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Authors: Hoppe and others

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Analyst: Randall Chun
Elisabeth Klarqvist
Larie Pampuch

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Article 1: Premium Assistance

Overview

This article establishes a premium assistance program for the 2017 calendar year to be administered by the commissioner of Minnesota Management and Budget. Eligible individuals are Minnesota residents who purchase health coverage in the individual market (through MNsure or outside of MNsure), meet program income requirements (incomes greater than 300 percent but not exceeding 800 percent of the federal poverty guidelines), are not receiving a premium tax credit, and are approved by the commissioner to receive premium assistance. For the period January 1, 2017, through December 31, 2017, premium assistance equals 25 percent of the premium for coverage purchased in the individual market. This article also requires the legislative auditor to audit implementation of the premium assistance program, and requires the commissioner of revenue to recapture premium assistance paid to ineligible individuals.

<u>**Section**</u>

1 **Premium assistance program established.** Directs the commissioner of Minnesota Management and Budget, in consultation with the commissioners of commerce and revenue, to establish and administer a premium assistance program for individuals who purchase qualified health coverage in 2017.

Provides an immediate effective date.

2 **Definitions.** Defines the following terms: commissioner, eligible individual, health plan, health plan company, individual market, Internal Revenue Code, modified adjusted gross income, premium assistance, program, qualified health coverage, and qualified premium.

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"Eligible individual" means a Minnesota resident who has purchased qualified health coverage for calendar year 2017, meets program income requirements, is not receiving a premium tax credit, and is approved by the commissioner for premium assistance.

"Qualified health coverage" means individual health coverage provided by a health plan company that is purchased through or outside of MNsure, is a qualified plan or meets the standards of a qualified plan, and is not a grandfathered plan under the Affordable Care Act.

"Qualified premium" means the premium paid for qualified health coverage by an eligible individual.

Provides an immediate effective date.

3 Premium assistance amount.

Subd. 1. Applications by individuals; notification of eligibility. (a) Allows eligible individuals to apply to the commissioner to receive premium assistance, at any time after the purchase of qualified health coverage, but no later than January 31, 2018. Requires the commissioner to prescribe the manner and form for applications, to include a Tennessen warning, and to make applications available on the agency Web site.

(b) Requires the commissioner to notify applicants of their eligibility status and any premium assistance amount.

Subd. 2. Health plan companies. (a) Through June 30, 2018, requires health plan companies, by the first of each month and at other times as required by the commissioner, to provide the commissioner with an effectuated coverage list with specified information for each individual for whom it provides qualified health coverage.

(b) Requires health plan companies to notify the commissioner of coverage terminations of eligible individuals within ten business days.

(c) Requires health plan companies to make application forms available on their Web sites and to include applications with premium notices for individual coverage.

Subd. 3. Income eligibility rules. (a) States that individuals who meet the requirements of this subdivision satisfy the income eligibility requirements of the program. Provides a definition of "poverty line."

(b) Provides that persons with incomes greater than 300 percent but not exceeding 800 percent of the poverty line are eligible for premium assistance.

Subd. 4. Determination of assistance amounts. (a) For the period January 1, 2017, through December 31, 2017, provides eligible individuals with premium assistance equal to 25 percent of the qualified premium for effectuated coverage.

(b) Requires the commissioner to determine premium assistance amounts so that the sum of premium assistance does not exceed the appropriation. Allows the commissioner to adjust premium assistance amounts to remain within the limits of the appropriation.

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Subd. 5. Provision of premium assistance to eligible individuals. (a) Requires the commissioner to provide premium assistance on a monthly basis to eligible individuals and to allow eligible individuals the option of direct deposit.

(b) States that if the commissioner, for administrative reasons, is not able to provide premium assistance owed to an eligible individual for one or more months, the commissioner must include the premium assistance owed with the premium assistance payment for the first month for which the commissioner is able to provide premium assistance in a timely manner.

(c) Provides that the commissioner may require eligible individuals to document and substantiate the payment of qualified premiums.

Subd. 6. Contracting. Allows the commissioner to contract with a third-party administrator to determine eligibility for and administer premium assistance.

Subd. 7. Verification. Requires the commissioner to verify that applicants for premium assistance are Minnesota residents. Allows the commissioner to access information from the Department of Employment and Economic Development and the Minnesota Department of Revenue.

Subd. 8. Data Practices. (a) Classifies information provided to the commissioner under subdivisions 1 and 2 as private data on individuals.

(b) Requires the commissioner to destroy data provided under subdivision 2 on June 30, 2018.

Provides an immediate effective date.

4 **Audit and program integrity.**

Subd. 1. Audit. Requires the legislative auditor to audit implementation of the premium assistance program by the commissioner to determine whether premium assistance payments align with the criteria in sections 2 and 3. Requires the legislative auditor to report a summary of findings to the legislative committees with jurisdiction over insurance and health by June 1, 2018.

Subd. 2. Program integrity. Requires the commissioner of revenue to ensure that only eligible individuals have received premium assistance. Requires the commissioner to review agency and tax record information to identify ineligible individuals who have received assistance and to recover the amount of any premium assistance paid to an ineligible individual.

Provides an immediate effective date.

5 **Transfer.** Transfers $300,157,000 in fiscal year 2017 from the budget reserve account to the general fund. Provides and immediate effective date.

6 **Appropriation.** Paragraph (a) appropriates $285,000,000 in fiscal year 2017 from the general fund to the commissioner of Minnesota Management and Budget to provide premium assistance. Limits administrative costs to three percent of the appropriation. States that the appropriation is onetime and available until June 30, 2018. Provides that any funds remaining from this appropriation cancel to the budget reserve account.

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Paragraph (b) provides that if the commissioner of Minnesota Management and Budget determines that the appropriation for administrative costs under paragraph (a) is inadequate, the commissioner may increase administrative spending by up to $20,000,000 using available amounts of the appropriation for agency operations for fiscal years 2017, 2018, or 2019. Requires the commissioner, before taking this action, to provide information justifying the higher expenditure to the chairs and ranking minority members of the legislative finance committees.

Paragraph (c) provides that if the commissioner of revenue determines that the Department of Revenue has administrative costs not funded in the act, the commissioner may use up to $7,802,000 for those costs by using available amounts of the appropriation for agency operations for fiscal years 2017, 2018, or 2019. Requires the commissioner, before taking this action, to provide information justifying the higher expenditure to the chairs and ranking minority members of the legislative finance committees.

Paragraph (d) appropriates $157,000 in fiscal year 2017 from the general fund to the legislative auditor to conduct the required audit. States that the appropriation is onetime and available until June 30, 2018. Provides that any funds remaining from this appropriation cancel to the budget reserve account.

Article 2: Insurance Market Reform

This article establishes disclosure requirements for proposed changes to insurance rates, modifies health insurance provisions governing stop loss coverage, establishes requirements for surprise billing and balance billing, allows health maintenance organizations to be organized as for-profit corporations, authorizes the establishment of self-insured agricultural cooperative health plans, establishes an appeals process related to network adequacy waivers, allows health carriers to sell individual health plans to employees of a small employer in compliance with federal law, authorizes health carriers to offer health plans that do not include mandated health benefits, establishes transition of care coverage for individual market enrollees who experience an involuntary termination of coverage, requires reports from the commissioner of commerce, and appropriates money to reimburse health plan companies for costs related to transition of care coverage.

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 completed data for proposed rate changes by health plan and geographic rating area, within ten days after the deadline for proposed rates to be filed with the commissioner.

2 **Health plan policies issued as stop loss coverage.** Amends § 60A.235, subd. 3. Modifies the circumstances under which an insurance policy issued as stop loss coverage must be issued as a health plan. An insurance policy issued as stop loss coverage must be issued as a health plan if the policy (1) has an attachment point for claims incurred per individual that is lower than $10,000 (under current law, the attachment point is $20,000); or (2) has an aggregate attachment point for all groups that is lower than 110 percent of expected claims (under current law, this aggregate attachment point applies only to groups of 51 or more, and

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there is a separate aggregate attachment point for groups of 50 or fewer). Strikes language allowing the commissioner to adjust the dollar amounts of these attachment points.

3 **Stop loss regulation; small employer coverage.** Amends § 60A.236. Modifies requirements for the claims settlement period that must be included in a contract for stop loss coverage. The claims settlement period must be no less favorable than (1) claims incurred during the contract period; and (2) paid by the plan during the contract period or within one month after the contract expires.

4 - 9 **Sections 4 to 9.** Current law requires health maintenance organizations that operate in Minnesota to be organized as nonprofit corporations. Sections 4 to 9 remove the nonprofit requirement and allow health maintenance organizations to be organized as a nonprofit or for-profit corporation in Minnesota or another state.

10 **Agricultural cooperative health plan.** Adds § 62H.18.

Subd. 1. Definitions. Defines terms: agricultural cooperative, broker, Employee Retirement Income Security Act (ERISA), enrollee, insurance agent, joint self-insurance plan or plan, service plan administrator, and trust.

Subd. 2. Exemption. Provides that a joint self-insurance plan is exempt from §§ 62H.01 to 62H.17 if it is administered by a trust that meets certain criteria relating to agricultural production, cooperative membership, and cooperative member voting.

Subd. 3. Plan requirements. Requires a joint self-insurance plan to offer health coverage to members, employees of members, employees of the agricultural cooperative, and dependents; have stop-loss coverage; establish a reserve fund to be held in trust; be governed by a board with certain requirements; use a service plan administrator; and meet ERISA requirements.

Subd. 4. Submission of documents to commissioner of commerce. Requires a joint self-insurance plan to submit certain documents to the commissioner of commerce.

Subd. 5. Participation; termination of participation. Requires a member to participate in a joint self-insurance plan for at least three years, with a financial penalty assessed for early departure.

Subd. 6. Single risk pool. Provides that enrollees of a joint self-insurance plan are part of a single risk pool.

Subd. 7. Promotion, marketing, sale of coverage. Allows a joint self-insurance plan to be promoted, marketed and sold to members, employees of members, employees of the agricultural cooperative, and dependents. Allows a cooperative organized under chapters 308A or 308B to promote or market a joint self-insurance plan to persons who may be eligible to participate.

Subd. 8. Taxation. Exempts joint self-insurance plans from the taxation imposed under section 297I.05, subdivision 12.

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Subd. 9. Compliance with other laws. Exempts a joint self-insurance plan from the mandated health benefits in chapters 62A and 62Q and continuation requirements if the plan otherwise complies with ERISA. Requires the plan to comply with applicable requirements of the Affordable Care Act.

11 **Appeal of waiver of network adequacy requirements.** Adds subd. 5a § 62K.10. If a health carrier receives a waiver of network adequacy requirements from the commissioner of health, allows a health care provider aggrieved by the waiver to appeal the decision to an administrative law judge (ALJ) using the contested case procedures. Establishes timeframes within which a contested case proceeding must be initiated, and requires each party to the case to pay equal amounts of costs. Allows the ALJ to uphold or nullify the waiver. Makes the ALJ's decision the final decision and allows a party to seek judicial review of the decision. If no judicial review is sought, requires a health carrier to comply with network adequacy requirements within a certain timeframe.

12 **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.

13 **Federal act and state mandates; compliance not required.** Adds § 62Q.022. Paragraph (a) provides that notwithstanding any state or federal law to the contrary, a health plan company may offer health plans that do not include federally required health benefit mandates.

Paragraph (b) provides that notwithstanding any state or federal law to the contrary, a health plan company may offer health plans that do not include some or all of the health benefit mandates in chapters 62A and 62Q, if the health plan company also offers a health plan in the same service area that includes all of the mandated health benefits.

14 **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.

15 **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. Also permits a participating provider to bill an enrollee for services not covered by the enrollee's health plan, if the enrollee consents in writing beforehand. (This language is currently section 62K.11, which applies to the individual and small group markets. Section 62K.11 is repealed in section 20 of this article).

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16 **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.

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.

17 **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 19 of this article or in article 1, section 6, to implement the act within the limits of existing appropriations.

18 **Insurance market options.** Requires the commissioner of commerce to report to the legislative committees with jurisdiction over insurance and health by February 15, 2017, on:

- a plan for implementing a residency verification process for enrollees with individual health plans; and
- past and current implementation of statutes governing flexible benefits plans, and recommendations for increasing the number of flexible benefits plans offered in the state.

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19	**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. (This is a portion of the amount transferred from the budget reserve account to the general fund, according to article 1, section 5.) Allows the commissioner to use up to three percent of the appropriation for administrative expenses. Specifies that this is a onetime appropriation and is available until June 30, 2018. Makes any remaining funds on June 30, 2018, cancel to the budget reserve account.
20	**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 non-covered services. This language is in section 15 of this article.