SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 1

(SENATE AUTHORS: BENSON, and Dahms)

DATE	D-PG	OFFICIAL STATUS
01/05/2017	37	Introduction and first reading
		Referred to Commerce and Consumer Protection Finance and Policy
01/11/2017		Comm report: To pass as amended and re-refer to Finance
		Comm report: To pass as amended
		Second reading

A bill for an act

relating to health care coverage; providing a temporary program to help pay for health insurance premiums; modifying requirements for health maintenance organizations; modifying provisions governing health insurance; requiring reports; establishing a state reinsurance program through the Minnesota Comprehensive Health Association; authorizing agricultural cooperative health plans; appropriating money; amending Minnesota Statutes 2016, sections 60A.08, subdivision 15; 60A.235, subdivision 3; 60A.236; 62D.02, subdivision 4; 62D.03, subdivision 1; 62D.05, subdivision 1; 62D.06, subdivision 1; 62D.19; 62E.02, subdivision 3; 62L.12, subdivision 2; proposing coding for new law in Minnesota Statutes, chapters 62E; 62H; repealing Minnesota Statutes 2016, section 62D.12, subdivision 9; Laws 2007, chapter 147, article 12, section 14, as amended.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

PREMIUM ASSISTANCE

Section 1. **PREMIUM ASSISTANCE PROGRAM ESTABLISHED.**

The commissioner of management and budget, in consultation with the commissioner of commerce and the commissioner of revenue, shall establish and administer a premium assistance program to help eligible individuals pay expenses for qualified health coverage in 2017.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. **DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 1 to 5, the following terms have the meanings given, unless the context clearly indicates otherwise.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of management and budget.

Subd. 3. **Eligible individual.** "Eligible individual" means an individual who:

(1) is a resident of Minnesota;

(2) purchased qualified health coverage for calendar year 2017;

(3) meets the income eligibility requirements under section 3, subdivision 3;

(4) is not receiving a premium assistance credit under section 36B of the Internal Revenue Code for calendar year 2017; and

(5) is approved by the commissioner as qualifying for premium assistance.

Subd. 4. **Health plan.** "Health plan" has the meaning provided in Minnesota Statutes, section 62A.011, subdivision 3.

Subd. 5. **Health plan company.** "Health plan company" means a health carrier, as defined in Minnesota Statutes, section 62A.011, subdivision 2, that provides qualified health coverage in the individual market through MNsure or outside of MNsure to Minnesota residents in 2017.

Subd. 6. **Individual market.** "Individual market" means the individual market as defined in Minnesota Statutes, section 62A.011, subdivision 5.

Subd. 7. **Internal Revenue Code.** "Internal Revenue Code" means the Internal Revenue Code as amended through December 31, 2016.

Subd. 8. **Modified adjusted gross income.** "Modified adjusted gross income" means the modified adjusted gross income for taxable year 2016, as defined in section 36B(d)(2)(B) of the Internal Revenue Code.

Subd. 9. **Premium assistance.** "Premium assistance," "assistance amount," or "assistance" means the amount allowed to an eligible individual as determined by the commissioner under section 3 as a percentage of the qualified premium.

Subd. 10. **Program.** "Program" means the premium assistance program established under section 1.

Subd. 11. **Qualified health coverage.** "Qualified health coverage" means an individual health plan, as defined under section 62A.011, subdivision 4, that is not a grandfathered plan, as defined under section 62A.011, subdivision 1b, provided by a health plan company through MNsure or outside of MNsure.

Subd. 12. **Qualified premium.** "Qualified premium" means the premium for qualified health coverage purchased by an eligible individual.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. **PREMIUM ASSISTANCE AMOUNT.**

Subdivision 1. **Applications by individuals; notification of eligibility.** (a) An eligible individual may apply to the commissioner to receive premium assistance under this section at any time after purchase of qualified health coverage, but no later than January 31, 2018. The commissioner shall prescribe the manner and form for applications, including requiring any information the commissioner considers necessary or useful in determining whether an applicant is eligible and the assistance amount allowed to the individual under this section. The commissioner shall make application forms available on the agency's Web site.

(b) The commissioner shall notify applicants of their eligibility status under the program, including, for applicants determined to be eligible, their premium assistance amount.

Subd. 2. **Health plan companies.** (a) The commissioner shall require a health plan company to provide to the commissioner the following information on an individual who has applied for premium assistance:

(1) whether the individual is covered by the health plan;

(2) the qualified premium for the coverage;

(3) whether the coverage is individual or family coverage; and

(4) whether the individual is receiving advance payment of the credit under section 36B of the Internal Revenue Code, as reported to the health plan company by MNsure.

(b) A health plan company must notify the commissioner of coverage terminations of eligible individuals within ten business days of termination of off-exchange qualified health coverage or within ten business days of MNsure reporting the coverage termination to the health plan company for qualified health coverage purchased through MNsure.

(c) Each health plan company shall make the application forms developed by the commissioner under subdivision 1 available on the company's Web site, and shall include application forms with premium notices for individual health coverage.

(d) This subdivision expires on July 1, 2018.

Subd. 3. **Income eligibility rules.** (a) Individuals with incomes that meet the requirements of this subdivision satisfy the income eligibility requirements for the program. For purposes

of this subdivision, "poverty line" has the meaning used in section 36B of the Internal Revenue Code, except that modified adjusted gross income, as reported on the individual's federal income tax return for tax year 2016, must be used instead of household income. For married separate filers claiming eligibility for family coverage, modified adjusted gross income equals the sum of that income reported by both spouses on their returns.

(b) The following income categories apply.

Modified Adjusted Gross Income:	Income Category:
(1) not exceeding 300 percent of poverty line;	not eligible
(2) greater than 300 percent but not exceeding 400 percent of the poverty line;	category 1
(3) greater than 400 percent but not exceeding 600 percent of the poverty line;	category 2
(4) greater than 600 percent but not exceeding 800 percent of the poverty line; and	category 3
(5) greater than 800 percent of the poverty line.	not eligible

Subd. 4. **Determination of assistance amounts.** (a) The commissioner shall determine premium assistance amounts as provided under this subdivision so that the estimated sum of all premium assistance for eligible individuals does not exceed the appropriation for this purpose.

(b) The commissioner shall determine premium assistance amounts as follows:

(1) for the period January 1, 2017, through March 31, 2017, eligible individuals in income categories 1, 2, and 3 qualify for premium assistance equal to 25 percent of the qualified premium for effectuated coverage;

(2) for the period April 1, 2017, through December 31, 2017, eligible individuals in income category 1 qualify for premium assistance equal to 30 percent of the qualified premium for effectuated coverage;

(3) for the period April 1, 2017, through December 31, 2017, eligible individuals in income category 2 qualify for premium assistance equal to 25 percent of the qualified premium for effectuated coverage; and

(4) for the period April 1, 2017, through December 31, 2017, eligible individuals in income category 3 qualify for premium assistance at a level to be determined by the commissioner based on the availability of funding, but not to exceed 20 percent of the qualified premium for effectuated coverage.

Subd. 5. **Provision of premium assistance to eligible individuals.** (a) The commissioner shall provide the premium assistance amount calculated under subdivision 4 on a monthly basis to each eligible individual. The commissioner shall provide each eligible individual with the option of receiving premium assistance through direct deposit to a financial institution.

(b) If the commissioner, for administrative reasons, is unable to provide an eligible individual with the premium assistance owed for one or more months for which the eligible individual had effectuated coverage, the commissioner shall include the premium assistance owed for that period with the premium assistance payment for the first month for which the commissioner is able to provide premium assistance in a timely manner.

(c) The commissioner may require an eligible individual to provide any documentation and substantiation of payment of the qualified premium that the commissioner considers appropriate.

Subd. 6. **Contracting.** The commissioner may contract with a third-party administrator to determine eligibility for and administer premium assistance under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. **AUDIT AND PROGRAM INTEGRITY.**

Subdivision 1. **Audit.** The legislative auditor shall audit implementation of the premium assistance program by the commissioner to determine whether premium assistance payments align with the criteria established in sections 2 and 3. The legislative auditor shall present a report summarizing findings of the audit to the legislative committees with jurisdiction over insurance and health by June 1, 2018.

Subd. 2. **Program integrity.** The commissioner of revenue has access to and shall review data from the Department of Management and Budget, the Department of Human Services, MNsure, and the taxable year 2016 tax returns to identify ineligible individuals who received health care premium assistance or individuals who received premium assistance in excess of the amount to which they are entitled. The commissioner of revenue shall recover the amount of any premium assistance paid on behalf of an ineligible individual or the amount in excess of the amount to which an individual is entitled, in the manner provided by law for the collection of unpaid taxes or erroneously paid refunds of taxes.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. **DATA PRACTICES.**

Information submitted by a health plan company under section 3, subdivision 2, and data on an individual who applies for or receives health care premium assistance are private data on individuals as defined in Minnesota Statutes, section 13.02, subdivision 12. The data may be shared with the commissioner of revenue for program integrity purposes under section 4, subdivision 2.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. **TRANSFER.**

$300,157,000 in fiscal year 2017 is transferred from the budget reserve account in Minnesota Statutes, section 16A.152, subdivision 1a, to the general fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. **APPROPRIATIONS.**

(a) $285,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget for premium assistance under section 3. No more than 6.7 percent of this appropriation is available to the commissioner for administrative costs. This is a onetime appropriation and is available until June 30, 2018. Any unexpended amount from this appropriation shall be transferred from the general fund to the budget reserve account in Minnesota Statutes, section 16A.152, subdivision 1a.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor to conduct the audit required by section 4. This is a onetime appropriation and is available until June 30, 2019.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 2

INSURANCE MARKET REFORMS

Section 1. Minnesota Statutes 2016, section 60A.08, subdivision 15, is amended to read:

Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related information filed with the commissioner under section 61A.02 shall be nonpublic data until the filing becomes effective.

(b) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic data until the filing becomes effective.

(c) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

(d) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic data until the filing becomes effective.

(e) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic data until the filing becomes effective.

(f) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under section 2794 of the Public Health Services Act and any amendments to, or regulations, or guidance issued under the act that are filed with the commissioner on or after September 1, 2011, the commissioner:

(1) may acknowledge receipt of the information;

(2) may acknowledge that the corresponding rate filing is pending review;

(3) must provide public access from the Department of Commerce's Web site to parts I and II of the Preliminary Justifications of the rate increases subject to review; and

(4) must provide notice to the public on the Department of Commerce's Web site of the review of the proposed rate, which must include a statement that the public has 30 calendar days to submit written comments to the commissioner on the rate filing subject to review.

(g) Notwithstanding paragraphs (b) and (c), for all filed proposed premium rates for individual health plans, as defined in section 62A.011, subdivision 4, and small employer plans, as defined in section 62L.02, subdivision 28, the commissioner must provide public access to compiled data of the proposed change to rates, separated by health plan and geographic rating area, on the Department of Commerce's Web site within ten business days after the filing deadline for the plans described under this paragraph.

EFFECTIVE DATE. This section is effective 30 days following final enactment.

Sec. 2. Minnesota Statutes 2016, section 60A.235, subdivision 3, is amended to read:

Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance company or health carrier issuing or renewing an insurance policy or other evidence of coverage, that provides coverage to an employer for health care expenses incurred under an employer-sponsored plan provided to the employer's employees, retired employees, or their dependents, shall issue the policy or evidence of coverage as a health plan if the policy or evidence of coverage:

(1) has a specific attachment point for claims incurred per individual that is lower than ~~$20,000~~ $10,000; or

~~(2) has an aggregate attachment point, for groups of 50 or fewer, that is lower than the greater of:~~

~~(i) $4,000 times the number of group members;~~

~~(ii) 120 percent of expected claims; or~~

~~(iii) $20,000; or~~

~~(3)~~ (2) has an aggregate attachment point ~~for groups of 51 or more~~ that is lower than 110 percent of expected claims.

(b) An insurer shall determine the number of persons in a group, for the purposes of this section, on a consistent basis, at least annually. Where the insurance policy or evidence of coverage applies to a contract period of more than one year, the dollar amounts set forth in paragraph (a), ~~clauses~~ clause (1) ~~and (2)~~, must be multiplied by the length of the contract period expressed in years.

~~(c) The commissioner may adjust the constant dollar amounts provided in paragraph (a), clauses (1), (2), and (3), on January 1 of any year, based upon changes in the medical component of the Consumer Price Index (CPI). Adjustments must be in increments of $100 and must not be made unless at least that amount of adjustment is required. The commissioner shall publish any change in these dollar amounts at least six months before their effective date.~~

~~(d)~~ (c) A policy or evidence of coverage issued by an insurance company or health carrier that provides direct coverage of health care expenses of an individual including a policy or evidence of coverage administered on a group basis is a health plan regardless of whether the policy or evidence of coverage is denominated as stop loss coverage.

EFFECTIVE DATE. This section is effective 30 days following final enactment, and applies to policies or evidence of coverage offered, issued, or renewed to an employer on or after that date.

Sec. 3. Minnesota Statutes 2016, section 60A.236, is amended to read:

60A.236 STOP LOSS REGULATION; SMALL EMPLOYER COVERAGE.

A contract providing stop loss coverage, issued or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must

include a claim settlement period no less favorable to the small employer or plan than ~~coverage of all~~ the following:

(1) claims incurred during the contract period ~~regardless of when the claims are~~; and

(2) paid by the plan during the contract period or within one month after expiration of the contract period.

EFFECTIVE DATE. This section is effective 30 days following final enactment, and applies to policies or evidence of coverage offered, issued, or renewed to an employer on or after that date.

Sec. 4. Minnesota Statutes 2016, section 62D.02, subdivision 4, is amended to read:

Subd. 4. **Health maintenance organization.** ~~(a)~~ "Health maintenance organization" means a ~~nonprofit~~ foreign or domestic corporation ~~organized under chapter 317A~~, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

~~(b) [Expired]~~

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2016, section 62D.03, subdivision 1, is amended to read:

Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state to the contrary, any ~~nonprofit~~ foreign or domestic corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.30. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.30.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. Minnesota Statutes 2016, section 62D.05, subdivision 1, is amended to read:

Subdivision 1. **Authority granted.** Any ~~nonprofit~~ corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30, operate as a health maintenance organization.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. Minnesota Statutes 2016, section 62D.06, subdivision 1, is amended to read:

Subdivision 1. **Governing body composition; enrollee advisory body.** The governing body of any health maintenance organization which is a ~~nonprofit~~ corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a ~~nonprofit~~ corporation has been authorized under sections 62D.01 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of enrollees and members elected by the enrollees and members from among the enrollees and members. For purposes of this section, "member" means a consumer who receives health care services through a self-insured contract that is administered by the health maintenance organization or its related third-party administrator. The number of members elected to the governing body shall not exceed the number of enrollees elected to the governing body. An enrollee or member elected to the governing board may not be a person:

(1) whose occupation involves, or before retirement involved, the administration of health activities or the provision of health services;

(2) who is or was employed by a health care facility as a licensed health professional; or

(3) who has or had a direct substantial financial or managerial interest in the rendering of a health service, other than the payment of a reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 8. Minnesota Statutes 2016, section 62D.19, is amended to read:

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30~~; in order to safeguard the underlying nonprofit status of health maintenance organizations;~~ and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 9. Minnesota Statutes 2016, section 62E.02, subdivision 3, is amended to read:

Subd. 3. **Health maintenance organization.** "Health maintenance organization" means a ~~nonprofit~~ corporation licensed and operated as provided in chapter 62D.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 10. Minnesota Statutes 2016, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) A health carrier may renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may renew conversion policies to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) A health carrier may sell, issue, or renew an individual health plan if coverage provided by the employer is determined to be unaffordable under the provisions of the Affordable Care Act as defined in section 62A.011, subdivision 1a.

(h) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

(i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

(j) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

(k) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

(l) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely

collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

(m) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the small employer, eligible employee, and individual health plan are in compliance with the 21st Century Cures Act, Public Law 114-255.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. **TRANSITION OF CARE COVERAGE FOR CALENDAR YEAR 2017; INVOLUNTARY TERMINATION OF COVERAGE.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Enrollee" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 2b.

(c) "Health plan" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 3.

(d) "Health plan company" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 4.

(e) "Individual market" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 5.

(f) "Involuntary termination of coverage" means the termination of a health plan due to a health plan company's refusal to renew the health plan in the individual market because the health plan company elects to cease offering individual market health plans in all or some geographic rating areas of the state.

Subd. 2. **Application.** This section applies to an enrollee who is subject to a change in health plans in the individual market due to an involuntary termination of coverage from a

health plan in the individual market after October 31, 2016, and before January 1, 2017, and who enrolls in a new health plan in the individual market for all or a portion of calendar year 2017 that goes into effect after December 31, 2016, and before March 2, 2017.

Subd. 3. **Change in health plans; transition of care coverage.** (a) If an enrollee satisfies the criteria in subdivision 2, the enrollee's new health plan company must provide, upon request of the enrollee or the enrollee's health care provider, authorization to receive services that are otherwise covered under the terms of the enrollee's calendar year 2017 health plan from a provider who provided care on an in-network basis to the enrollee during calendar year 2016 but who is out of network in the enrollee's calendar year 2017 health plan:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

(b) For all requests for authorization under this subdivision, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria in paragraph (a) or subdivision 2.

(c) The commissioner of management and budget must reimburse the enrollee's new health plan company for costs attributed to services authorized under this subdivision. Costs eligible for reimbursement under this paragraph are the difference between the health plan company's reimbursement rate for in-network providers for a service authorized under this subdivision and its rate for out-of-network providers for the service. The health plan company must seek reimbursement from the commissioner for costs attributed to services authorized under this subdivision, in a form and manner mutually agreed upon by the commissioner and the affected health plan companies. Total state reimbursements to health plan companies under this paragraph are subject to the limits of the available appropriation. In the event that funding for reimbursements to health plan companies is not sufficient to fully reimburse

health plan companies for the costs attributed to services authorized under this subdivision, health plan companies must continue to cover services authorized under this subdivision.

Subd. 4. **Limitations.** (a) Subdivision 3 applies only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of:

(i) the health plan company's reimbursement rate for in-network providers for the same or similar service; or

(ii) the provider's regular fee for that service;

(2) request authorization for services in the form and manner specified by the enrollee's new health plan company; and

(3) provide the enrollee's new health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 5. **Request for authorization.** The enrollee's health plan company may require medical records and other supporting documentation to be submitted with a request for authorization made under subdivision 3 to the extent that the records and other documentation are relevant to a determination regarding the existence of a condition under subdivision 3, paragraph (a). If authorization is denied, the health plan company must explain the criteria used to make its decision on the request for authorization and must explain the enrollee's right to appeal the decision. If an enrollee chooses to appeal a denial, the enrollee must appeal the denial within five business days of the date on which the enrollee receives the denial. If authorization is granted, the health plan company must provide the enrollee, within five business days of granting the authorization, with an explanation of how transition of care will be provided.

EFFECTIVE DATE. This section is effective for health plans issued after December 31, 2016, and before March 2, 2017, and that are in effect for all or a portion of calendar year 2017. This section expires June 30, 2018.

Sec. 12. **COSTS RELATED TO IMPLEMENTATION OF THIS ACT.**

A state agency that incurs administrative costs to implement any provision in this act and does not receive an appropriation for administrative costs in this act must implement the act within existing appropriations.

Sec. 13. **INSURANCE MARKET OPTIONS.**

The commissioner of commerce shall report by February 15, 2017, to the standing committees of the legislature having jurisdiction over insurance and health on:

(1) a plan to implement and operate a residency verification process for individual health insurance market participants; and

(2) the past and future use of Minnesota Statutes 2005, section 62L.056, and Minnesota Statutes, section 62Q.188, including:

(i) rate and form filings received, approved, or withdrawn;

(ii) barriers to current utilization, including federal and state laws; and

(iii) recommendations for allowing or increasing the offering of health plans compliant with Minnesota Statutes, section 62Q.188.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. **APPROPRIATION; COVERAGE FOR TRANSITION OF CARE.**

$15,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget to reimburse health plan companies for costs attributed to coverage of transition of care services. No more than 6.7 percent of this appropriation is available to the commissioner for administrative costs. This is a onetime appropriation and is available until June 30, 2021. Any unexpended amount from this appropriation shall be transferred from the general fund to the budget reserve account in Minnesota Statutes, section 16A.152, subdivision 1a.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 15. **REPEALER.**

Minnesota Statutes 2016, section 62D.12, subdivision 9, is repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 3

REINSURANCE

Section 1. **[62E.21] DEFINITIONS.**

Subdivision 1. **Application.** Solely for purposes of sections 62E.21 to 62E.24, the terms and phrases defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the Affordable Care Act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means the threshold dollar amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a plan year, after which threshold the claims costs for such benefits are eligible for Minnesota premium security plan payments.

Subd. 4. **Plan year.** "Plan year" means a calendar year for which an eligible health carrier provides coverage under a health plan in the individual market.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association established under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate, established by the board of the Minnesota Comprehensive Health Association, at which the association will reimburse the eligible health carrier for claims costs incurred for an enrolled individual's covered benefits in a plan year after the attachment point and before the reinsurance cap.

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means:

(1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D

offering health plans in the individual market and incurring claims costs for an individual enrollee's covered benefits in the applicable plan year that exceed the attachment point under the Minnesota premium security plan.

Subd. 9. **Individual market.** "Individual market" has the meaning as defined in section 62A.011, subdivision 5.

Subd. 10. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning as defined in section 62E.02, subdivision 14.

Subd. 11. **Minnesota premium security plan.** The "Minnesota premium security plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 12. **Reinsurance cap.** "Reinsurance cap" means the threshold dollar amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which threshold the claims costs for such benefits are no longer eligible for Minnesota premium security plan payments, established by the board of the Minnesota Comprehensive Health Association.

Sec. 2. **[62E.22] DUTIES OF COMMISSIONER.**

In the implementation and operation of the Minnesota premium security plan, established under section 62E.23, the commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the applicable plan year had the Minnesota premium security plan not been established, and submit this information as part of the rate filing.

Sec. 3. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**

Subdivision 1. **The Minnesota premium security plan as state-based reinsurance.** The association is Minnesota's reinsurance entity to administer the state-based reinsurance program, referred to throughout this chapter as the Minnesota premium security plan. The Minnesota premium security plan shall be designed to protect consumers by mitigating the impact of high-risk individuals on rates in the individual market.

Subd. 2. **Minnesota premium security plan parameters.** (a) The board shall propose to the commissioner the Minnesota premium security plan payment parameters for the next plan year by January 15 of the calendar year prior to the applicable plan year. In developing the proposed payment parameters, the board shall consider the anticipated impact to premiums. The commissioner shall approve the payment parameters no later than 14 calendar days following the board proposal. In developing the proposed payment parameters for plan years 2019 and after, the board may develop methods to account for variations in costs within the Minnesota premium security plan.

(b) For plan year 2018, the Minnesota premium security plan parameters, including the attachment point, reinsurance cap, and coinsurance rate, shall be established within the parameters of the appropriated funds as follows:

(1) the attachment point is set at $70,000;

(2) the reinsurance cap is set at $250,000; and

(3) the coinsurance rate is set at 50 percent.

(c) All eligible health carriers receiving Minnesota premium security plan payments must apply the Minnesota premium security plan's parameters established under paragraph (a) or paragraph (b) of this section, as applicable, when calculating reinsurance payments.

Subd. 3. **Payments under the Minnesota premium security plan.** (a) Each Minnesota premium security plan payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable plan year. If such claim costs do not exceed the attachment point, payment will be zero dollars. If such claim costs exceed the attachment point, payment will be calculated as the product of the coinsurance rate multiplied by the lesser of:

(1) such claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that the payments made to eligible health carriers must not exceed the eligible health carrier's total paid amount for any eligible claim. For purposes of this paragraph, total paid amount of an eligible claim means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data is submitted or made accessible under subdivision 4, paragraph (a), clause (1), of this section.

Subd. 4. **Requests for Minnesota premium security plan payments.** (a) An eligible health carrier may make a request for payment when the eligible health carrier's claims costs for an enrollee meet the criteria for payment under subdivision 2 and meet the requirements of this subdivision.

(1) to be eligible for Minnesota premium security plan payments, an eligible health carrier must provide to the association access to the data within the dedicated data environment established by the eligible health carrier under the federal Risk Adjustment Program. Eligible health carriers must submit an attestation to the board asserting entity compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines; and

(2) an eligible health carrier must provide the required access under clause (1) for the applicable plan year by April 30 of the year following the end of the applicable plan year.

(b) An eligible health carrier must make requests for payment in accordance with the requirements established by the board.

(c) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for Minnesota premium

security plan payments made pursuant to this section for a period of at least ten years, and must make those documents and records available upon request from the state or its designee for purposes of verification, investigation, audit, or other review of Minnesota premium security plan payment requests.

(d) The association or its designee may audit an eligible health carrier to assess its compliance with the requirements of section 62E.23. The eligible health carrier must ensure that its relevant contracts, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement under section 62E.23, the eligible health carrier may provide response to the draft audit report within 30 calendar days. Within 30 calendar days of the issuance of the final audit report, the eligible health carrier must complete the following:

(1) provide a written corrective action plan to the association for approval if the final audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement under section 62E.23;

(2) implement that plan; and

(3) provide to the association written documentation of the corrective actions once taken.

Subd. 5. **Notification of Minnesota premium security plan payments.** (a) For each applicable plan year, the association must notify eligible health carriers annually of Minnesota premium security plan payments, if applicable, to be made for the applicable plan year no later than June 30 of the year following the applicable plan year.

(b) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(c) For each applicable plan year, the board must provide to each eligible health carrier the calculation of total Minnesota premium security plan payment requests on a quarterly basis during the applicable plan year.

Subd. 6. **Disbursement of Minnesota premium security plan payments.** The association must:

(1) collect or access data required to determine Minnesota premium security plan payments from an eligible health carrier according to the data requirements under subdivision 5; and

(2) make Minnesota premium security plan payments to the eligible health carrier after receiving a valid claim for payment from that eligible health carrier by August 15 of the year following the applicable plan year.

Subd. 7. **Reserve surplus.** The association must use any monetary reserves of the association to offset costs of the Minnesota premium security plan.

Subd. 8. **Data.** Government data of the association under this section are private data on individuals or nonpublic data as defined in section 13.02, subdivision 9 or 12.

Subd. 9. **Appropriation.** $150,000,000 in fiscal year 2018 is appropriated from the general fund to the commissioner of commerce for the Minnesota Premium Security Plan under section 62E.23. This is a onetime appropriation and is available until June 30, 2019.

Sec. 4. **[62E.24] ACCOUNTING, REPORTING, AND AUDITING.**

Subdivision 1. **Accounting requirements.** The board must ensure that it keeps an accounting for each plan year of:

(1) all claims for Minnesota premium security plan payments received from eligible health carriers;

(2) all Minnesota premium security plan payments made to eligible health carriers;

(3) all administrative expenses incurred for the Minnesota premium security plan; and

(4) all assessments made for security plan costs.

Subd. 2. **Summary report.** The board must submit to the commissioner and make public a report on the Minnesota premium security plan operations for each plan year by November 1 following the applicable year or 60 calendar days following the last disbursement of Minnesota premium security plan payments for the applicable plan year.

Subd. 3. **Audits.** The commissioner or designee may conduct a financial or programmatic audit of the Minnesota premium security plan to assess its compliance with the requirements. The board must ensure that it and any relevant contractors, subcontractors, or agents cooperate with any audit. The Minnesota premium security plan is subject to audit by the legislative auditor.

Subd. 4. **Independent external audit.** The board must engage an independent qualified auditing entity to perform a financial and programmatic audit for each plan year of the Minnesota premium security plan in accordance with Generally Accepted Auditing Standards (GAAS). The board must:

(1) provide to the commissioner the results of the audit, in the manner and time frame to be specified by the commissioner;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit, and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency; and

(3) make public a summary of the results of the audit, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency.

Subd. 5. **Action on audit findings.** If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement under this act, the commissioner of commerce must ensure the board:

(1) within 60 calendar days of the issuance of the final audit report, provides a written corrective action plan to the commissioner for approval;

(2) implements that plan; and

(3) provides to the commissioner written documentation of the corrective actions once taken.

Sec. 5. **STATE INNOVATION WAIVER.**

Subdivision 1. **Authority to submit a waiver application.** The commissioner of commerce shall apply to the United States Secretary of Health and Human Services under United States Code, title 42, section 18052, for a waiver of applicable provisions of the Affordable Care Act with respect to health insurance coverage in the state for a plan year beginning on or after January 1, 2018, for the sole purpose of implementing the Minnesota premium security plan in a manner that maximizes federal funding for Minnesota. The Minnesota premium security board shall implement a state plan for meeting the waiver requirements in a manner consistent with state and federal law, and as approved by the United States Secretary of Health and Human Services. The commissioner is directed to apply for a waiver to ensure:

(1) eligible Minnesotans receive advance premium tax credits as though the Minnesota premium security plan did not exist; and

(2) federal funding for MinnesotaCare, as Minnesota's basic health program, continues to be based on the market premium and cost-sharing levels before the impact of reinsurance under the premium security plan, established under Minnesota Statutes, section 62E.23.

Subd. 2. **Consultation.** In developing the waiver application, the commissioner shall consult with the Department of Human Services and MNsure.

Subd. 3. **Application deadline.** The commissioner shall submit the application waiver to the appropriate federal agency on or before July 5, 2017. The commissioner shall follow all application instructions. The commissioner shall complete the draft application for public review and comment by June 1, 2017.

Subd. 4. **Appropriation.** $155,000 in fiscal year 2018 is appropriated to the commissioner of commerce to prepare and submit a state innovation waiver.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. **EFFECTIVE DATE.**

This article is effective the day following final enactment.

ARTICLE 4

AGRICULTURAL COOPERATIVE HEALTH PLAN

Section 1. **[62H.18] AGRICULTURAL COOPERATIVE HEALTH PLAN.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Agricultural cooperative" means a cooperative organized under chapter 308A or 308B that meets the requirements of subdivision 2.

(c) "Broker" means an insurance agent engaged in brokerage business according to section 60K.49.

(d) "Employee Retirement Income Security Act" means the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq.

(e) "Enrollee" means a natural person covered by a joint self-insurance plan operating under this section.

(f) "Insurance agent" has the meaning given to insurance agent in section 60A.02, subdivision 7.

(g) "Joint self-insurance plan" or "plan" means a plan or any other arrangement established by two or more entities authorized to transact business in the state, in order to jointly self-insure through a single employee welfare benefit plan funded through a trust, to provide health, dental, or other benefits as permitted under the Employee Retirement Income Security Act.

(h) "Service plan administrator" means a vendor of risk management services licensed under section 60A.23.

(i) "Trust" means a trust established to accept and hold assets of the joint self-insurance plan in trust and use and disperse funds in accordance with the terms of the written trust document and joint self-insurance plan for the sole purposes of providing benefits and defraying reasonable administrative costs.

Subd. 2. **Exemption.** A joint self-insurance plan is exempt from sections 62H.01 to 62H.17 and is instead governed by this section, if it is administered by a trust established by an agricultural cooperative that:

(1) has members who (i) actively work in production agriculture in Minnesota and file either Form 1065 or Schedule F with the member's income tax return; or (ii) provide direct services to production agriculture in Minnesota;

(2) specify criteria for membership in the agricultural cooperative in their articles of organization or bylaws; and

(3) grant at least 51 percent of the aggregate voting power on matters for which all members may vote to members who satisfy clause (1) and any additional criteria in the agricultural cooperative's articles of organization and bylaws.

Subd. 3. **Plan requirements.** A joint self-insurance plan operating under this section must:

(1) offer health coverage to members of the agricultural cooperative that establishes the plan and their dependents, to employees of members of the agricultural cooperative that establishes the plan and their dependents, or to employees of the agricultural cooperative that establishes the plan and their dependents;

(2) include aggregate stop-loss coverage and individual stop-loss coverage provided by an insurance company licensed in Minnesota;

(3) establish a reserve fund, certified by an actuary to be sufficient to cover unpaid claim liability for incurred but not reported liabilities in the event of plan termination. Certification from the actuary must include all maximum funding requirements for plan fixed cost requirements and current claims liability requirements, and must include a calculation of the reserve levels needed to fund all incurred but not reported liabilities in the event of member or plan termination. These reserve funds must be held in a trust;

(4) be governed by a board elected by members of an agricultural cooperative that participates in the plan;

(5) contract for services with a service plan administrator; and

(6) satisfy the requirements of the Employee Retirement Income Security Act that apply to employee welfare benefit plans.

Subd. 4. **Submission of documents to commissioner of commerce.** A joint self-insurance plan operating under this section must submit to the commissioner of commerce copies of all filings and reports that are submitted to the United States Department of Labor according to the Employee Retirement Income Security Act. Members participating in the joint self-insurance plan may designate an agricultural cooperative that establishes the plan as the entity responsible for satisfying the reporting requirements of the Employee Retirement Income Security Act, and for providing copies of these filings and reports to the commissioner of commerce.

Subd. 5. **Participation; termination of participation.** If a member chooses to participate in a joint self-insurance plan under this section, the member must participate in the plan for at least three consecutive years. If a member terminates participation in the plan before the end of the three-year period, a financial penalty may be assessed under the plan, not to exceed the amount contributed by the member to the plan reserves.

Subd. 6. **Single risk pool.** The enrollees of a joint self-insurance plan operating under this section shall be members of a single risk pool.

Subd. 7. **Promotion, marketing, sale of coverage.** Coverage in a joint self-insurance plan operating under this section may be promoted, marketed, and sold by an agricultural cooperative sponsoring the plan, insurance agents, and brokers, to members of agricultural cooperatives sponsoring the plan and their dependents, employees of members of agricultural cooperatives sponsoring the plan and their dependents, and employees of agricultural cooperatives sponsoring the plan and their dependents.

Subd. 8. **Compliance with other laws.** (a) A joint self-insurance plan operating under this section:

(1) is exempt from providing the mandated health benefits in chapters 62A and 62Q, if the plan otherwise provides the benefits required under the Employee Retirement Income Security Act;

(2) is exempt from the continuation requirements in sections 62A.146, 62A.16, 62A.17, 62A.20, and 62A.21, if the plan complies with the continuation requirements under the Employee Retirement Income Security Act; and

(3) must comply with all requirements of the Affordable Care Act, as defined in section 62A.011, subdivision 1a, to the extent that they apply to such plans.

(b) Section 297I.05, subdivision 12, paragraph (c), applies to a joint-self insurance plan operating under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. **REPEALER.**

Laws 2007, chapter 147, article 12, section 14, as amended by Laws 2010, chapter 344, section 4, Laws 2010, chapter 384, section 99, Laws 2013, chapter 135, article 1, section 9, is repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

APPENDIX
Article locations in S0001-2

62D.12 PROHIBITED PRACTICES.

Subd. 9. **Net earnings.** All net earnings of the health maintenance organization shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that health maintenance organizations may make payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.30, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

Laws 2007, chapter 147, article 12, section 14, as amended by Laws 2010, chapter 344, section 4; as amended by Laws 2010, chapter 384, section 99; as amended by Laws 2013, chapter 135, article 1, section 9

Sec. 4. Laws 2007, chapter 147, article 12, section 14, is amended to read:

Sec. 14. **AGRICULTURAL COOPERATIVE HEALTH PLAN FOR FARMERS.**

Subdivision 1. **Pilot project requirements.** Notwithstanding contrary provisions of Minnesota Statutes, chapter 62H, the following apply to a joint self-insurance pilot project administered by a trust sponsored by one or more agricultural cooperatives organized under Minnesota Statutes, chapter 308A or 308B, or under a federal charter for the purpose of offering health coverage to members of the cooperatives and their families, provided the project satisfies the other requirements of Minnesota Statutes, chapter 62H:

(1) Minnesota Statutes, section 62H.02, paragraph (b), does not apply;

(2) the notice period required under Minnesota Statutes, section 62H.02, paragraph (e), is 90 days;

(3) a joint self-insurance plan may elect to treat the sale of a health plan to or for an employer that has only one eligible employee who has not waived coverage as the sale of an individual health plan as allowed under Minnesota Statutes, section 62L.02, subdivision 26;

(4) Minnesota Statutes, section 297I.05, subdivision 12, paragraph (c), applies; and

(5) the trust must pay the assessment for the Minnesota Comprehensive Health Association as provided under Minnesota Statutes, section 62E.11.

Subd. 2. **Evaluation and renewal.** The pilot project authorized under this section is for a period of four years from the date of initial enrollment. The commissioner of commerce shall grant an extension of four additional years if the trust provides evidence that it remains in compliance with the requirements of this section and other applicable laws and rules. If the commissioner determines that the operation of the trust has not improved access, expanded health plan choices, or improved the affordability of health coverage for farm families, or that it has significantly damaged access, choice, or affordability for other consumers not enrolled in the trust, the commissioner shall provide at least 180 days' advance written notice to the trust and to the chairs of the senate and house finance and policy committees with jurisdiction over health and insurance of the commissioner's intention not to renew the pilot project at the expiration of a four-year period.

Subd. 3. **Use of surplus lines.** Plans created under this section may use surplus lines carriers to fulfill its obligations under chapter 62H.