SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 56

(SENATE AUTHORS: BENSON)

DATE	D-PG	OFFICIAL STATUS
01/09/2017	59	Introduction and first reading Referred to Health and Human Services Finance and Policy
01/11/2017		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to health care coverage; providing a temporary program to help pay for health insurance premiums; modifying requirements for health maintenance organizations; modifying provisions governing health insurance; requiring reports; appropriating money; amending Minnesota Statutes 2016, sections 62D.02, subdivision 4; 62D.03, subdivision 1; 62D.05, subdivision 1; 62D.06, subdivision 1; 62D.19; 62E.02, subdivision 3; 62L.12, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 2016, sections 62D.12, subdivision 9; 62K.11.

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

ARTICLE 1

PREMIUM ASSISTANCE

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

The commissioner of Minnesota Management and Budget, in consultation with the commissioner of commerce and the commissioner of revenue, shall establish and administer a premium assistance program to help eligible individuals pay expenses for qualified health coverage in 2017.

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

Sec. 2. **DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 1 to 5, the following terms have the meanings given, unless the context clearly indicates otherwise.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of Minnesota Management and Budget.

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

(1) is a resident of Minnesota;

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

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

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

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

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

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

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

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

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

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

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

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

(1) offered to individuals in the individual market;

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

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

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

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

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

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

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

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

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

(2) the qualified premium for the coverage;

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

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

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

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

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

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

(b) The following income categories apply.

Modified Adjusted Gross Income:	Income Category:
(1) not exceeding 300 percent of poverty line;	not eligible
(2) greater than 300 percent but not exceeding 400 percent of the poverty line;	category 1
(3) greater than 400 percent but not exceeding 600 percent of the poverty line;	category 2
(4) greater than 600 percent but not exceeding 800 percent of the poverty line; and	category 3
(5) greater than 800 percent of the poverty line.	not eligible

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 5. **TRANSFER.**

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

Sec. 6. **APPROPRIATIONS.**

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

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

ARTICLE 2

INSURANCE MARKET REFORMS

Section 1. Minnesota Statutes 2016, section 62D.02, subdivision 4, is amended to read:

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

~~(b) [Expired]~~

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

Sec. 2. Minnesota Statutes 2016, section 62D.03, subdivision 1, is amended to read:

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

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

Sec. 3. Minnesota Statutes 2016, section 62D.05, subdivision 1, is amended to read:

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

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

Sec. 4. Minnesota Statutes 2016, section 62D.06, subdivision 1, is amended to read:

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2016, section 62D.19, is amended to read:

62D.19 UNREASONABLE EXPENSES.

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

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30~~; in order to safeguard the underlying nonprofit status of health maintenance organizations;~~ and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

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

Sec. 6. Minnesota Statutes 2016, section 62E.02, subdivision 3, is amended to read:

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

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

Sec. 7. Minnesota Statutes 2016, section 62L.12, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(l) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

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

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

Sec. 8. **[62Q.556] UNAUTHORIZED PROVIDER SERVICES.**

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

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

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

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

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

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

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

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

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

(c) The services described in paragraph (a), clauses (2) to (4), are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

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

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

Sec. 9. **[62Q.557] BALANCE BILLING PROHIBITED.**

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

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

Sec. 10. **TRANSITION OF CARE COVERAGE FOR CALENDAR YEAR 2017; INVOLUNTARY TERMINATION OF COVERAGE.**

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

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

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

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

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

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

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

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

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

(i) an acute condition;

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

(iii) pregnancy beyond the first trimester of pregnancy;

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

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

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

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

(c) The commissioner of Minnesota Management and Budget must reimburse the enrollee's new health plan company for costs attributed to services authorized under this subdivision. Costs eligible for reimbursement under this paragraph are the difference between the health plan company's reimbursement rate for in-network providers for a service authorized under this subdivision and its rate for out-of-network providers for the service. The health plan company must seek reimbursement from the commissioner for costs attributed to services authorized under this subdivision, in a form and manner mutually agreed upon by the commissioner and the affected health plan companies. Total state reimbursements to health plan companies under this paragraph are subject to the limits of the available appropriation. In the event that funding for reimbursements to health plan companies is not sufficient to fully reimburse health plan companies for the costs attributed to services authorized under this subdivision, health plan companies must continue to cover services authorized under this subdivision.

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

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

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

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

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

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

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

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

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

Sec. 11. **COSTS RELATED TO IMPLEMENTATION OF THIS ACT.**

A state agency that incurs administrative costs to implement one or more provisions in this act and does not receive an appropriation for administrative costs in section 12 or article 1, section 6, must implement the act within the limits of existing appropriations.

Sec. 12. **APPROPRIATION; COVERAGE FOR TRANSITION OF CARE.**

$15,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of Minnesota Management and Budget to reimburse health plan companies for costs attributed to coverage of transition of care services under section 10. No more than three percent of this appropriation is available to the commissioner for administrative costs. This is a onetime appropriation and is available until expended.

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

Sec. 13. **REPEALER.**

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

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

APPENDIX
Article locations in 17-1455

62D.12 PROHIBITED PRACTICES.

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

62K.11 BALANCE BILLING PROHIBITED.

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

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