

SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1024

(SENATE AUTHORS: WIKLUND and Klein)		
DATE	D-PG	OFFICIAL STATUS
02/06/2025	297	Introduction and first reading
		Referred to Health and Human Services
03/13/2025		Comm report: To pass as amended and re-refer to Commerce and Consumer Protection

1.1

A bill for an act

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relating to health insurance; establishing a premium subsidy program administered

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by MNsure; providing a sunset for the Minnesota premium security plan;

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appropriating money; amending Minnesota Statutes 2024, section 62E.23,

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subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 62V;

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repealing Minnesota Statutes 2024, sections 62E.21; 62E.22; 62E.23; 62E.24;

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62E.25.

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

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Section 1. Minnesota Statutes 2024, section 62E.23, subdivision 1, is amended to read:

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Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance

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entity to administer the state-based reinsurance program referred to as the Minnesota premium

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security plan.

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(b) The association may apply for any available federal funding for the plan. All funds

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received by or appropriated to the association shall be deposited in the premium security

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plan account in section 62E.25, subdivision 1. The association shall notify the chairs and

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ranking minority members of the legislative committees with jurisdiction over health and

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human services and insurance within ten days of receiving any federal funds.

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(c) The association must collect or access data from an eligible health carrier that are

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necessary to determine reinsurance payments, according to the data requirements under

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subdivision 5, paragraph (c).

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(d) The board must not use any funds allocated to the plan for staff retreats, promotional

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giveaways, excessive executive compensation, or promotion of federal or state legislative

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or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, through August 15, 2026, the association must disburse all applicable reinsurance payments to an eligible health carrier.

(h) The association must disburse applicable reinsurance payments for claims costs incurred by eligible health carriers through December 31, 2025. Reinsurance payments are not available to eligible health carriers for claims costs incurred after December 31, 2025.

Sec. 2. **[62V.15] DEFINITIONS; PREMIUM SUBSIDY PROGRAM.**

Subdivision 1. **Scope.** For purposes of sections 62V.15 to 62V.17, the following terms have the meanings given.

Subd. 2. **Eligible individual.** (a) "Eligible individual" means a Minnesota resident who:
(1) is not receiving an advance premium tax credit under Code of Federal Regulations, title 26, part 1.36B-2, in a month in which the eligible individual's coverage is effective;
(2) is not enrolled in public program coverage under section 256B.055 or 256L.04; and
(3) purchased an individual health plan, as defined in section 62A.011.

(b) "Eligible individual" includes a person required to repay an advanced premium tax credit because the person's income was subsequently determined to exceed the maximum permissible amount to qualify as an applicable taxpayer under Code of Federal Regulations, title 26, part 1.36B-2.

Subd. 3. **Gross premium.** "Gross premium" means the amount billed for a health plan purchased by an eligible individual prior to a premium subsidy in a calendar year.

Subd. 4. **Net premium.** "Net premium" means the gross premium less the premium subsidy.

Subd. 5. **Premium subsidy.** "Premium subsidy" means a payment (1) made on behalf of an eligible individual to promote general welfare, and (2) that is not compensation for a service rendered.

3.1 Sec. 3. **[62V.16] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE**
3.2 **INDIVIDUALS.**

3.3 Subdivision 1. **Program established.** Beginning January 1, 2026, the board of directors
3.4 of MNsure, in consultation with the commissioners of commerce and human services, must
3.5 establish and administer the premium subsidy program authorized by this section to help
3.6 eligible individuals pay for coverage in the individual market.

3.7 Subd. 2. **Premium subsidy provided.** (a) A health carrier must provide a premium
3.8 subsidy to each eligible individual who purchases an individual health plan, as defined in
3.9 section 62A.011, from the health carrier. The premium subsidy must be provided for each
3.10 month the net premium is paid. An eligible individual must pay the net premium amount
3.11 to the health carrier.

3.12 (b) Each premium subsidy must be equal to 20 percent of the monthly gross premium
3.13 otherwise paid by or on behalf of the eligible individual for coverage purchased in the
3.14 individual market that covers the eligible individual and the eligible individual's spouse and
3.15 dependents.

3.16 (c) The premium subsidy must be excluded from a calculation used to determine eligibility
3.17 for a Department of Human Services program.

3.18 Subd. 3. **Payments to health carriers.** (a) The board must make payments to health
3.19 carriers on behalf of eligible individuals effectuating coverage for a calendar year for the
3.20 months during the calendar year for which the individual has paid the net premium amount
3.21 to the health carrier. A payment to a health carrier must be based on the premium subsidy
3.22 available to eligible individuals in the individual market, regardless of the cost of the coverage
3.23 purchased. The board must not withhold payment because a health carrier cannot prove an
3.24 enrollee is an eligible individual.

3.25 (b) In order to be eligible for payment, a health carrier seeking reimbursement from the
3.26 board must submit an invoice and supporting information to the board, using a form
3.27 developed by the board. The board must finalize the form by November 1, 2025.

3.28 (c) The board must consider a health carrier as a vendor under section 16A.124,
3.29 subdivision 3, and each monthly invoice must represent the services that have been completed
3.30 or delivered.

3.31 (d) With each November forecast under section 16A.103, the board must certify the
3.32 extent to which appropriations exceed forecast obligations under this subdivision.

4.1 Subd. 4. **Retroactive payments to individuals.** The board must make retroactive subsidy
4.2 payments directly to an individual for any month the individual is required to repay an
4.3 advanced premium tax credit because the individual's income exceeded the maximum
4.4 permissible amount to qualify as an applicable taxpayer under Code of Federal Regulations,
4.5 title 26, part 1.36B-2.

4.6 Subd. 5. **Data practices.** (a) The definitions in section 13.02 apply to this subdivision.

4.7 (b) Government data on an enrollee or health carrier under this section are private data
4.8 on individuals or nonpublic data, except that the total reimbursement requested by a health
4.9 carrier and the total state payment to the health carrier are public data.

4.10 Subd. 6. **Data sharing.** (a) Notwithstanding any law to the contrary, a government entity
4.11 is permitted to share or disseminate data as follows:

4.12 (1) the commissioner of human services must share data on public program enrollment
4.13 under sections 256B.055 and 256L.04 with the board; and

4.14 (2) the board must disseminate data on an enrollee's public program coverage enrollment
4.15 under sections 256B.055 and 256L.04 to health carriers to the extent the board determines
4.16 data sharing is necessary to determine the enrollee's eligibility for the premium subsidy
4.17 program authorized by this section.

4.18 (b) Data shared under this subdivision may be collected, stored, or used only to administer
4.19 the premium subsidy program authorized by this section, and must not be further shared or
4.20 disseminated except as otherwise provided by law.

4.21 **Sec. 4. [62V.17] APPLICABILITY OF GROSS PREMIUM.**

4.22 Notwithstanding premium subsidies provided under section 62V.16, subdivision 2, the
4.23 premium base to calculate any applicable premium taxes under chapter 297I is the gross
4.24 premium for health plans purchased by eligible individuals in the individual market.

4.25 **Sec. 5. APPROPRIATION.**

4.26 \$..... in fiscal year 2026 is appropriated from the general fund to the Board of Directors
4.27 of MNsure for premium assistance under Minnesota Statutes, section 62V.16. Any amount
4.28 that remains unexpended after fiscal year 2026 does not cancel and is available in fiscal
4.29 year 2027.

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Sec. 6. **REPEALER.**

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Minnesota Statutes 2024, sections 62E.21; 62E.22; 62E.23; 62E.24; and 62E.25, are

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repealed.

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EFFECTIVE DATE. This section is effective August 16, 2026.

62E.21 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

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

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

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

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

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

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

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

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

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

Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

62E.22 DUTIES OF COMMISSIONER.

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

62E.23 MINNESOTA PREMIUM SECURITY PLAN.

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members

of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

- (1) will stabilize or reduce premium rates in the individual market;
- (2) will increase participation in the individual market;
- (3) will improve access to health care providers and services for those in the individual market;
- (4) mitigate the impact high-risk individuals have on premium rates in the individual market;
- (5) take into account any federal funding available for the plan; and
- (6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at \$50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at \$250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

(c) Notwithstanding paragraph (a), the payment parameters for benefit years 2023 through 2027 are:

- (1) an attachment point of \$50,000;

- (2) a coinsurance rate of 80 percent; and
- (3) a reinsurance cap of \$250,000.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is \$0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

- (1) the claims costs minus the attachment point; or
- (2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

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

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

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

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

- (1) provide a written corrective action plan to the association for approval;
- (2) implement the approved plan; and
- (3) provide the association with written documentation of the corrective action once taken.

Subd. 6. **Data.** Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivision 9 or 12.

62E.24 ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.

Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year of all:

- (1) funds appropriated for reinsurance payments and administrative and operational expenses;
- (2) requests for reinsurance payments received from eligible health carriers;
- (3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** (a) The board must submit to the commissioner and to the chairs and ranking minority members of the legislative committees with jurisdiction over commerce and health and make available to the public quarterly reports on plan operations and an annual report summarizing the plan operations for each benefit year. All reports must be made public by posting the report on the Minnesota Comprehensive Health Association website. The annual summary must be made available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

(b) The reports must include information about:

(1) the reinsurance parameters used;

(2) the metal levels affected;

(3) the number of claims payments estimated and submitted for payment per products offered on-exchange and off-exchange and per eligible health carrier;

(4) the estimated reinsurance payments by plan type based on carrier-submitted templates;

(5) funds appropriated for reinsurance payments and administrative and operational expenses for each year, including the federal and state contributions received, investment income, and any other revenue or funds received;

(6) the total amount of reinsurance payments made to each eligible health carrier; and

(7) administrative and operational expenses incurred for the plan, including the total amount incurred and as a percentage of the plan's operational budget.

Subd. 3. **Legislative auditor.** The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. **Independent external audit.** (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association website and making the audit results otherwise available.

Subd. 5. **Actions on audit findings.** (a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

62E.25 ACCOUNTS.

Subdivision 1. **Premium security plan account.** The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. **Deposits.** Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. **Basic health plan trust account.** Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in Laws 2017, chapter 13, article 1, section 8, that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.