SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 2094

(SENATE AUTHORS: HANN)

DATE	D-PG	OFFICIAL STATUS
02/27/2012	3958	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; modifying eligibility for the healthy Minnesota contribution program; amending Minnesota Statutes 2010, section 256L.07, subdivision 3; Minnesota Statutes 2011 Supplement, sections 62E.14, subdivision 4g; 256L.031, subdivisions 1, 2, 3, 6.

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

Section 1. Minnesota Statutes 2011 Supplement, section 62E.14, subdivision 4g, is amended to read:

Subd. 4g. **Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** A person may enroll in the comprehensive plan with a waiver of the preexisting condition limitation in subdivision 3 if the person is eligible for the healthy Minnesota contribution program, and has been denied coverage as described under section 256L.031, subdivision 6. The six-month durational residency requirement specified in section 62E.02, subdivision 13, does not apply to individuals enrolled in the healthy Minnesota contribution program.

Sec. 2. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 1, is amended to read:

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than ~~200~~ 150 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

Sec. 3. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 2, is amended to read:

Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within ~~three~~ four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) ~~A health plan~~ Coverage purchased under this section must:

(1) ~~provide coverage for~~ include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, the second paragraph.

Sec. 4. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 3, is amended to read:

Subd. 3. **Determination of defined contribution amount.** (a) The commissioner shall determine the defined contribution sliding scale using the base contribution specified in paragraph (b) for the specified age ranges. The commissioner shall use a sliding scale for defined contributions that provides:

(1) persons with household incomes equal to 150 percent of the federal poverty guidelines with a defined contribution equal to 106 percent of the base contribution;

~~(1)~~ (2) persons with household incomes equal to 200 percent of the federal poverty guidelines with a defined contribution of 93 percent of the base contribution;

~~(2)~~ (3) persons with household incomes equal to 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

~~(3)~~ (4) persons with household incomes in evenly spaced increments between the percentages of the federal poverty guideline or income level specified in clauses (1) ~~and (2)~~ to (3) with a base contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) ~~and (2)~~ to (3).

19-29	$125
30-34	$135
35-39	$140
40-44	$175
45-49	$215
50-54	$295
55-59	$345
60+	$360

(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who are denied coverage under an individual health plan by a health plan company and who purchase coverage through the Minnesota Comprehensive Health Association.

Sec. 5. Minnesota Statutes 2011 Supplement, section 256L.031, subdivision 6, is amended to read:

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning July 1, 2012, MinnesotaCare enrollees ~~who are denied coverage in the individual health market by a health plan company in accordance with section 62A.65 are~~ eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association ~~and~~ may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and actual covered losses to MCHA related to the implementation of this section are appropriated annually to the commissioner of human services from the health care access fund and shall be paid to MCHA.

Sec. 6. Minnesota Statutes 2010, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) Families and individuals enrolled in the MinnesotaCare program must have no health coverage while enrolled or for at least four

months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 150 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:

(1) lacks two or more of the following:

(i) basic hospital insurance;

(ii) medical-surgical insurance;

(iii) prescription drug coverage;

(iv) dental coverage; or

(v) vision coverage;

(2) requires a deductible of $100 or more per person per year; or

(3) lacks coverage because the child has exceeded the maximum coverage for a particular diagnosis or the policy excludes a particular diagnosis.

The commissioner may change this eligibility criterion for sliding scale premiums in order to remain within the limits of available appropriations. The requirement of no health coverage does not apply to newborns.

(b) Coverage purchased as provided under section 256L.031, subdivision 2, medical assistance, ~~general assistance medical care,~~ and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.

(c) For purposes of this subdivision, an applicant or enrollee who is entitled to Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered to have health coverage. An applicant or enrollee who is entitled to premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage to establish eligibility for MinnesotaCare.

(d) Applicants who were recipients of medical assistance ~~or general assistance medical care~~ within one month of application must meet the provisions of this subdivision and subdivision 2.

(e) Cost-effective health insurance that was paid for by medical assistance is not considered health coverage for purposes of the four-month requirement under this section, except if the insurance continued after medical assistance no longer considered it cost-effective or after medical assistance closed.