State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3729

02/24/2020 Authored by Gruenhagen
The bill was read for the first time and referred to the Committee on Commerce

A bill for an act

relating to insurance; health; modifying requirements for health insurance underwriting, renewability, and benefits; creating the Minnesota health risk pool program; allowing the creation of unified personal health premium accounts; creating the Minnesota health contribution program; eliminating certain health plan market rules; requesting waivers; amending Minnesota Statutes 2018, sections 3.971, subdivision 6; 13.7191, by adding a subdivision; 60A.235, by adding a subdivision; 62A.65, subdivisions 3, 5, by adding a subdivision; 62L.03, subdivision 3, by adding a subdivision; 62L.08, subdivision 7, by adding a subdivision; 62Q.18, subdivision 10; 62V.05, subdivision 3; 290.0132, by adding a subdivision; 297I.05, subdivisions 1, 5; proposing coding for new law in Minnesota Statutes, chapters 62A; 62K; 62Q; 256L; proposing coding for new law as Minnesota Statutes, chapters 62X; 62Y; repealing Minnesota Statutes 2018, sections 62A.303; 62A.65, subdivision 2; 62K.01; 62K.02; 62K.03; 62K.04; 62K.05; 62K.06; 62K.08; 62K.09; 62K.10, subdivisions 1, 1a, 2, 3, 4, 6, 7, 8; 62K.11; 62K.12; 62K.13; 62K.14; 62K.15; 62L.08, subdivision 4; 62L.12, subdivisions 3, 4; Minnesota Statutes 2019 Supplement, sections 62K.07; 62K.075; 62K.10, subdivision 5.

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

ARTICLE 1

HEALTH INSURANCE REFORM

Section 1. Minnesota Statutes 2018, section 60A.235, is amended by adding a subdivision to read:

Subd. 3b. **Mid-sized group coverage.** Notwithstanding subdivision 3, aggregate attachment points under that subdivision are also subject to the maximums described in this subdivision. A group of persons between:

(1) 50 and 74 has a maximum specific attachment point of $30,000; and

(2) 75 and 100 has a maximum specific attachment point of $40,000.

Sec. 2. **[62A.101] MID-SIZED GROUP HEALTH INSURANCE RATES.**

Subdivision 1. **General premium variations.** Every health carrier must offer premium rates to groups with between 50 and 100 persons that are no more than 25 percent above and no more than 25 percent below the index rate charged to similar sized groups for the same or similar coverage, adjusted pro rata for rating periods that are less than one year. The premium variations permitted by this subdivision must be based only upon health status and claims experience. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted under this subdivision.

Subd. 2. **Limit on renewal premium increases.** The percentage increase in the premium rate charged to a group with between 50 and 100 persons for a new rating period must not exceed 15 percent annually plus inflationary trend, adjusted pro rata for rating periods that are less than one year.

Sec. 3. Minnesota Statutes 2018, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Nonrenewal of risk pools.** A health carrier offering individual health plans may not renew an individual health plan risk pool issued before January 1, 2021.

Sec. 4. Minnesota Statutes 2018, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates may vary based upon the ages of covered persons in accordance with the provisions of the Affordable Care Act.

~~(b) Premium rates may vary based upon geographic rating area. The commissioner shall grant approval if the following conditions are met:~~

~~(1) the areas are established in accordance with the Affordable Care Act;~~

~~(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and~~

~~(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in premium rates for each area, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.~~

~~(c)~~ (b) Premium rates may vary based upon tobacco use, in accordance with the provisions of the Affordable Care Act.

~~(d)~~ (c) In developing its premiums for a health plan, a health carrier shall take into account ~~only the following factors:~~

~~(1)~~ actuarially valid differences in rating factors permitted under paragraphs (a) and ~~(c);~~ ~~and~~ (b).

~~(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (b).~~

~~(e)~~ (d) The premium charged with respect to any particular individual health plan shall not be adjusted more frequently than annually or January 1 of the year following initial enrollment, except that the premium rates may be changed to reflect:

(1) changes to the family composition of the policyholder;

~~(2) changes in geographic rating area of the policyholder, as provided in paragraph (b);~~

~~(3)~~ (2) changes in age, as provided in paragraph (a);

~~(4)~~ (3) changes in tobacco use, as provided in paragraph ~~(c)~~ (b);

~~(5)~~ (4) transfer to a new health plan, reunderwriting, or enhanced coverage as requested by the policyholder; or

~~(6)~~ (5) other changes as provided under paragraphs (j) and (k), or as required by or otherwise expressly permitted by state or federal law or regulations.

~~(f)~~ (e) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

~~(g)~~ (f) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

~~(h)~~ (g) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect and actuarially valid changes in risks associated with the enrollee populations.

~~(i)~~ (h) A health carrier may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in

this paragraph. The rating practices guarantee must be in writing and must guarantee that the policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. A health carrier that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs ~~(b),~~ ~~(f),~~ (e) and ~~(h)~~ (g).

~~(j)~~ (i) The commissioner may establish regulations to implement the provisions of this subdivision.

(j) The state of Minnesota is a single geographic rating area for purposes of determining premium rates.

(k) Premium rates must be no more than 25 percent above and no more than 25 percent below the standard rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods that are less than one year.

Sec. 5. Minnesota Statutes 2018, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, ~~2014~~ 2021, no individual health plan may be offered, sold, issued, or renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, unless the limitation or exclusion is permitted under this subdivision or chapter 62L. An individual ~~age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014~~ who obtains coverage under this section may be subject to a preexisting condition limitation during the first 12 months of coverage if the individual was diagnosed or treated for that condition during the six months immediately preceding the date the application for coverage was received, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. ~~During plan years beginning prior to January 1, 2014,~~ An individual ~~who is age 19 or older and~~ who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, without a break of 63 days or more, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given

for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual ~~who is age 19 or older~~ must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02. ~~The prohibition on preexisting condition limitations for children age 18 or under does not apply to individual health plans that are grandfathered plans. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014, does not apply to individual health plans that are grandfathered plans.~~ An individual who has not maintained continuous coverage may be subject to a new 12-month preexisting condition limitation after each break in continuous coverage.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. ~~If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage.~~ The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. ~~The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan.~~ The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. ~~In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the~~

~~Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section.~~ Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

Sec. 6. **[62A.652] PREEXISTING CONDITIONS DISCLOSED AT TIME OF APPLICATION.**

An insurer is prohibited from canceling or rescinding a health insurance policy for a preexisting condition if the application or other information provided by the insured reasonably gave the insurer notice. An insurer is prohibited from restricting coverage for a preexisting condition if the application or other information provided by the insured reasonably gave the insurer notice. Preexisting condition limitations are offset or reduced by duration of time qualified if prior continuous coverage has been in place for the insured uninterrupted by a break of coverage that is 63 days or more.

Sec. 7. **[62A.68] HOSPITAL AND DOCTOR FIXED INDEMNITY INSURANCE.**

Subdivision 1. **Required.** Every health carrier must offer the following benefit packages as fixed indemnity health plans.

Subd. 2. **Tier one.** (a) For inpatient hospital confinement, a benefit of $1,000 per day, increasing by 25 percent for injury-related hospitalizations for each year an enrollee is enrolled in the health plan for a maximum of five years.

(b) For inpatient hospital intensive care or critical care units, a benefit of $2,000 per day for up to 31 days. This benefit is in addition to the benefit described in paragraph (a).

(c) For inpatient physician visits, a benefit of $100 per day, with a limit of one visit per day.

(d) For emergency services, a benefit of $200 per day, for up to two days.

(e) For ground or water ambulance services, a benefit of $500 per trip, with a one-trip maximum.

(f) For air ambulance services, a benefit of $5,000 per trip, with a one-trip maximum.

(g) For outpatient surgical services facility fees, a benefit of $500 per day, for up to two days.

(h) For surgery services:

(1) a benefit of $10,000 per day for significant, nondiagnostic invasive surgical procedures requiring general anesthesia and an open incision;

(2) a benefit of $5,000 per day for nondiagnostic surgical procedures requiring general anesthesia and an open incision;

(3) a benefit of $1,000 per day for surgical procedures requiring general anesthesia or conscious sedation; and

(4) a benefit of $500 per day for surgical procedures requiring local or regional anesthesia.

(i) For assistant surgeon services, 20 percent of the benefits described in paragraph (h) per day.

(j) For anesthesiologist services, 30 percent of the benefits described in paragraph (h) per day.

(k) For health care provider office visits for injury or illness, a benefit of $100 per visit, with a two-visit maximum.

(l) For a second surgical opinion, a benefit of $250 per day for one day.

(m) For preventative care visits, a benefit of $100 per day for one day.

(n) For outpatient lab and x-ray services, a benefit of $200 per test, with a one-test maximum.

(o) For outpatient diagnostic imaging services, a benefit of $500 per test, with a one-test maximum.

(p) For oral chemotherapy, a benefit of $1,000 per month for up to three months.

(q) For outpatient chemotherapy and radiation that is not oral, a benefit of $1,000 per day for up to 40 days.

Subd. 3. **Tier two.** (a) For inpatient hospital confinement, a benefit of $2,000 per day, increasing by 25 percent for injury-related hospitalizations for each year an enrollee is enrolled in the health plan for a maximum of five years.

(b) For inpatient hospital intensive care or critical care units, a benefit of $4,000 per day for up to 31 days. This benefit is in addition to the benefit described in paragraph (a).

(c) For inpatient physician visits, a benefit of $100 per day, with a limit of one visit per day.

(d) For emergency services, a benefit of $200 per day, for up to two days.

(e) For ground or water ambulance services, a benefit of $500 per trip, with a one-trip maximum.

(f) For air ambulance services, a benefit of $5,000 per trip, with a one-trip maximum.

(g) For outpatient surgical services facility fees, a benefit of $500 per day, for up to two days.

(h) For surgery services:

(1) a benefit of $10,000 per day for significant, nondiagnostic invasive surgical procedures requiring general anesthesia and an open incision;

(2) a benefit of $5,000 per day for nondiagnostic surgical procedures requiring general anesthesia and an open incision;

(3) a benefit of $1,000 per day for surgical procedures requiring general anesthesia or conscious sedation; and

(4) a benefit of $500 per day for surgical procedures requiring local or regional anesthesia.

(i) For assistant surgeon services, 20 percent of the benefits described in paragraph (h) per day.

(j) For anesthesiologist services, 30 percent of the benefits described in paragraph (h) per day.

(k) For health care provider office visits for injury or illness, a benefit of $100 per visit, with a two-visit maximum.

(l) For a second surgical opinion, a benefit of $250 per day for one day.

(m) For preventative care visits, a benefit of $100 per day for one day.

(n) For prescription drugs, a benefit of $20 for generic and $40 for nongeneric, with a 12-refill maximum per calendar year.

(o) For outpatient lab and x-ray services, a benefit of $200 per test, with a one-test maximum.

(p) For outpatient diagnostic imaging services, a benefit of $500 per test, with a one-test maximum.

(q) For oral chemotherapy, a benefit of $1,000 per month for up to three months.

(r) For outpatient chemotherapy and radiation that is not oral, a benefit of $1,000 per day for up to 40 days.

Subd. 4. **Tier three.** (a) For inpatient hospital confinement, a benefit of $3,000 per day, increasing by 25 percent for injury-related hospitalizations for each year an enrollee is enrolled in the health plan for a maximum of five years.

(b) For inpatient hospital intensive care or critical care units, a benefit of $6,000 per day for up to 31 days. This benefit is in addition to the benefit described in paragraph (a).

(c) For inpatient physician visits, a benefit of $100 per day, with a limit of one visit per day.

(d) For emergency services, a benefit of $300 per day, for up to two days.

(e) For ground or water ambulance services, a benefit of $500 per trip, with a one-trip maximum.

(f) For air ambulance services, a benefit of $5,000 per trip, with a one-trip maximum.

(g) For outpatient surgical services facility fees, a benefit of $1,000 per day, for up to two days.

(h) For surgery services:

(1) a benefit of $10,000 per day for significant, nondiagnostic invasive surgical procedures requiring general anesthesia and an open incision;

(2) a benefit of $5,000 per day for nondiagnostic surgical procedures requiring general anesthesia and an open incision;

(3) a benefit of $1,000 per day for surgical procedures requiring general anesthesia or conscious sedation; and

(4) a benefit of $500 per day for surgical procedures requiring local or regional anesthesia.

(i) For assistant surgeon services, 20 percent of the benefits described in paragraph (h) per day.

(j) For anesthesiologist services, 30 percent of the benefits described in paragraph (h) per day.

(k) For health care provider office visits for injury or illness, a benefit of $100 per visit, with a five-visit maximum.

(l) For a second surgical opinion, a benefit of $500 per day for one day.

(m) For preventative care visits, a benefit of $200 per day for one day.

(n) For prescription drugs, no benefits.

(o) For outpatient lab and x-ray services, a benefit of $300 per test, with a one-test maximum.

(p) For outpatient diagnostic imaging services, a benefit of $500 per test, with a one-test maximum.

(q) For oral chemotherapy, a benefit of $1,000 per month for up to three months.

(r) For outpatient chemotherapy and radiation that is not oral, a benefit of $1,000 per day for up to 40 days.

Subd. 5. **Tier four.** (a) For inpatient hospital confinement, a benefit of $4,000 per day, increasing by 25 percent for injury-related hospitalizations for each year an enrollee is enrolled in the health plan for a maximum of five years.

(b) For inpatient hospital intensive care or critical care units, a benefit of $2,000 per day for up to 60 days. This benefit is in addition to the benefit described in paragraph (a).

(c) For inpatient physician visits, a benefit of $100 per day, with a limit of one visit per day.

(d) For emergency services, a benefit of $300 per day, for up to three days.

(e) For ground or water ambulance services, a benefit of $500 per trip, with a one-trip maximum.

(f) For air ambulance services, a benefit of $5,000 per trip, with a one-trip maximum.

(g) For outpatient surgical services facility fees, a benefit of $500 per day, for up to three days.

(h) For surgery services:

(1) a benefit of $10,000 per day for significant, nondiagnostic invasive surgical procedures requiring general anesthesia and an open incision;

(2) a benefit of $5,000 per day for nondiagnostic surgical procedures requiring general anesthesia and an open incision;

(3) a benefit of $1,000 per day for surgical procedures requiring general anesthesia or conscious sedation; and

(4) a benefit of $500 per day for surgical procedures requiring local or regional anesthesia.

(i) For assistant surgeon services, 20 percent of the benefits described in paragraph (h) per day.

(j) For anesthesiologist services, 30 percent of the benefits described in paragraph (h) per day.

(k) For health care provider office visits for injury or illness, a benefit of $100 per visit, with a ten-visit maximum.

(l) For a second surgical opinion, a benefit of $500 per day for one day.

(m) For preventative care visits, a benefit of $250 per day for one day.

(n) For prescription drugs, a benefit of $10 for generic and $40 for nongeneric, with a 12-refill maximum per calendar year.

(o) For outpatient lab and x-ray services, a benefit of $100 per test, with a three-test maximum.

(p) For outpatient diagnostic imaging services, a benefit of $500 per test, with a one-test maximum.

(q) For oral chemotherapy, a benefit of $1,000 per month for up to three months.

(r) For outpatient chemotherapy and radiation that is not oral, a benefit of $500 per day for up to 20 days.

Subd. 6. **Tier five.** (a) For inpatient hospital confinement, a benefit of $5,000 per day, increasing by 25 percent for injury-related hospitalizations for each year an enrollee is enrolled in the health plan for a maximum of five years.

(b) For inpatient hospital intensive care or critical care units, a benefit of $2,000 per day for up to 60 days. This benefit is in addition to the benefit described in paragraph (a).

(c) For inpatient physician visits, a benefit of $100 per day, with a limit of one visit per day.

(d) For emergency services, a benefit of $300 per day, for up to three days.

(e) For ground or water ambulance services, a benefit of $500 per trip, with a one-trip maximum.

(f) For air ambulance services, a benefit of $5,000 per trip, with a one-trip maximum.

(g) For outpatient surgical services facility fees, a benefit of $500 per day, for up to three days.

(h) For surgery services:

(1) a benefit of $10,000 per day for significant, nondiagnostic invasive surgical procedures requiring general anesthesia and an open incision;

(2) a benefit of $5,000 per day for nondiagnostic surgical procedures requiring general anesthesia and an open incision;

(3) a benefit of $1,000 per day for surgical procedures requiring general anesthesia or conscious sedation; and

(4) a benefit of $500 per day for surgical procedures requiring local or regional anesthesia.

(i) For assistant surgeon services, 20 percent of the benefits described in paragraph (h) per day.

(j) For anesthesiologist services, 30 percent of the benefits described in paragraph (h) per day.

(k) For health care provider office visits for injury or illness, a benefit of $100 per visit, with a ten-visit maximum.

(l) For a second surgical opinion, a benefit of $500 per day for one day.

(m) For preventative care visits, a benefit of $250 per day for one day.

(n) For prescription drugs, a benefit of $10 for generic and $40 for nongeneric, with a 12-refill maximum per calendar year.

(o) For outpatient lab and x-ray services, a benefit of $100 per test, with a three-test maximum.

(p) For outpatient diagnostic imaging services, a benefit of $500 per test, with a one-test maximum.

(q) For oral chemotherapy, a benefit of $1,000 per month for up to three months.

(r) For outpatient chemotherapy and radiation that is not oral, a benefit of $500 per day for up to 20 days.

Subd. 7. **Tier six.** (a) For inpatient hospital confinement, a benefit of $5,000 per day, increasing by 25 percent for injury-related hospitalizations for each year an enrollee is enrolled in the health plan for a maximum of five years.

(b) For inpatient hospital intensive care or critical care units, a benefit of $10,000 per day for up to 31 days. This benefit is in addition to the benefit described in paragraph (a).

(c) For inpatient physician visits, a benefit of $100 per day, with a limit of two visits per day.

(d) For emergency services, a benefit of $500 per day, for up to two days.

(e) For ground or water ambulance services, a benefit of $1,000 per trip, with a one-trip maximum.

(f) For air ambulance services, a benefit of $5,000 per trip, with a one-trip maximum.

(g) For outpatient surgical services facility fees, a benefit of $1,000 per day, for up to three days.

(h) For surgery services:

(1) a benefit of $10,000 per day for significant, nondiagnostic invasive surgical procedures requiring general anesthesia and an open incision;

(2) a benefit of $5,000 per day for nondiagnostic surgical procedures requiring general anesthesia and an open incision;

(3) a benefit of $1,000 per day for surgical procedures requiring general anesthesia or conscious sedation; and

(4) a benefit of $500 per day for surgical procedures requiring local or regional anesthesia.

(i) For assistant surgeon services, 20 percent of the benefits described in paragraph (h) per day.

(j) For anesthesiologist services, 30 percent of the benefits described in paragraph (h) per day.

(k) For health care provider office visits for injury or illness, a benefit of $100 per visit, with a five-visit maximum.

(l) For a second surgical opinion, a benefit of $500 per day for one day.

(m) For preventative care visits, a benefit of $250 per day for one day.

(n) For prescription drugs, a benefit of $20 for generic and $40 for nongeneric, with a 12-refill maximum per calendar year.

(o) For outpatient lab and x-ray services, a benefit of $300 per test, with a one-test maximum.

(p) For outpatient diagnostic imaging services, a benefit of $1,000 per test, with a one-test maximum.

(q) For oral chemotherapy, a benefit of $2,000 per month for up to six months.

(r) For outpatient chemotherapy and radiation that is not oral, a benefit of $2,000 per day for up to 60 days.

Sec. 8. **[62K.16] TERMINATION OF COVERAGE DUE TO NONPAYMENT.**

(a) Notwithstanding section 62V.05, subdivision 5, a health carrier may terminate an enrollee's coverage due to premium nonpayment, regardless of whether the enrollee is receiving advance premium tax credits under the Affordable Care Act, if the enrollee has previously paid at least one full month's premium during the benefit year. Prior to terminating coverage, the health carrier must notify the enrollee of the premium payment delinquency, including the amount of premium owed.

(b) Coverage termination for premium nonpayment under this section is effective 30 days after the date the premium was due.

(c) The health carrier is not responsible for claims for services rendered to the enrollee during the grace period described in paragraph (b).

Sec. 9. Minnesota Statutes 2018, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee or have enrolled in a qualified health plan, as defined in section 62V.02, subdivision 11, must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare Parts A and B; or (3) coverage under medical assistance under chapter 256B.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any

employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer. An arrangement permitted under section 62L.12, subdivision 2, paragraph (l), is not an arrangement between the employer and the health carrier for purposes of this paragraph.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.

(d) If a small employer cannot meet either the participation or contribution requirement, the small employer may purchase coverage only during an open enrollment period each year between November 15 and December 15.

Sec. 10. Minnesota Statutes 2018, section 62L.03, is amended by adding a subdivision to read:

Subd. 4a. **Preexisting conditions.** (a) Preexisting conditions may be excluded by a health carrier for the first 12 months of coverage if the eligible employee was diagnosed or treated for that condition during the six months immediately preceding the enrollment date, but exclusionary riders must not be used. When calculating any length of preexisting condition limitation, a health carrier must credit the time period an eligible employee or dependent was previously covered by qualifying coverage, provided the individual maintains continuous coverage without a break of 63 days or more. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter. This chapter's requirements are in addition to the requirements of section 60A.082 and the rules adopted under it. An insurer is prohibited from canceling or rescinding a health insurance policy for a preexisting condition if the application or other information provided by the insured reasonably gave the insurer notice.

(b) A health carrier is prohibited from restricting coverage for a preexisting condition if the application or other information provided by the insured reasonably gave the insurer notice.

Sec. 11. Minnesota Statutes 2018, section 62L.08, is amended by adding a subdivision to read:

Subd. 1a. **General premium variations.** Each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the standard rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided the lifestyle factor and its effect upon premium rates have been deemed actuarially valid and approved by the commissioner. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted under this subdivision.

Sec. 12. Minnesota Statutes 2018, section 62L.08, subdivision 7, is amended to read:

Subd. 7. **Premium rate development.** (a) In developing its standard rates, rates, and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans; and

(2) ~~actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4~~ differences in the rating factors permitted in subdivisions 1a and 3.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Sec. 13. Minnesota Statutes 2018, section 62Q.18, subdivision 10, is amended to read:

Subd. 10. **Guaranteed issue.** (a) No health plan company shall offer, sell, or issue any health plan that does not make coverage available on a guaranteed issue basis ~~in accordance with the Affordable Care Act~~.

(b) Notwithstanding paragraph (a), a health plan company may offer, sell, or issue an individual health plan that contains a preexisting condition limitation or exclusion as permitted under section 62A.65, subdivision 5.

Sec. 14. **[62Q.678] HEALTH PLAN OPEN ENROLLMENT.**

(a) All health plans must be made available in the manner required by Code of Federal Regulations, title 45, section 147.104.

(b) In addition to the requirements under paragraph (a), any individual health plan:

(1) must be made available for purchase at any time during the calendar year; and

(2) is not retroactive from the date the application for coverage was received.

Sec. 15. Minnesota Statutes 2018, section 62V.05, subdivision 3, is amended to read:

Subd. 3. **Insurance producers.** (a) By April 30, 2013, the board, in consultation with the commissioner of commerce, shall establish certification requirements that must be met by insurance producers in order to assist individuals and small employers with purchasing coverage through MNsure. Prior to January 1, 2015, the board may amend the requirements, only if necessary, due to a change in federal rules.

~~(b) Certification requirements shall not exceed the requirements established under Code of Federal Regulations, title 45, part 155.220. Certification shall include training on health plans available through MNsure, available tax credits and cost-sharing arrangements, compliance with privacy and security standards, eligibility verification processes, online enrollment tools, and basic information on available public health care programs. Training required for certification under this subdivision shall qualify for continuing education requirements for insurance producers required under chapter 60K, and must comply with course approval requirements under chapter 45.~~

~~(c)~~ (b) Producer compensation shall be established by health carriers ~~that provide health plans through MNsure. The structure of compensation to insurance producers must be similar~~, and must be consistent and comparable for health plans sold through MNsure and outside MNsure.

~~(d)~~ (c) Any insurance producer compensation structure established by a health carrier for the small group market must include compensation for defined contribution plans that involve multiple health carriers. The compensation offered must be commensurate with other small group market defined health plans.

~~(e) Any insurance producer assisting an individual or small employer with purchasing coverage through MNsure must disclose, orally and in writing, to the individual or small employer at the time of the first solicitation with the prospective purchaser the following:~~

~~(1) the health carriers and qualified health plans offered through MNsure that the producer is authorized to sell, and that the producer may not be authorized to sell all the qualified health plans offered through MNsure;~~

~~(2) that the producer may be receiving compensation from a health carrier for enrolling the individual or small employer into a particular health plan; and~~

~~(3) that information on all qualified health plans offered through MNsure is available through the MNsure website.~~

~~For purposes of this paragraph, "solicitation" means any contact by a producer, or any person acting on behalf of a producer made for the purpose of selling or attempting to sell coverage through MNsure. If the first solicitation is made by telephone, the disclosures required under this paragraph need not be made in writing, but the fact that disclosure has been made must be acknowledged on the application.~~

~~(f)~~ (d) Beginning January 15, 2015, each health carrier that offers or sells qualified health plans through MNsure shall report in writing to the board and the commissioner of commerce the compensation and other incentives it offers or provides to insurance producers with regard to each type of health plan the health carrier offers or sells both inside and outside of MNsure. Each health carrier shall submit a report annually and upon any change to the compensation or other incentives offered or provided to insurance producers.

~~(g)~~ (e) Nothing in this chapter shall prohibit an insurance producer from offering professional advice and recommendations to a small group purchaser based upon information provided to the producer.

~~(h)~~ (f) An insurance producer that offers health plans in the small group market shall notify each small group purchaser of which group health plans qualify for Internal Revenue Service approved section 125 tax benefits. The insurance producer shall also notify small group purchasers of state law provisions that benefit small group plans when the employer agrees to pay 50 percent or more of its employees' premium, or when employees enroll in a qualified health plan. Individuals who are eligible for cost-effective medical assistance ~~will~~ and individuals who enroll in qualified health plans count toward the 75 percent participation requirement in section 62L.03, subdivision 3.

~~(i)~~ (g) Nothing in this subdivision shall be construed to limit the licensure requirements or regulatory functions of the commissioner of commerce under chapter 60K.

Sec. 16. Minnesota Statutes 2018, section 290.0132, is amended by adding a subdivision to read:

Subd. 30. **Expenditures for medical care and health insurance.** (a) The amount paid during the taxable year for medical care, as defined in section 213(d) of the Internal Revenue Code, but excluding any amount described in paragraph (b), is a subtraction.

(b) The subtraction under this subdivision does not include amounts:

(1) compensated by insurance or paid or reimbursed by an employer or a plan under sections 104 (health care reimbursement accounts), 105 (accident and health plans), 125 (cafeteria and flexible spending accounts), 223 (health care savings accounts), or other similar provisions of the Internal Revenue Code; or

(2) used to compute the credit under section 290.0672.

Sec. 17. **REPEALER.**

Minnesota Statutes 2018, sections 62A.303; 62A.65, subdivision 2; 62L.08, subdivision 4; and 62L.12, subdivisions 3 and 4, are repealed.

Sec. 18. **EFFECTIVE DATE.**

Sections 1 to 15 and 17 are effective January 1, 2021, or upon the effective date of any necessary federal waivers or law changes, whichever is later, and apply to health plans offered, issued, or renewed on or after that date. Section 16 is effective for taxable years beginning after December 31, 2020.

ARTICLE 2
HEALTH RISK POOL PROGRAM

Section 1. Minnesota Statutes 2018, section 3.971, subdivision 6, is amended to read:

Subd. 6. **Financial audits.** The legislative auditor shall audit the financial statements of the state of Minnesota required by section 16A.50 and, as resources permit, Minnesota State Colleges and Universities, the University of Minnesota, state agencies, departments, boards, commissions, offices, courts, and other organizations subject to audit by the legislative auditor, including, but not limited to, the State Agricultural Society, Agricultural Utilization Research Institute, Enterprise Minnesota, Inc., Minnesota Historical Society, ClearWay Minnesota, Minnesota Sports Facilities Authority, Metropolitan Council, Metropolitan Airports Commission, Minnesota Health Risk Pool Association, and Metropolitan Mosquito Control District. Financial audits must be conducted according to

generally accepted government auditing standards. The legislative auditor shall see that all provisions of law respecting the appropriate and economic use of public funds and other public resources are complied with and may, as part of a financial audit or separately, investigate allegations of noncompliance.

Sec. 2. Minnesota Statutes 2018, section 13.7191, is amended by adding a subdivision to read:

Subd. 26. **Minnesota Health Risk Pool Association.** Certain data maintained by the Minnesota Health Risk Pool Association is classified under section 62X.05, subdivision 6.

Sec. 3. **[62X.01] CITATION.**

This chapter may be cited as the "Minnesota Health Risk Pool Association Act."

Sec. 4. **[62X.02] DEFINITIONS.**

Subdivision 1. **Application.** For the purposes of this chapter, the terms defined in this section have the meanings given them.

Subd. 2. **Board.** "Board" means the board of directors of the Minnesota Health Risk Pool Association established under section 62X.05, subdivision 2.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 4. **Eligible individual.** "Eligible individual" means a natural person who has received a diagnosis of one of the conditions in section 62X.06, subdivision 1, paragraph (b), that qualifies claims for the person to be submitted by a member for risk pool payments under the program.

Subd. 5. **Health carrier.** "Health carrier" means a health carrier as defined in section 62A.011, subdivision 2.

Subd. 6. **Risk pool program or program.** "Risk pool program" or "program" means the risk pool program created by this chapter.

Subd. 7. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4.

Subd. 8. **Individual market.** "Individual market" means the market for individual health plans, as defined in section 62A.011, subdivision 5.

Subd. 9. **Member.** "Member" means a health carrier offering, issuing, or renewing individual health plans to a Minnesota resident.

Subd. 10. **Minnesota Health Risk Pool Association or association.** "Minnesota Health Risk Pool Association" or "association" means the association created under section 62X.05, subdivision 1.

Subd. 11. **Risk pool payments.** "Risk pool payments" means a payment made by the association to a member under the requirements of the program and this chapter.

Sec. 5. **[62X.03] DUTIES OF COMMISSIONER.**

The commissioner may:

(1) formulate general policies to advance the purposes of this chapter;

(2) supervise the creation of the Minnesota Health Risk Pool Association, subject to the limits described in section 62X.05;

(3) appoint advisory committees;

(4) conduct periodic audits to ensure the accuracy of the data submitted by members and the association, and the compliance of the association and members with requirements of the plan of operation and this chapter;

(5) contract with the federal government or any other unit of government to ensure program coordination with other individual health plan reinsurance or subsidy programs;

(6) contract with health carriers and others for administrative services; and

(7) adopt, amend, suspend, and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of this chapter.

Sec. 6. **[62X.04] APPROVAL OF RISK POOL PAYMENTS.**

Subdivision 1. **Information submitted to commissioner.** The association must submit to the commissioner information regarding the risk pool payments the association anticipates making for the calendar year immediately following the year the information is submitted. The information must include historical risk pool payment data, underlying principles of the model used to calculate anticipated risk pool payments, and any other relevant information or data the association used to determine anticipated risk pool payments for the following calendar year. This information must be submitted to the commissioner by August 30 of each year for risk pool payments anticipated to be made in the calendar year immediately following the year the information is submitted. By October 15 each year, the commissioner must approve or modify the anticipated risk pool payment schedule.

Subd. 2. **Modification by commissioner.** The commissioner may modify the association's anticipated risk pool payment schedule submitted under subdivision 1 on the basis of the following criteria:

(1) whether the association is complying with the requirements contained in the plan of operation and this chapter;

(2) the degree to which the computations and conclusions consider the current and future individual market regulations;

(3) the degree to which any sample used to compute the effect on premiums reasonably reflects projected individual market circumstances, using accepted actuarial principles;

(4) the degree to which the computations and conclusions consider the current and future health care needs and health condition demographics of Minnesota residents purchasing individual health plans;

(5) the actuarially projected effect of the risk pool payments upon both total enrollment in the individual market and the nature of the risks assumed by the association;

(6) the financial cost to the individual market and the entire health insurance market in this state;

(7) the projected cost of all risk pool payments in relation to funding available for the program; and

(8) other relevant factors determined by the commissioner.

Sec. 7. **[62X.05] MINNESOTA HEALTH RISK POOL ASSOCIATION.**

Subdivision 1. **Creation; tax exemption.** The Minnesota Health Risk Pool Association is established to promote the stabilization and cost control of individual health plans in Minnesota. Membership in the association consists of all health carriers offering, issuing, or renewing individual health plans in Minnesota. The association is exempt from the taxes imposed under chapter 297I and any other laws of this state. All property owned by the association is exempt from taxation.

Subd. 2. **Board of directors; organization.** (a) The board of directors of the association is made up of 11 members as follows: six directors selected by members, subject to approval by the commissioner, one of whom must be a health actuary; five public directors selected by the commissioner, four of whom must be individual health plan enrollees, and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area.

(b) In determining voting rights to elect directors at the member's meeting, each member is entitled to vote in person or proxy. The vote must be a weighted vote based upon the member's cost of accident and health insurance premium, subscriber contract charges, or health maintenance contract payment in the individual market, derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner.

(c) When approving directors of the board, the commissioner must consider, among other things, whether all types of members are fairly represented. Directors selected by members may be reimbursed from the money of the association for expenses incurred as directors, but otherwise must not be compensated by the association for their services.

Subd. 3. **Membership.** All members must maintain membership in the association as a condition of participating in the individual market in Minnesota.

Subd. 4. **Operation.** The association must submit its articles, bylaws, and operating rules to the commissioner for approval. The adoption and amendment of articles, bylaws, and operating rules by the association, and the approval of the articles, bylaws, and operating rules by the commissioner, are exempt from sections 14.001 to 14.69.

Subd. 5. **Open meetings.** All meetings of the board and any committees must comply with the provisions of chapter 13D.

Subd. 6. **Data.** The association and board are subject to chapter 13. Data received by the association and board from a member that is data on individuals is private data on individuals, as defined in section 13.02, subdivision 12.

Subd. 7. **Appeals.** An appeal may be filed with the commissioner within 30 days after notice of an action, ruling, or decision by the board. A final action or order of the commissioner under this subdivision is subject to judicial review under chapter 14. In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.

Subd. 8. **Antitrust exemption.** In the performance of duties as members of the association, the members are exempt from sections 325D.49 to 325D.66.

Subd. 9. **General powers.** The association may:

(1) exercise the powers granted to insurers under the laws of Minnesota;

(2) sue or be sued;

(3) establish administrative and accounting procedures to operate the association; and

(4) enter into contracts with insurers, similar associations in other states, or with other persons to perform administrative functions, including the functions provided in section 62X.06.

Subd. 10. **Rulemaking.** The association is exempt from the Administrative Procedure Act. However, to the extent the association wishes to adopt rules, it may use section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to rules adopted under this subdivision.

Sec. 8. **[62X.06] ASSOCIATION; ADMINISTRATION OF PROGRAM.**

Subdivision 1. **Acceptance of risk.** (a) The association must accept a transfer to the program from a member of the risk and cost associated with providing health coverage to an eligible individual when the eligible individual discloses to the member in the application for an individual health plan that the eligible individual has received a diagnosis of at least one of the conditions in paragraph (b).

(b) The diagnosis necessary to qualify as an eligible individual are:

(1) AIDS/HIV;

(2) Alzheimer's disease;

(3) amyotrophic lateral sclerosis (ALS);

(4) angina pectoris;

(5) anorexia nervosa or bulimia;

(6) aortic aneurysm;

(7) ascites;

(8) chemical dependency;

(9) chronic pancreatitis;

(10) chronic renal failure;

(11) cirrhosis of the liver;

(12) coronary insufficiency;

(13) coronary occlusion;

(14) Crohn's Disease (regional enteritis);

(15) cystic fibrosis;

(16) dermatomyositis;

(17) Friedreich's ataxia;

(18) hemophilia;

(19) hepatitis C;

(20) history of major organ transplant;

(21) Huntington Chorea;

(22) hydrocephalus;

(23) insulin dependent diabetes;

(24) leukemia;

(25) malignant lymphoma;

(26) malignant tumors;

(27) metastatic cancer;

(28) motor/sensory aphasia;

(29) multiple sclerosis;

(30) muscular dystrophy;

(31) myasthenia gravis;

(32) myocardial infarction;

(33) myotonia;

(34) open heart surgery;

(35) paraplegia;

(36) Parkinson's Disease;

(37) polyarteritis nodosa;

(38) polycystic kidney;

(39) primary cardiomyopathy;

(40) progressive systemic sclerosis (Scleroderma);

(41) quadriplegia;

(42) stroke;

(43) syringomyelia;

(44) systemic lupus erythematosus (SLE);

(45) Wilson's disease; and

(46) any other injury or illness at the member's discretion.

Subd. 2. **Payment to members.** (a) The association must reimburse members on a quarterly basis for claims paid on behalf of an eligible individual whose risk and cost has been transferred to the program.

(b) Risk pool payments related to any one eligible individual is limited to $5,000,000 over the lifetime of the individual, without consideration of whether the risk pool payments are made to one or more members.

Subd. 3. **Plan of operation.** (a) The association, in consultation with the commissioners of health and commerce, must create a plan of operation to administer the program. The plan of operation must be updated as necessary by the board, in consultation with the commissioners.

(b) The plan of operation must include:

(1) guidance to members regarding the use of diagnosis codes to identify eligible individuals;

(2) a description of the data a member submitting a risk pool payment request must provide to the association for the association to implement and administer the program, including data necessary for the association to determine a member's eligibility for risk pool payments;

(3) the manner and time period in which a member must provide the data described in clause (2);

(4) requirements for report submissions by an association member;

(5) requirements for processing reports received by the association under section 62X.07, subdivision 2, paragraph (a), clause (5);

(6) requirements for conducting audits under section 62X.08; and

(7) requirements for an annual actuarial study of Minnesota's individual market the association must order, that:

(i) measures the program's impact;

(ii) recommends program funding levels; and

(iii) analyzes possible changes in the individual market, including the impact of the possible changes.

Subd. 4. **Use of premium payments.** The association must apply all premiums received from members to pay for transferred risks. The association may pay normal administrative and operational expenses.

Subd. 5. **Prior notification of potential enrollees.** (a) A member market must notify all applicants prior to enrollment of the potential for data transfer to the association. Notification must include:

(1) a description of the potential transfer of cost and risk of the enrollee, transfer of premium payments, and transfer of medical claims to the association;

(2) the address and telephone number of the association; and

(3) the Tennessen warning required under section 13.04, subdivision 2.

(b) Before a member accepts an application the member must obtain on a separate document the potential enrollee's signature acknowledging receipt of the notification, and a separate signature providing the individual's consent to data sharing if the member transfers the risk and cost of the individual to the association.

Sec. 9. **[62X.07] MEMBERS; COMPLIANCE WITH PROGRAM.**

Subdivision 1. **Transfer of risk.** A member transferring the risk and cost associated with providing health coverage to an eligible individual to the program must comply with this section. A member must transfer the risk and cost of the eligible individual after receiving a completed application for an individual health plan from the individual. The application must disclose that the individual, or a member of the individual's family if a family policy is being requested, has been diagnosed with one of the conditions listed in section 62X.06, subdivision 1, paragraph (b). The program is effective on the effective date of the individual health plan and continues until the eligible individual ceases coverage with the member.

Subd. 2. **Risk pool payments.** (a) A member is eligible for risk pool payments to reimburse the member for the claims of an eligible individual if the member:

(1) provides evidence to the association that the individual is an eligible individual;

(2) is currently paying the eligible individual's claims;

(3) pays to the association under paragraph (c) the premium the member receives under an individual health plan for the eligible individual;

(4) pays to the association under paragraph (d) any pharmacy rebates the member receives for health care services provided to the eligible individual; and

(5) reports and pays to the association any payments applicable to the eligible individual that the member collects relating to:

(i) third-party liabilities;

(ii) payments the member recovers for overpayment;

(iii) payments for commercial reinsurance recoveries;

(iv) estimated federal cost-sharing reduction payments made under United States Code, title 42, section 18071; and

(v) estimated advanced premium tax credits paid to the member on behalf of an eligible individual made under United States Code, title 26, section 36B.

(b) A member that has transferred the associated risk and cost of an eligible individual to the program must submit to the program all data and information required by the association, in a manner determined by the association.

(c) A member must provide the program all premiums received for coverage under an individual health plan from an eligible individual whose risk and associated cost has been transferred to the program. A member must transfer all premiums, less all normal issuance administrative and maintenance costs, to the program immediately after receipt. For each additional eligible individual covered under a family policy who has a separately identifiable premium equal to $0, the member must pay the association the next highest separately identifiable premium under the family policy.

(d) A member must pay the association a pharmacy rebate required to be paid under paragraph (a), clause (4), within 30 days of the date the pharmacy rebate was received.

Subd. 3. **Duties; members.** (a) A member must comply with the plan of operation created under section 62X.06, subdivision 3, in order to receive risk pool payments under the program.

(b) A member must continue to administer and manage an eligible individual's individual health plan under the terms of the individual health plan after the risk and cost associated with the eligible individual has been transferred to the program.

(c) A member may not vary premium rates based on whether the risk and cost associated with an eligible individual has been transferred to the program.

(d) After the risk and cost of an eligible individual has been transferred to the program, the risk and cost remain with the program for the benefit plan year.

(e) For a claim to qualify for risk pool payments from the program, a member must submit claims incurred by an eligible individual whose risk and associated cost has been transferred to the program within 12 months of the claim being incurred.

Sec. 10. **[62X.08] ACCOUNTS AND AUDITS.**

Subdivision 1. **Reports and audits.** (a) The association must maintain its books, records, accounts, and operations on a calendar-year basis.

(b) The association must conduct a final accounting with respect to each calendar year after April 15 the next calendar year.

(c) Claims for eligible individuals whose associated risk and cost have been transferred to the program that are incurred during a calendar year and are submitted for reimbursement before April 15 the next calendar year must be allocated to the calendar year in which the claims were incurred. Claims for eligible individuals whose associated risk and cost have been transferred to the program that are incurred during a calendar year and are submitted for reimbursement after April 15 the next calendar year must be allocated to a later calendar year, as provided by the plan of operation.

(d) If the association fund's total receipts with respect to a calendar year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that calendar year, all claims for reimbursement allocable to that calendar year must be proportionately reduced to the extent necessary to prevent a deficit in the fund for that calendar year. Any reduction in claims for reimbursement with respect to a calendar year must apply to all claims allocable to that calendar year without regard to when those claims are submitted for reimbursement. Any reduction must be applied to each claim in the same proportion.

(e) The association must establish a process to audit every member that transfers the cost and associated risk of an eligible individual to the program. Audits may include both an audit conducted in connection with commencement of a member's first transfer to the program and up to four periodic audits each year throughout a member's participation in the program.

(f) Each calendar year, the association must engage an independent third-party auditor to perform a financial and programmatic audit in accordance with generally accepted auditing standards. The association must provide a copy of the audit to the commissioner when the

association receives the audit and must publish a copy of the audit on the association's website within 14 days of the date the audit was received.

Subd. 2. **Annual settle-up.** (a) The association must establish a settle-up process with respect to a calendar year to reflect adjustments made in establishing the final accounting for that calendar year. The adjustments include, but are not limited to:

(1) the crediting of premiums received with respect to the cost and associated risks of an eligible person being transferred after the end of the calendar year;

(2) retroactive reductions or other adjustments in reimbursements necessary to prevent a deficit in the association fund for that calendar year; and

(3) retroactive reductions to prevent a windfall to a member as a result of third party recoveries, recovery of overpayments, commercial reinsurance recoveries, federal cost-sharing reductions made under United States Code, title 42, section 18071, advanced premium tax credits paid under United States Code, title 26, section 36B, or risk adjustments made under United States Code, title 42, section 18063, for that calendar year.

The settle-up must occur after April 15 of the calendar year immediately after the year the settle-up applies to.

(b) With respect to the risk adjustment transfers as determined by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and Center for Consumer Information and Insurance Oversight:

(1) the commissioner must review the risk adjustment transfers to determine the impact the transfer of risk and associated cost of an eligible individual to the program has had, if any;

(2) the review must occur no later than 60 days after the notice of final risk adjustment transfers by the Center for Consumer Information and Insurance Oversight is published;

(3) if the commissioner notifies a member of the amount of any risk adjustment transfer it received that does not accurately reflect benefits provided under the program:

(i) the member must pay that amount to the association within 30 days of the date the member received notice from the commissioner; and

(ii) as appropriate, the commissioner must refund to the member the amount that made the federal risk adjustment payment; and

(4) a member must submit to the commissioner, in a form acceptable to the commissioner, all data requested by the commissioner by March of the year immediately following the year the risk adjustment applies to.

Sec. 11. **[62X.09] ASSESSMENT ON ISSUERS OF ACCIDENT AND HEALTH INSURANCE POLICIES.**

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

(b) "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11; or

(8) accident only coverage, issued by licensed and tested insurance agents or solicitors, that provides reasonable benefits in relation to the cost of covered services.

Clause (4) does not apply to hospital indemnity coverage sold by an insurer to an applicant who is not currently covered by a qualified plan at the time the coverage is sold.

(c) "Market member" means companies regulated under chapter 62A that offer, sell, issue, or renew policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota employees insurance program established in section 43A.317; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining a market member's liability under subdivision 2, payments received from or on behalf of Minnesota residents for coverage by

a health maintenance organization or community integrated service network are considered accident and health insurance premiums.

Subd. 2. **Assessment.** The association must make an annual determination of each market member's financial liability, if any, to support the program, as provided under section 62X.10. The association may make an annual fiscal year-end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the market members whose aggregate assessments comprised a minimum of 90 percent of the most recent prior annual assessment if the association deems that methodology to be the most administratively efficient and cost-effective means of assessment, and as may be necessary to ensure the association's financial capability to meet the incurred or estimated claims expenses, program administrative costs, and program operational costs until the association's next annual fiscal year-end assessment. An assessment payment is due within 30 days of the date a market member receives a written notice of a fiscal year-end or interim assessment. Failure by a market member to pay the assessment to the association within 30 days is grounds for termination of the market member's ability to issue accident and health insurance policies in Minnesota. A market member that ceases to do accident and health insurance business in Minnesota remains liable for assessments through the calendar year the market member's accident and health insurance business ceased. The association may decline to levy an assessment against a market member if the assessment determined under this subdivision does not exceed $10.

Sec. 12. **[62X.10] FUNDING OF PROGRAM.**

(a) The association account is created in the special revenue fund of the state treasury. Funds in the account are appropriated to the association to operate the program. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the association account must be credited to the association account.

(b) The association must fund the program using the following sources, in the following priority order:

(1) any federal funds available, whether through grants or otherwise;

(2) the funds in section 15;

(3) the tax imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations under section 297I.05, subdivision 5; and

(4) the assessment, if any, under section 62X.09.

(c) The program must not exceed $..... in claims, administrative, and operational costs per calendar year.

Sec. 13. Minnesota Statutes 2018, section 297I.05, subdivision 1, is amended to read:

Subdivision 1. **Domestic and foreign companies.** Except as otherwise provided in this section, a tax is imposed on every domestic and foreign insurance company. The rate of tax is equal to two percent of all gross premiums less return premiums on all direct business received by the insurer or agents of the insurer in Minnesota, in cash or otherwise, during the year. This tax must be paid into the association account.

Sec. 14. Minnesota Statutes 2018, section 297I.05, subdivision 5, is amended to read:

Subd. 5. **Health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.** (a) A tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums on all direct business received by the organization, network, or corporation or its agents in Minnesota, in cash or otherwise, in the calendar year.

(b) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the ~~health care access fund~~ association account. Refunds of overpayments of tax imposed by this subdivision must be paid from the ~~health care access fund~~ association account. There is annually appropriated from the ~~health care access fund~~ association account to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Sec. 15. **TRANSFER.**

$..... in fiscal year 2021 is transferred from the health care access fund to the commissioner of commerce for transfer to the association account in the special revenue fund for the purposes described in Minnesota Statutes, section 62X.10.

Sec. 16. **EFFECTIVE DATE.**

Sections 1 to 11 are effective January 1, 2022, and apply to individual health plans providing coverage on or after that date. Sections 12 to 15 are effective the day following final enactment and apply to individual health plans providing coverage on or after January 1, 2021, until December 31, 2021.

ARTICLE 3

UNIFIED PERSONAL HEALTH PREMIUM ACCOUNT

Section 1. **[62Y.01] DEFINITIONS.**

Subdivision 1. **Scope of definitions.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 3. **Dependent.** "Dependent" means an individual's spouse or tax dependent.

Subd. 4. **Health insurance.** "Health insurance" means:

(1) individual health insurance and individual policies that cover cancer, accidents, critical illness, hospital confinement/medical bridge, short-term disability, long-term care, and high deductible health plans including those that are compatible with health savings accounts; and

(2) any other coverages identified under sections 60A.06, subdivision 1, clause (5), paragraph (a); 62Q.01, subdivisions 4a and 6; and 62Q.188.

Subd. 5. **Trustee.** "Trustee" means an entity that has trust powers under state or federal law.

Subd. 6. **Unified personal health premium account or account.** "Unified personal health premium account" or "account" means a trust account created to receive funds from multiple sources to pay or reimburse for health insurance premiums.

Subd. 7. **Unified personal health premium account administrator or administrator.** "Unified personal health premium account administrator" or "administrator" means an entity that has the authority to administer a unified personal health premium account.

Sec. 2. **[62Y.02] REGISTRATION REQUIRED.**

(a) Only a private-sector entity or individual registered with the commissioner as a unified personal health premium account administrator may administer an account on behalf of a Minnesota resident.

(b) To register under this section, a private sector entity or individual must be:

(1) a licensed insurance producer, as defined in section 60K.31, subdivision 6, under the insurance authority described in section 60K.38, subdivision 1, paragraph (b), clause (1), (2), or (5);

(2) a licensed vendor of risk management services or entity administering a self-insurance or insurance plan under section 60A.23, subdivision 8; or

(3) a federally or state-chartered bank or credit union.

(c) An applicant for registration under this section must pay a $250 fee for initial registration and a $50 fee for each three-year renewal.

Sec. 3. **[62Y.03] UNIFIED PERSONAL HEALTH PREMIUM ACCOUNT ADMINISTRATION; REQUIREMENTS.**

Subdivision 1. **Nature of arrangements.** (a) A unified personal health premium account administrator under contract with an employer must conduct business in accordance with a written contract.

(b) Administrators may conduct business directly with individuals in accordance with a written agreement.

(c) The written agreement between a unified personal health premium account administrator and its customer must specify (i) the services to be provided to the customer, (ii) the payment for each service, including administrative costs, and (iii) the timing and method of each payment or type of payment.

(d) An administrator may administer unified personal health premium accounts separately or in conjunction with other employee benefit services, including services that facilitate and coordinate tax-preferred payments for health care and coverage under Internal Revenue Code, sections 105, 106, and 9831(d).

(e) An administrator must create and maintain records of receipts, payments, and other transactions, sufficient to enable the individual to benefit from tax advantages available to the individual for health insurance paid by or on behalf of the individual under Internal Revenue Code, sections 105, 106, 125, and other relevant sections, and under Minnesota income tax law. The records and procedures must be capable of segregating funds to maintain restrictions on the funds received from contributors.

(f) Individual insurance market products paid for through the account under this section are not an employer-sponsored plan subject to state or federal group insurance market requirements.

Subd. 2. **Trust account requirements.** (a) Contributions to an individual's account may be made by the individual, the individual's employer or former employer, the individual's

family members or dependents, charitable organizations, a government entity, or any other source.

(b) A contributor to the account may restrict the use of funds the contributor contributes to the payment of premiums for one or more of the types of health insurance included in section 62Y.01, subdivision 4.

(c) A trust created and trustees appointed under this chapter must:

(1) have the powers granted under, and must comply with, the provisions under chapter 501B that are relevant to a trust created for purposes of this chapter;

(2) permit financial contributions from multiple sources, including tax-preferred contributions from individuals and employers and nontax-preferred contributions from individuals and other sources;

(3) use funds exclusively for the benefit of the individual account holder or the individual's tax dependents;

(4) make funds available for the payment of premiums on any type of health insurance included in section 62Y.01, subdivision 4, from any insurance company, subject to any restriction under paragraph (b);

(5) grant the unified personal health premium account administrator authority to direct payments to insurance companies or to reimburse account owners for qualified health insurance premium expenses;

(6) segregate funds to maintain restrictions on the funds received from contributors; and

(7) guarantee that funds contributed by an employer will remain available to the account holder after the account holder's term of employment with the employer ends.

Sec. 4. **[62Y.04] COORDINATION WITH HEALTHY MINNESOTA PROGRAM.**

The commissioner of human services must enter into agreements under which unified personal health premium account administrators may receive public funds to subsidize payment of premiums for health coverage provided to eligible individuals who have a trust account for that purpose.

Sec. 5. **[256L.032] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.**

Subdivision 1. **Defined contributions to enrollees.** (a) The commissioner must provide a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3, to each MinnesotaCare enrollee who (1) does not reside

in a county that offers county-based purchasing, (2) is eligible under section 256L.04, subdivision 7, and (3) has a family income equal to or greater than 200 percent of the federal poverty guidelines.

(b) Enrollees eligible under this section must 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 are governed by 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.

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.

(b) An enrollee must select a health plan within four calendar months of the date the enrollee is approved for 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) Coverage purchased under this section may be in the form of a flexible benefits plan under section 62Q.188.

(d) Coverage purchased under this section must comply with the coverage limitations specified under section 256L.03, subdivision 1, paragraph (b).

Subd. 3. **Determination of defined contribution amount.** The commissioner must determine the defined contribution sliding scale using the base contribution for specific age ranges. The commissioner must use a sliding scale for defined contributions based on the federal poverty guidelines for household income.

Subd. 4. **Administration by commissioner.** (a) The commissioner must administer the defined contributions. The commissioner must:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies for enrollee health plan coverage.

(b) Health plan premium nonpayment results in disenrollment from MinnesotaCare, effective the first day of the calendar month immediately following the calendar month when the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage are prohibited from reenrolling until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, must develop an efficient and cost-effective method to refer eligible applicants to professional insurance agent associations.

Sec. 6. **EFFECTIVE DATE.**

Sections 1 to 5 are effective the day following final enactment.

ARTICLE 4
FEDERAL WAIVER

Section 1. **STATE INNOVATION WAIVER.**

Subdivision 1. **Submission of waiver application.** The commissioner of commerce must apply to the secretary of the Department of Health and Human Services under United States Code, title 42, sections 18051 and 18052, and for a state innovation waiver to implement any sections of this act that necessitate a waiver for plan years beginning on or after January 1, 2021.

Subd. 2. **Consultation.** When developing the waiver application, the commissioner must consult with the commissioner of human services and the commissioner of health.

Subd. 3. **Application timelines; notification.** The commissioner must submit the waiver application to the Secretary of Health and Human Services on or before July 5, 2020. The commissioner must make a draft application available for public review and comment on or before June 1, 2020. The commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance and health care of any federal actions regarding the waiver request.

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

ARTICLE 5

REPEALER

Section 1. **REPEALER.**

Minnesota Statutes 2018, sections 62K.01; 62K.02; 62K.03; 62K.04; 62K.05; 62K.06; 62K.08; 62K.09; 62K.10, subdivisions 1, 1a, 2, 3, 4, 6, 7, and 8; 62K.11; 62K.12; 62K.13; 62K.14; and 62K.15, are repealed.

Minnesota Statutes 2019 Supplement, sections 62K.07; 62K.075; and 62K.10, subdivision 5, are repealed.

62A.303 PROHIBITION; SEVERING OF GROUPS.

Section 62L.12, subdivisions 3 and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

62A.65 INDIVIDUAL MARKET REGULATION.

Subd. 2. **Guaranteed renewal.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan, except for nonpayment of premiums, fraud, or misrepresentation.

62K.01 TITLE.

This chapter may be cited as the "Minnesota Health Plan Market Rules."

62K.02 PURPOSE AND SCOPE.

Subdivision 1. **Purpose.** The market rules set forth in this chapter serve to clarify and provide guidance on the application of state law and certain requirements of the Affordable Care Act on all health carriers offering health plans in Minnesota, whether or not through MNsure, to ensure fair competition for all health carriers in Minnesota, to minimize adverse selection, and to ensure that health plans are offered in a manner that protects consumers and promotes the provision of high-quality affordable health care, and improved health outcomes. This chapter contains the regulatory requirements as specified in section 62V.05, subdivision 5, paragraph (b), and shall fully satisfy the requirements of section 62V.05, subdivision 5, paragraph (b).

Subd. 2. **Scope.** (a) This chapter applies only to health plans offered in the individual market or the small group market.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

(c) If a health carrier issues or renews individual or small group health plans in other states, this chapter applies only to health plans issued or renewed in this state to a Minnesota resident, or to cover a resident of the state, or issued or renewed to a small employer that is actively engaged in business in this state, unless otherwise specified.

(d) This chapter does not apply to short-term coverage as defined in section 62A.65, subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision 1b.

62K.03 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments, and any federal guidance or regulations issued under these acts.

Subd. 3. **Dental plan.** "Dental plan" means a dental plan as defined in section 62Q.76, subdivision 3.

Subd. 4. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 5. **Health carrier.** "Health carrier" means a health carrier as defined in section 62A.011, subdivision 2.

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3.

Subd. 7. **Individual health plan.** "Individual health plan" means an individual health plan as defined in section 62A.011, subdivision 4.

Subd. 8. **Limited-scope pediatric dental plan.** "Limited-scope pediatric dental plan" means a dental plan meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of

1986, as amended, that provides only pediatric dental benefits meeting the requirements of the Affordable Care Act and is offered by a health carrier. A limited-scope pediatric dental plan includes a dental plan that is offered separately or in conjunction with an individual or small group health plan to individuals who have not attained the age of 19 years as of the beginning of the policy year or to a family.

Subd. 9. **MNsure.** "MNsure" means MNsure as defined in section 62V.02.

Subd. 10. **Preferred provider organization.** "Preferred provider organization" means a health plan that provides discounts to enrollees or subscribers for services they receive from certain health care providers.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in the Affordable Care Act and has been certified by the board of MNsure in accordance with chapter 62V to be offered through MNsure.

Subd. 12. **Small group health plan.** "Small group health plan" means a health plan issued by a health carrier to a small employer as defined in section 62L.02, subdivision 26.

62K.04 MARKET RULES; VIOLATION.

Subdivision 1. **Compliance.** (a) A health carrier issuing an individual health plan to a Minnesota resident or a small group health plan to provide coverage to a small employer that is actively engaged in business in Minnesota shall meet all of the requirements set forth in this chapter. The failure to meet any of the requirements under this chapter constitutes a violation of section 72A.20.

(b) The requirements of this chapter do not apply to short-term coverage as defined in section 62A.65, subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision 1c.

Subd. 2. **Penalties.** In addition to any other penalties provided by the laws of this state or by federal law, a health carrier or any other person found to have violated any requirement of this chapter may be subject to the administrative procedures, enforcement actions, and penalties provided under section 45.027 and chapters 62D and 72A.

62K.05 FEDERAL ACT; COMPLIANCE REQUIRED.

A health carrier shall comply with all provisions of the Affordable Care Act to the extent that it imposes a requirement that applies in this state. Compliance with any provision of the Affordable Care Act is required as of the effective date established for that provision in the federal act, except as otherwise specifically stated earlier in state law.

62K.06 METAL LEVEL MANDATORY OFFERINGS.

Subdivision 1. **Identification.** A health carrier that offers individual or small group health plans in Minnesota must provide documentation to the commissioner of commerce to justify actuarial value levels as specified in section 1302(d) of the Affordable Care Act for all individual and small group health plans offered inside and outside of MNsure.

Subd. 2. **Minimum levels.** (a) A health carrier that offers a catastrophic plan or a bronze level health plan within a service area in either the individual or small group market must also offer a silver level and a gold level health plan in that market and within that service area.

(b) A health carrier with less than five percent market share in the respective individual or small group market in Minnesota is exempt from paragraph (a), until January 1, 2017, unless the health carrier offers a qualified health plan through MNsure. If the health carrier offers a qualified health plan through MNsure, the health carrier must comply with paragraph (a).

Subd. 3. **MNsure restriction.** MNsure may not, by contract or otherwise, mandate the types of health plans to be offered by a health carrier to individuals or small employers purchasing health plans outside of MNsure. Solely for purposes of this subdivision, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clause (6).

Subd. 4. **Metal level defined.** For purposes of this section, the metal levels and catastrophic plans are defined in section 1302(d) and (e) of the Affordable Care Act.

Subd. 5. **Enforcement.** The commissioner of commerce shall enforce this section.

62K.07 INFORMATION DISCLOSURES.

Subdivision 1. **Generally.** (a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost-sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.

(b) A health carrier offering an individual or small group health plan must comply with all information disclosure requirements of all applicable state and federal law, including the Affordable Care Act.

(c) Except for qualified health plans sold on MNsure, information reported under paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02, subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be reported by MNsure for qualified health plans sold through MNsure.

Subd. 2. **Prescription drug costs.** (a) Each health carrier that offers a prescription drug benefit in its individual health plans or small group health plans shall include in the applicable rate filing required under section 62A.02 the following information about covered prescription drugs:

(1) the 25 most frequently prescribed drugs in the previous plan year;

(2) the 25 most costly prescription drugs as a portion of the individual health plan's or small group health plan's total annual expenditures in the previous plan year;

(3) the 25 prescription drugs that have caused the greatest increase in total individual health plan or small group health plan spending in the previous plan year;

(4) the projected impact of the cost of prescription drugs on premium rates;

(5) if any health plan offered by the health carrier requires enrollees to pay cost-sharing on any covered prescription drugs including deductibles, co-payments, or coinsurance in an amount that is greater than the amount the enrollee's health plan would pay for the drug absent the applicable enrollee cost-sharing and after accounting for any rebate amount; and

(6) if the health carrier prohibits third-party payments including manufacturer drug discounts or coupons that cover all or a portion of an enrollee's cost-sharing requirements including deductibles, co-payments, or coinsurance from applying toward the enrollee's cost-sharing obligations under the enrollee's health plan.

(b) The commissioner of commerce, in consultation with the commissioner of health, shall release a summary of the information reported in paragraph (a) at the same time as the information required under section 62A.02, subdivision 2, paragraph (c).

Subd. 3. **Enforcement.** The commissioner of commerce shall enforce this section.

62K.075 PROVIDER NETWORK NOTIFICATIONS.

(a) A health carrier must provide on the carrier's website the provider network for each product offered by the carrier, and must update the carrier's website at least once a month with any changes to the carrier's provider network, including provider changes from in-network status to out-of-network status. A health carrier must also provide on the carrier's website, for each product offered by the carrier, a list of the current waivers of the requirements in section 62K.10, subdivision 2 or 3, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health carrier must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change

was posted as required under paragraph (a) unless the health carrier notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health carrier is able to verify that the health carrier's website displayed the correct provider network status on the health carrier's website at the time the service was provided.

(c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required by paragraph (b).

62K.08 MARKETING STANDARDS.

Subdivision 1. **Marketing.** (a) A health carrier offering individual or small group health plans must comply with all applicable provisions of the Affordable Care Act, including, but not limited to, the following:

(1) compliance with all state laws pertaining to the marketing of individual or small group health plans; and

(2) establishing marketing practices and benefit designs that will not have the effect of discouraging the enrollment of individuals with significant health needs in the health plan.

(b) No marketing materials may lead consumers to believe that all health care needs will be covered.

Subd. 2. **Enforcement.** The commissioner of commerce shall enforce this section.

62K.09 ACCREDITATION STANDARDS.

Subdivision 1. **Accreditation; general.** (a) A health carrier that offers any individual or small group health plans in Minnesota outside of MNsure must be accredited in accordance with this subdivision. A health carrier must obtain accreditation through URAC, the National Committee for Quality Assurance (NCQA), or any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans by January 1, 2018. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner of health.

(b) A health carrier that rents a provider network is exempt from this subdivision, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent market share in either the individual or small group market in Minnesota.

Subd. 2. **Accreditation; MNsure.** (a) MNsure shall require all health carriers offering a qualified health plan through MNsure to obtain the appropriate level of accreditation no later than the third year after the first year the health carrier offers a qualified health plan through MNsure. A health carrier must take the first step of the accreditation process during the first year in which it offers a qualified health plan. A health carrier that offers a qualified health plan on January 1, 2014, must obtain accreditation by the end of the 2016 plan year.

(b) To the extent a health carrier cannot obtain accreditation due to low volume of enrollees, an exception to this accreditation criterion may be granted by MNsure until such time as the health carrier has a sufficient volume of enrollees.

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

Subd. 4. **Enforcement.** The commissioner of health shall enforce this section.

62K.10 GEOGRAPHIC ACCESSIBILITY; PROVIDER NETWORK ADEQUACY.

Subdivision 1. **Applicability.** (a) This section applies to all health carriers that either require an enrollee to use or that create incentives, including financial incentives, for an enrollee to use, health care providers that are managed, owned, under contract with, or employed by the health carrier. A health carrier that does not manage, own, or contract directly with providers in Minnesota is exempt from this section, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent in either the individual or small group market in Minnesota.

(b) Health carriers renting provider networks from other entities must submit the rental agreement or contract to the commissioner of health for approval. In reviewing the agreements or contracts, the commissioner shall review the agreement or contract to ensure that the entity contracting with health care providers accepts responsibility to meet the requirements in this section.

Subd. 1a. **Health care provider system access.** For those counties in which a health carrier actively markets an individual health plan, the health carrier must offer, in those same counties, at

least one individual health plan with a provider network that includes in-network access to more than a single health care provider system. This subdivision is applicable only for the year in which the health carrier actively markets an individual health plan.

Subd. 2. **Primary care; mental health services; general hospital services.** The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services.

Subd. 3. **Other health services.** The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

Subd. 5. **Waiver.** (a) A health carrier may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $500 for each application to waive the requirements in subdivision 2 or 3 for one or more provider types per county, and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address the network inadequacy, and, for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) The commissioner shall establish guidelines for evaluating waiver applications, standards governing approval or denial of a waiver application, and standards for steps that health carriers must take to address the network inadequacy and allow the health carrier to meet network adequacy requirements within a reasonable time period. The commissioner shall review each waiver application using these guidelines and standards and shall approve a waiver application only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for taking these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health carrier demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health carrier is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) The waiver shall automatically expire after one year. Upon or prior to expiration of a waiver, a health carrier unable to meet the requirements in subdivision 2 or 3 must submit a new waiver

application under paragraph (a) and must also submit evidence of steps the carrier took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the carrier for the most recent one-year period, the commissioner shall also examine the steps the carrier took during that one-year period to address network inadequacy, and shall only approve a subsequent waiver application that satisfies the requirements in paragraph (b), demonstrates that the carrier took the steps it proposed to address network inadequacy, and explains why the carrier continues to be unable to satisfy the requirements in subdivision 2 or 3.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Subd. 6. **Referral centers.** Subdivisions 2 and 3 shall not apply if an enrollee is referred to a referral center for health care services. A referral center is a medical facility that provides highly specialized medical care, including but not limited to organ transplants. A health carrier or preferred provider organization may consider the volume of services provided annually, case mix, and severity adjusted mortality and morbidity rates in designating a referral center.

Subd. 7. **Essential community providers.** Each health carrier must comply with section 62Q.19.

Subd. 8. **Enforcement.** The commissioner of health shall enforce this section.

62K.11 BALANCE BILLING PROHIBITED.

(a) A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service. A network provider is permitted to bill an enrollee the approved co-payment, deductible, or coinsurance.

(b) A network provider is permitted to bill an enrollee for services not covered by the enrollee's health plan as long as the enrollee agrees in writing in advance before the service is performed to pay for the noncovered service.

62K.12 QUALITY ASSURANCE AND IMPROVEMENT.

Subdivision 1. **General.** (a) All health carriers offering an individual health plan or small group health plan must have a written internal quality assurance and improvement program that, at a minimum:

(1) provides for ongoing evaluation of the quality of health care provided to its enrollees;

(2) periodically reports the evaluation of the quality of health care to the health carrier's governing body;

(3) follows policies and procedures for the selection and credentialing of network providers that is consistent with community standards;

(4) conducts focused studies directed at problems, potential problems, or areas with potential for improvements in care;

(5) conducts enrollee satisfaction surveys and monitors oral and written complaints submitted by enrollees or members; and

(6) collects and reports Health Effectiveness Data and Information Set (HEDIS) measures and conducts other quality assessment and improvement activities as directed by the commissioner of health.

(b) The commissioner of health shall submit a report to the chairs and ranking minority members of senate and house of representatives committees with primary jurisdiction over commerce and health policy by February 15, 2015, with recommendations for specific quality assurance and improvement standards for all Minnesota health carriers. The recommended standards must not require duplicative data gathering, analysis, or reporting by health carriers.

Subd. 2. **Exemption.** A health carrier that rents a provider network is exempt from this section, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent market share in either the individual or small group market in Minnesota.

Subd. 3. **Waiver.** A health carrier that has obtained accreditation through the URAC for network management; quality improvement; credentialing; member protection; and utilization management, or has achieved an excellent or commendable level ranking from the National Committee for Quality Assurance (NCQA), shall be deemed to meet the requirements of subdivision 1. Proof of accreditation

must be submitted to the commissioner of health in a form prescribed by the commissioner. The commissioner may adopt rules to recognize similar accreditation standards from any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans.

Subd. 4. **Enforcement.** The commissioner of health shall enforce this section.

62K.13 SERVICE AREA REQUIREMENTS.

(a) Any health carrier that offers an individual or small group health plan, must offer the health plan in a service area that is at least the entire geographic area of a county unless serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of enrollees. The service area for any individual or small group health plan must be established without regard to racial, ethnic, language, concentrated poverty, or health status-related factors, or other factors that exclude specific high-utilizing, high-cost, or medically underserved populations.

(b) If a health carrier that offers an individual or small group health plan requests to serve less than the entire county, the request must be made to the commissioner of health on a form and manner determined by the commissioner and must provide specific data demonstrating that the service area is not discriminatory, is necessary, and is in the best interest of enrollees.

(c) The commissioner of health shall enforce this section.

62K.14 LIMITED-SCOPE PEDIATRIC DENTAL PLANS.

(a) Limited-scope pediatric dental plans must be offered to the extent permitted under the Affordable Care Act: (1) on a guaranteed issue and guaranteed renewable basis; (2) with premiums rated on allowable rating factors used for health plans; and (3) without any exclusions or limitations based on preexisting conditions.

(b) Notwithstanding paragraph (a), a health carrier may discontinue a limited scope pediatric dental plan at the end of a plan year if the health carrier provides written notice to enrollees before coverage is to be discontinued that the particular plan is being discontinued and the health carrier offers enrollees other dental plan options that are the same or substantially similar to the dental plan being discontinued in terms of premiums, benefits, cost-sharing requirements, and network adequacy. The written notice to enrollees must be provided at least 105 days before the end of the plan year.

(c) Limited-scope pediatric dental plans must ensure primary care dental services are available within 60 miles or 60 minutes' travel time.

(d) If a stand-alone dental plan as defined under the Affordable Care Act or a limited-scope pediatric dental plan is offered, either separately or in conjunction with a health plan offered to individuals or small employers, the health plan shall not be considered in noncompliance with the requirements of the essential benefit package in the Affordable Care Act because the health plan does not offer coverage of pediatric dental benefits if these benefits are covered through the stand-alone or limited-scope pediatric dental plan, to the extent permitted under the Affordable Care Act.

(e) Health carriers offering limited-scope pediatric dental plans must comply with this section and sections 62K.07, 62K.08, 62K.13, and 62K.15.

(f) The commissioner of commerce shall enforce paragraphs (a) and (b). Any limited-scope pediatric dental plan that is to be offered to replace a discontinued dental plan under paragraph (b) must be approved by the commissioner of commerce in terms of cost and benefit similarity, and the commissioner of health in terms of network adequacy similarity. The commissioner of health shall enforce paragraph (c).

62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS.

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNsure. Nothing in this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) Health carriers offering individual health plans must provide a special enrollment period for enrollment in the individual market by employees of a small employer that offers a qualified small

employer health reimbursement arrangement in accordance with United States Code, title 26, section 9831(d). The special enrollment period shall be available only to employees newly hired by a small employer offering a qualified small employer health reimbursement arrangement, and to employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement. For employees newly hired by the small employer, the special enrollment period shall last for 30 days after the employee's first day of employment. For employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement, the special enrollment period shall last for 30 days after the date the arrangement is initially offered to employees.

(d) The commissioner of commerce shall enforce this section.

62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

Subd. 4. **Geographic premium variations.** Premium rates may vary based on geographic rating areas set by the commissioner. The commissioner shall grant approval if the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in rates.

62L.12 PROHIBITED PRACTICES.

Subd. 3. **Agent's licensure.** An agent licensed under chapter 60K or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual health plans to eligible employees and dependents of a small employer that meets the participation and contribution requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to disciplinary action, including the revocation or suspension of license, under section 60K.43 or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section 60K.43. The action of the commissioner is subject to judicial review as provided under chapter 14. This section does not apply to any action performed by an agent that would be permitted for a health carrier under subdivision 2.

Subd. 4. **Employer prohibition.** A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.