A bill for an act

relating to health; modifying health care provisions; amending welfare data provisions; changing medical assistance eligibility; amending MinnesotaCare provisions; establishing MinnesotaCare II; allowing the commissioner to receive federal matching money for managed care oversight; establishing a physician-directed care coordination program; establishing the Minnesota Health Insurance Exchange; requiring certain employers to offer Section 125 Plans; amending Minnesota Statutes 2006, sections 13.46, subdivision 2; 62A.65, subdivision 3; 62E.141; 62L.12, subdivision 2; 256.01, subdivision 2b; 256B.057, subdivision 8; 256B.0625, by adding a subdivision; 256L.02, subdivision 3, by adding subdivisions; 256L.04, subdivision 1; 256L.05, subdivision 5, by adding a subdivision; 256L.06, subdivision 3; 256L.12, subdivision 7; 256L.15, subdivisions 1a, 2, by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapters 62A; 256L; repealing Minnesota Statutes 2006, section 256L.15, subdivision 2.

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

ARTICLE 1
HEALTH INSURANCE

Section 1. Minnesota Statutes 2006, section 13.46, subdivision 2, is amended to read:

Subd. 2. **General.** (a) Unless the data is summary data or a statute specifically provides a different classification, data on individuals collected, maintained, used, or disseminated by the welfare system is private data on individuals, and shall not be disclosed except:

(1) according to section 13.05;

(2) according to court order;

(3) according to a statute specifically authorizing access to the private data;

(4) to an agent of the welfare system, including a law enforcement person, attorney, or investigator acting for it in the investigation or prosecution of a criminal or civil proceeding relating to the administration of a program;

(5) to personnel of the welfare system who require the data to verify an individual's identity; determine eligibility, amount of assistance, and the need to provide services to an individual or family across programs; evaluate the effectiveness of programs; and investigate suspected fraud;

(6) to administer federal funds or programs;

(7) between personnel of the welfare system working in the same program;

(8) to the Department of Revenue to administer and evaluate tax refund or tax credit programs and to identify individuals who may benefit from these programs. The following information may be disclosed under this paragraph: an individual's and their dependent's names, dates of birth, Social Security numbers, income, addresses, and other data as required, upon request by the Department of Revenue. Disclosures by the commissioner of revenue to the commissioner of human services for the purposes described in this clause are governed by section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited to, the dependent care credit under section 290.067, the Minnesota working family credit under section 290.0671, the property tax refund and rental credit under section 290A.04, and the Minnesota education credit under section 290.0674;

(9) between the Department of Human Services, the Department of Education, and the Department of Employment and Economic Development for the purpose of monitoring the eligibility of the data subject for unemployment benefits, for any employment or training program administered, supervised, or certified by that agency, for the purpose of administering any rehabilitation program or child care assistance program, whether alone or in conjunction with the welfare system, or to monitor and evaluate the Minnesota family investment program by exchanging data on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons;

(11) data maintained by residential programs as defined in section 245A.02 may be disclosed to the protection and advocacy system established in this state according to Part C of Public Law 98-527 to protect the legal and human rights of persons with developmental disabilities or other related conditions who live in residential facilities for these persons if the protection and advocacy system receives a complaint by or on behalf

of that person and the person does not have a legal guardian or the state or a designee of the state is the legal guardian of the person;

(12) to the county medical examiner or the county coroner for identifying or locating relatives or friends of a deceased person;

(13) data on a child support obligor who makes payments to the public agency may be disclosed to the Minnesota Office of Higher Education to the extent necessary to determine eligibility under section 136A.121, subdivision 2, clause (5);

(14) participant Social Security numbers and names collected by the telephone assistance program may be disclosed to the Department of Revenue to conduct an electronic data match with the property tax refund database to determine eligibility under section 237.70, subdivision 4a;

(15) the current address of a Minnesota family investment program participant may be disclosed to law enforcement officers who provide the name of the participant and notify the agency that:

(i) the participant:

(A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony under the laws of the jurisdiction from which the individual is fleeing; or

(B) is violating a condition of probation or parole imposed under state or federal law;

(ii) the location or apprehension of the felon is within the law enforcement officer's official duties; and

(iii) the request is made in writing and in the proper exercise of those duties;

(16) the current address of a recipient of general assistance or general assistance medical care may be disclosed to probation officers and corrections agents who are supervising the recipient and to law enforcement officers who are investigating the recipient in connection with a felony level offense;

(17) information obtained from food support applicant or recipient households may be disclosed to local, state, or federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food Stamp Act, according to Code of Federal Regulations, title 7, section 272.1(c);

(18) the address, Social Security number, and, if available, photograph of any member of a household receiving food support shall be made available, on request, to a local, state, or federal law enforcement officer if the officer furnishes the agency with the name of the member and notifies the agency that:

(i) the member:

(A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

(B) is violating a condition of probation or parole imposed under state or federal law; or

(C) has information that is necessary for the officer to conduct an official duty related to conduct described in subitem (A) or (B);

(ii) locating or apprehending the member is within the officer's official duties; and

(iii) the request is made in writing and in the proper exercise of the officer's official duty;

(19) the current address of a recipient of Minnesota family investment program, general assistance, general assistance medical care, or food support may be disclosed to law enforcement officers who, in writing, provide the name of the recipient and notify the agency that the recipient is a person required to register under section 243.166, but is not residing at the address at which the recipient is registered under section 243.166;

(20) certain information regarding child support obligors who are in arrears may be made public according to section 518A.74;

(21) data on child support payments made by a child support obligor and data on the distribution of those payments excluding identifying information on obligees may be disclosed to all obligees to whom the obligor owes support, and data on the enforcement actions undertaken by the public authority, the status of those actions, and data on the income of the obligor or obligee may be disclosed to the other party;

(22) data in the work reporting system may be disclosed under section 256.998, subdivision 7;

(23) to the Department of Education for the purpose of matching Department of Education student data with public assistance data to determine students eligible for free and reduced price meals, meal supplements, and free milk according to United States Code, title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state funds that are distributed based on income of the student's family; and to verify receipt of energy assistance for the telephone assistance plan;

(24) the current address and telephone number of program recipients and emergency contacts may be released to the commissioner of health or a local board of health as defined in section 145A.02, subdivision 2, when the commissioner or local board of health has reason to believe that a program recipient is a disease case, carrier, suspect case, or at risk of illness, and the data are necessary to locate the person;

(25) to other state agencies, statewide systems, and political subdivisions of this state, including the attorney general, and agencies of other states, interstate information

networks, federal agencies, and other entities as required by federal regulation or law for the administration of the child support enforcement program;

(26) to personnel of public assistance programs as defined in section 256.741, for access to the child support system database for the purpose of administration, including monitoring and evaluation of those public assistance programs;

(27) to monitor and evaluate the Minnesota family investment program by exchanging data between the Departments of Human Services and Education, on recipients and former recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter 119B, or medical programs under chapter 256B, 256D, or 256L;

(28) to evaluate child support program performance and to identify and prevent fraud in the child support program by exchanging data between the Department of Human Services, Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b), without regard to the limitation of use in paragraph (c), Department of Health, Department of Employment and Economic Development, and other state agencies as is reasonably necessary to perform these functions; ~~or~~

(29) counties operating child care assistance programs under chapter 119B may disseminate data on program participants, applicants, and providers to the commissioner of education~~.~~; or

(30) according to section 256L.02, subdivision 6, between the welfare system and the Minnesota Health Insurance Exchange, under section 62A.67, in order to enroll and collect premiums from individuals in the MinnesotaCare program under chapter 256L and to administer the individual's and their families' participation in the program.

(b) Information on persons who have been treated for drug or alcohol abuse may only be disclosed according to the requirements of Code of Federal Regulations, title 42, sections 2.1 to 2.67.

(c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16), (17), or (18), or paragraph (b), are investigative data and are confidential or protected nonpublic while the investigation is active. The data are private after the investigation becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

(d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but is not subject to the access provisions of subdivision 10, paragraph (b).

For the purposes of this subdivision, a request will be deemed to be made in writing if made through a computer interface system.

Sec. 2. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments.** The commissioner shall develop and implement a pay-for-performance system to provide performance payments to medical groups that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L. The commissioner may receive any federal matching money that is made available through the medical assistance program for managed care oversight contracted through vendors including consumer surveys, studies, and external quality reviews as required by the Federal Balanced Budget Act of 1997, Code of Federal Regulations, title 42, part 438, subpart E. Any federal money received for managed care oversight is appropriated to the commissioner for this purpose. The commissioner may expend the federal money received in either year of the biennium.

Sec. 3. Minnesota Statutes 2006, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above 275 percent of the federal poverty guidelines for the same size family but less than or equal to ~~280~~ 305 percent of the federal poverty guidelines for the same size family.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the Office of the Revisor of Statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2006, section 256B.0625, is amended by adding a subdivision to read:

Subd. 49. **Physician-directed care coordination services.** The commissioner shall develop and implement a physician-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program will provide payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans, have a dedicated care coordinator, have an adequate number of fee-for-service clients, have evaluation mechanisms, and quality improvement processes to qualify for reimbursement.

Sec. 5. Minnesota Statutes 2006, section 256L.02, subdivision 3, is amended to read:

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As

part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house Ways and Means Committee and the senate Finance Committee, and the Legislative Commission on Health Care Access, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of finance makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

(c) The commissioner shall work in cooperation with the Minnesota Health Insurance Exchange under section 62A.67 to make adjustments under paragraph (b) as required under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 6. Minnesota Statutes 2006, section 256L.02, is amended by adding a subdivision to read:

Subd. 5. **Enrollment responsibilities.** According to section 256L.05, subdivision 6, effective January 1, 2009, the Minnesota Health Insurance Exchange under section 62A.67 shall assume responsibility for enrolling eligible applicants and enrollees in a health

plan for MinnesotaCare coverage. The commissioner shall maintain responsibility for determining eligibility for MinnesotaCare.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 7. Minnesota Statutes 2006, section 256L.02, is amended by adding a subdivision to read:

Subd. 6. **Exchange of data.** An entity that is part of the welfare system as defined in section 13.46, subdivision 1, paragraph (c), and the Minnesota Health Insurance Exchange under section 62A.67 may exchange private data about individuals without the individual's consent in order to enroll and collect premiums from individuals in the MinnesotaCare program under chapter 256L and to administer the individual's and the individual's family's participation in the program. This subdivision only applies if the entity that is part of the welfare system and the Minnesota Health Insurance Exchange have entered into an agreement that complies with the requirements in Code of Federal Regulations, title 45, section 164.314.

Sec. 8. Minnesota Statutes 2006, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) A child in a family with family income equal to or less than 300 percent of the federal poverty guidelines for the applicable family size is eligible for MinnesotaCare under this section. Adults in families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds $50,000.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner of human services shall notify the Office of the Revisor of Statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2006, section 256L.05, subdivision 5, is amended to read:

Subd. 5. **Availability of private insurance.** (a) The commissioner~~, in consultation with the commissioners of health and commerce,~~ shall provide information regarding the availability of private health insurance coverage and the~~ possibility of disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), to all: (1) families enrolled in the MinnesotaCare program whose gross family income is equal to or more than 225 percent of the federal poverty guidelines; and (2) single adults and households without children enrolled in the MinnesotaCare program whose gross family income is equal to or more than 165 percent of the federal poverty guidelines. This information must be provided~~ Minnesota Health Insurance Exchange under section 62A.67 upon initial enrollment and annually thereafter. ~~The commissioner shall also include information regarding the availability of private health insurance coverage in~~

(b) The notice of ineligibility provided to persons subject to disenrollment under section 256L.07, subdivision 1, paragraphs (b) and (c), must include information about assistance with identifying and selecting private health insurance coverage provided by the Minnesota Health Insurance Exchange under section 62A.67.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 10. Minnesota Statutes 2006, section 256L.05, is amended by adding a subdivision to read:

Subd. 6. **Minnesota Health Insurance Exchange.** The commissioner shall refer all MinnesotaCare applicants and enrollees to the Minnesota Health Insurance Exchange under section 62A.67. The Minnesota Health Insurance Exchange shall provide those referred with assistance in selecting a managed care plan through which to receive MinnesotaCare covered services and in analyzing health plans available through the private market. MinnesotaCare applicants and enrollees shall effect enrollment in a managed care plan or a private market health plan product through the Minnesota Health Insurance Exchange.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 11. Minnesota Statutes 2006, section 256L.06, subdivision 3, is amended to read:

Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the commissioner for MinnesotaCare.

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments at the time of eligibility renewal, based upon both increases and decreases in enrollee income~~, at the time the change in income is reported~~; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

(c) Premiums are calculated on a calendar month basis and may be paid on a monthly, quarterly, or semiannual basis, with the first payment due upon notice from the commissioner of the premium amount required. The commissioner shall inform applicants and enrollees of these premium payment options. Premium payment is required before enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments received before noon are credited the same day. Premium payments received after noon are credited on the next working day.

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed. Persons disenrolled for nonpayment who pay all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.

EFFECTIVE DATE. This section is effective January 1, 2009, or upon federal approval, whichever is later. The commissioner shall notify the Office of the Revisor of Statutes when federal approval is obtained.

Sec. 12. **[256L.075] MINNESOTACARE II OPTION ESTABLISHED.**

Subdivision 1. **Program established; enrollment.** The Minnesota Health Insurance Exchange under section 62A.67, in consultation with the commissioner, shall establish

and administer a program that subsidizes the purchase of private market health plans for children eligible for MinnesotaCare in families with family income above 200 percent, but not exceeding 300 percent, of the federal poverty guidelines. The program established under this section is referred to as MinnesotaCare II. The private market health coverage provided under this section is an alternative to coverage under section 256L.03. Notwithstanding section 256L.12, children obtaining coverage under this section shall enroll in a health plan, as defined in section 62A.011, subdivision 3, through the individual markets that covers, at a minimum, the standard benefit set established in subdivision 2. Enrollment under this section is administered by the Minnesota Health Insurance Exchange. Eligibility under this section is determined by the commissioner. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, apply to this section unless otherwise specified.

Subd. 2. **Benefit set.** The Minnesota Health Insurance Exchange, in consultation with the commissioner, shall establish a standard benefit set for health plans that qualify for a subsidy under this section. The standard benefit set must be reviewed, and, if necessary, modified on an annual basis. Notwithstanding section 256L.03, subdivision 5, the benefit set may require co-payments, deductibles, and maximum annual out-of-pocket enrollee cost-sharing limits.

Subd. 3. **Health carrier participation.** (a) Health insurers with at least three percent of the market share of premium volume from individual market health plans as determined from loss ratio reports filed under section 62A.021, subdivision 1, paragraph (h), shall offer at least one health plan that covers the standard benefit set, or its actuarial equivalent as determined by the commissioner of commerce, to children enrolled under this section. Health insurers shall offer a health plan that covers the standard benefit set, without a subsidy, to adults so that families can enroll in a single plan. Health insurers that are not required to participate may participate voluntarily. The Minnesota Health Insurance Exchange shall certify those health plans that meet the standards in subdivision 2 and qualify for a subsidy under this section.

(b) Health insurers offering coverage under this section may offer up to three additional health plan products approved by the commissioner of commerce as actuarially equivalent or better than the standard plan established in subdivision 2. The additional products must also qualify for a subsidy if purchased to cover children eligible under this section.

(c) Nothing in this subdivision requires guaranteed issue of Minnesota Care II health plans.

Subd. 4. **State subsidy; premium.** The cost of coverage for children enrolled under this section shall be subsidized based on a sliding scale. The amount of the subsidy provided for a child shall be equal to the cost of the least expensive health plan certified to participate under this section less an amount equal to one-half of the premium that would be paid for the child under section 256L.15, subdivision 2. The commissioner shall pay the subsidy to the Minnesota Health Insurance Exchange. The premium for a child enrolled under this section is equal to the difference between the cost of the health plan through which the coverage is provided and the amount of the subsidy. The subsidy amount for a family with three children shall apply to families with more than three children. The premium shall be paid to the Minnesota Health Insurance Exchange.

Subd. 5. **Enrollment; limitation on changing plans.** Notwithstanding section 256L.04, subdivision 1, individual children in a family may enroll under this section or under section 256L.03. A child enrolled under this section may change health plans or switch to coverage under section 256L.03 once annually during an open enrollment period. An enrollee may change health plans or switch to coverage under section 256L.03 at other times during the year if the family of the child experiences a qualifying life event, including, but not limited to, marriage, divorce, a change in dependent status, change in family size, or a change in eligibility for state health care programs under this chapter or chapter 256B or 256D.

Subd. 6. **Bonus accounts incentive.** The Minnesota Health Insurance Exchange shall administer bonus accounts for families with children enrolled under this section. Funds must be credited to a bonus account when a child covered under this section achieves specific goals for preventive services or healthy behaviors. Funds credited to an account can be used by a family to reimburse qualified medical expenses as defined in section 213(d) of the Internal Revenue Code. The commissioner, in consultation with the Minnesota Health Insurance Exchange, shall establish a schedule of preventive service and healthy behavior goals that qualify for a credit and corresponding credit amounts. Families with children enrolled under this section can qualify for credits of up to $50 per year per child, up to a maximum of $150 per year per family. Funds held in the account are available to a family until:

(1) there is no longer a child under age 21 in the family; or

(2) no child in the family has been enrolled under chapter 256B or 256L, or in a health plan through the Minnesota Health Insurance Exchange for the past six months.

Subd. 7. **Federal approval.** The commissioner shall seek all federal waivers and approvals necessary to implement and receive federal financial participation for expenditures under this section.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 13. Minnesota Statutes 2006, section 256L.12, subdivision 7, is amended to read:

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; ~~and~~

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services~~.~~; and

(9) shall participate in the Minnesota Health Insurance Exchange under section 62A.67 for the purpose of enrolling individuals under this chapter.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 14. Minnesota Statutes 2006, section 256L.15, subdivision 1a, is amended to read:

Subd. 1a. **Payment options.** (a) The commissioner may offer the following payment options to an enrollee:

(1) payment by check;

(2) payment by credit card;

(3) payment by recurring automatic checking withdrawal;

(4) payment by onetime electronic transfer of funds;

(5) payment by wage withholding with the consent of the employer and the employee; or

(6) payment by using state tax refund payments.

At application or reapplication, a MinnesotaCare applicant or enrollee may authorize the commissioner to use the Revenue Recapture Act in chapter 270A to collect funds from the applicant's or enrollee's refund for the purposes of meeting all or part of the applicant's or enrollee's MinnesotaCare premium obligation. The applicant or enrollee may authorize the commissioner to apply for the state working family tax credit on behalf of the applicant or enrollee. The setoff due under this subdivision shall not be subject to the $10 fee under section 270A.07, subdivision 1.

(b) Effective January 1, 2009, the Minnesota Health Insurance Exchange under section 62A.67 is responsible for collecting MinnesotaCare premiums.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 15. Minnesota Statutes 2006, section 256L.15, subdivision 2, is amended to read:

Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish a sliding fee scale to determine the percentage of monthly gross individual or family income that households at different income levels must pay to obtain coverage through the MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly gross individual or family income. The sliding fee scale must contain separate tables based on enrollment of one, two, or three or more persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, up to a family size of five. The sliding fee scale for a family of five must be used for families of more than five. Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14. If a family or individual reports increased income after enrollment, premiums shall be adjusted at the time the change in income is reported.

(b) Children in families whose gross income is above 275 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

~~(c) After calculating the percentage of premium each enrollee shall pay under paragraph (a), eight percent shall be added to the premium.~~

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 16. Minnesota Statutes 2006, section 256L.15, is amended by adding a subdivision to read:

Subd. 2a. **Sliding fee scale; monthly gross individual or family income.** (a) The commissioner shall establish sliding fee scales to determine the premiums that individuals or families must pay to obtain coverage through the MinnesotaCare program. The sliding fee scales must be based on the enrollee's monthly gross individual or family income. Separate sliding fee scales shall be established for adults and children. The sliding fee scale premiums for adults and children will be combined to develop a single MinnesotaCare premium for a family.

(b) The sliding fee scale for adults must contain separate tables based on enrollment of one or two persons. The sliding fee scale begins with a premium of 1.5 percent of monthly gross individual or family income for individuals or families with incomes below the limits for the medical assistance program for families and children in effect on January 1, 1999, and proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and 8.8 percent. These percentages are matched to evenly spaced income steps ranging from the medical assistance income limit for families and children in effect on January 1, 1999, to 275 percent of the federal poverty guidelines for the applicable family size, subject to paragraph (d). Effective October 1, 2003, the commissioner shall increase each percentage by 0.5 percentage points for enrollees with income greater than 100 percent but not exceeding 200 percent of the federal poverty guidelines and shall increase each percentage by 1.0 percentage points for families and children with incomes greater

than 200 percent of the federal poverty guidelines. The sliding fee scale and percentages are not subject to the provisions of chapter 14.

(c) The sliding fee scale for children begins with a premium of $11 per child for households with incomes equal to or greater than 150 percent of the federal poverty guidelines. Premiums must be adjusted at evenly spaced income steps at increments of five percent of the federal poverty guidelines to a maximum premium of $88 per child for households with incomes equal to 300 percent of the federal poverty guidelines. Premiums must be calculated for up to three children per family. Premiums for children must be adjusted annually at an amount that is proportional to the annual adjustment in premiums for adults. The sliding fee scale in this paragraph does not apply to children enrolled under section 256L.075. The sliding fee scale is not subject to the provisions of chapter 14.

(d) The total family premium established in this section shall be based on a household with one or two adults and one, two, or three children. The sliding fee scale for a family with three children must be used for families with more than three children.

(e) If a family or individual reports a change in income after enrollment, premiums shall not be adjusted until eligibility renewal.

(f) Children in families whose gross income is above 300 percent of the federal poverty guidelines shall pay the maximum premium. The maximum premium is defined as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare cases paid the maximum premium, the total revenue would equal the total cost of MinnesotaCare medical coverage and administration. In this calculation, administrative costs shall be assumed to equal ten percent of the total. The costs of medical coverage for pregnant women and children under age two and the enrollees in these groups shall be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 17. Minnesota Statutes 2006, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **Premium discount incentive.** Adults and families with children are eligible for a premium reduction of $3 per month for each child who met goals for preventive care or an adult who met goals for cardiac or diabetes care in the previous calendar year. The maximum premium reduction may not exceed $15 per month per family. The commissioner, in consultation with the Minnesota Health Insurance Exchange, shall establish specific goals for preventive care, cardiac, or diabetes care that

make an enrollee eligible for the premium reduction. The premium discount incentive is administered by the Minnesota Health Insurance Exchange under section 62A.67. Children enrolled under section 256L.075 are not eligible for the premium incentive.

EFFECTIVE DATE. This section is effective January 1, 2009.

Sec. 18. **REPEALER.**

Minnesota Statutes 2006, section 256L.15, subdivision 2, is repealed January 1, 2009.

ARTICLE 2
HEALTH CARE ACCESS AND QUALITY

Section 1. Minnesota Statutes 2006, 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 must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age for adults aged 19 and above of up to plus or minus 50 percent of the index rate. Premium rates for children under the age of 19 may not vary based on age, regardless of whether the child is covered as a dependent or as a primary insured.

(c) A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to establish separate index rates

for each such region. The commissioner shall grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(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 index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and 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 (b); and

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

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

(h) 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, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(i) An insurer 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. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (c), (f), and (h).

Sec. 2. **[62A.67] MINNESOTA HEALTH INSURANCE EXCHANGE.**

Subdivision 1. **Title; citation.** This section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. **Creation; tax exemption.** The Minnesota Health Insurance Exchange is created for the limited purpose of providing individuals with greater access, choice, portability, and affordability of health insurance products. The Minnesota Health Insurance Exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

Subd. 3. **Definitions.** The following terms have the meanings given them unless otherwise provided in text.

(a) "Board" means the board of directors of the Minnesota Health Insurance Exchange under subdivision 13.

(b) "Commissioner" means:

(1) the commissioner of commerce for health insurers subject to the jurisdiction of the Department of Commerce;

(2) the commissioner of health for health insurers subject to the jurisdiction of the Department of Health; or

(3) either commissioner's designated representative.

(c) "Exchange" means the Minnesota Health Insurance Exchange.

(d) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(e) "Individual market health plans," unless otherwise specified, means individual market health plans defined in section 62A.011 and MinnesotaCare II products as defined in chapter 256L.

(f) "Section 125 Plan" means a Premium Only Plan under section 125 of the Internal Revenue Code.

Subd. 4. **Insurer and health plan participation.** All health plans as defined in section 62A.011, subdivision 3, issued or renewed in the individual market shall participate in the exchange. No health plans in the individual market may be issued or renewed outside of the exchange. Group health plans as defined in section 62A.10

shall not be offered through the exchange. Health plans offered through the Minnesota Comprehensive Health Association as defined in section 62E.10 are offered through the exchange to eligible enrollees as determined by the Minnesota Comprehensive Health Association. Health plans offered through MinnesotaCare and MinnesotaCare II under chapter 256L are offered through the exchange to eligible enrollees as determined by the commissioner of human services.

Subd. 5. **Approval of health plans.** No health plan may be offered through the exchange unless the commissioner has first certified that:

(1) the insurer seeking to offer the health plan is licensed to issue health insurance in the state; and

(2) the health plan meets the requirements of this section, and the health plan and the insurer are in compliance with all other applicable health insurance laws.

Subd. 6. **Individual market health plans.** Individual market health plans offered through the exchange continue to be regulated by the commissioner as specified in chapters 62A, 62C, 62D, 62E, 62Q, and 72A, and must include the following provisions that apply to all health plans issued or renewed through the exchange:

(1) premiums for children under the age of 19 shall not vary by age in the exchange; and

(2) premiums for children under the age of 19 must be excluded from rating factors under section 62A.65, subdivision 3, paragraph (b).

Subd. 7. **MinnesotaCare II health plans.** Health plans approved for MinnesotaCare II under section 256L.075 shall be offered by participating insurers to exchange participants not enrolled in MinnesotaCare II.

Subd. 8. **Individual participation and eligibility.** Individuals are eligible to purchase health plans directly through the exchange or through an employer Section 125 Plan under section 62A.68. Nothing in this section requires guaranteed issue of individual market health plans offered through the exchange. Individuals are eligible to purchase individual market health plans through the exchange by meeting one or more of the following qualifications:

(1) the individual is a Minnesota resident, meaning the individual is physically residing on a permanent basis in a place that is the person's principal residence and from which the person is absent only for temporary purposes;

(2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency;

(3) the individual is not a Minnesota resident but is employed by an employer physically located within the state and the individual's employer does not offer a group

health insurance plan as defined in section 62A.10, but does offer a Section 125 Plan through the exchange under section 62A.68;

(4) the individual is not a Minnesota resident but is self-employed and the individual's principal place of business is in the state; or

(5) the individual is a dependent as defined in section 62L.02, of another individual who is eligible to participate in the exchange.

Subd. 9. **Continuation of coverage.** Enrollment in a health plan may be canceled for nonpayment of premiums, fraud, or changes in eligibility for MinnesotaCare under chapter 256L. Enrollment in an individual market health plan may not be canceled or renewed because of any change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility as defined in this section.

Subd. 10. **Responsibilities of the exchange.** The exchange shall serve as the sole entity for enrollment and collection and transfer of premium payments for health plans offered through the exchange. The exchange shall be responsible for the following functions:

(1) publicize the exchange, including but not limited to its functions, eligibility rules, and enrollment procedures;

(2) provide assistance to employers to set up an employer Section 125 Plan under section 62A.68;

(3) create a system to allow individuals to compare and enroll in health plans offered through the exchange;

(4) create a system to collect and transmit to the applicable plans all premium payments or contributions made by or on behalf of individuals, including developing mechanisms to receive and process automatic payroll deductions for individuals enrolled in employer Section 125 Plans;

(5) refer individuals interested in MinnesotaCare or MinnesotaCare II under chapter 256L to the Department of Human Services to determine eligibility;

(6) establish a mechanism with the Department of Human Services to transfer premiums and subsidies for MinnesotaCare and MinnesotaCare II to qualify for federal matching payments;

(7) administer bonus accounts as defined in chapter 256L to reimburse MinnesotaCare II enrollees for qualified medical expenses under section 213(d) of the Internal Revenue Code;

(8) collect and assess information for eligibility for bonus accounts and premium incentives under chapter 256L;

(9) upon request, issue certificates of previous coverage according to the provisions of HIPAA and as referenced in section 62Q.181 to all such individuals who cease to be covered by a participating health plan through the exchange;

(10) establish procedures to account for all funds received and disbursed by the exchange for individual participants of the exchange; and

(11) make available to the public, at the end of each calendar year, a report of an independent audit of the exchange's accounts.

Subd. 11. **Powers of the exchange.** The exchange shall have the power to:

(1) contract with insurance producers licensed in accident and health insurance under chapter 60K and vendors to perform one or more of the functions specified in subdivision 10;

(2) contract with employers to act as the plan administrator for participating employer Section 125 Plans and to undertake the obligations required by federal law of a plan administrator;

(3) establish and assess fees on health plan premiums of health plans purchased through the exchange to fund the cost of administering the exchange;

(4) seek and directly receive grant funding from government agencies or private philanthropic organizations to defray the costs of operating the exchange;

(5) establish and administer rules and procedures governing the operations of the exchange;

(6) establish one or more service centers within Minnesota;

(7) sue or be sued or otherwise take any necessary or proper legal action;

(8) establish bank accounts and borrow money; and

(9) enter into agreements with the commissioners of commerce, health, human services, revenue, employment and economic development, and other state agencies as necessary for the exchange to implement the provisions of this section.

Subd. 12. **Dispute resolution.** The exchange shall establish procedures for resolving disputes with respect to the eligibility of an individual to participate in the exchange. The exchange does not have the authority or responsibility to intervene in or resolve disputes between an individual and a health plan or health insurer. The exchange shall refer complaints from individuals participating in the exchange to the commissioner of human services to be resolved according to sections 62Q.68 to 62Q.73.

Subd. 13. **Governance.** The exchange shall be governed by a board of directors with 11 members. The board shall convene on or before July 1, 2007, after the initial board members have been selected. The initial board membership consists of the following:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) four members appointed by a joint committee of the Minnesota senate and the Minnesota house of representatives to serve three-year terms; and

(5) four members appointed by the governor to serve three-year terms.

Subd. 14. **Subsequent board membership.** Ongoing membership of the exchange consists of the following effective July 1, 2010:

(1) the commissioner of commerce;

(2) the commissioner of human services;

(3) the commissioner of health;

(4) four members appointed by the governor with the approval of a joint committee of the senate and house of representatives to serve two- or three-year terms. Appointed members may serve more than one term; and

(5) four members elected by the membership of the exchange of which two are elected to serve a two-year term and two are elected to serve a three-year term. Elected members may serve more than one term.

Subd. 15. **Operations of the board.** Officers of the board of directors are elected by members of the board and serve one-year terms. Six members of the board constitutes a quorum, and the affirmative vote of six members of the board is necessary and sufficient for any action taken by the board. Board members serve without pay, but are reimbursed for actual expenses incurred in the performance of their duties.

Subd. 16. **Operations of the exchange.** The board of directors shall appoint an exchange director who shall:

(1) be a full-time employee of the exchange;

(2) administer all of the activities and contracts of the exchange; and

(3) hire and supervise the staff of the exchange.

Subd. 17. **Insurance producers.** When a producer licensed in accident and health insurance under chapter 60K enrolls an eligible individual in the exchange, the health plan chosen by an individual may pay the producer a commission.

Subd. 18. **Implementation.** Health plan coverage through the exchange begins on January 1, 2009. The exchange must be operational to assist employers and individuals by September 1, 2008, and be prepared for enrollment by December 1, 2008. Enrollees of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association as of December 2, 2008, are automatically enrolled in the exchange on January 1, 2009, in the same health plan and at the same premium that they were enrolled as of December 2, 2008, subject to the provisions of this section. As of January 1,

2009, all enrollees of individual market health plans, MinnesotaCare, and the Minnesota Comprehensive Health Association shall make premium payments to the exchange.

Subd. 19. **Study of insurer issue requirements.** In consultation with the commissioners of commerce and health, the exchange shall study and make recommendations on rating requirements and risk adjustment mechanisms that could be implemented to facilitate increased enrollment in the exchange by employers and employees through employer Section 125 Plans. The exchange shall report study findings and recommendations to the chairs of house and senate committees having jurisdiction over commerce and health by January 15, 2011.

Sec. 3. **[62A.68] SECTION 125 PLANS.**

Subdivision 1. **Definitions.** The following terms have the meanings given unless otherwise provided in text:

(a) "Current employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on such employed person or persons.

(c) "Section 125 Plan" means a Premium Only Plan under section 125 of the Internal Revenue Code.

(d) "Exchange" means the Minnesota Health Insurance Exchange under section 62A.67.

(e) "Exchange director" means the appointed director under section 62A.67, subdivision 16.

Subd. 2. **Section 125 Plan requirement.** Effective January 1, 2009, all employers with 11 or more current employees shall offer a Section 125 Plan through the exchange to allow their employees to pay for health insurance premiums with pretax dollars. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a group health insurance plan as defined in 62A.10;

(2) employers that offer group health insurance through a self-insured plan as defined in section 62E.02; and

(3) employers with fewer than 11 current employees, except that employers under this clause may voluntarily offer a Section 125 Plan.

Subd. 3. **Tracking compliance.** By July 1, 2008, the exchange, in consultation with the commissioners of commerce, health, employment and economic development, and

revenue shall establish a method for tracking employer compliance with the Section 125 Plan requirement.

Subd. 4. **Employer requirements.** Employers that are required to offer or choose to offer a Section 125 Plan through the exchange shall enter into an annual binding agreement with the exchange, which includes the terms in paragraphs (a) to (h).

(a) The employer shall designate the exchange director to be the plan's administrator for the employer's plan and the exchange director agrees to undertake the obligations required of a plan administrator under federal law.

(b) Only the coverage and benefits offered by participating insurers in the exchange constitutes the coverage and benefits of the participating employer plan.

(c) Any individual eligible to participate in the exchange may elect coverage under any participating health plan for which they are eligible, and neither the employer nor the exchange shall limit choice of coverage from among all the participating insurance plans for which the individual is eligible.

(d) The employer shall deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages and make payments to the exchange as directed by employees for health plans employees enroll in through the exchange.

(e) The employer shall not offer individuals eligible to participate in the exchange any separate or competing group health plan under section 62A.10.

(f) The employer reserves the right to determine the terms and amounts of the employer's contribution to the plan, if any.

(g) The employer shall make available to the exchange any of the employer's documents, records, or information, including copies of the employer's federal and state tax and wage reports that are necessary for the exchange to verify:

(1) that the employer is in compliance with the terms of its agreement with the exchange governing the participating employer plan;

(2) that the participating employer plan is in compliance with applicable state and federal laws, including those relating to nondiscrimination in coverage; and

(3) the eligibility of those individuals enrolled in the participating employer plan.

(h) The exchange shall not provide the participating employer plan with any additional or different services or benefits not otherwise provided or offered to all other participating employer plans.

Subd. 5. **Section 125 eligible health plans.** Individuals eligible to enroll in health plans through an employer Section 125 Plan through the exchange may enroll in any health plan offered through the exchange for which the individual is eligible including

individual market health plans, MinnesotaCare and MinnesotaCare II, and the Minnesota Comprehensive Health Association.

Sec. 4. Minnesota Statutes 2006, section 62E.141, is amended to read:

62E.141 INCLUSION IN EMPLOYER-SPONSORED PLAN.

No employee of an employer that offers a group health plan, under which the employee is eligible for coverage, is eligible to enroll, or continue to be enrolled, in the comprehensive health association, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under the employer's health plan. This section does not apply to persons enrolled in the Comprehensive Health Association as of June 30, 1993. With respect to persons eligible to enroll in the health plan of an employer that has more than 29 current employees, as defined in section 62L.02, this section does not apply to persons enrolled in the Comprehensive Health Association as of December 31, 1994.

Sec. 5. Minnesota Statutes 2006, section 62L.12, subdivision 2, is amended to read:

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

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

(c) A health carrier may sell, issue, or renew conversion policies under section 62E.16 to eligible employees.

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

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

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

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

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

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

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

(k) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), or 62E.16, at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

The employer must provide a written and signed statement to the health carrier that the employer is not contributing directly or indirectly to the employee's premiums. The

health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's other current or future employees.

(l) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans through the Minnesota Health Insurance Exchange under section 62A.67 or 62A.68.