HOUSE RESEARCH

Bill Summary

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Overview

The federal Affordable Care Act gives states the option of establishing a basic health program, to provide coverage to persons with incomes greater than 133 percent but not exceeding 200 percent of the federal poverty guidelines who meet program eligibility criteria. The federal government will provide to states operating a basic health program funding equal to 95 percent of the premium tax credits and cost-sharing reductions that would have been provided had program enrollees obtained coverage through a health benefit exchange. Recent federal guidance has stated that the basic health program can be implemented beginning January 1, 2015.

This bill makes number of changes to the MinnesotaCare program, effective January 1, 2014. These changes include: (1) eliminating the $10,000 annual inpatient hospital limit; (2) eliminating the program's insurance barriers (no access to employer-subsidized insurance, no other health coverage, four-month uninsured requirement); and (3) requiring the use of modified adjusted gross income as the program's income methodology.

This bill establishes the MinnesotaCare program as the state's basic health program, effective January 1, 2015. The bill specifies eligibility criteria and covered services, and requirements for the delivery of services. The bill also eliminates premiums and asset requirements for MinnesotaCare enrollees.

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1 **MinnesotaCare federal receipts.** Amends § 16A.724, subd. 3. Dedicates all federal funding received for implementation and administration of MinnesotaCare as a basic health program to that program, and requires this money to be deposited into the health care access fund. Allows this money to be used only for that program, to: purchase health coverage for enrollees, reduce enrollee premiums and cost-sharing, or provide additional benefits. Strikes language related to the deposit of federal funds for administrative costs. Provides a January 1, 2015 effective date.

2 **Federal approval.** Amends § 256.01, by adding subd. 35. (a) Requires the commissioner to seek federal authority necessary to operate a health insurance program for persons with incomes up to 275 percent of FPG. The proposal must seek to secure all federal funding available from at least the following sources:

(1) premium tax credits and cost sharing subsidies for individuals with incomes above 133 percent and at or below 275 percent of FPG, who would otherwise be enrolled in the Minnesota Insurance Marketplace;

(2) Medicaid; and

(3) other funding sources identified by the commissioner that support coverage or care redesign.

(b) Requires funding received to be used to design and implement a health insurance program that is streamlined and meets the needs of Minnesotans with income up to 275 percent of FPG. Specifies program criteria.

(c) Directs the commissioner to develop and submit a proposal consistent with the criteria in paragraph (b), and seek all federal authority necessary to implement the program. Requires the commissioner to consult with stakeholder groups and consumers in developing the proposal.

(d) Authorizes the commissioner to seek any available federal waivers and approvals prior to 2017.

(e) Requires the commissioner to report progress to the relevant legislative committees by December 1, 2014.

(f) Gives the commissioner authority to accept and spend federal funds.

3 **Affordable care act.** Amends § 256L.01, by adding subd. 1b. Defines the Affordable Care Act (ACA) as Public Law 111-148, as amended by Public Law 111-152, and any amendments to or regulations or guidance issued under those acts.

4 **Health Insurance Marketplace.** Amends § 256L.01, by adding subd. 4b. Defines the Minnesota Insurance Marketplace as that enacted in H.F. 5/S.F. 1.

5 **MinnesotaCare.** Amends § 256L.01, by adding subd. 6. Defines MinnesotaCare as a health coverage program that meets the requirements of chapter 256L and the requirements for a

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basic health program under § 1331 of the ACA. Provides a January 1, 2015 effective date.

6 **Modified adjusted gross income and household income.** Amends § 256L.01, by adding subd. 7. Provides that modified adjusted gross income and household income have the meaning provided in § 2002 of the ACA. Provides a January 1, 2014 effective date.

7 **Participating entity.** Amends § 256L.01, by adding subd. 6. Defines a participating entity as a health plan company, county-based purchasing plan, accountable care organization or other entity operating a health care delivery systems demonstration project, an entity operating a county integrated health care delivery network pilot project, or a network of health care providers established to offer services under MinnesotaCare. Provides a January 1, 2015 effective date.

8 **Commissioner's duties.** Amends § 256L.02, subd. 2. Requires payment for MinnesotaCare services to be made to all participating entities under contract with the commissioner. Requires the commissioner to administer MinnesotaCare as a basic health program and to adopt necessary rules. Provides that nothing in chapter 256L is intended to violate the ACA and prohibits the commissioner from implementing any provision that violates the ACA. Requires the commissioner to conduct outreach as provided under § 256.962. Provides a January 1, 2015 effective date.

9 **Determination of funding adequacy.** Amends § 256L.02, by adding subd. 5. Requires the commissioners of revenue and management and budget, in consultation with the commissioner of human services, to conduct an assessment of health care taxes, including the gross premiums tax, the provider tax, and Medicaid surcharges, and their relationship to the long-term solvency of the health care access fund, as part of the November 2013 forecast. Requires the commissioners to determine the amount of state funding that will be needed after December 31, 2019, in addition to federal basic health plan payments, for the MinnesotaCare program, and to evaluate the stability and likelihood of long-term federal funding. Requires the commissioners to report results to the legislature by January 15, 2014, including recommendations for changes to state revenue for the fund, if state funding will continue to be required.

10 **Federal approval.** Amends § 256L.02, by adding subd. 6. (a) Requires the commissioner of human services to seek federal approval to implement the MinnesotaCare program as a basic health program. Requires the commissioner to seek to include, in any agreement with the Centers for Medicare and Medicaid Services, procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of the program. Requires the procedures to address the timing of payments, payment reconciliation, enrollee risk adjustment, and minimizing state financial risk. Requires the commissioner of human services to consult with the commissioner of management and budget, when developing the basic health plan proposal to be submitted to the federal government.

(b) Requires the commissioner of human services, in consultation with the commissioner of management and budget, to work with the Centers for Medicare and Medicaid Services to establish a process for the reconciliation and adjustment of federal payments, that balances state and federal liability over time. Requires the commissioner to request that the state and

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enrollees be held harmless in the reconciliation process for three years, to allow the state to develop a statistically valid methodology to predict enrollment trends and their effect on federal payments.

(c) Allows the commissioner of human services, through December 31, 2015, to modify the MinnesotaCare program, if this is necessary to enhance benefits or provider access or reduce cost-sharing and premiums, in order to comply with the terms and conditions of federal approval. Prohibits the commissioner from reducing benefits, limiting provider access, or increasing cost-sharing and premiums. If the commissioner modifies MinnesotaCare, requires the commissioner to provide the legislature with at least ten working days notice before notifying enrollees and participating entities. Provides that the cost of program changes become part of the program's base funding.

Provides an immediate effective date.

11 **Coordination with Minnesota Insurance Marketplace.** Amends § 256L.02, by adding subd. 7. States that MinnesotaCare shall be considered a MAGI public health care program for purposes of the Minnesota Insurance Marketplace.

12 **Covered health services.** Amends § 256L.03, subd. 1. Expands covered health services under MinnesotaCare, to include all health services reimbursed under MA, and all essential health benefits required under the ACA, with the exception of nursing facility services and ICF/DD services, and except as provided in this section. Provides a January 1, 2015 effective date.

13 **Inpatient hospital services.** Amends § 256L.03, subd. 3. Eliminates the $10,000 annual limit on inpatient hospital benefits. Provides a January 1, 2014 effective date.

14 **Cost-sharing.** Amends § 256L.03, by adding subd. 4a. (a) Modifies MinnesotaCare cost-sharing requirements, by repealing existing cost-sharing requirements (see repealer section) and reinstating modified cost-sharing language that is based on the requirements for MA.

This has the effect of modifying existing MinnesotaCare cost-sharing, by:

- eliminating the 10 percent coinsurance requirement for inpatient hospital services;

- eliminating a $25 copayment for eyeglasses;

- reducing the copayment for generic prescriptions from $3 to $1, setting a copayment limit for prescription drugs of $12/month, and exempting antipsychotic drugs from copayments; and

- subject to federal approval, increasing the copayment for nonemergency visits to an emergency room from $3.50 to $20.

(b) Reinstates current MinnesotaCare law that exempts mental health services from the copayment for nonpreventive visits.

(c) Gives the commissioner the authority to allow participating entities to waive the family

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deductible (under current law, the scope of this authority is limited to managed care and county-based purchasing plans, both of which are included in the definition of participating entity).

(d) Adds to MinnesotaCare law a provision from MA law that allows the commissioner to waive the collection of the family deductible from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

Provides a January 1, 2015 effective date.

15 **Loss ratio.** Amends § 256L.03, by adding subd. 4b. Requires coverage provided through the MinnesotaCare program to have a medical loss ratio of at least 85 percent. Provides a January 1, 2015 effective date.

16 **Cost-sharing.** Amends § 256L.03, subd. 5. Modifies MinnesotaCare cost-sharing requirements that will apply for the period January 1, 2014 through December 31, 2014. Eliminates the inpatient hospital coinsurance requirement and makes other changes related to elimination of the $10,000 annual inpatient hospital limit. Provides a January 1, 2014 effective date.

17 **Lien.** Amends § 256L.03, subd. 6. Modifies the definition of "state agency" by replacing references to prepaid health plans and county-based purchasing entities with a reference to participating entities. This amendment is to a provision that gives the state agency a lien for the cost of covered health services upon causes of action accruing to the enrollee or the enrollee's legal representative. Provides a January 1, 2015 effective date.

18 **General requirements.** Amends § 256L.04, by adding subd. 1c. To be eligible for the MinnesotaCare, requires a person to meet the eligibility requirements of this section. Provides that a person eligible for MinnesotaCare shall not be treated as a qualified individual and is not eligible to enroll in a qualified health plan offered through the health benefit exchange. Provides a January 1, 2015 effective date.

19 **Eligibility groups; income limits.** Amends § 256L.04, by adding subd. 1d. (a) To be eligible for the program, requires a person to:

(1) be a resident of Minnesota;

(2) not be eligible under MA;

(3) have a household income that is greater than 133 but does not exceed 200 percent of FPG, except that a noncitizen lawfully present, who is not eligible for Medicaid due to immigration status, may have a household income that is less than or equal to 133 percent of FPG;

(4) not be eligible for minimum essential coverage as defined in the Internal Revenue Code (IRC), unless this is employer-sponsored coverage that is not affordable, as defined in the IRC; and

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(5) not have attained the age of 65 as of the beginning of the plan year.

Note: The IRC generally defines minimum essential coverage as Medicare, Medicaid, CHIP, TRICARE and other coverage for members of the military, veterans health benefits, coverage under an eligible employer sponsored plan, coverage under a health plan offered in the individual market, or coverage under a grandfathered health plan, and other specified coverage. The IRC defines coverage as affordable if the premium cost to the individual does not exceed eight percent of income.

(b) Requires the commissioner to calculate income eligibility using MAGI and apply a standard five percent income disregard.

Provides a January 1, 2014 effective date for paragraph (b) and a January 1, 2015 effective date for paragraph (a).

20 **Application assistance and information availability.** Amends § 256L.05, subd. 1. Allows applicants to submit their applications online, in person, by mail, or by phone in accordance with the ACA, and by any other means by which MA applications may be submitted. Allows applicants to submit applications through the health benefit exchange or through the MinnesotaCare program. Requires MinnesotaCare applications and application assistance to be available at locations at which MA applications must be made available (in addition to those locations already listed in law). Requires online assistance to be available for applicants filing applications with the health benefit exchange. Provides a January 1, 2014 effective date.

21 **Streamlined application and enrollment process.** Amends § 256L.05, by adding subd. 1d. Requires the commissioner to work with the board of the health benefit exchange and local human services agencies to develop a single, streamlined application and automatic enrollment process that meets ACA requirements, including the requirement that the process be structured to maximize the typical applicant's ability to complete the form satisfactorily. Provides an immediate effective date.

22 **Commissioner's duties.** Amends § 256L.05, subd. 2. Makes conforming changes, adding references to the Minnesota Insurance Marketplace and the ACA. Provides a January 1, 2014 effective date.

23 **Effective date of coverage.** Amends § 256L.05, subd. 3. Makes conforming changes related to the elimination of premiums under MinnesotaCare (see repealer section). Also eliminates provisions setting different coverage dates for newborns, newly adoptive children, and other new family members. Strikes language that limits the start of benefits to the day following discharge, if an enrollee is hospitalized on the first day of coverage. Provides a January 1, 2015 effective date.

24 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Makes conforming changes related to the elimination of premiums under MinnesotaCare Provides a January 1, 2015 effective date.

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25 **Retroactive coverage.** Amends § 256L.05, by amending subd. 3c. Makes conforming changes related to the elimination of premiums under MinnesotaCare. Also eliminates an obsolete reference to GAMC. Provides a January 1, 2015 effective date.

26 **General requirements.** Amends § 256L.07, subd. 1. Eliminates references to MinnesotaCare insurance barriers (no employer-subsidized insurance, no other health coverage, four-months uninsured). These provisions are repealed later in the bill. Provides a January 1, 2014 effective date.

27 **Residency requirement.** Amends § 256L.09, subd. 2. Requires MinnesotaCare enrollees to be residents of the state as provided in the ACA. (Current law bases residency on federal Medicaid requirements.) Provides a January 1, 2015 effective date.

28 **Medical assistance rate to be used.** Amends § 256L.11, subd. 1. Makes a conforming change, striking cross-references to provisions repealed elsewhere. Also eliminates MinnesotaCare provider rate reductions. Provides a January 1, 2015 effective date.

29 **Rate increases.** Amends § 256L.11, by adding subd. 1a. Effective January 1, 2015, requires the commissioner to increase MinnesotaCare payment rates for basic care, physician and professional, and dental services by an unspecified percentage. Requires payments to participating entities to reflect this increase.

30 **Service delivery.** Adds § 256L.121.

Subd. 1. Competitive process. Requires the commissioner to establish a competitive process for contracting with participating entities for the offering of standard health plans. Requires coverage to be available beginning January 1, 2015. Requires each standard health plan to cover the services listed in section 256L.03 and meet the requirements of that section. States that the competitive process must meet the requirements of the ACA and be designed to increase access to high-quality health care coverage options. Requires the commissioner, to the extent feasible, to seek to ensure that enrollees have the choice of coverage from more than one participating entity within a geographic area.

Subd. 2. Other requirements for participating entities. Directs the commissioner to require participating entities, as a condition of contract, to document: (1) the provision of culturally and linguistically appropriate services, including marketing materials, to enrollees; and (2) the inclusion in essential community providers in provider networks

Subd. 3 Coordination with state-administered health programs. Requires the commissioner to coordinate the administration of MinnesotaCare with medical assistance and other state-administered health programs. Specifies requirements for coordination.

Provides an immediate effective date.

31 **Plan for consolidation of public programs.** Requires the commissioner of human services to develop and present to the legislature, by January 15, 2014, a plan for a consolidated and streamlined state health care program that combines MA and MinnesotaCare, uses a standard and simplified application process through the Minnesota Insurance Marketplace, and

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provides seamless delivery and coordination of services between state health care programs and coverage available through the marketplace.

32 **Revisor's instruction.** Directs the revisor to remove references to sections repealed in the bill and make conforming changes.

33 **Repealer; MinnesotaCare program.**

Repeals the following MinnesotaCare provisions, effective January 1, 2014:

§ 256L.01, subd. 4a (definition of gross income) and 5 (definition of income)

§ 256L.031 (Healthy Minnesota Defined Contribution Program for adults without children with incomes greater than or equal to 200 but not exceeding 250 percent of FPG)

§ 256L.07, subd. 2 (no access to employer-subsidized coverage) and 3 (no other health coverage; 4 months uninsured requirement)

Repeals the following MinnesotaCare provisions, effective January 1, 2015:

§ 256L.01, subd. 3 (definition of eligible providers) and 3a (definition of family with children)

§ 256L.02, subd. 3 (financial management of MinnesotaCare).

§ 256L.03, subd. 1a (covered services for pregnant women and children); 3 (inpatient hospital services); 4 (coordination with MA); 5 (cost-sharing).

§ 256L.04, subd. 1 (eligibility for families and children); 1b (eligibility for children above 275% of FPG); 2a (required application for pension, disability, and other benefits); 7 (eligibility for adults without children); 7a (ineligibility for persons exceeding income limits); 8 (applicants potentially eligible for MA); 9 (reference to GAMC); 13 (relative caretakers and other groups).

§ 256L.05, subd. 1b (enrollment for former GAMC enrollees); 1c (streamlined enrollment procedures); 5 (provision of information on private insurance).

§ 256L.06, subd. 3 (commissioner's duties related to administration of premiums).

§ 256L.07, subd. 1, 4, 5, 8, and 9 (eligibility criteria for MinnesotaCare).

§ 256L.09, subd. 1, 4, 5, 6, 7 (provisions related to residency).

§ 256L.11, subd. 2a, 3, 6 (provisions related to provider payment).

§ 256L.12 (provisions related to managed care).

§ 256L.15, subd. 1 (premium payment); 1a (premium payment options); 1b (premiums not refundable); 2 (sliding scale for premiums).

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§ 256L.17, subd. 1, 2, 3, 4, and 5 (MinnesotaCare asset requirement).