State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 4332

02/28/2024 Authored by Norris and Acomb
The bill was read for the first time and referred to the Committee on Taxes

A bill for an act

relating to taxation; gross revenues; creating a health insurance claims assessment; proposing coding for new law in Minnesota Statutes, chapter 295.

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

Section 1. **[295.65] CLAIMS EXPENDITURE ASSESSMENT.**

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

(b) "Commissioner" means the commissioner of revenue.

(c) "Claims-related expenses" means any of the following:

(1) cost containment expenses, including but not limited to payments for utilization review, coordinated care or case management, disease management, medication review management, risk assessment, or similar administrative services intended to reduce the claims paid for health care services provided to covered individuals by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping covered individuals maintain or improve their health;

(2) payments that are made to or by an organized group of health care providers in accordance with managed care risk arrangements or network access agreements that are unrelated to the provisions of health care services to specific covered individuals; and

(3) general administrative expenses.

(d) "Domicile" has the meaning provided in Minnesota Rules, part 8001.0300, subpart 2. A rebuttable presumption exists that an individual's home address as maintained by the health plan company or third-party administrator indicates where that individual is domiciled.

(e) "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims exceeding a stated level for a group as a whole or protection against a high-dollar claim on any one individual.

(f) "Group health plan" means an employee welfare benefit plan as defined in section (1) of subtitle A of title 1 of the Employee Retirement Income Security Act of 1974, Public Law 93-406, United States Code, title 29, section 1002, to the extent the health plan provides medical care, including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. Group health plan includes an employer directly operating a self-insurance plan for its employees' benefits and an entity that administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions.

(g) "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4; a county-based purchasing plan authorized under section 256B.692; an integrated health partnership authorized under section 256B.0755; and a group health plan sponsor. Notwithstanding the foregoing, health plan company does not include a corporation as defined in section 317A.011, a nonprofit limited liability company organized under section 322C.1101, or a foreign nonprofit entity.

(h) "Health care provider" or "provider" means a health care provider as defined in section 62J.03, subdivision 8.

(i) "Health care services" means the following:

(1) services included in providing medical care, dental care, pharmaceutical benefits, or hospitalization, including but not limited to services provided in a hospital, surgical center, or health care facility;

(2) ancillary services, including but not limited to ambulatory services and emergency and nonemergency transportation;

(3) services provided by a health care provider, including but not limited to health care professionals licensed by the state; and

(4) behavioral health services, including but not limited to mental health and substance abuse services.

(j) "Managed care risk arrangement" means an arrangement where participating hospitals and health care providers agree to a managed care risk incentive that shares favorable or unfavorable claims experience. A managed care risk arrangement payment to a participating health care provider is generally subject to a retention requirement and the distribution of that retained payment is contingent on the result of the risk incentive arrangement.

(k) "Network access arrangement" means an agreement that allows a network access to another provider network for certain services that are not readily available in the accessing network.

(l) "Paid claims" mean actual payments, including net adjustments, made to a health care provider or reimbursed to an individual by a health plan company or third-party administrator or excess loss or stop loss insurer. Paid claims include: payments, including net adjustments, made under a service contract for administrative services only, for health care services provided under group health plans; any claims for service in this state by a pharmacy benefits manager; and individual, nongroup, and group insurance coverage to residents of this state paid in this state that affect the rights of an insured in this state and bear a reasonable relation to this state, regardless of whether the coverage is delivered, renewed, or issued for delivery in this state. If a health plan company or a third-party administrator is contractually entitled to withhold a certain amount from payments due to providers of health care services in order to help ensure that the providers can fulfill any quality or financial obligations they may have under a managed care risk arrangement, the full amounts due to the providers before that amount is withheld shall be included in paid claims. A paid claim does not include any of the following:

(1) claims-related expenses;

(2) payments made to a qualifying provider under an incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services provided to specific covered individuals;

(3) claims paid by a health plan company or third-party administrator for: a specified accident, accident-only coverage, credit, disability income, long-term care, health-related claims under automobile insurance, homeowners insurance, farmowners insurance, commercial multi-peril insurance, and workers' compensation or coverage issued as a supplement to liability insurance;

(4) claims paid for services provided to a nonresident of Minnesota;

(5) claims paid under a federal employee health benefit program, Medicare, Medicare Advantage, Medicare part D, Tricare, or by the United States Veterans Administration;

(6) reimbursements to individuals under a flexible spending arrangement as that term is defined in section 106(c)(2) of the Internal Revenue Code; a health savings account as defined in section 223 of the Internal Revenue Code; an Archer medical savings account as defined in section 220 of the Internal Revenue Code; a Medicare Advantage MSA as defined in section 138 of the Internal Revenue Code; or other health reimbursement arrangement authorized under federal law; and

(7) health care services costs paid by an individual under the individual's health plan cost-sharing requirements, including deductibles, coinsurance, or co-payments.

(m) "Resident" means an individual whose domicile is in Minnesota.

(n) "Self-insurance plan" has the meaning given in section 60A.23, subdivision 8.

(o) "Third-party administrator" means an entity subject to section 60A.23, subdivision 8, and a pharmacy benefit manager as defined under section 62W.02, subdivision 15, that pays claims for pharmaceutical services under a contract with a health plan company or self-insurer. Notwithstanding the foregoing, third-party administrator does not include an entity performing such services on behalf of a corporation as defined in section 317A.011, a nonprofit limited liability company organized under section 322C.1101, or a foreign nonprofit entity.

Subd. 2. **Claims expenditure assessment.** (a) For dates of service beginning on or after January 1, 2024, an assessment of two percent shall be collected from each health plan company and third-party administrator on the claims paid by that health plan company or third-party administrator.

(b) If a group health plan uses the services of a third-party administrator or excess loss or stop loss insurer, the following shall apply:

(1) a group health plan sponsor is not responsible for an assessment under this section for a paid claim if the assessment on that claim has been paid by a third-party administrator or excess loss or stop loss insurer, except as provided in subdivision 3;

(2) except as provided in clause (4), the third-party administrator is responsible for all assessments on paid claims paid by the third-party administrator;

(3) except as provided in clause (4), the excess loss or stop loss insurer is responsible for all assessments on paid claims paid by the excess loss or stop loss insurer; and

(4) if there is both a third-party administrator and an excess loss or stop loss insurer servicing a group health plan, the third-party administrator is responsible for all assessments for paid claims that are not reimbursed by the excess loss or stop loss insurer and the excess

loss or stop loss insurer is responsible for all assessments for paid claims that are reimbursable to the excess loss or stop loss insurer.

(c) To the extent an assessment paid under this section for paid claims is inaccurate due to subsequent claims adjustments or recoveries, subsequent filings shall be adjusted to accurately reflect the correct assessment based on actual claims paid.

Subd. 3. **Collection methodology.** (a) A health plan company or third-party administrator may collect the assessment levied under this section from an individual, employer, or group health plan sponsor, subject to the following:

(1) any methodology used must be applied uniformly within a line of business; and

(2) the amount collected must only reflect the assessment levied under this section and must not include any additional amounts such as administrative expenses.

(b) The amount collected by a health plan company under this subdivision shall not be considered as an element or factor of a rate for purposes of rate filing or approval requirements with the commissioner of commerce.

Subd. 4. **Filing; payment method.** (a) Every health plan company and third-party administrator with paid claims subject to the assessment under this section shall file with the commissioner on April 30, July 30, October 30, and January 30 of each year a return for the preceding calendar quarter in a form prescribed by the commissioner. Each health plan company and third-party administrator shall pay to the commissioner the amount of the assessment imposed under this section for the paid claims included in the return. The commissioner may require each health plan company and third-party administrator to file with the commissioner an annual reconciliation return.

(b) If a due date falls on a Saturday, Sunday, or state or federal holiday, the return and assessments are due the next succeeding business day.

(c) The commissioner may require that payment of the assessment be made by an electronic funds transfer method approved by the commissioner.

Subd. 5. **Records; failure to file return.** (a) A health plan company or third-party administrator liable for an assessment under this section shall keep accurate and complete records and pertinent documents as required by the commissioner.

(b) If a health plan company or third-party administrator fails to file a return or keep proper records as required under this subdivision, or if the commissioner has reason to believe that any records kept or returns filed are inaccurate or incomplete and that additional assessments are due, the commissioner may assess the amount of the assessment due from

the health plan company or third-party administrator based on information that is available or that may become available to the commissioner.

Subd. 6. **Failure to pay assessment.** The commissioner shall notify the commissioners of commerce and health of any final determination that a health plan company or third-party administrator has failed to pay an assessment, interest, or penalty when due. The commissioner of commerce or commissioner of health may suspend or revoke, after notice and hearing, the certificate of authority or license to operate in this state. A certificate of authority or license that is suspended or revoked under this subdivision shall not be reinstated until any delinquent assessment, interest, or penalty has been paid.

Subd. 7. **Deposit of revenues.** The commissioner shall deposit all revenues and interest derived from the assessment imposed under this section in the health care access fund. All revenues and interest derived from the assessment imposed by this section shall be appropriated only for the administration of the MinnesotaCare and medical assistance programs, the implementation of the assessment imposed under subdivision 2, and existing ongoing appropriations.

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