HOUSE RESEARCH

Bill Summary

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Authors: Atkins and others

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Analyst: Tom Pender (651) 296-1885
Mark Shepard (651-296-5051

Overview

This bill creates a health insurance exchange in Minnesota, consistent with the federal Affordable Care Act (the "ACA"). The intent is for Minnesota to create and operate a Minnesota-designed health insurance exchange, rather than have the federal government operate a federally-designed health insurance exchange in Minnesota. Federal law allows states to design and operate their own exchanges, so long as the exchange meets certain federal requirements. The health insurance exchange created in this bill is named the "Minnesota Insurance Marketplace," which this summary will refer to as "the marketplace."

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1 **Minnesota Insurance Marketplace.** Specifies that classification and storage of data of the Minnesota Insurance Marketplace ("the exchange") is governed by section 7 of this bill.

2 **Title.** Names this new chapter of law (chapter 62V) the "Minnesota Insurance Marketplace Act."

3 **Definitions.** Defines nine terms used in this bill.

4 **Minnesota Insurance Marketplace; establishment.**

Subd. 1. Creation. Creates the marketplace as a board in the executive branch of state government. Summarizes six of its functions.

Subd. 2. Application of other law. Specifies general Minnesota governmental operations laws that govern the exchange and its board members, including laws

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dealing with reviews and audits by the legislative auditor, conflicts of interest, receipt of gifts, compliance with the Open Meeting Law, and when certain types of meetings can or must be closed to the public. Exempts the exchange from the following otherwise required provisions:

(1) the Administrative Procedure Act (chapter 14) rulemaking procedures, but the Marketplace is not exempt from contested cases procedures;

(2) the laws creating and governing the Department of Administration (chapter 16B) and those governing state procurement of goods and services (chapter 16C), except for specified sections relating to contracts for services and a section which requires efforts by state agencies to purchase from small businesses, including those owned by targeted group members and by veterans. Requires also, however, that the exchange establish "an open and competitive procurement process" for the exchange that complies with those chapters to the extent practicable for the exchange.

5 Governance.

Subd. 1. Board. The exchange's board of directors has seven members.

Subd. 2. Appointment. The board members are appointed to a four-year term, following the initial staggered-term lot determination and are classified as follows:

(1) Of one group of three board members, one represents individual market consumers, one represents public program enrollees, and one represents small employers. These members are appointed by the governor, with advice and consent of both the senate and the house of representatives, acting separately.

(2) Of a second group of three board members, one member represents the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one represents the areas of public health, health disparities, public health care programs, and the uninsured; and one represents health policy issues relating to the small group and individual markets. These members also are appointed by the governor, with advice and consent of both the senate and the house of representatives, acting separately.

(3) The seventh board member is the Commissioner of Human Services or a designee.

Provides that section 15.0597, relating to the usual process for making appointments to public entities, applies to this appointment process, except for the commissioner and the initial appointments. Requires that initial appointments be made 30 days after enactment. Requires appointments to be consistent with federal law. Provides that upon appointment, a board member shall exercise duties of office immediately, but that the appointment terminates if both the house and the senate vote not to confirm.

Subd. 3. Terms. (a) Limits board members to no more than two consecutive terms, except for the commissioner or designee who serves until replaced by the governor.

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(b) Permits a board member to resign at any time.

(c) Board members, not including the commissioner or designee, will initially serve a staggered term of 2, 3, or 4 years determined by lot.

Subd. 4. Conflicts of interest. Requires that board members appointed to the six positions other than the one reserved for the Commissioner of Human Services, not have, within one year before or during their appointment, any type of employment, service on a board of directors, or other representation position with any health carrier, health care provider, navigator, insurance producer, or other entity that sells anything to or through the exchange. Provides that a board member must not serve as a lobbyist, as defined in Minnesota Statutes, section 10A.01.

Subds. 5 to 13. These subdivisions deal with details of the board's internal operations, including the first meeting, the board chair, officers, vacancies, removal, meetings, quorum, compensation, and advisory committees. Compensation of board members is $55 per day plus expenses, including cost of child care.

6 Responsibilities and powers of the Minnesota Insurance Marketplace.

Subd. 1. General. (a) Requires the board to operate the exchange in compliance with this bill and applicable state and federal law.

(b) Lists the board's powers, including employing personnel and delegating responsibilities to the director and other personnel. Specifies that the director and managerial staff are unclassified state employees and are subject to a compensation plan prepared by the board, submitted to Minnesota Management and Budget ("MMB") for review and comment, and approved by the LCC and the legislature under section 3.855, except that section 15A.0815, subd. 5(e), relating to the salary of the head of a new agency or commission, does not apply. Requires the board to establish policies and procedures to gather public comment and to provide notice in the State Register. Requires the board to adopt bylaws, policies, and procedures within 180 days of enactment.

Subd. 2. Operations funding. (a) Permits the board, beginning January 1, 2015, to retain or collect 3.5 percent of premiums from the individual and small group market premiums (not the public programs) to fund the operations of the exchange.

(b) Requires the board, prior to January 1, 2015, to retain or collect the premiums described above to fund the operations of the exchange.

Subd. 3. Insurance producers. (The term "insurance producers" is a relatively new term that refers to insurance agents or brokers who market insurance to individuals or employers for insurance companies that provide insurance, in this case, health insurance.)

(a) Requires the Commissioner of MMB, in consultation with the Commissioner of Commerce, to certify insurance producers to sell health benefit plans through the

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exchange. Requires that producers have four hours of training specific to selling products through the exchange, in addition to meeting the regular licensing requirements required of insurance producers.

(b) Specifies that insurance producers will be paid commissions by the insurance companies for selling health insurance through the exchange. They will not be paid by the exchange. Requires that the insurance premiums be equivalent regardless of whether the insurance is sold inside or outside of the exchange.

(c) Requires that each insurance company that sells health insurance in the exchange provide the exchange with a report on a quarterly basis, showing the compensation and other incentives it offers to its insurance producers in connection with each type of health insurance product the insurance company offers or sells both inside and outside of the exchange.

(d) Prohibits an insurance producer that offers health insurance for the small group market in the exchange from discouraging an employer from choosing a "defined-contribution" type of group health insurance. (In a defined-contribution arrangement, the employer gives each employee a fixed amount of money (may vary based on whether the employee wants family coverage) to buy whatever level of health insurance the employee wants, and the employee has to pay the difference if the employee wants better coverage than the employer's contribution can buy. In contrast, a defined-benefit arrangement is the more traditional type of employer-sponsored health insurance, in which the employer chooses a specific group insurance policy and pays a fixed amount toward the premium (again, may vary between individual and family coverage), leaving the employees to pay the rest of the premium.)

(e) Requires that an insurance producer that offers health insurance through the exchange to tell prospective purchasers through the exchange which insurance company or companies the producer is authorized to sell health insurance for through the exchange. The producer must make that disclosure at the first contact between the insurance producer and the customer.

Subd. 4. Navigator; in-person assisters; call center. (a) Permits the board of the exchange to create policies and procedures regarding arrangements to help people decide whether to obtain insurance through the exchange and if so, which insurance policy to buy. This also involves arrangements to help people decide whether and how to apply for public programs, such as medical assistance, which will be administered only through the exchange. These are scheduled to be implemented in for 2015.

(b) Describes how the needs for assistance described in paragraph (a) will be met until 2014.

(c) Requires the Commissioner of MMB to arrange a toll-free phone number for the exchange and hire or contract for more resources related to this subdivision if necessary.

Subd. 5. Health carrier requirements; participation. (a) Gives the board

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authority to create certification requirements for health insurers and health insurance policies offered through the exchange, unless the legislature, by June 30, 2013, enacts regulatory requirements described in this paragraph (a).

(b) Permits the board to, if it chooses, be an "active purchaser" of health benefit plans from health insurers by choosing which health benefit plans and insurers to allow to participate in the exchange. Requires the board to provide health coverage choices that provide the optimal combination of choice, value, quality, and service. The choices must be in the best interest of individuals and small employers and be within federal requirements. Specifies criteria for the board to consider when determining the best interest.

(c) Provides a special requirement, beginning January 1, 2015, related to coverage made available by the exchange that applies to Indian health care providers.

Subd. 6. Appeals. Specifies the appeals procedures available in connection with appeals of determinations made by the marketplace. Provides that this subdivision does not apply if a state agency appeal is available under section 256.045, which relates to the public health care programs.

Subd. 7. Agreements; consultation. (a) Requires the board to enter into agreements with the Office of Enterprise Technology, for information technology services that ensure coordination with public health programs; with the Commissioner of Human Services for coordination with public health care programs and other services; with the Commissioners of Commerce and Health for various enforcement and other services;

(b) & (c) Requires the board to consult with the Commissioners of Commerce and Health and with Indian tribes and organizations regarding operations of the marketplace;

(d) Requires the board to establish advisory committees to allow stakeholders to share their perspectives regarding operation of the marketplace.

Subd. 8. Limitations; risk-bearing. Prohibits the board from bearing insurance risk or entering into any agreement with health care providers to pay claims. States that this subdivision does not prohibit the board from providing insurance to its employees.

7 **Data.** Says that the Marketplace is a sate agency for purposes of the Data Practices Act, and is subject to all provisions of chapter 13.

Specifies the classification, status, and permitted use of government data held or obtained by the marketplace on individuals, employees of employers, and employers that use the marketplace.

Requires the marketplace to provide a Tennesen warning, as provided in the Data Practices Act, to individuals asked to supply private data. Requires the warning to list each person or

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entity authorized by law to receive or access data and to list the specific ways in which the data will be used. Prohibits the marketplace from using the data in any manner not described in the Tennesen warning. Also requires the marketplace to give notice of a data subject's rights related to handling of genetic information.

Requires that by October 1, 2013, the marketplace enter into a written data sharing agreement with any entity with which the exchange is authorized to share private or nonpublic data. Specifies required terms and conditions of the agreement.

8 **Funds.** Requires that all funds received by the marketplace must be deposited in a dedicated fund that may earn interest and are appropriated to the marketplace for the purpose for which the funds were received. The funds do not cancel and remain available until spent.

9 **Report.** Requires the marketplace to submit a report to the legislature by January 15, 2015, and on each January 15 thereafter. The report must cover the marketplace's performance, meeting responsibilities, and an accounting of its budget activities.

10 **Expiration and sunset exclusion.** Provides that the Minnesota Marketplace Act does not expire and that the marketplace is not subject to review under chapter 3D (Minnesota Sunset Act).

11 **Right not to participate.** Provides that nothing in this chapter infringes on the right of a Minnesota citizen not to participate in the marketplace.

12 **Transition of authority.** (a) Says that the Commissioner MMB will be in charge of the marketplace assets and responsibilities until the marketplace board has adopted bylaws, policies, and procedures under this chapter.

(b) Requires that the commissioner transfer those assets and responsibilities to the marketplace board upon compliance with paragraph (a).

13 **Minnesota comprehensive health insurance termination.** This section involves the state's high-risk pool, the Minnesota Comprehensive Health Association (MCHA), which is a nonprofit corporation created and governed under state law. The section gives the Commissioner of Commerce authority to implement the phase-out and eventual termination of MCHA, beginning no later than January 1, 2014.

14 **Effective date.** Makes this act effective the day following final enactment. Says that any actions taken by state agencies before then that involve design, development, or implementation must be considered actions taken on behalf of the marketplace and are governed by this chapter (62V) and state law. Specifies that health coverage provided by the exchange can begin January 1, 2014.