# HOUSE RESEARCH

## Bill Summary

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**Authors:** Atkins and others
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**Analyst:** Tom Pender (651) 296-1885



### Article 1: Conformity with Affordable Care Act

## Overview

This article consists of 93 technical amendments to conform Minnesota health insurance laws to the federal Affordable Care Act. This will permit Minnesota to enforce those provisions of the federal Affordable Care Act, as an alternative to federal enforcement. This bill summary does not summarize those technical conforming provisions.

House floor amendments to article 1 added two non-technical provisions involving abortion. They are in section 89, subdivision 6; and in section 92.

### Article 2: Market Rules

## Overview

This article deals with the market rules that will apply to health carriers and health plans in connection with health coverage in Minnesota sold inside and outside of the exchange. These market rules involve Minnesota laws, federal laws under the Affordable Care Act, and provisions specifying how they will be coordinated.

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**1** **Application.** Provides that an existing geographic accessibility law will apply only to grandfathered health plans effective January 1, 2014. (Section 11 provides other geographic

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accessibility standards that will apply to other health plans then.)

**2** **Title.** Names this new chapter of laws "Minnesota Health Plan Market Rules."

**3** **Purpose and scope.**

**Subd. 1. Purpose.** Says the market rules provided in this chapter of laws are intended to clarify and provide guidance on the application of state and federal laws, including those enacted in the Affordable Care Act, in regard to health plans whether offered inside or outside of the exchange. Says the goals are to ensure a level playing field for health carriers, minimize adverse selection, and ensure consumer protection, high-quality affordable care, and improved health outcomes. References a provision of H.F. 5 as requiring that the state enact the types of market rules contained in this bill.

**Subd. 2. Scope.** Says this chapter applies to all health plans offered in the individual or small group market, except for short-term coverage and grandfathered plan coverage.

**4** **Definitions.** Defines twelve terms used in this article.

**5** **Market rules; violation.**

**Subd. 1. Compliance.** Requires health carriers that issue health plans in Minnesota to comply with this chapter. Makes a violation subject to enforcement under section 72A.20. Excludes short-term coverage and grandfathered coverage.

**Subd. 2. Penalties.** Says that violations of this chapter are subject to enforcement under section 45.027 and chapters 62D and 72A. (Chapter 62D governs HMOs, and section 45.027 and chapter 72A apply to other types of insurers.)

**6** **Federal act; conformity required.** Requires health carriers to comply with the ACA to the extent it impose a requirement that applies in this state. Requires compliance as of the effective date stated in the ACA, unless required earlier under Minnesota law.

**7** **Metal level mandatory offerings.**

**Subd. 1. Identification.** Requires a health carrier that offers an individual or small group health plan in Minnesota, whether inside or outside of the exchange, to provide proof that the health plan satisfies the "metal level" at which the health carrier wishes to market the health plan. (The "metal level" refers to the bronze, silver, gold, and platinum designations that indicate the percent, from lowest (bronze 60 percent) to highest (platinum 90 percent), of the full actuarial value of the benefits covered by the health plan that the health plan will pay.)

**Subd. 2. Minimum levels.** (a) Requires a health carrier that offers a catastrophic or bronze level health plan within a service area in either the individual or small group market to also offer a silver level and a gold level in that market and service area. (b) Exempts a health carrier that has less than five percent in the respective individual or

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small group market in MN from compliance with paragraph (a) until 2017, unless the health carrier offers a qualified health plan through the exchange. If so, the health carrier must comply with paragraph (a).

**Subd. 3. Minnesota Insurance Marketplace restriction.** Prohibits the exchange from mandating the types of health plans to be offered by a health carrier to individuals or small groups purchasing outside of the exchange. Includes hearing, dental, and vision coverage.

**Subd. 4. Metal level defined.** States where in state statutes the metal levels and catastrophic plans are defined.

**Subd. 5. Enforcement.** Directs the commissioner of commerce to enforce this section.

**8** **Information disclosures.** (a) Lists eight types of information a health carrier must submit in a format determined by the commissioner of commerce. (b) Requires that health carriers that offer an individual or small group health plan comply with all information disclosure requirements of state and federal law, including the ACA. (c) Makes information provided under paragraph (a), clauses (3) and (4), nonpublic data, except for qualified health plans sold in the exchange. (d) Requires the commissioner of commerce to enforce this section.

**9** **Marketing standards.**

**Subd. 1. General.** Requires a health carrier offering individual or small group coverage to comply with the ACA, including state marketing laws, and also to establish marketing practices and benefit designs that will not discourage enrollment of individuals who have significant health needs. Prohibits leading consumers to believe that all health care needs will be covered.

**Subd. 2. Enforcement.** Requires the commissioner of commerce to enforce this section.

**10** **Accreditation standards.**

**Subd. 1. Accreditation; general.** Requires any health carrier that offers individual or small group health plans in this state outside of the exchange to be accredited under this subdivision. Requires that the accreditation be obtained by January 1, 2018, and mentions three sources of accreditation. Requires proof of accreditation to be submitted to the commissioner of health. Exempts from the requirement health carriers that rent a provider network, unless the health carrier is part of a holding company that meets certain requirements.

**Subd. 2. Accreditation; Minnesota insurance marketplace.** Requires the exchange to require all health carriers that offer a qualified health plan through the exchange to obtain certification no later than the third year after the first year the carrier offers a qualified health plan through the exchange. Requires a carrier to take the first step of the accreditation process in the first year in which it offers a QHP (in

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the exchange). Requires a carrier that offers a QHP (in the exchange) on January 1, 2014, to obtain accreditation by the end of the 2016 plan year. If a carrier cannot obtain accreditation because of low volume, permits the exchange to grant an exception until the carrier has enough enrollees.

**Subd. 3. Oversight. A** health carrier must comply with a request from the commissioner of health to confirm accreditation or progress toward it.

**Subd. 4. Enforcement.** Requires the commissioner of health to enforce this section.

**11 Geographic accessibility; provider network adequacy.**

**Subd. 1. Applicability.** Says this section applies to all health carriers that offer an individual or small group plan that designates a network or networks of providers that are under contract to the carrier, or that is a preferred provider organization. Requires submission of rental agreements or contracts to the commissioner of health.

**Subd. 2. Primary care; mental health services; general hospital services.** Requires that all three types of these services must be available to enrollees within 30 miles or thirty minutes to the nearest participating or preferred provider.

**Subd. 3. Other health services.** Requires specialty physician, ancillary, specialized hospital, and all other services not listed in subdivision 2 to be available within 60 miles or 60 minutes to the nearest provider.

**Subd. 4. Network adequacy.** Requires each "designated" provider network to include a sufficient number and types of providers to make sure covered services are available without delay. Requires the commissioner of health, when determining network adequacy, to consider the availability of five types of services listed in the subdivision.

**Subd. 5. Waiver.** Allows a health carrier or preferred provider organization to apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if unable to meet them. Requires the application to supply specific data showing that compliance is not feasible for the applicant and information on steps that have or will be taken to address the inadequacy. Provides a waiver that expires after four years.

**Subd. 6. Referral centers.** Says that subdivisions 2 and 3 do not apply if an enrollee is referred to a referral center. Defines a referral center and lists some factors that may considered in designating one.

**Subd. 7. Essential community providers.** Requires each carrier to comply with section 62Q.19 in regard to access to covered services for low-income, high-risk, special-needs individuals or those living in a medical shortage area.

**Subd. 8. Enforcement.** Requires the commissioner of health to enforce this

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section.

**12** **Balance billing prohibited.** Prohibits a network provider from billing an enrollee for any amount in excess of the amount contracted as full payment between the health carrier and the provider. Permits billing for an approved co-payment, deductible, or coinsurance. Permits a network provider to bill the enrollee for services not covered by the health plan if the enrollee has agreed to that in advance.

**13** **Quality assurance and improvement.** Requires health carriers offering an individual or small group health plan to have a written internal quality assurance and improvement program. Lists six things that must be in that program. Requires the commissioner of health to submit a report to certain legislators by February 15, 2015, with recommendations for quality assurance and improvement standards for all carriers. Exempts a health carrier that rents a provider network from this requirement, unless it is part of a holding company that meets certain requirements. Requires a report that recommends quality assurance and improvement standards for all MN health carriers. Prohibits those standards from requiring duplicative data gathering, analysis, or reporting by health carriers. Provides for waivers from certain requirements if the health carrier has met the standards of certain organizations. Requires the commissioner of health to enforce this section.

**14** **Service area requirements.** Requires carriers to offer individual and small group plans in service areas that are at least as large as a county, unless a smaller area is necessary, nondiscriminatory, and in the best interests of enrollees. Requires that the service area be established without regard to listed factors that exclude high utilizing, high-cost, or medically underserved populations. Requires requests to serve less than a county to be submitted to the commissioner of health and to provide data proving that the service area is not discriminatory, is necessary, and in the best interests of enrollees. Requires the commissioner of health to enforce this section.

**15** **Limited-scope pediatric dental plans.** Requires that limited scope pediatric dental plans be offered on a guaranteed issue basis with premiums based on rating factors used for health plans. Requires that the plans make pediatric dental services available within 60 minutes or 60 miles. Requires carriers that offer these plans to comply with this section and sections 8, 9, and 14 of this chapter.

**16** **Annual open enrollment periods.** Requires health carriers to limit annual enrollment in the individual market to annual open enrollment periods for the marketplace. Does not limit use of special or limited open enrollment periods as defined under the ACA. Requires health carriers to inform applicants and enrollees of open and special enrollment periods.

**17** **Designation.** Adds hospitals and affiliated specialty clinics whose inpatients are mostly under age 21 to a list of essential community providers based upon specified requirements. Makes this section effective the day following final enactment.

**18** **Effective Date.** Makes this act effective for health plans offered, sold, issued, or renewed on or after January 1, 2015, unless otherwise specified.