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STATE OF MINNESOTA
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S.F. No. 1153

(SENATE AUTHORS: ABELER)

DATE	D-PG	OFFICIAL STATUS
02/20/2017	666	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 an individual health plan reinsurance program; appropriating money; amending Minnesota Statutes 2016, sections 13.7191, by adding a subdivision; 62A.65, subdivisions 3, 5; 62L.02, subdivision 26; 62L.03, by adding a subdivision; 62L.08, subdivision 7, by adding a subdivision; 62Q.18, subdivision 10; 297I.05, subdivision 5; proposing coding for new law in Minnesota Statutes, chapters 62A; 62K; 62Q; proposing coding for new law as Minnesota Statutes, chapter 62W; repealing Minnesota Statutes 2016, sections 62A.65, subdivision 2; 62L.08, subdivision 4.

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

ARTICLE 1

HEALTH INSURANCE REFORM

Section 1. **[62A.614] 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 unless the coverage is restricted at the time the policy is issued and the restriction is disclosed in writing to the insured at the time the policy is issued.

Sec. 2. 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~~ must be no more than ten percent above and no more than 50 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. The premium variations permitted by this paragraph must be based only upon health status and claims experience. For purposes of this paragraph, 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 by the commissioner to be actuarially valid and have been approved by the commissioner. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

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

(d) 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), (b), and (c)~~; and~~

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

(e) The state of Minnesota shall constitute a single geographic rating area for purposes of setting premium rates.

(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)~~ (2) changes in age, as provided in paragraph (a);

~~(4)~~ (3) changes in tobacco use, as provided in paragraph (c);

~~(5)~~ (4) transfer to a new health plan, reunderwriting, or enhanced coverage as requested by the policyholder; or

~~(6)~~ (5) other changes 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. 3. 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~~ 2018, 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, 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. 4. **[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. 5. Minnesota Statutes 2016, section 62L.02, subdivision 26, is amended to read:

Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar year and a plan year, a person, sole proprietorship, firm, corporation, partnership, association, or other entity actively engaged in business in Minnesota, including a political subdivision of the state, that employed an average of at least one, ~~not including a sole proprietor,~~ but not more than 50 current employees on business days during the preceding calendar year and that employs at least one current employee~~, not including a sole proprietor,~~ on the first day of the plan year. A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than ~~two~~ one current ~~employees~~ employee. Entities that are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single employer for purposes of determining the number of current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based upon the average number of current employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For purposes of this definition, the term employer includes any predecessor of the employer. An employer that has more than 50 current employees but has 50 or fewer employees, as "employee" is defined under United States Code, title 29, section 1002(6), is a small employer under this subdivision.

(b) Where an association, as defined in section 62L.045, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association and health benefit plans it provides to small employers, are subject to section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code,

title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

(d) Small group health plans offered through MNsure under chapter 62V to employees of a small employer are not considered individual health plans, regardless of whether the health plan is purchased using a defined contribution from the small employer.

Sec. 6. Minnesota Statutes 2016, section 62L.03, is amended by adding a subdivision to read:

Subd. 4a. **Preexisting conditions.** 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. 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.

Sec. 7. 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, industry of the employer, 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. 8. 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. 9. 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. 10. **[62Q.461] CHOICE IN CONTRACEPTIVE COVERAGE.**

Subdivision 1. **Applicability.** This section applies to individual health plans and small group health plans, as defined in section 62K.03, subdivision 12, offered, issued, or renewed by a health plan company.

Subd. 2. **Requirement to provide enrollee choice.** A health plan company must offer a health plan option to enrollees that does not include coverage for contraceptive methods that are abortifacients. For purposes of this requirement, "contraceptive methods that are abortifacients" include hormonal and copper intrauterine devices, Plan B and Ella emergency contraception (morning after pills), and other methods of contraception that prevent implantation of the fertilized egg or affect the implanted embryo.

Sec. 11. **[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. 12. **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, section 18052, for a state innovation waiver to implement the requirements of article 1, sections 2 to 11 and 13, of this act for plan years beginning on or after January 1, 2018.

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, 2017. The commissioner shall make a draft application available for public review and comment by June 1, 2017. 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.

Sec. 13. **REPEALER.**

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

Sec. 14. **EFFECTIVE DATE.**

Sections 1 to 11 and 13 are effective January 1, 2018, 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.

ARTICLE 2

REINSURANCE PROGRAM

Section 1. Minnesota Statutes 2016, section 13.7191, is amended by adding a subdivision to read:

Subd. 23. **Minnesota Health Reinsurance Association.** Certain data maintained by the Minnesota Health Reinsurance Association is classified under section 62W.05, subdivision 6.

Sec. 2. **[62W.01] CITATION.**

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

Sec. 3. **[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 Reinsurance 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 reinsurance payments under the program.

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

Subd. 6. **Health reinsurance program or program.** "Health reinsurance program" or "program" means the system of reinsurance 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 Reinsurance Association or association.** "Minnesota Health Reinsurance Association" or "association" means the association created under section 62W.05, subdivision 1.

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

Sec. 4. **[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 Reinsurance 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. 5. **[62W.04] APPROVAL OF REINSURANCE PAYMENTS.**

Subdivision 1. **Information submitted to commissioner.** The association must submit to the commissioner information regarding the reinsurance payments the association anticipates making for the calendar year following the year in which the information is submitted. The information must include historical reinsurance payment data, underlying principles of the model used to calculate anticipated reinsurance payments, and any other relevant information or data the association used to determine anticipated reinsurance payments for the following calendar year. This information must be submitted to the commissioner by August 30 of each year, for reinsurance 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 reinsurance payment schedule.

Subd. 2. **Modification by commissioner.** The commissioner may modify the association's anticipated reinsurance 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 reinsurance 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 entire health insurance market in this state;

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

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

Sec. 6. **[62W.05] MINNESOTA HEALTH REINSURANCE ASSOCIATION.**

Subdivision 1. **Creation; tax exemption.** The Minnesota Health Reinsurance 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 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. 7. **[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:

(i) AIDS/HIV;

(ii) Alzheimer's disease;

(iii) amyotrophic lateral sclerosis (ALS);

(iv) angina pectoris;

(v) anorexia nervosa or bulimia;

(vi) aortic aneurysm;

(vii) ascites;

(viii) chemical dependency;

(ix) chronic pancreatitis;

(x) chronic renal failure;

(xi) cirrhosis of the liver;

(xii) coronary insufficiency;

(xiii) coronary occlusion;

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

(xv) cystic fibrosis;

(xvi) dermatomyositis;

(xvii) Friedreich's ataxia;

(xviii) hemophilia;

(xix) hepatitis C;

(xx) history of major organ transplant;

(xxi) Huntington Chorea;

(xxii) hydrocephalus;

(xxiii) insulin dependent diabetes;

(xxiv) leukemia;

(xxv) malignant lymphoma;

(xxvi) malignant tumors;

(xxvii) metastatic cancer;

(xxviii) motor/sensory aphasia:

(xxix) multiple sclerosis;

(xxx) muscular dystrophy;

(xxxi) myasthenia gravis;

(xxxii) myocardial infarction;

(xxxiii) myotonia;

(xxxiv) open heart surgery;

(xxxv) paraplegia;

(xxxvi) Parkinson's Disease;

(xxxvii) polyarteritis nodosa;

(xxxviii) polycystic kidney;

(xxxix) primary cardiomyopathy;

(xl) progressive systemic sclerosis (Scleroderma);

(xli) quadriplegia;

(xlii) stroke;

(xliii) syringomylia;

(xliv) systemic lupus erythematosis (SLE); and

(xlv) Wilson's disease.

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) Reinsurance payments related to any one eligible individual is limited to $5,000,000 over the lifetime of the individual, without consideration of whether the reinsurance 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 reinsurance 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 reinsurance 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 retain all premiums it receives in excess of administrative and operational expenses and claims paid for eligible individuals whose associated risk and cost has been transferred to the program, in that order. The association must apply any excess premiums toward payment of future administrative and operational expenses and claims incurred for eligible individuals whose associated risk and cost has been transferred to the program.

Sec. 8. **[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 within ten days of 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). Reinsurance by 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. **Reinsurance payments.** (a) A member is eligible for reinsurance 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 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 pay the association the separately identifiable premium amount the member received under the individual health plan covering the eligible individual within 30 days of the association accepting the risk and cost transferred to it with respect to an eligible individual. If the eligible individual is covered under a family policy providing health coverage and the eligible individual that has a separately identifiable premium equal to $0, the member shall pay the association the highest separately identifiable premium under the family policy. 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.

(e) Reinsurance payments for any one eligible individual are limited to $5,000,000 over the lifetime of the individual, without consideration of whether the reinsurance payments are made to one or more members.

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 reinsurance 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 reinsurance 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. 9. **[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 reinsurance 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 reinsurance 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. 10. **[62W.10] 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.11, 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. 11. **[62W.11] FUNDING OF PROGRAM.**

(a) The reinsurance association fund 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 reinsurance association account not currently needed, shall be credited to the reinsurance association fund 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 appropriation in section 13, which should be used by the association to cover the claims, administrative, and operational costs of the program in an equal amount each year until December 31, 2022;

(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.10.

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

Sec. 12. 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~~ reinsurance association fund. Refunds of overpayments of tax imposed by this subdivision must be paid from the ~~health care access~~ reinsurance association fund. There is annually appropriated from the ~~health care access~~ reinsurance association fund to the commissioner the amount necessary to make any refunds of the tax imposed under this subdivision.

Sec. 13. **APPROPRIATION.**

$..... in fiscal year 2018 is appropriated from the health care access fund to the commissioner of commerce for transfer to the reinsurance association fund account in the special revenue fund for the purposes described in Minnesota Statutes, section 62W.10.

Sec. 14. **EFFECTIVE DATE.**

Sections 1 to 13 are effective the day following final enactment and apply to individual health plans providing coverage on or after January 1, 2018.

APPENDIX
Article locations in 17-2884

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.