

**SENATE
STATE OF MINNESOTA
NINETIETH SESSION**

S.F. No. 1

(SENATE AUTHORS: BENSON, and Dahms)

DATE	D-PG	OFFICIAL STATUS
01/05/2017	37	Introduction and first reading
		Referred to Commerce and Consumer Protection Finance and Policy
01/11/2017		Comm report: To pass as amended and re-refer to Finance

1.1 A bill for an act

1.2 relating to health care coverage; providing a temporary program to help pay for

1.3 health insurance premiums; modifying requirements for health maintenance

1.4 organizations; modifying provisions governing health insurance; requiring reports;

1.5 appropriating money; amending Minnesota Statutes 2016, sections 60A.08,

1.6 subdivision 15; 60A.235, subdivision 3; 60A.236; 62D.02, subdivision 4; 62D.03,

1.7 subdivision 1; 62D.05, subdivision 1; 62D.06, subdivision 1; 62D.19; 62E.02,

1.8 subdivision 3; 62L.12, subdivision 2; proposing coding for new law in Minnesota

1.9 Statutes, chapter 62Q; repealing Minnesota Statutes 2016, sections 62D.12,

1.10 subdivision 9; 62K.11.

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

1.12 style="text-align:center">**ARTICLE 1**

1.13 style="text-align:center">**PREMIUM ASSISTANCE**

1.14 Section 1. **PREMIUM ASSISTANCE PROGRAM ESTABLISHED.**

1.15 The commissioner of Minnesota Management and Budget, in consultation with the

1.16 commissioner of commerce and the commissioner of revenue, shall establish and administer

1.17 a premium assistance program to help eligible individuals pay expenses for qualified health

1.18 coverage in 2017.

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

1.20 Sec. 2. **DEFINITIONS.**

1.21 Subdivision 1. **Scope.** For purposes of sections 1 to 5, the following terms have the

1.22 meanings given, unless the context clearly indicates otherwise.

1.23 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of Minnesota

1.24 Management and Budget.

2.1 Subd. 3. **Eligible individual.** "Eligible individual" means an individual who:

2.2 (1) is a resident of Minnesota;

2.3 (2) purchased qualified health coverage for calendar year 2017;

2.4 (3) meets the income eligibility requirements under section 3, subdivision 3;

2.5 (4) is not receiving a premium assistance credit under section 36B of the Internal Revenue
2.6 Code for calendar year 2017; and

2.7 (5) is approved by the commissioner as qualifying for premium assistance.

2.8 Subd. 4. **Health plan.** "Health plan" has the meaning provided in Minnesota Statutes,
2.9 section 62A.011, subdivision 3.

2.10 Subd. 5. **Health plan company.** "Health plan company" means a health carrier, as
2.11 defined in Minnesota Statutes, section 62A.011, subdivision 2, that provides qualified health
2.12 coverage in the individual market through MNsure or outside of MNsure to Minnesota
2.13 resident individuals in 2017.

2.14 Subd. 6. **Individual market.** "Individual market" means the individual market as defined
2.15 in Minnesota Statutes, section 62A.011, subdivision 5.

2.16 Subd. 7. **Internal Revenue Code.** "Internal Revenue Code" means the Internal Revenue
2.17 Code as amended through December 31, 2016.

2.18 Subd. 8. **Modified adjusted gross income.** "Modified adjusted gross income" means
2.19 the modified adjusted gross income for taxable year 2016, as defined in section 36B(d)(2)(B)
2.20 of the Internal Revenue Code.

2.21 Subd. 9. **Premium assistance.** "Premium assistance," "assistance amount," or "assistance"
2.22 means the amount allowed to an eligible individual as determined by the commissioner
2.23 under section 3 as a percentage of the qualified premium.

2.24 Subd. 10. **Program.** "Program" means the premium assistance program established
2.25 under section 1.

2.26 Subd. 11. **Qualified health coverage.** "Qualified health coverage" means health coverage
2.27 provided under a qualified health plan, as defined in Minnesota Statutes, section 62V.02,
2.28 subdivision 11, or provided under a health plan that meets the standards of a qualified health
2.29 plan except that it is not purchased through MNsure, and is:

2.30 (1) offered to individuals in the individual market;

3.1 (2) not a grandfathered health plan, as defined in section 36B of the Internal Revenue
3.2 Code; and

3.3 (3) provided by a health plan company through MNsure or outside of MNsure.

3.4 Subd. 12. **Qualified premium.** "Qualified premium" means the premium for qualified
3.5 health coverage purchased by an eligible individual.

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

3.7 Sec. 3. **PREMIUM ASSISTANCE AMOUNT.**

3.8 Subdivision 1. **Applications by individuals; notification of eligibility.** (a) An eligible
3.9 individual may apply to the commissioner to receive premium assistance under this section
3.10 at any time after purchase of qualified health coverage, but no later than January 31, 2018.
3.11 The commissioner shall prescribe the manner and form for applications, including requiring
3.12 any information the commissioner considers necessary or useful in determining whether an
3.13 applicant is eligible and the assistance amount allowed to the individual under this section.
3.14 The commissioner shall make application forms available on the agency's Web site.

3.15 (b) The commissioner shall notify applicants of their eligibility status under the program,
3.16 including, for applicants determined to be eligible, their premium assistance amount.

3.17 Subd. 2. **Health plan companies.** (a) By the first of each month, and any other times
3.18 the commissioner requires, each health plan company shall provide to the commissioner an
3.19 effectuated coverage list with the following information for each individual for whom it
3.20 provides qualified health coverage:

3.21 (1) name, address, and age of each individual covered by the health plan, and any other
3.22 identifying information that the commissioner determines appropriate to administer the
3.23 program;

3.24 (2) the qualified premium for the coverage;

3.25 (3) whether the coverage is individual or family coverage;

3.26 (4) whether the individual is receiving advance payment of the credit under section 36B
3.27 of the Internal Revenue Code; and

3.28 (5) any additional information the commissioner determines appropriate to administer
3.29 the program.

3.30 (b) A health plan company must notify the commissioner of coverage terminations of
3.31 eligible individuals within ten business days.

4.1 (c) Each health plan company shall make the application forms developed by the
 4.2 commissioner under subdivision 1 available on the company's Web site, and shall include
 4.3 application forms with premium notices for individual health coverage.

4.4 Subd. 3. **Income eligibility rules.** (a) Individuals with incomes that meet the requirements
 4.5 of this subdivision satisfy the income eligibility requirements for the program. For purposes
 4.6 of this subdivision, "poverty line" has the meaning used in section 36B of the Internal
 4.7 Revenue Code, except that modified adjusted gross income, as reported on the individual's
 4.8 federal income tax return for tax year 2016, must be used instead of household income. For
 4.9 married separate filers claiming eligibility for family coverage, modified adjusted gross
 4.10 income equals the sum of that income reported by both spouses on their returns.

4.11 (b) The following income categories apply.

<u>Modified Adjusted Gross Income:</u>	<u>Income Category:</u>
4.12 <u>(1) not exceeding 300 percent of poverty line;</u>	<u>not eligible</u>
4.13 <u>(2) greater than 300 percent but not exceeding</u>	<u>category 1</u>
4.14 <u>400 percent of the poverty line;</u>	
4.15 <u>(3) greater than 400 percent but not exceeding</u>	<u>category 2</u>
4.16 <u>600 percent of the poverty line;</u>	
4.17 <u>(4) greater than 600 percent but not exceeding</u>	<u>category 3</u>
4.18 <u>800 percent of the poverty line; and</u>	
4.19 <u>(5) greater than 800 percent of the poverty</u>	<u>not eligible</u>
4.20 <u>line.</u>	

4.22 Subd. 4. **Determination of assistance amounts.** (a) The commissioner shall determine
 4.23 premium assistance amounts as provided under this subdivision so that the estimated sum
 4.24 of all premium assistance for eligible individuals does not exceed the appropriation for this
 4.25 purpose.

4.26 (b) The commissioner shall determine premium assistance amounts as follows:

4.27 (1) for the period January 1, 2017, through March 31, 2017, eligible individuals in income
 4.28 categories 1, 2, and 3 qualify for premium assistance equal to 25 percent of the qualified
 4.29 premium for effectuated coverage;

4.30 (2) for the period April 1, 2017, through December 31, 2017, eligible individuals in
 4.31 income category 1 qualify for premium assistance equal to 30 percent of the qualified
 4.32 premium for effectuated coverage;

4.33 (3) for the period April 1, 2017, through December 31, 2017, eligible individuals in
 4.34 income category 2 qualify for premium assistance equal to 25 percent of the qualified
 4.35 premium for effectuated coverage; and

5.1 (4) for the period April 1, 2017, through December 31, 2017, eligible individuals in
5.2 income category 3 qualify for premium assistance at a level to be determined by the
5.3 commissioner based on the availability of funding, but not to exceed 20 percent of the
5.4 qualified premium for effectuated coverage.

5.5 Subd. 5. **Provision of premium assistance to eligible individuals.** (a) The commissioner
5.6 shall provide the premium assistance amount calculated under subdivision 4 on a monthly
5.7 basis to each eligible individual. The commissioner shall provide each eligible individual
5.8 with the option of receiving premium assistance through direct deposit to a financial
5.9 institution.

5.10 (b) If the commissioner, for administrative reasons, is unable to provide an eligible
5.11 individual with the premium assistance owed for one or more months for which the eligible
5.12 individual had effectuated coverage, the commissioner shall include the premium assistance
5.13 owed for that period with the premium assistance payment for the first month for which the
5.14 commissioner is able to provide premium assistance in a timely manner.

5.15 (c) The commissioner may require an eligible individual to provide any documentation
5.16 and substantiation of payment of the qualified premium that the commissioner considers
5.17 appropriate.

5.18 Subd. 6. **Contracting.** The commissioner may contract with a third-party administrator
5.19 to determine eligibility for and administer premium assistance under this section.

5.20 Subd. 7. **Verification.** The commissioner shall verify that persons applying for premium
5.21 assistance are residents of Minnesota. The commissioner may access information from the
5.22 Department of Employment and Economic Development and the Minnesota Department
5.23 of Revenue when verifying residency.

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

5.25 Sec. 4. **AUDIT AND PROGRAM INTEGRITY.**

5.26 Subdivision 1. **Audit.** The legislative auditor shall audit implementation of the premium
5.27 assistance program by the commissioner to determine whether premium assistance payments
5.28 align with the criteria established in sections 2 and 3. The legislative auditor shall present
5.29 a report summarizing findings of the audit to the legislative committees with jurisdiction
5.30 over insurance and health by June 1, 2018.

5.31 Subd. 2. **Program integrity.** The commissioner of revenue shall ensure that only eligible
5.32 individuals, as defined in section 2, subdivision 3, have received premium assistance. The
5.33 commissioner of revenue shall review information available from Minnesota Management

6.1 and Budget, the Department of Human Services, MNsure, and the most recent Minnesota
 6.2 tax records to identify ineligible individuals who received premium assistance. The
 6.3 commissioner of revenue shall recover the amount of any premium assistance paid on behalf
 6.4 of an ineligible individual from the ineligible individual, in the manner provided by law for
 6.5 the collection of unpaid taxes or erroneously paid refunds of taxes.

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

6.7 Sec. 5. **TRANSFER.**

6.8 \$300,500,000 in fiscal year 2017 is transferred from the budget reserve account in
 6.9 Minnesota Statutes, section 16A.152, subdivision 1a, to the general fund.

6.10 Sec. 6. **APPROPRIATIONS.**

6.11 (a) \$285,000,000 in fiscal year 2017 is appropriated from the general fund to the
 6.12 commissioner of Minnesota Management and Budget for purposes of providing premium
 6.13 assistance under section 3. No more than three percent of this appropriation is available to
 6.14 the commissioner for administrative costs. This is a onetime appropriation and is available
 6.15 until June 30, 2018.

6.16 (b) \$500,000 in fiscal year 2017 is appropriated from the general fund to the legislative
 6.17 auditor to conduct the audit required by section 4. This is a onetime appropriation and is
 6.18 available until expended.

6.19 **ARTICLE 2**

6.20 **INSURANCE MARKET REFORMS**

6.21 Section 1. Minnesota Statutes 2016, section 60A.08, subdivision 15, is amended to read:

6.22 Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related
 6.23 information filed with the commissioner under section 61A.02 shall be nonpublic data until
 6.24 the filing becomes effective.

6.25 (b) All forms, rates, and related information filed with the commissioner under section
 6.26 62A.02 shall be nonpublic data until the filing becomes effective.

6.27 (c) All forms, rates, and related information filed with the commissioner under section
 6.28 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

6.29 (d) All forms, rates, and related information filed with the commissioner under section
 6.30 70A.06 shall be nonpublic data until the filing becomes effective.

7.1 (e) All forms, rates, and related information filed with the commissioner under section
7.2 79.56 shall be nonpublic data until the filing becomes effective.

7.3 (f) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under
7.4 section 2794 of the Public Health Services Act and any amendments to, or regulations, or
7.5 guidance issued under the act that are filed with the commissioner on or after September 1,
7.6 2011, the commissioner:

7.7 (1) may acknowledge receipt of the information;

7.8 (2) may acknowledge that the corresponding rate filing is pending review;

7.9 (3) must provide public access from the Department of Commerce's Web site to parts I
7.10 and II of the Preliminary Justifications of the rate increases subject to review; and

7.11 (4) must provide notice to the public on the Department of Commerce's Web site of the
7.12 review of the proposed rate, which must include a statement that the public has 30 calendar
7.13 days to submit written comments to the commissioner on the rate filing subject to review.

7.14 (g) Notwithstanding paragraphs (b) and (c), for all rates for individual health plans, as
7.15 defined in section 62A.011, subdivision 4, and small employer plans, as defined in section
7.16 62L.02, subdivision 28, the commissioner must provide:

7.17 (1) public access to the information described in clause (2) from the Department of
7.18 Commerce's Web site within ten days of receiving a rate filing from a health plan, as defined
7.19 in section 62A.011, subdivision 3; and

7.20 (2) compiled data of the proposed change to rates separated by health plan and geographic
7.21 rating area.

7.22 **EFFECTIVE DATE.** This section is effective 30 days following final enactment.

7.23 Sec. 2. Minnesota Statutes 2016, section 60A.235, subdivision 3, is amended to read:

7.24 Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance company
7.25 or health carrier issuing or renewing an insurance policy or other evidence of coverage, that
7.26 provides coverage to an employer for health care expenses incurred under an
7.27 employer-sponsored plan provided to the employer's employees, retired employees, or their
7.28 dependents, shall issue the policy or evidence of coverage as a health plan if the policy or
7.29 evidence of coverage:

7.30 (1) has a specific attachment point for claims incurred per individual that is lower than
7.31 ~~\$20,000~~ \$10,000; or

8.1 ~~(2) has an aggregate attachment point, for groups of 50 or fewer, that is lower than the~~
 8.2 ~~greater of:~~

8.3 ~~(i) \$4,000 times the number of group members;~~

8.4 ~~(ii) 120 percent of expected claims; or~~

8.5 ~~(iii) \$20,000; or~~

8.6 ~~(3) (2) has an aggregate attachment point for groups of 51 or more that is lower than~~
 8.7 ~~110 percent of expected claims.~~

8.8 (b) An insurer shall determine the number of persons in a group, for the purposes of this
 8.9 section, on a consistent basis, at least annually. Where the insurance policy or evidence of
 8.10 coverage applies to a contract period of more than one year, the dollar amounts set forth in
 8.11 paragraph (a), ~~clauses~~ clause (1) ~~and (2)~~, must be multiplied by the length of the contract
 8.12 period expressed in years.

8.13 ~~(c) The commissioner may adjust the constant dollar amounts provided in paragraph~~
 8.14 ~~(a), clauses (1), (2), and (3), on January 1 of any year, based upon changes in the medical~~
 8.15 ~~component of the Consumer Price Index (CPI). Adjustments must be in increments of \$100~~
 8.16 ~~and must not be made unless at least that amount of adjustment is required. The commissioner~~
 8.17 ~~shall publish any change in these dollar amounts at least six months before their effective~~
 8.18 ~~date.~~

8.19 ~~(d) (c)~~ (c) A policy or evidence of coverage issued by an insurance company or health carrier
 8.20 that provides direct coverage of health care expenses of an individual including a policy or
 8.21 evidence of coverage administered on a group basis is a health plan regardless of whether
 8.22 the policy or evidence of coverage is denominated as stop loss coverage.

8.23 **EFFECTIVE DATE.** This section is effective 30 days following final enactment, and
 8.24 applies to policies or evidence of coverage offered, issued, or renewed to an employer on
 8.25 or after that date.

8.26 Sec. 3. Minnesota Statutes 2016, section 60A.236, is amended to read:

8.27 **60A.236 STOP LOSS REGULATION; SMALL EMPLOYER COVERAGE.**

8.28 A contract providing stop loss coverage, issued or renewed to a small employer, as
 8.29 defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must
 8.30 include a claim settlement period no less favorable to the small employer or plan than
 8.31 coverage of all the following:

8.32 (1) claims incurred during the contract period regardless of when the claims are; and

9.1 (2) paid by the plan during the contract period or within one month after expiration of
 9.2 the contract period.

9.3 **EFFECTIVE DATE.** This section is effective 30 days following final enactment, and
 9.4 applies to policies or evidence of coverage offered, issued, or renewed to an employer on
 9.5 or after that date.

9.6 Sec. 4. Minnesota Statutes 2016, section 62D.02, subdivision 4, is amended to read:

9.7 Subd. 4. **Health maintenance organization.** ~~(a)~~ "Health maintenance organization"
 9.8 means a ~~nonprofit~~ foreign or domestic corporation organized under chapter 317A, or a local
 9.9 governmental unit as defined in subdivision 11, controlled and operated as provided in
 9.10 sections 62D.01 to 62D.30, which provides, either directly or through arrangements with
 9.11 providers or other persons, comprehensive health maintenance services, or arranges for the
 9.12 provision of these services, to enrollees on the basis of a fixed prepaid sum without regard
 9.13 to the frequency or extent of services furnished to any particular enrollee.

9.14 ~~(b) [Expired]~~

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

9.16 Sec. 5. Minnesota Statutes 2016, section 62D.03, subdivision 1, is amended to read:

9.17 Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state
 9.18 to the contrary, any ~~nonprofit~~ foreign or domestic corporation organized to do so or a local
 9.19 governmental unit may apply to the commissioner of health for a certificate of authority to
 9.20 establish and operate a health maintenance organization in compliance with sections 62D.01
 9.21 to 62D.30. No person shall establish or operate a health maintenance organization in this
 9.22 state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic
 9.23 consideration in conjunction with a health maintenance organization or health maintenance
 9.24 contract unless the organization has a certificate of authority under sections 62D.01 to
 9.25 62D.30.

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

9.27 Sec. 6. Minnesota Statutes 2016, section 62D.05, subdivision 1, is amended to read:

9.28 Subdivision 1. **Authority granted.** Any ~~nonprofit~~ corporation or local governmental
 9.29 unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30,
 9.30 operate as a health maintenance organization.

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

10.1 Sec. 7. Minnesota Statutes 2016, section 62D.06, subdivision 1, is amended to read:

10.2 Subdivision 1. **Governing body composition; enrollee advisory body.** The governing
 10.3 body of any health maintenance organization which is a ~~nonprofit~~ corporation may include
 10.4 enrollees, providers, or other individuals; provided, however, that after a health maintenance
 10.5 organization which is a ~~nonprofit~~ corporation has been authorized under sections 62D.01
 10.6 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of
 10.7 enrollees and members elected by the enrollees and members from among the enrollees and
 10.8 members. For purposes of this section, "member" means a consumer who receives health
 10.9 care services through a self-insured contract that is administered by the health maintenance
 10.10 organization or its related third-party administrator. The number of members elected to the
 10.11 governing body shall not exceed the number of enrollees elected to the governing body. An
 10.12 enrollee or member elected to the governing board may not be a person:

10.13 (1) whose occupation involves, or before retirement involved, the administration of
 10.14 health activities or the provision of health services;

10.15 (2) who is or was employed by a health care facility as a licensed health professional;
 10.16 or

10.17 (3) who has or had a direct substantial financial or managerial interest in the rendering
 10.18 of a health service, other than the payment of a reasonable expense reimbursement or
 10.19 compensation as a member of the board of a health maintenance organization.

10.20 After a health maintenance organization which is a local governmental unit has been
 10.21 authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall
 10.22 be established. The enrollees who make up this advisory body shall be elected by the enrollees
 10.23 from among the enrollees.

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

10.25 Sec. 8. Minnesota Statutes 2016, section 62D.19, is amended to read:

10.26 **62D.19 UNREASONABLE EXPENSES.**

10.27 No health maintenance organization shall incur or pay for any expense of any nature
 10.28 which is unreasonably high in relation to the value of the service or goods provided. The
 10.29 commissioner of health shall implement and enforce this section by rules adopted under
 10.30 this section.

10.31 In an effort to achieve the stated purposes of sections 62D.01 to 62D.30; ~~in order to~~
 10.32 ~~safeguard the underlying nonprofit status of health maintenance organizations;~~ and to ensure

11.1 that the payment of health maintenance organization money to major participating entities
 11.2 results in a corresponding benefit to the health maintenance organization and its enrollees,
 11.3 when determining whether an organization has incurred an unreasonable expense in relation
 11.4 to a major participating entity, due consideration shall be given to, in addition to any other
 11.5 appropriate factors, whether the officers and trustees of the health maintenance organization
 11.6 have acted with good faith and in the best interests of the health maintenance organization
 11.7 in entering into, and performing under, a contract under which the health maintenance
 11.8 organization has incurred an expense. The commissioner has standing to sue, on behalf of
 11.9 a health maintenance organization, officers or trustees of the health maintenance organization
 11.10 who have breached their fiduciary duty in entering into and performing such contracts.

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

11.12 Sec. 9. Minnesota Statutes 2016, section 62E.02, subdivision 3, is amended to read:

11.13 Subd. 3. **Health maintenance organization.** "Health maintenance organization" means
 11.14 a nonprofit corporation licensed and operated as provided in chapter 62D.

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

11.16 Sec. 10. Minnesota Statutes 2016, section 62L.12, subdivision 2, is amended to read:

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

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

11.24 (c) A health carrier may renew conversion policies to eligible employees.

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

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

12.1 (f) A health carrier may sell, issue, or renew an individual health plan, if the individual
12.2 has elected to buy the individual health plan not as part of a general plan to substitute
12.3 individual health plans for a group health plan nor as a result of any violation of subdivision
12.4 3 or 4.

12.5 (g) A health carrier may sell, issue, or renew an individual health plan if coverage
12.6 provided by the employer is determined to be unaffordable under the provisions of the
12.7 Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

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

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

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

12.23 (l) A health carrier may offer, sell, issue, or renew an individual health plan to one or
12.24 more employees of a small employer if the individual health plan is marketed directly to
12.25 all employees of the small employer and the small employer does not contribute directly or
12.26 indirectly to the premiums or facilitate the administration of the individual health plan. The
12.27 requirement to market an individual health plan to all employees does not require the health
12.28 carrier to offer or issue an individual health plan to any employee. For purposes of this
12.29 paragraph, an employer is not contributing to the premiums or facilitating the administration
12.30 of the individual health plan if the employer does not contribute to the premium and merely
12.31 collects the premiums from an employee's wages or salary through payroll deductions and
12.32 submits payment for the premiums of one or more employees in a lump sum to the health
12.33 carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), at the
12.34 request of an employee, the health carrier may bill the employer for the premiums payable

13.1 by the employee, provided that the employer is not liable for payment except from payroll
13.2 deductions for that purpose. If an employer is submitting payments under this paragraph,
13.3 the health carrier shall provide a cancellation notice directly to the primary insured at least
13.4 ten days prior to termination of coverage for nonpayment of premium. Individual coverage
13.5 under this paragraph may be offered only if the small employer has not provided coverage
13.6 under section 62L.03 to the employees within the past 12 months.

13.7 (m) A health carrier may offer, sell, issue, or renew an individual health plan to one or
13.8 more employees of a small employer if the small employer, eligible employee, and individual
13.9 health plan are in compliance with the 21st Century Cures Act, Public Law 114-255.

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

13.11 Sec. 11. **[62Q.556] UNAUTHORIZED PROVIDER SERVICES.**

13.12 Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph
13.13 (c), unauthorized provider services occur when an enrollee receives services:

13.14 (1) from a nonparticipating provider at a participating hospital or ambulatory surgical
13.15 center, when the services are rendered:

13.16 (i) due to the unavailability of a participating provider;

13.17 (ii) by a nonparticipating provider without the enrollee's knowledge; or

13.18 (iii) due to the need for unforeseen services arising at the time the services are being
13.19 rendered;

13.20 (2) from a nonparticipating provider in a participating provider's practice setting under
13.21 circumstances not described in clause (1);

13.22 (3) from a participating provider that sends a specimen taken from the enrollee in the
13.23 participating provider's practice setting to a nonparticipating laboratory, pathologist, or other
13.24 medical testing facility; or

13.25 (4) not described in clause (3) that are performed by a nonparticipating provider, if a
13.26 referral for the services is required by the health plan.

13.27 (b) Unauthorized provider services do not include emergency services as defined in
13.28 section 62Q.55, subdivision 3.

13.29 (c) The services described in paragraph (a), clauses (2) to (4), are not unauthorized
13.30 provider services if the enrollee gives advance written consent to the provider acknowledging

14.1 that the use of a provider, or the services to be rendered, may result in costs not covered by
14.2 the health plan.

14.3 Subd. 2. **Prohibition.** An enrollee must have the same cost-sharing requirements for
14.4 unauthorized provider services, including co-payments, deductibles, coinsurance, coverage
14.5 restrictions, and coverage limitations as those applicable to services received by the enrollee
14.6 from a participating provider.

14.7 **EFFECTIVE DATE.** This section is effective 30 days following final enactment and
14.8 applies to provider services provided on or after that date.

14.9 **Sec. 12. [62Q.557] BALANCE BILLING PROHIBITED.**

14.10 A participating provider is prohibited from billing an enrollee for any amount in excess
14.11 of the allowable amount the health plan company has contracted for with the provider as
14.12 total payment for the health care services. A participating provider is permitted to bill an
14.13 enrollee the approved co-payment, deductible, or coinsurance.

14.14 **EFFECTIVE DATE.** This section is effective July 1, 2017, and applies to health plans
14.15 offered, issued, or renewed to a Minnesota resident on or after that date.

14.16 **Sec. 13. TRANSITION OF CARE COVERAGE FOR CALENDAR YEAR 2017;**
14.17 **INVOLUNTARY TERMINATION OF COVERAGE.**

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

14.20 (b) "Enrollee" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision
14.21 2b.

14.22 (c) "Health plan" has the meaning given in Minnesota Statutes, section 62Q.01,
14.23 subdivision 3.

14.24 (d) "Health plan company" has the meaning given in Minnesota Statutes, section 62Q.01,
14.25 subdivision 4.

14.26 (e) "Individual market" has the meaning given in Minnesota Statutes, section 62A.011,
14.27 subdivision 5.

14.28 (f) "Involuntary termination of coverage" means the termination of a health plan due to
14.29 a health plan company's refusal to renew the health plan in the individual market because
14.30 the health plan company elects to cease offering individual market health plans in all or
14.31 some geographic rating areas of the state.

15.1 Subd. 2. **Application.** This section applies to an enrollee who is subject to a change in
15.2 health plans in the individual market due to an involuntary termination of coverage from a
15.3 health plan in the individual market after October 31, 2016, and before January 1, 2017,
15.4 and who enrolls in a new health plan in the individual market for all or a portion of calendar
15.5 year 2017 that goes into effect after December 31, 2016, and before March 2, 2017.

15.6 Subd. 3. **Change in health plans; transition of care coverage.** (a) If an enrollee satisfies
15.7 the criteria in subdivision 2, the enrollee's new health plan company must provide, upon
15.8 request of the enrollee or the enrollee's health care provider, authorization to receive services
15.9 that are otherwise covered under the terms of the enrollee's calendar year 2017 health plan
15.10 from a provider who provided care on an in-network basis to the enrollee during calendar
15.11 year 2016 but who is out of network in the enrollee's calendar year 2017 health plan:

15.12 (1) for up to 120 days if the enrollee has received a diagnosis of, or is engaged in a
15.13 current course of treatment for, one or more of the following conditions:

15.14 (i) an acute condition;

15.15 (ii) a life-threatening mental or physical illness;

15.16 (iii) pregnancy beyond the first trimester of pregnancy;

15.17 (iv) a physical or mental disability defined as an inability to engage in one or more major
15.18 life activities, provided the disability has lasted or can be expected to last for at least one
15.19 year or can be expected to result in death; or

15.20 (v) a disabling or chronic condition that is in an acute phase; or

15.21 (2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected
15.22 lifetime of 180 days or less.

15.23 (b) For all requests for authorization under this subdivision, the health plan company
15.24 must grant the request for authorization unless the enrollee does not meet the criteria in
15.25 paragraph (a) or subdivision 2.

15.26 (c) The commissioner of Minnesota Management and Budget must reimburse the
15.27 enrollee's new health plan company for costs attributed to services authorized under this
15.28 subdivision. Costs eligible for reimbursement under this paragraph are the difference between
15.29 the health plan company's reimbursement rate for in-network providers for a service
15.30 authorized under this subdivision and its rate for out-of-network providers for the service.
15.31 The health plan company must seek reimbursement from the commissioner for costs
15.32 attributed to services authorized under this subdivision, in a form and manner mutually
15.33 agreed upon by the commissioner and the affected health plan companies. Total state

16.1 reimbursements to health plan companies under this paragraph are subject to the limits of
16.2 the available appropriation. In the event that funding for reimbursements to health plan
16.3 companies is not sufficient to fully reimburse health plan companies for the costs attributed
16.4 to services authorized under this subdivision, health plan companies must continue to cover
16.5 services authorized under this subdivision.

16.6 Subd. 4. **Limitations.** (a) Subdivision 3 applies only if the enrollee's health care provider
16.7 agrees to:

16.8 (1) accept as payment in full the lesser of:

16.9 (i) the health plan company's reimbursement rate for in-network providers for the same
16.10 or similar service; or

16.11 (ii) the provider's regular fee for that service;

16.12 (2) request authorization for services in the form and manner specified by the enrollee's
16.13 new health plan company, if the provider chooses to request authorization; and

16.14 (3) provide the enrollee's new health plan company with all necessary medical information
16.15 related to the care provided to the enrollee.

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

16.18 Subd. 5. **Request for authorization.** The enrollee's health plan company may require
16.19 medical records and other supporting documentation to be submitted with a request for
16.20 authorization under subdivision 3. If authorization is denied, the health plan company must
16.21 explain the criteria used to make its decision on the request for authorization and must
16.22 explain the enrollee's right to appeal the decision. If an enrollee chooses to appeal a denial,
16.23 the enrollee must appeal the denial within five business days of the date on which the enrollee
16.24 receives the denial. If authorization is granted, the health plan company must provide the
16.25 enrollee, within five business days of granting the authorization, with an explanation of
16.26 how transition of care will be provided.

16.27 **EFFECTIVE DATE.** This section is effective for health plans issued after December
16.28 31, 2016, and before March 2, 2017, and that are in effect for all or a portion of calendar
16.29 year 2017. This section expires June 30, 2018.

17.1 **Sec. 14. COSTS RELATED TO IMPLEMENTATION OF THIS ACT.**

17.2 A state agency that incurs administrative costs to implement one or more provisions in
17.3 this act and does not receive an appropriation for administrative costs in section 16 or article
17.4 1, section 6, must implement the act within the limits of existing appropriations.

17.5 **Sec. 15. INSURANCE MARKET OPTIONS.**

17.6 The commissioner of commerce shall report by February 15, 2017, to the standing
17.7 committees of the legislature having jurisdiction over insurance and health on:

17.8 (1) a plan to implement and operate a residency verification process for individual health
17.9 insurance market participants; and

17.10 (2) the past and future use of Minnesota Statutes 2005, section 62L.056, and Minnesota
17.11 Statutes, section 62Q.188, including:

17.12 (i) rate and form filings received, approved, or withdrawn;

17.13 (ii) barriers to current utilization, including federal and state laws; and

17.14 (iii) recommendations for allowing or increasing the offering of health plans compliant
17.15 with Minnesota Statutes, section 62Q.188.

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

17.17 **Sec. 16. APPROPRIATION; COVERAGE FOR TRANSITION OF CARE.**

17.18 \$15,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner
17.19 of Minnesota Management and Budget to reimburse health plan companies for costs attributed
17.20 to coverage of transition of care services under section 13. No more than three percent of
17.21 this appropriation is available to the commissioner for administrative costs. This is a onetime
17.22 appropriation and is available until expended.

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

17.24 **Sec. 17. REPEALER.**

17.25 (a) Minnesota Statutes 2016, section 62D.12, subdivision 9, is repealed effective the
17.26 day following final enactment.

17.27 (b) Minnesota Statutes 2016, section 62K.11, is repealed effective July 1, 2017.

APPENDIX
Article locations in 17-1270

ARTICLE 1	PREMIUM ASSISTANCE	Page.Ln 1.12
ARTICLE 2	INSURANCE MARKET REFORMS	Page.Ln 6.19

62D.12 PROHIBITED PRACTICES.

Subd. 9. **Net earnings.** All net earnings of the health maintenance organization shall be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. No health maintenance organization shall provide for the payment, whether directly or indirectly, of any part of its net earnings, to any person as a dividend or rebate; provided, however, that health maintenance organizations may make payments to providers or other persons based upon the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to sections 62D.01 to 62D.30, revoke the certificate of authority of any health maintenance organization in violation of this subdivision.

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 is performed to pay for the noncovered service.