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(SENATE AUTHORS: ABELER, Benson, Koran, Gazelka and Dahms)

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03/19/2018	6787	Introduction and first reading Referred to Commerce and Consumer Protection Finance and Policy

A bill for an act

relating to insurance; health; modifying requirements for health insurance underwriting, renewability, and benefits; creating the Minnesota health risk pool program; allowing the creation of unified personal health premium accounts; creating the Minnesota health contribution program; requesting waivers; amending Minnesota Statutes 2016, sections 13.7191, by adding a subdivision; 60A.235, by adding a subdivision; 62A.65, subdivisions 3, 5, by adding a subdivision; 62L.03, subdivision 3, by adding a subdivision; 62L.08, subdivision 7, by adding a subdivision; 62Q.18, subdivision 10; 62V.05, subdivision 3; 290.0132, by adding a subdivision; 297I.05, subdivisions 1, 5; Minnesota Statutes 2017 Supplement, section 3.971, subdivision 6; proposing coding for new law in Minnesota Statutes, chapters 62A; 62K; 62Q; 256L; proposing coding for new law as Minnesota Statutes, chapters 62W; 62X; repealing Minnesota Statutes 2016, sections 62A.303; 62A.65, subdivision 2; 62L.08, subdivision 4; 62L.12, subdivisions 3, 4.

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

ARTICLE 1

HEALTH INSURANCE REFORM

Section 1. Minnesota Statutes 2016, section 60A.235, is amended by adding a subdivision to read:

Subd. 3b. **Mid-sized group coverage.** Notwithstanding subdivision 3, aggregate attachment points under that subdivision are also subject to the maximums described in this subdivision. A group of persons between:

(1) 50 and 74 has a maximum specific attachment point of $30,000; and

(2) 75 and 100 has a maximum specific attachment point of $40,000.

Sec. 2. **[62A.101] MID-SIZED GROUP HEALTH INSURANCE RATES.**

Subdivision 1. **General premium variations.** Every health carrier must offer premium rates to groups with between 50 and 100 persons that are no more than 25 percent above and no more than 25 percent below the index rate charged to similar sized groups 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 and claims experience. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

Subd. 2. **Limit on renewal premium increases.** The percentage increase in the premium rate charged to a group with between 50 and 100 persons for a new rating period must not exceed 15 percent annually, plus inflationary trend, adjusted pro rata for rating periods of less than one year.

Sec. 3. Minnesota Statutes 2016, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Nonrenewal of risk pools.** A health carrier offering individual health plans may not renew an individual health plan risk pool issued before January 1, 2019.

Sec. 4. Minnesota Statutes 2016, 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 may vary based upon the ages of covered persons in accordance with the provisions of the Affordable Care Act.

(b) Premium rates may vary based upon geographic rating area. The commissioner shall grant approval if the following conditions are met:

(1) the areas are established in accordance with the Affordable Care Act;

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

(c) Premium rates may vary based upon tobacco use, in accordance with the provisions of the Affordable Care Act.

(d) Premium rates must be no more than 25 percent above and no more than 25 percent below the standard rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year.

(e) In developing its 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~~, (c)~~;~~, and (d); and

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

~~(e)~~ (f) The premium charged with respect to any particular individual health plan shall not be adjusted more frequently than annually or January 1 of the year following initial enrollment, except that the premium rates may be changed to reflect:

(1) changes to the family composition of the policyholder;

(2) changes in geographic rating area of the policyholder, as provided in paragraph (b);

(3) changes in age, as provided in paragraph (a);

(4) changes in tobacco use, as provided in paragraph (c);

(5) transfer to a new health plan, reunderwriting, or enhanced coverage as requested by the policyholder; or

(6) other changes as provided under paragraph (d), or required by or otherwise expressly permitted by state or federal law or regulations.

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

~~(h)~~ (i) 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 and actuarially valid changes in risks associated with the enrollee populations.

~~(i)~~ (j) A health carrier 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. A health carrier that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (b), ~~(f),~~ (g), and ~~(h)~~ (i).

~~(j)~~ (k) The commissioner may establish regulations to implement the provisions of this subdivision.

Sec. 5. Minnesota Statutes 2016, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, ~~2014~~ 2019, no individual health plan may be offered, sold, issued, or renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, unless the limitation or exclusion is permitted under this subdivision or chapter 62L. An individual ~~age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014~~ who obtains coverage pursuant to this section may be subject to a preexisting condition limitation during the first 12 months of coverage if the individual was diagnosed or treated for that condition during the six months immediately preceding the date of application for coverage was received, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. ~~During plan years beginning prior to January 1, 2014,~~ An individual ~~who is age 19 or older and~~ who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, without a break of 63 days or more, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting

conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual ~~who is age 19 or older~~ must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02. ~~The prohibition on preexisting condition limitations for children age 18 or under does not apply to individual health plans that are grandfathered plans. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014, does not apply to individual health plans that are grandfathered plans.~~ An individual who has not maintained continuous coverage may be subject to a new 12-month preexisting condition limitation after each break in continuous coverage.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. ~~If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage.~~ The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. ~~The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan.~~ The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. ~~In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that~~

~~amount if necessary to otherwise comply with this section.~~ Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

Sec. 6. **[62A.652] PREEXISTING CONDITIONS DISCLOSED AT TIME OF APPLICATION.**

No insurer may cancel or rescind a health insurance policy for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice. No insurer may restrict coverage for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice. Preexisting condition limitations are offset or reduced by duration of time qualified if prior continuous coverage has been in place for the insured uninterrupted by a break of coverage 63 days or more.

Sec. 7. **[62K.16] TERMINATION OF COVERAGE DUE TO NONPAYMENT.**

(a) Notwithstanding section 62V.05, subdivision 5, a health carrier may terminate coverage of enrollees due to the nonpayment of premiums regardless of whether the enrollee is receiving advance premium tax credits under the Affordable Care Act if the enrollee has previously paid at least one full month's premium during the benefit year. Prior to termination, the health carrier must notify the enrollee of the premium payment delinquency, including the amount of premium owed.

(b) Termination of coverage for nonpayment of premiums under this section is effective 30 days following the date the premium was due.

(c) The health carrier is not responsible for claims for services rendered to the enrollee during the grace period described in paragraph (b).

Sec. 8. Minnesota Statutes 2016, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee or have enrolled in a qualified health plan, as defined in section 62V.02, subdivision 11, must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of

coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) coverage under Medicare Parts A and B; or (3) coverage under medical assistance under chapter 256B.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer. An arrangement permitted under section 62L.12, subdivision 2, paragraph (l), is not an arrangement between the employer and the health carrier for purposes of this paragraph.

(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.

(d) If a small employer cannot meet either the participation or contribution requirement, the small employer may purchase coverage only during an open enrollment period each year between November 15 and December 15.

Sec. 9. Minnesota Statutes 2016, section 62L.03, is amended by adding a subdivision to read:

Subd. 4a. **Preexisting conditions.** (a) Preexisting conditions may be excluded by a health carrier for the first 12 months of coverage if the eligible employee was diagnosed or treated for that condition during the six months immediately preceding the enrollment date, but exclusionary riders must not be used. When calculating any length of preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying coverage, provided that the individual maintains continuous coverage, meaning without a break of 63 days or more. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether

the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter, and this chapter's requirements are in addition to the requirements of that section and the rules adopted under it. No insurer may cancel or rescind a health insurance policy for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice.

(b) No health carrier may restrict coverage for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice.

Sec. 10. Minnesota Statutes 2016, section 62L.08, is amended by adding a subdivision to read:

Subd. 1a. **General premium variations.** Each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the standard rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, and duration of coverage from the date of issue. For purposes of this subdivision, 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 to be actuarially valid and approved by the commissioner. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted to be used under this subdivision.

Sec. 11. Minnesota Statutes 2016, section 62L.08, subdivision 7, is amended to read:

Subd. 7. **Premium rate development.** (a) In developing its standard rates, rates, and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans; and

(2) ~~actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4~~ differences in the rating factors permitted in subdivisions 1a and 3.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Sec. 12. Minnesota Statutes 2016, section 62Q.18, subdivision 10, is amended to read:

Subd. 10. **Guaranteed issue.** (a) No health plan company shall offer, sell, or issue any health plan that does not make coverage available on a guaranteed issue basis ~~in accordance with the Affordable Care Act~~.

(b) Notwithstanding paragraph (a), a health plan company may offer, sell, or issue an individual health plan that contains a preexisting condition limitation or exclusion as permitted under section 62A.65, subdivision 5.

Sec. 13. **[62Q.678] HEALTH PLAN OPEN ENROLLMENT.**

(a) All health plans must be made available in the manner required by Code of Federal Regulations, title 45, section 147.104.

(b) In addition to the requirements of paragraph (a), any individual health plan:

(1) must be made available for purchase at any time during the calendar year; and

(2) is not retroactive from the date on which the application for coverage was received.

Sec. 14. Minnesota Statutes 2016, section 62V.05, subdivision 3, is amended to read:

Subd. 3. **Insurance producers.** (a) By April 30, 2013, the board, in consultation with the commissioner of commerce, shall establish certification requirements that must be met by insurance producers in order to assist individuals and small employers with purchasing coverage through MNsure. Prior to January 1, 2015, the board may amend the requirements, only if necessary, due to a change in federal rules.

~~(b) Certification requirements shall not exceed the requirements established under Code of Federal Regulations, title 45, part 155.220. Certification shall include training on health plans available through MNsure, available tax credits and cost-sharing arrangements, compliance with privacy and security standards, eligibility verification processes, online enrollment tools, and basic information on available public health care programs. Training required for certification under this subdivision shall qualify for continuing education requirements for insurance producers required under chapter 60K, and must comply with course approval requirements under chapter 45.~~

~~(c)~~ (b) Producer compensation shall be established by health carriers ~~that provide health plans through MNsure. The structure of compensation to insurance producers must be similar~~ and be consistent and comparable for health plans sold through MNsure and outside MNsure.

~~(d)~~ (c) Any insurance producer compensation structure established by a health carrier for the small group market must include compensation for defined contribution plans that involve multiple health carriers. The compensation offered must be commensurate with other small group market defined health plans.

~~(e) Any insurance producer assisting an individual or small employer with purchasing coverage through MNsure must disclose, orally and in writing, to the individual or small employer at the time of the first solicitation with the prospective purchaser the following:~~

~~(1) the health carriers and qualified health plans offered through MNsure that the producer is authorized to sell, and that the producer may not be authorized to sell all the qualified health plans offered through MNsure;~~

~~(2) that the producer may be receiving compensation from a health carrier for enrolling the individual or small employer into a particular health plan; and~~

~~(3) that information on all qualified health plans offered through MNsure is available through the MNsure Web site.~~

~~For purposes of this paragraph, "solicitation" means any contact by a producer, or any person acting on behalf of a producer made for the purpose of selling or attempting to sell coverage through MNsure. If the first solicitation is made by telephone, the disclosures required under this paragraph need not be made in writing, but the fact that disclosure has been made must be acknowledged on the application.~~

~~(f)~~ (d) Beginning January 15, 2015, each health carrier that offers or sells qualified health plans through MNsure shall report in writing to the board and the commissioner of commerce the compensation and other incentives it offers or provides to insurance producers with regard to each type of health plan the health carrier offers or sells both inside and outside of MNsure. Each health carrier shall submit a report annually and upon any change to the compensation or other incentives offered or provided to insurance producers.

~~(g)~~ (e) Nothing in this chapter shall prohibit an insurance producer from offering professional advice and recommendations to a small group purchaser based upon information provided to the producer.

~~(h)~~ (f) An insurance producer that offers health plans in the small group market shall notify each small group purchaser of which group health plans qualify for Internal Revenue Service approved section 125 tax benefits. The insurance producer shall also notify small group purchasers of state law provisions that benefit small group plans when the employer agrees to pay 50 percent or more of its employees' premium or when employees enroll in

a qualified health plan. Individuals who are eligible for cost-effective medical assistance and individuals who enroll in qualified health plans will count toward the 75 percent participation requirement in section 62L.03, subdivision 3.

~~(i)~~ (g) Nothing in this subdivision shall be construed to limit the licensure requirements or regulatory functions of the commissioner of commerce under chapter 60K.

Sec. 15. Minnesota Statutes 2016, section 290.0132, is amended by adding a subdivision to read:

Subd. 23. **Expenditures for medical care and health insurance.** (a) The amount paid during the taxable year for medical care, as defined in section 213(d) of the Internal Revenue Code, but excluding any amount described in paragraph (b), is a subtraction.

(b) The subtraction under this subdivision does not include amounts:

(1) compensated by insurance or paid or reimbursed by an employer or a plan under sections 104 (health care reimbursement accounts), 105 (accident and health plans), 125 (cafeteria and flexible spending accounts), 223 (health care savings accounts), or other similar provisions of the Internal Revenue Code; or

(2) used to compute the credit under section 290.0672.

Sec. 16. **REPEALER.**

Minnesota Statutes 2016, sections 62A.303; 62A.65, subdivision 2; 62L.08, subdivision 4; and 62L.12, subdivisions 3 and 4, are repealed.

Sec. 17. **EFFECTIVE DATE.**

Sections 1 to 14 and 16 are effective January 1, 2019, or upon the effective date of any necessary federal waivers or law changes, whichever is later, and apply to health plans offered, issued, or renewed on or after that date. Section 15 is effective for taxable years beginning after December 31, 2018.

ARTICLE 2

HEALTH RISK POOL PROGRAM

Section 1. Minnesota Statutes 2017 Supplement, section 3.971, subdivision 6, is amended to read:

Subd. 6. **Financial audits.** The legislative auditor shall audit the financial statements of the state of Minnesota required by section 16A.50 and, as resources permit, Minnesota

State Colleges and Universities, the University of Minnesota, state agencies, departments, boards, commissions, offices, courts, and other organizations subject to audit by the legislative auditor, including, but not limited to, the State Agricultural Society, Agricultural Utilization Research Institute, Enterprise Minnesota, Inc., Minnesota Historical Society, ClearWay Minnesota, Minnesota Sports Facilities Authority, Metropolitan Council, Metropolitan Airports Commission, Minnesota Health Risk Pool Association, and Metropolitan Mosquito Control District. Financial audits must be conducted according to generally accepted government auditing standards. The legislative auditor shall see that all provisions of law respecting the appropriate and economic use of public funds and other public resources are complied with and may, as part of a financial audit or separately, investigate allegations of noncompliance.

Sec. 2. Minnesota Statutes 2016, section 13.7191, is amended by adding a subdivision to read:

Subd. 24. **Minnesota Health Risk Pool Association.** Certain data maintained by the Minnesota Health Risk Pool Association is classified under section 62W.05, subdivision 6.

Sec. 3. **[62W.01] CITATION.**

This chapter may be cited as the "Minnesota Health Risk Pool Association Act."

Sec. 4. **[62W.02] DEFINITIONS.**

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

Subd. 2. **Board.** "Board" means the board of directors of the Minnesota Health Risk Pool Association, as established under section 62W.05, subdivision 2.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 4. **Eligible individual.** "Eligible individual" means a natural person who has received a diagnosis of one of the conditions in section 62W.06, subdivision 1, paragraph (a), that qualifies claims for the person to be submitted by a member for risk pool payments under the program.

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

Subd. 6. **Risk pool program or program.** "Risk pool program" or "program" means the risk pool program created by this chapter.

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

Subd. 8. **Individual market.** "Individual market" means the market for individual health plans, as defined in section 62A.011, subdivision 5.

Subd. 9. **Member.** "Member" means a health carrier offering, issuing, or renewing individual health plans to a Minnesota resident.

Subd. 10. **Minnesota Health Risk Pool Association or association.** "Minnesota Health Risk Pool Association" or "association" means the association created under section 62W.05, subdivision 1.

Subd. 11. **Risk pool payments.** "Risk pool payments" means a payment made by the association to a member according to the requirements of the program and this chapter.

Sec. 5. **[62W.03] DUTIES OF COMMISSIONER.**

The commissioner may:

(1) formulate general policies to advance the purposes of this chapter;

(2) supervise the creation of the Minnesota Health Risk Pool Association within the limits described in section 62W.05;

(3) appoint advisory committees;

(4) conduct periodic audits to ensure the accuracy of the data submitted by members and the association, and compliance of the association and members with requirements of the plan of operation and this chapter;

(5) contract with the federal government or any other unit of government to ensure coordination of the program with other individual health plan reinsurance or subsidy programs;

(6) contract with health carriers and others for administrative services; and

(7) adopt, amend, suspend, and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of this chapter.

Sec. 6. **[62W.04] APPROVAL OF RISK POOL PAYMENTS.**

Subdivision 1. **Information submitted to commissioner.** The association must submit to the commissioner information regarding the risk pool payments the association anticipates making for the calendar year following the year in which the information is submitted. The

information must include historical risk pool payment data, underlying principles of the model used to calculate anticipated risk pool payments, and any other relevant information or data the association used to determine anticipated risk pool payments for the following calendar year. This information must be submitted to the commissioner by August 30 of each year, for risk pool payments anticipated to be made in the calendar year following the year in which the information is submitted. By October 15 of each year, the commissioner must approve or modify the anticipated risk pool payment schedule.

Subd. 2. **Modification by commissioner.** The commissioner may modify the association's anticipated risk pool payment schedule, as described in subdivision 1, on the basis of the following criteria:

(1) whether the association is in compliance with the requirements of the plan of operation and this chapter;

(2) the degree to which the computations and conclusions take into consideration the current and future individual market regulations;

(3) the degree to which any sample used to compute the effect on premiums reasonably reflects circumstances projected to exist in the individual market through the use of accepted actuarial principles;

(4) the degree to which the computations and conclusions take into consideration the current and future health care needs and health condition demographics of Minnesota residents purchasing individual health plans;

(5) the actuarially projected effect of the risk pool payments upon both total enrollment in the individual market, and the nature of the risks assumed by the association;

(6) the financial cost to the individual market, and the entire health insurance market in this state;

(7) the projected cost of all risk pool payments in relation to funding available for the program; and

(8) other relevant factors, as determined by the commissioner.

Sec. 7. **[62W.05] MINNESOTA HEALTH RISK POOL ASSOCIATION.**

Subdivision 1. **Creation; tax exemption.** The Minnesota Health Risk Pool Association is established to promote the stabilization and cost control of individual health plans in the state. Membership in the association consists of all health carriers offering, issuing, or renewing individual health plans in the state. The association is exempt from the taxes

imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

Subd. 2. **Board of directors; organization.** (a) The board of directors of the association shall be made up of 11 members as follows: six directors selected by members, subject to approval by the commissioner, one of which must be a health actuary; five public directors selected by the commissioner, four of whom must be individual health plan enrollees, and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area.

(b) In determining voting rights to elect directors at the member's meeting, each member shall be entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of accident and health insurance premium, subscriber contract charges, or health maintenance contract payment, derived from or on behalf of Minnesota residents in the previous calendar year, in the individual market, as determined by the commissioner.

(c) In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services.

Subd. 3. **Membership.** All members shall maintain their membership in the association as a condition of participating in the individual market in this state.

Subd. 4. **Operation.** The association shall submit its articles, bylaws, and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws, and operating rules by the association and the approval by the commissioner thereof shall be exempt from sections 14.001 to 14.69.

Subd. 5. **Open meetings.** All meetings of the board and any committees shall comply with the provisions of chapter 13D.

Subd. 6. **Data.** The association and board are subject to chapter 13. Data received by the association and board from a member that is data on individuals is private data on individuals, as defined in section 13.02, subdivision 12.

Subd. 7. **Appeals.** An appeal may be filed with the commissioner within 30 days after notice of an action, ruling, or decision by the board. A final action or order of the commissioner under this subdivision is subject to judicial review in the manner provided by chapter 14. In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.

Subd. 8. **Antitrust exemption.** In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325D.49 to 325D.66.

Subd. 9. **General powers.** The association may:

(1) exercise the powers granted to insurers under the laws of this state;

(2) sue or be sued;

(3) establish administrative and accounting procedures for the operation of the association; and

(4) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions including the functions provided for in section 62W.06.

Subd. 10. **Rulemaking.** The association is exempt from the Administrative Procedure Act. However, to the extent the association wishes to adopt rules, they may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to rules adopted under this subdivision.

Sec. 8. **[62W.06] ASSOCIATION; ADMINISTRATION OF PROGRAM.**

Subdivision 1. **Acceptance of risk.** (a) The association must accept a transfer to the program from a member of the risk and cost associated with providing health coverage to an eligible individual when the eligible individual discloses to the member in their application for an individual health plan that they have received a diagnosis of at least one of the conditions in paragraph (b).

(b) The diagnosis necessary to qualify as an eligible individual are:

(1) AIDS/HIV;

(2) Alzheimer's disease;

(3) amyotrophic lateral sclerosis (ALS);

(4) angina pectoris;

(5) anorexia nervosa or bulimia;

(6) aortic aneurysm;

(7) ascites;

(8) chemical dependency;

(9) chronic pancreatitis;

(10) chronic renal failure;

(11) cirrhosis of the liver;

(12) coronary insufficiency;

(13) coronary occlusion;

(14) Crohn's Disease (regional enteritis);

(15) cystic fibrosis;

(16) dermatomyositis;

(17) Friedreich's ataxia;

(18) hemophilia;

(19) hepatitis C;

(20) history of major organ transplant;

(21) Huntington Chorea;

(22) hydrocephalus;

(23) insulin dependent diabetes;

(24) leukemia;

(25) malignant lymphoma;

(26) malignant tumors;

(27) metastatic cancer;

(28) motor/sensory aphasia:

(29) multiple sclerosis;

(30) muscular dystrophy;

(31) myasthenia gravis;

(32) myocardial infarction;

(33) myotonia;

(34) open heart surgery;

(35) paraplegia;

(36) Parkinson's Disease;

(37) polyarteritis nodosa;

(38) polycystic kidney;

(39) primary cardiomyopathy;

(40) progressive systemic sclerosis (Scleroderma);

(41) quadriplegia;

(42) stroke;

(43) syringomylia;

(44) systemic lupus erythematosis (SLE);

(45) Wilson's disease; and

(46) any other injury or illness at the member's discretion.

Subd. 2. **Payment to members.** (a) The association must reimburse members on a quarterly basis for claims paid on behalf of an eligible individual whose risk and cost has been transferred to the program.

(b) Risk pool payments related to any one eligible individual is limited to $5,000,000 over the lifetime of the individual, without consideration of whether the risk pool payments are made to one or more members.

Subd. 3. **Plan of operation.** (a) The association, in consultation with the commissioners of health and commerce, must create a plan of operation to administer the program. The plan of operation must be updated as necessary by the board, in consultation with the commissioners.

(b) The plan of operation must include:

(1) guidance to members regarding the use of diagnosis codes for the purposes of identifying eligible individuals;

(2) a description of the data a member submitting a risk pool payment request must provide to the association for the association to implement and administer the program. This includes data necessary for the association to determine a member's eligibility for risk pool payments;

(3) the manner and time period in which a member must provide the data described in clause (3);

(4) requirements for reports to be submitted by a member to the association;

(5) requirements for the processing of reports received under section 62W.07, subdivision 2, clause (5), by the association;

(6) requirements for conducting audits in compliance with section 62W.08; and

(7) requirements for an annual actuarial study of this state's individual market to be ordered by the association that:

(i) measures the impact of the program;

(ii) recommends funding levels for the program; and

(iii) analyzes possible changes in the individual market and the impact of the changes.

Subd. 4. **Use of premium payments.** The association must apply all premiums received from members to payment of the transferred risks. The association may pay normal administrative and operational expenses.

Subd. 5. **Prior notification of potential enrollees.** (a) A member market must notify all applicants prior to enrollment of the potential for the transfer of data to the association. Notification must include:

(1) a description of the potential transfer of cost and risk of the enrollee, transfer of premium payments, and transfer of medical claims to the association;

(2) the address and telephone number of the association; and

(3) the Tennessen warning required by section 13.04, subdivision 2.

(b) Before a member accepts an application the member must obtain the potential enrollee's signature on a separate document acknowledging receipt of the notification, and a separate signature providing the individual's consent for data sharing if the member transfers the risk and cost of the individual to the association.

Sec. 9. **[62W.07] MEMBERS; COMPLIANCE WITH PROGRAM.**

Subdivision 1. **Transfer of risk.** A member must transfer the risk and cost associated with providing health coverage to an eligible individual to the program in compliance with this section. A member must transfer the risk and cost of the eligible individual after receiving a completed application for an individual health plan from the individual, which application discloses that the individual, or a member of the individual's family if a family policy is being requested, has been diagnosed with one of the conditions listed in section 62W.06,

subdivision 1, paragraph (b). The program is effective as the effective date of the individual health plan and continues until the eligible individual ceases coverage with the member.

Subd. 2. **Risk pool payments.** (a) A member is eligible for risk pool payments to reimburse the member for the claims of an eligible individual if the member:

(1) provides evidence to the association that the individual is an eligible individual;

(2) is currently paying the claims of the eligible individual;

(3) pays to the association, pursuant to paragraph (c), the premium the member receives under an individual health plan for the eligible individual;

(4) pays to the association, pursuant to paragraph (d), any pharmacy rebates the member receives for health care services provided to the eligible individual; and

(5) reports and pays to the association payments applicable to the eligible individual that the member collects relating to:

(i) third-party liabilities;

(ii) payments the member recovers for overpayment;

(iii) payments for commercial reinsurance recoveries;

(iv) estimated federal cost-sharing reduction payments made under United States Code, title 42, section 18071; and

(v) estimated advanced premium tax credits paid to the member on behalf of an eligible individual made under United States Code, title 26, section 36B.

(b) A member that has transferred the associated risk and cost of an eligible individual to the program must submit to the program all data and information required by the association, in a manner determined by the association.

(c) A member must provide the program all premiums received for coverage under an individual health plan from an eligible individual whose risk and associated cost has been transferred to the program. A member must transfer all premiums, less all normal issuance administrative and maintenance costs to the program immediately after receipt. For each additional eligible individual covered under a family policy who has a separately identifiable premium equal to $0, the member shall pay the association the next highest separately identifiable premium under the family policy.

(d) A member must pay the association a pharmacy rebate required to be paid pursuant to paragraph (a), clause (4), within 30 days of receiving the pharmacy rebate.

Subd. 3. **Duties; members.** (a) A member must comply with the plan of operation created under section 62W.06, subdivision 3, in order to receive risk pool payments under the program.

(b) A member must continue to administer and manage an eligible individual's individual health plan in accordance with the terms of the individual health plan after the risk and cost associated with the eligible individual has been transferred to the program.

(c) A member may not vary premium rates based on whether the risk and cost associated with an eligible individual has been transferred to the program.

(d) After the risk and cost of an eligible individual has been transferred to the program, the risk and cost will remain with the program for the benefit plan year.

(e) For a claim to qualify for risk pool payments from the program, a member must submit claims incurred by an eligible individual whose risk and associated cost has been transferred to the program within 12 months of the claim being incurred.

Sec. 10. **[62W.08] ACCOUNTS AND AUDITS.**

Subdivision 1. **Reports and audits.** (a) The association shall maintain its books, records, accounts, and operations on a calendar-year basis.

(b) The association shall conduct a final accounting with respect to each calendar year after April 15 of the following calendar year.

(c) Claims for eligible individuals whose associated risk and cost have been transferred to the program that are incurred during a calendar year and are submitted for reimbursement before April 15 of the following calendar year must be allocated to the calendar year in which they are incurred. Claims submitted after April 15 following the calendar year in which they are incurred must be allocated to a later calendar year in accordance with the plan of operation.

(d) If the total receipts of the association fund with respect to a calendar year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that calendar year, all claims for reimbursement allocable to that calendar year shall be reduced proportionately to the extent necessary to prevent a deficit in the fund for that calendar year. Any reduction in claims for reimbursement with respect to a calendar year must apply to all claims allocable to that calendar year without regard to when those claims are submitted for reimbursement, and any reduction will be applied to each claim in the same proportion.

(e) The association must establish a process for auditing every member that transfers the cost and associated risk of an eligible individual to the program. Audits may include both an audit conducted in connection with commencement of a member's first transfer to the program and periodic audits up to four times a year throughout a member's participation in the program.

(f) The association must engage an independent third-party auditor to perform a financial and programmatic audit for each calendar year in accordance with generally accepted auditing standards. The association shall provide a copy of the audit to the commissioner at the time the association receives the audit, and publish a copy of the audit on the association's Web site within 14 days of receiving the audit.

Subd. 2. **Annual settle-up.** (a) The association shall establish a settle-up process with respect to a calendar year to reflect adjustments made in establishing the final accounting for that calendar year. The adjustments include, but are not limited to:

(1) the crediting of premiums received with respect to the cost and associated risks of an eligible person being transferred after the end of the calendar year;

(2) retroactive reductions or other adjustments in reimbursements necessary to prevent a deficit in the association fund for that calendar year; and

(3) retroactive reductions to prevent a windfall to a member as a result of third party recoveries, recovery of overpayments, commercial reinsurance recoveries, federal cost-sharing reductions made under United States Code, title 42, section 18071, advanced premium tax credits paid under United States Code, title 26, section 36B, or risk adjustments made under United States Code, title 42, section 18063, for that calendar year.

The settle-up must occur after April 15 following the calendar year to which it relates.

(b) With respect to the risk adjustment transfers as determined by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and Center for Consumer Information and Insurance Oversight:

(1) the commissioner must review the risk adjustment transfers to determine the impact the transfer of risk and associated cost of an eligible individual to the program has had, if any;

(2) the review must occur not later than 60 days after publication of the notice of final risk adjustment transfers by the Center for Consumer Information and Insurance Oversight;

(3) if the commissioner notifies a member of the amount of any risk adjustment transfer it received that does not accurately reflect benefits provided under the program:

(i) the member must pay that amount to the association within 30 days of receiving the notice from the commissioner; and

(ii) as appropriate, the commissioner must refund that amount to the member that made the federal risk adjustment payment; and

(4) a member must submit to the commissioner, in a form acceptable to the commissioner, all data requested by the commissioner by March of the year following the year to which the risk adjustment applies.

Sec. 11. **[62W.09] ASSESSMENT ON ISSUERS OF ACCIDENT AND HEALTH INSURANCE POLICIES.**

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

(b) "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage which is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued pursuant to chapter 62B;

(6) designed solely to provide dental or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11; or

(8) accident only coverage issued by licensed and tested insurance agents or solicitors which provides reasonable benefits in relation to the cost of covered services.

The provisions of clause (4) shall not apply to hospital indemnity coverage which is sold by an insurer to an applicant who is not then currently covered by a qualified plan.

(c) "Market member" means those companies regulated under chapter 62A and offering, selling, issuing, or renewing policies or contracts of accident and health insurance; health maintenance organizations regulated under chapter 62D; nonprofit health service plan corporations regulated under chapter 62C; community integrated service networks regulated under chapter 62N; fraternal benefit societies regulated under chapter 64B; the Minnesota

employees insurance program established in section 43A.317; and joint self-insurance plans regulated under chapter 62H. For the purposes of determining liability of market members pursuant to subdivision 2, payments received from or on behalf of Minnesota residents for coverage by a health maintenance organization or community integrated service network shall be considered to be accident and health insurance premiums.

Subd. 2. **Assessment.** The association shall make an annual determination of each market member's financial liability for the support of the program, in accordance with the requirements of section 62W.10, if any, and may make an annual fiscal year-end assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the market members whose aggregate assessments comprised a minimum of 90 percent of the most recent prior annual assessment, in the event that the association deems that methodology to be the most administratively efficient and cost-effective means of assessment, and as may be necessary to ensure the financial capability of the association in meeting the incurred or estimated claims expenses, and administrative and operational costs of the program until the association's next annual fiscal year-end assessment. Payment of an assessment shall be due within 30 days of receipt by a market member of a written notice of a fiscal year-end or interim assessment. Failure by a market member to tender to the association the assessment within 30 days shall be grounds for termination of the market member's ability to issue accident and health insurance policies in Minnesota. A market member which ceases to do accident and health insurance business within the state shall remain liable for assessments through the calendar year during which accident and health insurance business ceased. The association may decline to levy an assessment against a market member if the assessment, as determined herein, would not exceed $10.

Sec. 12. **[62W.10] FUNDING OF PROGRAM.**

(a) The association account is created in the special revenue fund of the state treasury. Funds in the account are appropriated to the association for the operation of the program. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the association account not currently needed, shall be credited to the association account.

(b) The association shall fund the program using the following sources, in the following order:

(1) any federal funds available, whether through grants or otherwise;

(2) the funds in section 13;

(3) the tax imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations under section 297I.05, subdivision 5; and

(4) the assessment, if any, authorized by section 62W.09.

(c) The program shall not exceed $..... in claims, administrative, and operational costs per calendar year.

Sec. 13. Minnesota Statutes 2016, section 297I.05, subdivision 1, is amended to read:

Subdivision 1. **Domestic and foreign companies.** Except as otherwise provided in this section, a tax is imposed on every domestic and foreign insurance company. The rate of tax is equal to two percent of all gross premiums less return premiums on all direct business received by the insurer or agents of the insurer in Minnesota, in cash or otherwise, during the year. This tax shall be paid into the association account.

Sec. 14. Minnesota Statutes 2016, section 297I.05, subdivision 5, is amended to read:

Subd. 5. **Health maintenance organizations, nonprofit health service plan corporations, and community integrated service networks.** (a) A tax is imposed on health maintenance organizations, community integrated service networks, and nonprofit health care service plan corporations. The rate of tax is equal to one percent of gross premiums less return premiums on all direct business received by the organization, network, or corporation or its agents in Minnesota, in cash or otherwise, in the calendar year.

(b) The commissioner shall deposit all revenues, including penalties and interest, collected under this chapter from health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations in the ~~health care access fund~~ association account. Refunds of overpayments of tax imposed by this subdivision must be paid from the ~~health care access fund~~ association account. There is annually appropriated from the ~~health care access fund~~ association account to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Sec. 15. **TRANSFER.**

$..... in fiscal year 2019 is transferred from the health care access fund to the commissioner of commerce for transfer to the association account in the special revenue fund for the purposes described in Minnesota Statutes, section 62W.10, and section 12.

Sec. 16. **EFFECTIVE DATE.**

Sections 1 to 11 are effective January 1, 2020, and apply to individual health plans providing coverage on or after that date. Sections 12 to 15 are effective the day following final enactment and apply to individual health plans providing coverage on or after January 1, 2019, until December 31, 2019.

ARTICLE 3

UNIFIED PERSONAL HEALTH PREMIUM ACCOUNT

Section 1. **[62X.01] DEFINITIONS.**

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

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 3. **Dependent.** "Dependent" means an individual's spouse or tax dependent.

Subd. 4. **Health insurance.** "Health insurance" means:

(1) individual health insurance and individual policies that cover cancer, accidents, critical illness, hospital confinement/medical bridge, short-term disability, long-term care, and high deductible health plans including those that are compatible with health savings accounts; and

(2) any other coverages identified under sections 60A.06, subdivision 1, clause (5), paragraph (a); 62Q.01, subdivisions 4a and 6; and 62Q.188.

Subd. 5. **Trustee.** "Trustee" means an entity that has trust powers under state or federal law.

Subd. 6. **Unified personal health premium account or account.** "Unified personal health premium account" or "account" means a trust account created for the purpose of receiving funds from multiple sources for the payment of, or reimbursement for, health insurance premiums.

Subd. 7. **Unified personal health premium account administrator or administrator.** "Unified personal health premium account administrator" or "administrator" means an entity that has the authority to administer a unified personal health premium account.

Sec. 2. **[62X.02] REGISTRATION REQUIRED.**

(a) Only a private-sector entity or individual registered with the commissioner as a unified personal health premium account administrator may administer an account on behalf of a resident of this state.

(b) To register under this section, a private sector entity or individual must be:

(1) a licensed insurance producer, as defined in section 60K.31, subdivision 6, under the insurance authority described in section 60K.38, subdivision 1, paragraph (b), clause (1), (2), or (5);

(2) a licensed vendor of risk management services or entity administering a self-insurance or insurance plan under section 60A.23, subdivision 8; or

(3) a federally or state-chartered bank or credit union.

(c) An applicant for registration under this section shall pay a fee of $250 for initial registration and $50 for each three-year renewal.

Sec. 3. **[62X.03] REQUIREMENTS; ADMINISTRATION OF UNIFIED PERSONAL HEALTH PREMIUM ACCOUNT.**

Subdivision 1. **Nature of arrangements.** (a) Administrators of a unified personal health premium account under contract with an employer must conduct business in accordance with a written contract.

(b) Administrators may conduct business directly with individuals in accordance with a written agreement.

(c) The written agreement between a unified personal health premium account administrator and its customer must specify the services to be provided to the customer, the payment for each service including administrative costs, and the timing and method of each payment or type of payment.

(d) An administrator may administer unified personal health premium accounts separately or in conjunction with other employee benefit services, including services that facilitate and coordinate tax-preferred payments for health care and coverage under Internal Revenue Code, sections 105, 106, and 9831(d).

(e) An administrator shall create and maintain records of receipts, payments, and other transactions, sufficient to enable the individual to benefit from tax advantages available to the individual under Internal Revenue Code, sections 105, 106, 125, and other relevant sections, and under Minnesota income tax law, for health insurance paid by or on behalf of

the individual. The records and procedures must be capable of segregating funds to maintain restrictions on the funds received from contributors.

(f) Individual insurance market products paid for through the account under this section are not an employer-sponsored plan subject to state or federal group insurance market requirements.

Subd. 2. **Trust account requirements.** (a) Contributions to an individual's account may be made by the individual, the individual's employer or former employer, the individual's family members or dependents, charitable organizations, a government entity, or any other source.

(b) A contributor to the account may restrict the use of funds the contributor contributes to the payment of premiums for one or more of the types of health insurance included in section 62X.01, subdivision 4.

(c) A trust created and trustees appointed under this chapter shall:

(1) have the powers granted under, and shall comply with, the provisions of chapter 501B that are relevant to a trust created for purposes of this chapter;

(2) allow for financial contributions from multiple sources, including tax-preferred contributions from individuals and employers and nontax-preferred contributions from individuals and other sources;

(3) restrict funds to be used exclusively for the benefit of the individual account holder or the individual's tax dependents;

(4) make funds available for the payment of premiums on any type of health insurance included in section 62X.01, subdivision 4, from any insurance company, subject to any restriction under paragraph (b);

(5) grant the unified personal health premium account administrator authority to direct payments to insurance companies or to reimburse account owners for qualified health insurance premium expenses;

(6) segregate funds to maintain restrictions on the funds received from contributors; and

(7) guarantee that funds contributed by an employer will remain available to the account holder after the account holder's term of employment with the employer ends.

Sec. 4. **[62X.04] COORDINATION WITH HEALTHY MINNESOTA PROGRAM.**

The commissioner of human services shall enter into agreements under which unified personal health premium account administrators may receive public funds for use as subsidies toward payment of premiums for health coverage provided to eligible individuals who have a trust account for that purpose.

Sec. 5. **[256L.032] HEALTHY MINNESOTA CONTRIBUTION PROGRAM.**

Subdivision 1. **Defined contributions to enrollees.** (a) The commissioner shall provide each MinnesotaCare enrollee, with the exception of those residing in counties that offer county-based purchasing, eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply to enrollees obtaining coverage under this section.

Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) An enrollee must select a health plan within four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) Coverage purchased under this section may be in the form of a flexible benefits plan under section 62Q.188.

(d) Coverage purchased under this section must comply with the coverage limitations specified in section 256L.03, subdivision 1, paragraph (b).

Subd. 3. **Determination of defined contribution amount.** The commissioner shall determine the defined contribution sliding scale using the base contribution for specific age ranges. The commissioner shall use a sliding scale for defined contributions based on the federal poverty guidelines for household income.

Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Sec. 6. **EFFECTIVE DATE.**

Sections 1 to 5 are effective the day following final enactment.

ARTICLE 4

FEDERAL WAIVER

Section 1. **STATE INNOVATION WAIVER.**

Subdivision 1. **Submission of waiver application.** The commissioner of commerce must apply to the secretary of the Department of Health and Human Services under United States Code, title 42, sections 18051 and 18052, and for a state innovation waiver to implement any sections of this act that necessitate a waiver for plan years beginning on or after January 1, 2019.

Subd. 2. **Consultation.** In developing the waiver application, the commissioner shall consult with the commissioner of human services and the commissioner of health.

Subd. 3. **Application timelines; notification.** The commissioner shall submit the waiver application to the Secretary of Health and Human Services on or before July 5, 2018. The commissioner shall make a draft application available for public review and comment by June 1, 2018. The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance and health care of any federal actions regarding the waiver request.

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

APPENDIX
Article locations in SF3601-0

62A.303 PROHIBITION; SEVERING OF GROUPS.

Section 62L.12, subdivisions 3 and 4, apply to all employer group health plans, as defined in section 62A.011, regardless of the size of the group.

62A.65 INDIVIDUAL MARKET REGULATION.

Subd. 2. **Guaranteed renewal.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan, except for nonpayment of premiums, fraud, or misrepresentation.

62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

Subd. 4. **Geographic premium variations.** Premium rates may vary based on geographic rating areas set by the commissioner. The commissioner shall grant approval if the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in rates.

62L.12 PROHIBITED PRACTICES.

Subd. 3. **Agent's licensure.** An agent licensed under chapter 60K or section 62C.17 who knowingly and willfully breaks apart a small group for the purpose of selling individual health plans to eligible employees and dependents of a small employer that meets the participation and contribution requirements of section 62L.03, subdivision 3, is guilty of an unfair trade practice and subject to disciplinary action, including the revocation or suspension of license, under section 60K.43 or 62C.17. The action must be by order and subject to the notice, hearing, and appeal procedures specified in section 60K.43. The action of the commissioner is subject to judicial review as provided under chapter 14. This section does not apply to any action performed by an agent that would be permitted for a health carrier under subdivision 2.

Subd. 4. **Employer prohibition.** A small employer shall not encourage or direct an employee or applicant to:

(1) refrain from filing an application for health coverage when other similarly situated employees may file an application for health coverage;

(2) file an application for health coverage during initial eligibility for coverage, the acceptance of which is contingent on health status, when other similarly situated employees may apply for health coverage, the acceptance of which is not contingent on health status;

(3) seek coverage from another health carrier, including, but not limited to, MCHA; or

(4) cause coverage to be issued on different terms because of the health status or claims experience of that person or the person's dependents.