(d) Requires the commissioner to treat health carriers as vendors, for purposes of prompt pay requirements. Specifies that each monthly invoice represents the completed delivery of service.

Subd. 4. Data privacy. (a) Provides that the definitions in chapter 13 apply to this subdivision.

(b) Classifies government data on an enrollee or health carrier under this section as 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.

(b) Requires government data on enrollees and health carriers to be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later.

Section

3 **Audit.** (a) Requires the legislative auditor to conduct audits of health carriers' supporting data, to determine whether payments align with the criteria. Requires the commissioner of human services to provide necessary data. Requires the commissioner to withhold or charge back payments to health carriers to the extent payments do not align with the criteria.

(b) Requires the legislative auditor to audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements. Requires the auditor to report the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. Requires the commissioner, in consultation with the commissioners of commerce and health, to develop and implement a process to recover from health carriers premium subsidies received for enrollees determined to be ineligible. Allows the auditor, when conducting the audit, and the commissioner, when determining the amount of premium subsidy to be recovered, to take into account the extent to which a health carrier makes use of the Minnesota eligibility system.

4 **Applicability of gross premium.** Provides that the gross premium is the base for calculating any premium taxes for individual health plans.

5 **Sunset.** Provides that this article sunsets June 30, 2018.

6 **Transfer.** Transfers $326,945,000 in fiscal year 2017 from the budget reserve account to the general fund.

7 **Appropriation.** (a) Appropriates $311,788,000 in fiscal year 2017 from the general fund to the commissioner of management and budget for premium assistance under section 2. States that the appropriation is onetime and available through June 30, 2018.

(b) Appropriates $157,000 in fiscal year 2017 from the general fund to the legislative auditor for section 3. States that the appropriation is onetime.

(c) Provides that any unexpended amount from the appropriation in paragraph (a) after June 30, 2018, shall be transferred on July 1, 2018, from the general fund to the budget reserve account.

8 **Effective date.** States that sections 1 to 7 are effective the day following final enactment.

Article 2: Insurance Market Reforms

Overview

This article establishes disclosure requirements for proposed changes to insurance rates, modifies health insurance provisions governing stop loss coverage, establishes requirements for surprise billing, allows health maintenance organizations to be organized as for-profit corporations, authorizes the establishment of self-insured agricultural cooperative health plans, establishes an appeals process related to network adequacy waivers, allows health carriers to sell individual health plans to employees of a small employer in compliance with federal law, establishes transition of care coverage for individual market enrollees who experience an involuntary termination of coverage, requires a report from the commissioner of commerce, and appropriates money to reimburse health plan companies for costs related to transition of care coverage.

Section

1 **Classification of insurance filings data.** Amends § 60A.08, subd. 15. For rates filed with the commissioner of commerce for health plans in the individual and small group markets, requires the commissioner to provide public access to compiled data for proposed rate changes by health plan and geographic rating area, within ten days after the deadline for proposed rates to be filed with the commissioner.

2 **Health plan policies issued as stop loss coverage.** Amends § 60A.235, subd. 3. Modifies the circumstances under which an insurance policy issued as stop loss coverage must be issued as a health plan. An insurance policy issued as stop loss coverage must be issued as a health plan if the policy has an aggregate attachment point for all groups that is lower than 110 percent of expected claims (under current law, this aggregate attachment point applies only to groups of 51 or more, and there is a separate aggregate attachment point for groups of 50 or fewer). Strikes language allowing the commissioner to adjust the dollar amounts of attachment points.

3 **Stop loss regulation; small employer coverage.** Amends § 60A.236. Modifies requirements for the claims settlement period that must be included in a contract for stop loss coverage. The claims settlement period must be no less favorable than (1) claims incurred during the contract period; and (2) paid by the plan during the contract period or within three months after the contract expires.

4 - 9 **Sections 4 to 9.** Current law requires health maintenance organizations that operate in Minnesota to be organized as nonprofit corporations. Sections 4 to 9 remove the nonprofit requirement and allow health maintenance organizations to be organized as a nonprofit or for-profit corporation in Minnesota or another state.

10 **Agricultural cooperative health plan.** Adds § 62H.18.

Subd. 1. Definitions. Defines terms: agricultural cooperative, broker, Employee Retirement Income Security Act (ERISA), enrollee, insurance agent, joint self-insurance plan or plan, service plan administrator, and trust.

Subd. 2. Exemption. Provides that a joint self-insurance plan, its service plan administrator, stop loss carrier, and broker assisting the cooperative are exempt from §§ 62H.01 to 62H.17 if the plan is administered by a trust that meets certain criteria relating to involvement in production agriculture, cooperative membership, and cooperative member voting.

Subd. 3. Plan requirements. Requires a joint self-insurance plan to offer health coverage to members, employees of members, employees of the agricultural cooperative, and dependents; have stop-loss coverage; establish a reserve fund to be held in trust; be governed by a board with certain requirements; use a service plan administrator; and meet ERISA requirements for employee welfare benefit plans.

Subd. 4. Submission of documents to commissioner of commerce. Requires a joint self-insurance plan to submit certain documents to the commissioner of commerce.

Section

Subd. 5. Participation; termination of participation. Requires a member to participate in a joint self-insurance plan for at least three consecutive years, with a financial penalty assessed for early departure.

Subd. 6. Single risk pool. Provides that enrollees of a joint self-insurance plan are part of a single risk pool, and requires the plan's size to be based on the total enrollees in the risk pool.

Subd. 7. Promotion, marketing, sale of coverage. Allows a joint self-insurance plan to be promoted, marketed and sold by insurance agents and brokers to members, employees of members, employees of the agricultural cooperative, and dependents. Allows a cooperative organized under chapters 308A or 308B to promote or market a joint self-insurance plan to persons who may be eligible to participate.

Subd. 8. Taxation. Exempts joint self-insurance plans from the taxation imposed under section 297I.05, subdivision 12.

Subd. 9. Compliance with other laws. Exempts a joint self-insurance plan from the mandated health benefits in chapters 62A and 62Q and continuation requirements if the plan otherwise complies with ERISA. Requires the plan to comply with applicable requirements of the Affordable Care Act.

11 **Appeal of waiver of network adequacy requirements.** Adds subd. 5a § 62K.10. If a health carrier receives a waiver of network adequacy requirements from the commissioner of health, allows a health care provider aggrieved by the waiver to appeal the decision to an administrative law judge (ALJ) using the contested case procedures. Establishes timeframes within which a contested case proceeding must be initiated, and requires notice to the health carrier that received the waiver. Allows the ALJ to uphold or nullify the waiver. Allows the prevailing party to seek an award of fees and expenses from the non-prevailing party. Makes the ALJ's decision the final decision and allows a party to seek judicial review of the decision. If no judicial review is sought, requires a health carrier to comply with network adequacy requirements within a certain timeframe.

12 **Exceptions.** Amends § 62L.12, subd. 2. Authorizes a health carrier to sell an individual health plan to an employee of a small employer, provided the small employer, employee, and individual health plan comply with the 21st Century Cures Act.

13 **Unauthorized provider services.** Adds § 62Q.556.

Subd. 1. Unauthorized provider services. Paragraph (a) lists services that constitute unauthorized provider services: services from a nonparticipating provider at a participating facility in certain circumstances and situations in which a participating provider sends a specimen to a nonparticipating lab.

Paragraph (b) specifies that emergency services are not unauthorized provider services.

Paragraph (c) provides that a participating provider sending a specimen to a nonparticipating lab is not unauthorized if the enrollee provides advance written consent acknowledging that using the provider or obtaining the service might result in costs not covered by the health plan.

Section

Subd. 2. Prohibition. Paragraph (a) specifies that an enrollee's financial responsibility for unauthorized provider services must be the same as for services the enrollee receives from a participating provider. Requires a health plan company to apply cost-sharing requirements for unauthorized provider services to the enrollee's annual out-of-pocket limit.

Paragraph (b) requires a health plan company to negotiate reimbursement with the nonparticipating provider, and provides for binding arbitration if the health plan company and provider cannot come to a resolution.

Paragraph (c) requires the commissioner of health to consult with the Bureau of Mediation Services to develop a list of qualified professionals for health plan companies and providers to use to resolve disputes regarding reimbursement.

Paragraph (d) specifies what an arbitrator must consider when making a determination regarding provider reimbursement.

14 **Other entities.** Amends § 297I.05, subd. 12. Exempts agricultural cooperative health plans authorized by this article from the 2 percent tax on claims paid during the fund's fiscal year (this amendment is to conform with section 62H.18, subdivision 8).

15 **Transition of care coverage for calendar year 2017; involuntary termination of coverage.** Provides for transition of care coverage for enrollees who experienced involuntary terminations of coverage in the individual market in 2016 and obtain coverage from a new individual health plan for 2017.

Subd. 1. Definitions. Defines terms: enrollee, health plan, health plan company, individual market, involuntary termination of coverage.

Subd. 2. Application. Specifies that the transition of care coverage provisions apply to an enrollee who experienced an involuntary termination of coverage from an individual health plan in November or December 2016 and enrolls in a new individual health plan that goes into effect in January or February 2017.

Subd. 3. Change in health plans; transition of care coverage. For eligible enrollees, requires the enrollee's new health plan company to authorize the enrollee to receive services from a provider who was in-network for the enrollee's 2016 health plan but is out of network for the enrollee's 2017 health plan. An enrollee or provider must request authorization, and authorization lasts for up to 120 days for specified conditions or for the rest of the enrollee's life if the enrollee's life expectancy is 180 days or less.

Subd. 4. Limitations. Paragraph (a) establishes requirements for health care providers.

Paragraph (b) specifies that a health plan company is not required to cover a service or treatment not covered by the enrollee's health plan.

Subd. 5. Request for authorization. Allows an enrollee's health plan company to require certain medical records and supporting documentation to be submitted with an authorization request. Specifies information a health plan company must provide if a request for authorization is denied and if a request for authorization is granted.

Section

Subd. 6. Reimbursement. Requires the commissioner of management and budget to reimburse the enrollee's new health plan company for the cost of claims the health plan company certifies as eligible for reimbursement. Specifies that the cost eligible for reimbursement is the difference between the in-network level of benefits and the out-of-network level of benefits under the enrollee's health plan. Limits total reimbursements to the amount of the available appropriation, and allows the commissioner to prorate equally across all claims paid as necessary. Specifies that the enrollee is subject to in-network cost-sharing.

16 **Costs related to implementation of this act.** Requires a state agency that incurs administrative costs related to implementation of this act and does not receive an appropriation for administrative costs, to implement the act within the limits of existing appropriations.

17 **Insurance market options.** Requires the commissioner of commerce to report to the legislative committees with jurisdiction over insurance and health by March 1, 2017, on past and current implementation of statutes governing flexible benefits plans, and recommendations for increasing the number of flexible benefits plans offered in the state.

18 **Appropriation.** Appropriates $15,000,000 from the general fund to the commissioner of management and budget to reimburse health plan companies for costs of claims eligible for reimbursement for coverage for transition of care services. (This is a portion of the amount transferred from the budget reserve account to the general fund, according to article 1, section 6.) Allows the commissioner to use up to $272,400 of the appropriation for administrative expenses for transition of care services and the premium subsidy program. Specifies that this is a onetime appropriation and is available until June 30, 2018. Transfers any remaining funds on June 30, 2018, cancel to the budget reserve account.

19 **Repealer.** Repeals:

- **Section 62D.12, subd. 9** requires HMO net earnings to be devoted to nonprofit purposes of the HMO in providing comprehensive care. This section is repealed as part of changes to allow HMOs to be organized as for-profits; and
- **Laws 2007, chapter 147, article 12, section 14,** as amended, is a pilot program to establish an agricultural cooperative health plan for farmers.