State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1704

02/27/2017 Authored by Dean, M.,
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to health; adding provisions to the Minnesota Health Plan Market Rules; designating essential community provider; requiring audits of health carriers' financial records; allowing in certain circumstances continuation of services when an enrollee changes health plans; amending Minnesota Statutes 2016, sections 62K.10, subdivisions 4, 5; 62Q.19, by adding a subdivision; 62Q.56, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. Minnesota Statutes 2016, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** (a) 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.

(b) Each carrier offering a health plan in any service area established under section 62K.13 that includes one or more counties with fewer than 32 people per square mile, as measured by the United States Census Bureau, must offer at least one plan at each metal level with a designated provider network that includes all available accredited primary care providers offering health care services within that service area.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to health plans with an effective date on or after January 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) A health carrier or preferred provider organization 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 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 because:

(i) the health carrier or preferred provider organization conducted a good faith search for providers and there were no providers physically present in the service area; or

(ii) the providers physically present in the service area did not meet the health carrier's or the preferred provider organization's credentialing requirements; and

(2) include information as to the steps that were and will be taken to address the network inadequacy.

The waiver shall automatically expire after four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.

(b) A health carrier or preferred provider organization's contract with an exclusive provider, such as an accountable care organization or other entity operating a health care delivery system, is not by itself a basis for a waiver from the requirements of this section.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to health plans with an effective date on or after January 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 62Q.19, is amended by adding a subdivision to read:

Subd. 8. **Federal designation.** Any provider that meets the definition of an essential community provider under section 340B of the Public Health Service Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act must also be designated by the commissioner as an essential community provider under this section.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to health plans with an effective date on or after January 1, 2018.

Sec. 4. **[62Q.371] AUDIT OF HEALTH CARRIERS.**

Subdivision 1. **Applicability.** This section applies to all health carriers, as defined by section 62A.011, subdivision 2, and affiliated health plan companies, except for fraternal benefit societies and joint self-insurance employee health plans.

Subd. 2. **Financial examinations required regularly.** (a) The legislative auditor shall annually audit the financial records of all health carriers to determine whether health carriers properly allocate medical and administrative expenses across various product lines including but not limited to state public programs, the individual insurance market, the small group insurance market, the large group insurance market, the market for self-insured businesses or any insurance market operations outside Minnesota. The audit required by this section shall adhere to the standards described in section 60A.1291. The first audit shall include financial records for products sold during the 2012 to 2016 years. Subsequent audits may be limited to products sold in the single most current year for which data are available.

(b) For purposes of the audit, health carriers shall aggregate and make available to the auditor on request quarterly financial and utilization information for separate lines of commercial businesses, including the employer market, the individual and small group market, the market for services delivered to self-insured employers, and commercial health coverage provided under section 256B.69, subdivision 9c.

Subd. 3. **Administrative expenses.** The audit shall determine whether health carriers appropriately attributed administrative expenses and investment income to each respective product line and whether health carriers' costs for providing all forms of commercial insurance have been funded exclusively through surplus from commercial lines of business

or built into premiums for the commercial population. The auditor shall use the standard of "administrative expenses" as described in section 259B.69, subdivision 5i, or describe an alternative standard determined by the auditor to be appropriate for this audit.

Subd. 4. **Reserves.** The audit shall evaluate all forms of health carriers' reserves, including capital reserves, policy deficiency reserves, ongoing claims reserves and other forms of financial vehicles intended to reserve against financial and business risk, to determine whether there has been commingling of reserves from state health care programs and commercial market revenue and make recommendations for any changes to state law required to prevent the possibility of commingling in the future. The audit shall additionally track financial transactions between nonprofit foundations or affiliated entities of health carriers to determine their timing, use and source of transferred funds, including whether the transferred funds should be classified as reserves.

Subd. 5. **Other state operations.** The audit shall report on whether financial resources derived from Minnesota payers have been used to expand or subsidize health carrier business operations in other states.

Subd. 6. **Provider rate variation.** As part of the audit, the auditor shall make recommendations on any changes in law needed to regularly evaluate the differences between prices extended to providers for commercial and state health care program enrollees through a statistically valid sampling of rates paid to providers. As part of this effort, the auditor may consider recommending changes to better align existing public program and commercial insurance financial reporting by health carriers to the Departments of Human Services, Health, and Commerce. The auditor may coordinate the activity required by this subdivision with an existing evaluation effort by the commissioners of human services and health.

Subd. 7. **Access to data.** (a) The legislative auditor, and any contracted vendor that the auditor engages to carry out the requirements of this section, shall have timely access to any health carrier data necessary to complete the requirements of this section. Data requested from health carriers, including new reporting under subdivision 2, paragraph (b), shall be provided within 30 days of a written request by the auditor.

(b) In addition, the legislative auditor shall have access to all information reported by health carriers to:

(1) the commissioner of health under chapters 62J and 62U and Minnesota Rules, chapters 4642 and 4653;

(2) the National Association of Insurance Commissioners;

(3) the commissioner of commerce; and

(4) any vendor completing the financial audits required under section 256B.69, subdivision 9e.

(c) Effective January 1, 2018, and on a quarterly basis thereafter, each health carrier must provide to the legislative auditor, and any contracted vendor that it engages to carry out the requirements of this section, the equivalent commercial health insurance information for all elements of data described in section 256B.69, subdivision 9c, paragraph (b).

Subd. 8. **Reporting.** The legislative auditor shall submit an interim report with initial findings from the audit to the Legislative Audit Commission and the legislative committees with jurisdiction over health policy and finance by December 1, 2017, and a final report by May 1, 2018. In subsequent years, the legislative auditor shall publish new audit findings by April 1.

Subd. 9. **Authority.** The legislative auditor may use any existing authority under sections 3.971 to 3.979, including the power to subpoena while conducting the audit.

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

Sec. 5. Minnesota Statutes 2016, section 62Q.56, is amended by adding a subdivision to read:

Subd. 1c. **Change in health care provider; involuntary termination of coverage.** (a) The protections and requirements of subdivision 1a also apply to any enrollee subject to a change in health plan in the individual market, as defined by section 62A.011, subdivision 5, due to the health plan company's refusal to renew the health plan in the individual market because the health plan company elects to cease offering individual market health plans in all or some geographic rating areas of the state.

(b) If an enrollee satisfies the eligibility criteria in subdivision 1a, paragraph (b), the enrollee's new health plan must provide, upon request of the enrollee or the enrollee's health care provider, authorization to receive services that are otherwise covered under the terms of the enrollee's new health plan from a provider who provided care on an in-network basis to the enrollee during the prior calendar year but who is out of network in the enrollee's new health plan.

(c) For all requests for authorization under this subdivision, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria in subdivision 1a, paragraph (b), clause (1).

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

(e) The enrollee's health plan company may require medical records and other supporting documentation to be submitted with a request for authorization made under subdivision 3 to the extent that the records and other documentation are relevant to a determination regarding the existence of a condition under in subdivision 1a, paragraph (b). If authorization is denied, the health plan company must explain the criteria used to make its decision on the request for authorization and must explain the enrollee's right to appeal the decision. If an enrollee chooses to appeal a denial, the enrollee must appeal the denial within five business days of the date on which the enrollee receives the denial. If authorization is granted, the health plan company must provide the enrollee, within five business days of granting the authorization, with an explanation of how transition of care will be provided.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to health plans with an effective date on or after January 1, 2018.