State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 779

02/21/2013 Authored by Atkins and Huntley
The bill was read for the first time and referred to the Committee on Commerce and Consumer Protection Finance and Policy
03/11/2013 Adoption of Report: Pass as Amended and re-referred to the Committee on Health and Human Services Policy

A bill for an act

relating to health plan regulation; establishing health plan market rules; modifying the designation of essential community providers; amending Minnesota Statutes 2012, section 62Q.19, subdivision 1; proposing coding for new law as Minnesota Statutes, chapter 62K.

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

Section 1. **[62K.01] TITLE.**

This chapter may be cited as the "Minnesota Health Plan Market Rules."

Sec. 2. **[62K.02] PURPOSE AND SCOPE.**

Subdivision 1. **Purpose.** The market rules set forth in this chapter serve to clarify and provide guidance on the application of state law and certain requirements of the Affordable Care Act on all health carriers offering health plans in Minnesota, whether or not through the Minnesota Insurance Marketplace, to ensure fair competition for all health carriers in Minnesota, to minimize adverse selection, and to ensure that health plans are offered in a manner that protects consumers and promotes the provision of high-quality affordable health care, and improved health outcomes. This chapter contains the regulatory requirements as specified in Minnesota Statutes, section 62V.05, subdivision 5, paragraph (b), if enacted in 2013 H.F. No. 5/S.F. No. 1 and, upon enactment, shall fully satisfy the requirements of Minnesota Statutes, section 62V.05, subdivision 5, paragraph (b), if enacted in 2013 H.F. No. 5/S.F. No. 1.

Subd. 2. **Scope.** (a) This chapter applies only to health plans offered in the individual market or the small group market, except short-term coverage as defined in section 62A.65, subdivision 7.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

(c) If a health carrier issues or renews individual or small group health plans in other states, this chapter applies only to health plans issued or renewed in this state to a Minnesota resident, or to cover a resident of the state, or issued or renewed to a small employer that is actively engaged in business in this state, unless otherwise specified.

(d) This chapter does not apply to short-term coverage as defined in section 62A.65, subdivision 7.

Sec. 3. **[62K.03] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to it, or guidance and regulations issued under those acts.

Subd. 3. **Dental plan.** "Dental plan" means a dental plan as defined in section 62Q.76, subdivision 3.

Subd. 4. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 5. **Health carrier.** "Health carrier" means a health carrier as defined in section 62A.011, subdivision 2.

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3.

Subd. 7. **Individual health plan.** "Individual health plan" means an individual health plan as defined in section 62A.011, subdivision 4.

Subd. 8. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace" means the Minnesota Insurance Marketplace as defined in Minnesota Statutes, section 62V.02, if enacted in 2013 H.F. No. 5/S.F. No. 1.

Subd. 9. **Preferred provider organization.** "Preferred provider organization" means a health plan that provides discounts to enrollees or subscribers for services they receive from certain health care providers.

Subd. 10. **Small group health plan.** "Small group health plan" means a health plan issued by a health carrier to a small employer as defined in section 62L.02, subdivision 26.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act and has been certified by the board of the Minnesota Insurance Marketplace in accordance with Minnesota Statutes, chapter 62V, if enacted in 2013 H.F. No. 5/S.F. No. 1 to be offered through the Minnesota Insurance Marketplace.

Sec. 4. **[62K.04] MARKET RULES; VIOLATION.**

Subdivision 1. **Compliance.** (a) A health carrier issuing an individual health plan issued to a Minnesota resident or a small group health plan issued to provide coverage to a small employer that is actively engaged in business in Minnesota shall meet all of the requirements set forth in this chapter. The failure to meet any of the requirements under this chapter constitutes a violation of section 72A.20.

(b) The requirements of this chapter do not apply to individual or small group health plans issued before January 1, 2015.

(c) The requirements of this chapter do not apply to short-term coverage as defined in section 62A.65.

Subd. 2. **Penalties.** In addition to any other penalties provided by the laws of this state or by federal law, a health carrier or any other person found to have violated any requirement of this chapter may be subject to the administrative procedures, enforcement actions, and penalties provided under section 45.027 and chapters 62D and 72A.

Sec. 5. **[62K.05] FEDERAL ACT; COMPLIANCE REQUIRED.**

A health carrier shall comply with all provisions of the Affordable Care Act to the extent that it imposes a requirement that applies in this state. Compliance with any provision of the Affordable Care Act is required as of the effective date established for that provision in the federal act, except as otherwise specifically stated earlier in state law.

Sec. 6. **[62K.06] METAL LEVEL MANDATORY OFFERINGS.**

Subdivision 1. **Identification.** A health carrier that offers individual or small group health plans in Minnesota must provide documentation to the commissioner of commerce to justify actuarial value levels as specified in section 1302 of the Affordable Care Act for all individual and small group health plans offered inside and outside of the Minnesota Insurance Marketplace.

Subd. 2. **Minimum levels.** (a) A health carrier that offers any individual or small group health plan, either inside or outside of the Minnesota Insurance Marketplace, must offer at a minimum a silver level and a gold level health plan to Minnesota residents, as

well as for each health plan offered, a health plan in which the only enrollees are children, who, as of the beginning of a policy year, have not attained the age of 21 years.

(b) A health carrier with less than five percent market share in either the individual or small group market in Minnesota is exempt from paragraph (a), until January 1, 2020, unless the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace. If the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace, the health carrier must comply with paragraph (a).

Subd. 3. **Minnesota Insurance Marketplace restriction.** The Minnesota Insurance Marketplace may not, by contract or otherwise, mandate the types of health plans to be offered by a health carrier to individuals or small employers purchasing health plans outside of the Minnesota Insurance Marketplace. For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clause (6).

Subd. 4. **Metal level defined.** For purposes of this section, the metal levels are defined in section 62Q.81, subdivision 1, paragraph (c).

Subd. 5. **Enforcement.** The commissioner of commerce shall enforce this section.

Sec. 7. **[62K.07] INFORMATION DISCLOSURES.**

(a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost-sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.

(b) A health carrier offering an individual or small group health plan must comply with all information disclosure requirements of all applicable state and federal law, including the Affordable Care Act. To the extent that both state and federal law impose information disclosures or standards with respect to a health plan, the health carrier must comply with the disclosure requirement that provides the greater consumer protection to Minnesota residents.

(c) The commissioner of commerce shall enforce this section.

Sec. 8. **[62K.08] MARKETING STANDARDS.**

Subdivision 1. **General.** A health carrier offering individual or small group health plans must comply with all applicable provisions of the Affordable Care Act, including, but not limited to, the following:

(1) compliance with all state laws pertaining to the marketing of individual or small group health plans; and

(2) establishing marketing practices and benefit designs that will not have the effect of discouraging the enrollment of individuals with significant health needs in the health plan.

Subd. 2. **Specific requirements.** (a) Any written marketing materials must include a statement of enrollee information and rights as described in chapter 62D.

(b) Detailed marketing materials must affirmatively disclose all exclusions and limitations on the services offered.

(c) No market materials may lead consumers to believe that all health care needs will be covered.

(d) All marketing materials must contain the following language in bold print: **This health care plan may not cover all your health care expenses, read your contract carefully to determine which expenses are covered.**

Subd. 3. **Enforcement.** The commissioner of commerce shall enforce this section.

Sec. 9. **[62K.09] ACCREDITATION STANDARDS.**

Subdivision 1. **Accreditation; general.** (a) A health carrier that offers any individual or small group health plans in Minnesota outside of the Minnesota Insurance Marketplace must be accredited in accordance with this subdivision. A health carrier must obtain accreditation through URAC, the National Committee for Quality Assurance (NCQA), or any entity recognized by the United States Department of Health and Human Services for accreditation of health insurance issuers or health plans by January 1, 2018. Proof of accreditation must be submitted to the commissioner of health in a form prescribed by the commissioner of health.

(b) A health carrier with less than five percent market share in either the individual or small group market in Minnesota is exempt from this subdivision until January 1, 2020.

Subd. 2. **Accreditation; Minnesota Insurance Marketplace.** (a) The Minnesota Insurance Marketplace shall require all health carriers offering a qualified health plan through the Minnesota Insurance Marketplace to obtain the appropriate level of accreditation no later than the third year after the first year the health carrier offers a qualified health plan through the Minnesota Insurance Marketplace. A health carrier must take the first step of the accreditation process during the first year in which it offers

a qualified health plan. A health carrier that offers a qualified health plan on January 1, 2014, must obtain accreditation by the end of the 2016 plan year.

(b) To the extent a health carrier cannot obtain accreditation due to low volume of enrollees, an exception to this accreditation criterion may be granted by the Minnesota Insurance Marketplace until such time as the health carrier has a sufficient volume of enrollees.

Subd. 3. **Enforcement.** The commissioner of health shall enforce this section.

Sec. 10. **[62K.10] GEOGRAPHIC ACCESSIBILITY; PROVIDER NETWORK ADEQUACY.**

Subdivision 1. **Applicability.** This section applies to all health carriers offering an individual and small group health plan that designates a network or networks of contracted providers, or is a preferred provider organization.

Subd. 2. **Primary care; mental health services; general hospital services.** Primary care, mental health, and general hospital services must be available to enrollees within 30 miles or 30 minutes' travel time to the nearest participating or preferred provider.

Subd. 3. **Other health services.** Specialty physician services, ancillary services, specialized hospital services, and all other covered health services must be available to enrollees within 60 miles or 60 minutes' travel time to the nearest participating or preferred provider.

Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient number and type of providers 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) 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

(5) 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.

Subd. 5. **Waiver.** 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 made on a form provided by the commissioner and must 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.

Subd. 6. **Referral centers.** Subdivisions 2 and 3 shall not apply if an enrollee is referred to a referral center for health care services. A referral center is a medical facility that provides highly specialized medical care, including but not limited to organ transplants and bariatric surgery. A health carrier or preferred provider organization may consider the volume of services provided annually, case mix, and severity adjusted mortality and morbidity rates in designating a referral center.

Subd. 7. **Essential community providers.** Each health carrier must comply with section 62Q.19 to ensure reasonable and timely access to covered services for low-income, high-risk, special-needs individuals or those living in a medical shortage area.

Subd. 8. **Enforcement.** The commissioner of health shall enforce this section.

Sec. 11. **[62K.11] BALANCE BILLING PROHIBITED.**

(a) A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service. A network provider is permitted to bill an enrollee the approved co-payment deductible or coinsurance.

(b) A network provider is permitted to bill an enrollee for services not covered by the enrollee's health plan as long as the enrollee agrees in writing in advance before the service if performed to pay for the noncovered service.

Sec. 12. **[62K.12] QUALITY ASSURANCE AND IMPROVEMENT.**

(a) All health carriers offering an individual health plan or small group health plan must have a written internal quality assurance and improvement program that, at a minimum:

(1) provides for ongoing evaluation of the quality of health care provided to its enrollees;

(2) periodically reports the evaluation of the quality of health care to the health carrier's governing body;

(3) follows policies and procedures for the selection and credentialing of network providers that is consistent with community standards;

(4) conducts focused studies directed at problems, potential problems, or areas with potential for improvements in care;

(5) conducts enrollee satisfaction surveys and monitors oral and written complaints submitted by enrollees or members; and

(6) collects and reports Health Effectiveness Data and Information Set (HEDIS) measures and conducts other quality assessment and improvement activities as directed by the commissioner of health.

(b) The commissioner of health shall submit a report to the chairs and ranking minority members of senate and house of representatives committees with primary jurisdiction over commerce and health policy by February 15, 2015, with recommendations for specific quality assurance and improvement standards for all Minnesota health carriers.

(c) The commissioner of health shall enforce this section.

Sec. 13. **[62K.13] SERVICE AREA REQUIREMENTS.**

(a) Health carriers must offer individual and small group health plans in service areas that are at least the entire geographic area of a county unless serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of enrollees. The service area for any individual or small group health plan must be established without regard to racial, ethnic, language, or health status-related factors, or other factors that exclude specific high-utilizing, high-cost, or medically underserved populations.

(b) If a health carrier requests to serve less than the entire county, the request must be made to the commissioner of health on a form and manner determined by the commissioner and must provide specific data demonstrating that the service area is not discriminatory, is necessary, and is in the best interest of enrollees.

Sec. 14. **[62K.14] NETWORK PROVIDER DIRECTORIES.**

Health carriers offering qualified health plans through the Minnesota Insurance Marketplace must submit information on network providers to the Minnesota Insurance Marketplace. The Minnesota Insurance Marketplace and the commissioner of health must collaborate to determine the form and manner in which this information shall be provided to the Minnesota Insurance Marketplace and the commissioner of health. Health carriers must provide this information at least quarterly and more frequently as determined by the Minnesota Insurance Marketplace or the commissioner of health.

Sec. 15. **[62K.15] LIMITED SCOPE DENTAL PLANS.**

(a) Limited scope dental plans must be offered on a guaranteed issue basis with premiums rated on allowable rating factors used for health plans. The commissioner of commerce shall enforce this paragraph.

(b) Limited scope dental plans must ensure dental services are available within 30 miles or 30 minutes' travel time. The commissioner of health shall enforce this paragraph.

(c) Health carriers offering limited scope dental plans must comply with this section and sections 62K.07, 62K.08, 62K.13, and 62K.14.

Sec. 16. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions;

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds; ~~or~~

(6) a birth center licensed under section 144.615~~.~~; or

(7) a hospital or hospital system whose inpatients are predominantly under 21 years of age.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.