SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 805

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DATE	D-PG	OFFICIAL STATUS
03/14/2011	504	Introduction and first reading Referred to State Government Innovation and Veterans

A bill for an act

relating to state government; making changes to the public employees insurance program; amending Minnesota Statutes 2010, sections 43A.23, subdivision 1; 43A.316, subdivision 8.

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

Section 1. Minnesota Statutes 2010, section 43A.23, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The commissioner is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the benefit plans. Contracts entered into are not subject to the requirements of sections 16C.16 to 16C.19. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. Each benefit contract must be for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. A carrier licensed under chapter 62A is exempt from the taxes imposed by chapter 297I on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured, including chapters 62J, 62M, and 62Q. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall comply with section 62D.123 and geographic access standards for health maintenance organizations adopted by the commissioner of health in rule under chapter 62D.

(c) Notwithstanding paragraph (b), a self-insured hospital and medical product offered under sections 43A.22 to 43A.30 is not required to extend dependent coverage to an eligible employee's unmarried child under the age of 25 to the full extent required under chapters 62A and 62L. Dependent coverage must, at a minimum, extend to an eligible employee's unmarried child who is under the age of 19 or an unmarried child under the age of 25 who is a full-time student. A person who is at least 19 years of age but who is under the age of 25 and who is not a full-time student must be permitted to be enrolled as a dependent of an eligible employee until age 25 if the person:

(1) was a full-time student immediately prior to being ordered into active military service, as defined in section 190.05, subdivision 5b or 5c;

(2) has been separated or discharged from active military service; and

(3) would be eligible to enroll as a dependent of an eligible employee, except that the person is not a full-time student.

The definition of "full-time student" for purposes of this paragraph includes any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this definition of "full-time student."

(d) Beginning January 1, ~~2010~~ 2012, the health insurance benefit plans offered ~~in the commissioner's plan under section 43A.18, subdivision 2, and the managerial plan under section 43A.18, subdivision 3,~~ to state employees, including legislators and legislative staff, must ~~include an option for a~~ be HSA-eligible high-deductible health ~~plan~~ plans with a $5,000 annual deductible option that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code. The following provisions apply:

(1) the in-network annual out-of-pocket maximum for each annual deductible shall be $10,000;

(2) the employer shall make a $1,500 deposit to an individual HSA and $2,500 for a family and the deposit is dependent upon available biennial appropriation for this purpose;

(3) the plans must cover in-network preventive care at 100 percent not subject to the deductible and, once the deductible has been met, cover other care with no further enrollee cost-sharing; and

(4) all premium amounts for the high-deductible health plans shall be paid by the employee.

Sec. 2. Minnesota Statutes 2010, section 43A.316, subdivision 8, is amended to read:

Subd. 8. **Continuation of coverage.** (a) A former employee of an employer participating in the program who is receiving a public pension disability benefit or an annuity or has met the age and service requirements necessary to receive an annuity under chapter 353, 353C, 354, 354A, 356, 423, 423A, 424, or Minnesota Statutes 2008, chapter 422A, and the former employee's dependents, are eligible to participate in the program. This participation is at the person's expense unless a collective bargaining agreement or personnel policy provides otherwise. Premiums for these participants must be established by the commissioner and the participants shall pay all premium amounts. The plans shall be high-deductible health insurance plans with a $5,000 deductible.

The commissioner may provide policy exclusions for preexisting conditions only when there is a break in coverage between a participant's coverage under the employment-based group insurance program and the participant's coverage under this section. An employer shall notify an employee of the option to participate under this paragraph no later than the effective date of retirement. The retired employee or the employer of a participating group on behalf of a current or retired employee shall notify the commissioner within 30 days of the effective date of retirement of intent to participate in the program according to the rules established by the commissioner.

(b) The spouse of a deceased employee or former employee may purchase the benefits provided at premiums established by the commissioner if the spouse was a dependent under the employee's or former employee's coverage under this section at the time of the death. The spouse remains eligible to participate in the program as long as the group that included the deceased employee or former employee participates in the program. Coverage under this clause must be coordinated with relevant insurance benefits provided through the federally sponsored Medicare program.

(c) The program benefits must continue in the event of strike permitted by section 179A.18, if the exclusive representative chooses to have coverage continue and the employee pays the total monthly premiums when due.

(d) A participant who discontinues coverage may not reenroll.

Persons participating under these paragraphs shall make appropriate premium payments in the time and manner established by the commissioner.

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