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" or "the exchange."

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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.

Subd. 3. Continued operation of a private marketplace. States that nothing in this chapter shall be construed so as to: (1) prohibit the offering outside of the Minnesota Insurance Marketplace of health benefit plans to qualified individuals or qualified employers; (2) prohibit a qualified employee from enrolling in, or a qualified employer from selecting, a health benefit plan offered outside of the marketplace; (3) restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in the marketplace; and (4) compel an individual to enroll in a qualified health plan or to participate in the marketplace.

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

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the initial appointments. Requires that initial appointments be made by April 30, 2013. 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. Requires one of the members appointed under clauses (1) and (2) to have experience in representing the needs of vulnerable populations and persons with disabilities. Also requires the board to include representation from outside of the seven-county metropolitan area.

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.

(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 two, three, or four years determined by lot.

Subd. 4. Conflicts of interest. (a) 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, institutional health care provider or other entity providing health care, 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.

(b) Requires directors to recuse themselves from discussion and voting if the director has a conflict of interest.

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 Legislative Coordinating Commission (LCC) and the legislature under section 3.855, except that section 15A.0815, subdivision 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

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board to adopt bylaws, policies, and procedures within 180 days of enactment. Provides that if these policies and procedures are "rules" as defined in the Administrative Procedure Act, the board must publish proposed rules in the State Register, and allow 30 days for interested parties to comment, before publishing notice of adoption in the State Register. Provides that rules published in the State Register before January 1, 2014, take effect upon publication, and rules published on or after January 1, 2014, take effect 30 days after publication.

Subd. 2. Operations funding. (a) Prior to January 1, 2015, permits the board to retain or collect up to 3.5 percent of premiums from the individual and small group market premiums (not the public programs) to fund cash reserves of the marketplace, but limits the amount collected to 25 percent of the Minnesota Comprehensive Health Association (MCHA) assessments collected for CY 2012.

(b) Beginning January 1, 2015, permits the board to retain or collect up to 3.5 percent of premiums from the individual and small group market premiums (not the public programs) to fund operations of the marketplace, but limits the amount collected to 50 percent of the MCHA assessments collected for CY 2012.

(c) Beginning January 1, 2016, permits the board to retain or collect up to 3.5 percent of premiums from the individual and small group market premiums (not the public programs) to fund operations of the marketplace, but limits the annual growth in the amount collected or retained to the rate of inflation after accounting for year-to-year enrollment changes and provides that the amount may never exceed 100 percent of the MCHA assessments collected for CY 2012.

Subd. 3. Abortion coverage prohibited. Provides that no abortion coverage may be provided by a qualified health plan offered through the Minnesota Insurance Marketplace. Specifies three exceptions.

Subd. 4. 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 board, in consultation with the Commissioner of Commerce, to certify insurance producers to sell health benefit plans through the 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. Specifies certain contents of this training, and other requirements related to 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

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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) Provides that this act does not prohibit an insurance producer from offering advice to a small group purchaser.

(e) Prohibits an insurance producer that offers health benefit plans in the individual market from selling or renewing an individual plan to a person whose income indicates the person may be eligible for premium assistance or an exchange enrollment public health program administered by the Commissioner of Human Services without informing the person of the person's potential eligibility for those programs, and either offering assistance in determining eligibility or referring the person for assistance in determining eligibility.

(f) Requires an insurance producer that offers health benefit plans in the small group market to notify each small group purchaser of which plans qualify for tax benefits under section 125 of the Internal Revenue Code, and of state laws that benefit small group plans when the employer agrees to pay 50 percent or more if its employees' premiums. Provides that persons who are eligible for cost effective medical assistance will count toward the 75 percent participation requirement in current law requiring guaranteed coverage for certain small employers.

(g) Requires an insurance producer assisting an individual or small employer with purchasing coverage through the exchange to disclose, at the time of first solicitation, the following: (1) the carriers and plans the producer is authorized to sell; (2) that the producer may be receiving compensation from a health carrier for enrolling the individual or small employer into a plan; and (3) that information on all qualified health plans offered through the exchange is available through the exchange website. Specifies disclosure requirements if the first solicitation is made by telephone.

Subd. 5. 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. Provides that the policies and procedures must require a person complete at least eight hours of training before working as an in-person assister or working on behalf of a navigator on behalf of people seeking insurance through the exchange. 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 2015.

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

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(d) Sets requirements for training standards for the navigator program. For CY 2014, requires the Commissioner of Human Services to ensure that the existing Minnesota Health Care Outreach program provides application assistance for both qualified health plans offered through the marketplace and public health care programs.

(e) Provides that an individual or entity acting as a navigator or in-person assister is personally liable for damages resulting from acts or omissions in providing assistance to marketplace participants.

Subd. 6. Health carrier requirements; participation. (a) Gives the board the power, beginning January 1, 2015, to establish certification requirements for health carriers and health benefit plans in the marketplace unless by June 1, 2013, the legislature enacts regulatory requirements that apply uniformly to all health carriers and health benefit plans in the individual and small group markets and satisfy federal certification requirements for the marketplace.

(b) Requires that certification requirements under paragraph (a) include provider network adequacy requirements that are not inconsistent with the most popular plans under paragraph (c).

(c) Prohibits requiring a health carrier to participate in the marketplace. Beginning January 1, 2015, requires the board to approve two health benefit plans, one of which must be the "most popular one" that the health carrier offers. Requires that the plans be offered at four actuarial levels that vary in the percentage of costs covered by the plan. Specifies how "popularity" will be determined based upon past enrollment.

(d) Provides that if a health carrier participating in the marketplace also offers health benefit plans outside of the marketplace, the health carrier must offer those plans at two actuarial levels in each service area.

(e) Beginning January 1, 2015, gives the board the power to select health benefit plans in addition to those in paragraph (c) to be offered in the marketplace. Specifies the criteria the board must consider.

(f) For health benefit plans offered through the marketplace on Indian reservations beginning in 2015, requires use of the most current federal requirements for provider agreements with Indian health care providers.

(g) Provides that for 2014, the board will not have the power to select health carriers and health benefit plans for participation in the marketplace, but will have the power to verify eligibility for participation under federal certification guidance in place January 1, 2013. However, any catastrophic health plan will be eligible.

(h) Gives the board the authority to decertify health carriers and health benefit plans that fail to comply with federal certification requirements.

Subd. 7. Appeals. Specifies the appeals procedures available in connection with appeals of determinations made by the marketplace. Provides that this subdivision

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does not apply if a state agency appeal is available under section 256.045, which relates to the public health care programs.

Subd. 8. 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 healthcare programs; with the Commissioner of Human Services for coordination with public health care programs and other services; and with the Commissioners of Commerce and Health for various enforcement and other services. Requires the board to establish interagency agreements to transfer funds to other agencies for their costs relating to implementing the marketplace, excluding MA allocatable costs.

(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 an advisory committee to allow stakeholders to provide information and advise the board regarding operation of the marketplace.

Subd. 9. 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 practices.** Says that the marketplace is a state agency for purposes of the Data Practices Act, and is subject to all provisions of chapter 13. Defines terms.

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.

Forbids the marketplace from sharing or disseminating outside of the marketplace data that indicates whether or not an individual or employee participating in the marketplace has a history of tobacco use or owns guns or has a firearm in their home.

Requires the marketplace to provide a Tennesen warning, as provided in the Data Practices Act, to individuals asked to supply private data. Also requires the marketplace to give notice of a data subject's rights related to handling of genetic information and notice of the records retention policy of the marketplace.

Provides that only individuals with explicit authorization from the board may access not public data maintained by the marketplace. Specifies procedures to limit and to track access to data. Provides that the board must revoke the authorization of any person who accesses data in violation of this section of chapter 13. Requires that if an individual is determined to have willfully gained access to data without board authorization, the board must forward the matter to the county attorney. Provides that these limits do not affect authority of the Legislative Auditor under current law or the right of a marketplace participant to enter, update, or access data if the participant is the subject of the data.

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Forbids the marketplace from selling its data.

8 **Funds.** Requires that all funds received by the marketplace must be deposited in a dedicated account in the special revenue fund that may earn interest and are appropriated to the marketplace for the purpose for which the funds were received.

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. Requires the exchange to publish its administrative and operational costs on its website, and specifies information to be reported.

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 **Right to physician of choice.** States that nothing in this chapter prohibits a person using a federal premium tax credit or cost-sharing subsidy to purchase a health plan through the exchange from receiving care from the physician of their choice.

13 **Transition of authority.** (a) Says that the Commissioner of 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).

14 **Minnesota comprehensive health insurance termination.** This section involves the state's high-risk pool, MCHA, which is a nonprofit corporation created and governed under state law. The section gives the Commissioner of Commerce, in consultation with the exchange board, the authority to determine the need for and to implement the eventual appropriate termination of coverage provided by MCHA, beginning no sooner than January 1, 2014.

15 **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.