HOUSE RESEARCH

Bill Summary

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Overview

This bill establishes disclosure requirements for proposed changes to insurance rates; establishes requirements for surprise billing and balance billing; allows health maintenance organizations to be organized as for-profit corporations; 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; 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 proposed rate changes by health plan and geographic rating area within ten days of proposed rates being filed.

2 – 7 Current law requires health maintenance organizations that operate in Minnesota to be organized as nonprofit corporations. Sections 2 to 7 remove the nonprofit requirement and allow health maintenance organizations to be organized as a nonprofit or for-profit corporation in Minnesota or another state.

8 **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.

Section

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

Subd. 1. Unauthorized provider services. Paragraph (a) lists services that constitute unauthorized provider services.

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

Paragraph (c) provides that certain services are 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.

Subd. 2. Prohibition. Requires cost-sharing requirements for unauthorized provider services to be the same as those that apply to services from a participating provider.

10 **Balance billing prohibited.** Adds § 62Q.557. Prohibits a provider in a health plan network from billing an enrollee for any amount in addition to the amount the provider has agreed to accept from the health plan company as the total payment for the health care service, but allows billing for a copayment, deductible, or coinsurance. (This language is currently section 62K.11, paragraph (a), which applies to the individual and small group markets. Section 62K.11 is repealed in section 14).

11 **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. Requires the commissioner of management and budget to reimburse the enrollee's new health plan company for costs attributed to authorized transition of care services. Limits reimbursements to health plan companies to the amount appropriated for this purpose, and requires health plan companies to continue to authorize transition of care services even if appropriations are not sufficient to reimburse for the cost of the service.

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

Section

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 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.

12 **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 in section 13 to implement the act within the limits of existing appropriations.

13 **Appropriation; coverage for transition of care.** Appropriates $15,000,000 from the general fund to the commissioner of management and budget to reimburse health plan companies for costs attributed to coverage for transition of care services. Allows the commissioner to use up to three percent of the appropriation for administrative expenses. Specifies that this is a one-time appropriation and is available until expended.

14 **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
- **Section 62K.11** (prohibits a provider from balance billing an enrollee for amounts in excess of the amount agreed upon between the health carrier and provider for the service, and allows a provider to bill an enrollee for services not covered in the enrollee's health plan if the enrollee consents in writing beforehand to pay for the noncovered services).