State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 5

A bill for an act

relating to insurance; health; creating a state-operated reinsurance program; appropriating money; amending Minnesota Statutes 2016, section 62E.10, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 62E.

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

Section 1. Minnesota Statutes 2016, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of eleven members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; five public directors selected by the commissioner, at least two of whom must be plan enrollees, two of whom are covered under an individual plan subject to assessment under section 62E.11 or group plan offered by an employer subject to assessment under section 62E.11, and one of whom must be a licensed insurance agent. For purposes of the Minnesota premium security plan, as defined in section 62E.22, subdivision 11, the commissioner of management and budget is a nonvoting member. At least two of the public directors must reside outside of the seven-county metropolitan area. In determining voting rights at members' meetings, 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 self-insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing 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. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

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

Sec. 2. **[62E.21] TITLE.**

Sections 62E.21 to 62E.25 may be cited as the "Minnesota Premium Security Plan Act."

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

Sec. 3. **[62E.22] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" has the meaning given in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a plan year, beyond which the claims costs for benefits are eligible for Minnesota premium security plan payments.

Subd. 4. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 5. **Coinsurance rate.** "Coinsurance rate" means the rate, established by the board of the Minnesota Comprehensive Health Association, at which the association will reimburse the eligible health carrier for claims costs incurred for an enrolled individual's covered benefits in a plan year after the attachment point and before the reinsurance cap.

Subd. 6. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 7. **Eligible health carrier.** "Eligible health carrier" means any of the following that offers health plans in the individual market and incurs claims costs for an individual enrollee's covered benefits in the applicable plan year that exceeds the attachment point under the Minnesota premium security plan: (1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; (2) a nonprofit health service plan corporation operating under chapter 62C; or (3) a health maintenance organization operating under chapter 62D.

Subd. 8. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 9. **Plan year.** "Plan year" means the calendar year for which an eligible health carrier provides coverage for a health plan in the individual market.

Subd. 10. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 11. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program created under section 62E.24.

Subd. 12. **Reinsurance cap.** "Reinsurance cap" means the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for Minnesota premium security plan payments.

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

Sec. 4. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN; DUTIES OF COMMISSIONER.**

The commissioner shall:

(1) submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance within 60 days of the commissioner making publicly available the final and approved premium rates, or by December 1, whichever is later. The report must include information on what the premium increases in the individual market will be for the next plan year if the plan is not fully funded; and

(2) require eligible health carriers to calculate the premium amount they would have charged for the applicable plan year if the plan was not in effect and submit this information as part of their rate filing.

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

Sec. 5. **[62E.24] MINNESOTA PREMIUM SECURITY PLAN.**

Subdivision 1. **Administration.** (a) The association shall administer the state-based reinsurance program, the Minnesota premium security plan.

(b) The plan payment parameters must be designed by the board to protect those purchasing insurance on the individual market by mitigating the impact of high-risk individuals on rates in the individual market.

Subd. 2. **Operation.** (a) The board shall propose to the commissioner the plan payment parameters for the next plan year by January 15 of the year before the applicable plan year. In developing the proposed payment parameters, the board shall consider the anticipated impact to premiums. The commissioner shall approve the payment parameters no later than 14 days following the board's proposal. In developing the proposed payment parameters for plan year 2019 and thereafter, the board may develop methods to account for variations in costs within the plan.

(b) If the approved payment parameters are not fully funded by the legislature by July 1 of the year before the applicable plan year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the applicable appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next plan year.

(c) For plan year 2018, the plan parameters, including the attachment point, reinsurance cap, and coinsurance rate, shall be established within the parameters of the appropriated funds no later than 30 calendar days following the enactment of this act or 30 calendar days following the appropriation of funds, whichever is later.

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) The board shall ensure that the plan funds projected to be appropriated for any applicable plan year are reasonably calculated to cover additional payments that are projected to be made under the plan.

(f) Eligible health carriers receiving plan payments must apply the plan's parameters established under paragraph (a), (b), or (c), as applicable, when calculating amounts they are eligible to receive from the plan.

Subd. 3. **Payments.** (a) Each plan payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable plan year. If such claims costs do not exceed the attachment point, payment is $0. If such claims costs exceed the attachment point, payment will be calculated as the product of the coinsurance rate multiplied by the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that the payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. For purposes of this paragraph, total amount paid of an eligible claim means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 4, paragraph (b).

Subd. 4. **Requests for Minnesota premium security plan payments.** (a) An eligible health carrier may make a request for payment when the eligible health carrier's claims costs for an enrollee meet the criteria for payment under subdivision 3 and meet the requirements of this subdivision.

(b) In order to receive plan payments, an eligible health carrier must provide to the association access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(c) An eligible health carrier must provide the required access under paragraph (b) for the applicable plan year by April 30 of each year of the year following the end of the applicable plan year.

(d) An eligible health carrier must make requests for payment in accordance with any requirements established by the board.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for plan payments made pursuant to this section for a period of at least ten years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of plan payment requests.

(f) The association may audit an eligible health carrier to assess its compliance with the requirements this section. The eligible health carrier must cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible

health carrier may respond to the draft audit report within 30 days. Within 30 days of the issuance of the final audit report, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval if the final audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement under this section;

(2) implement the plan described in clause (1); and

(3) provide the association with documentation of the corrective actions taken.

Subd. 5. **Notice.** (a) For each applicable plan year, the association must notify eligible health carriers of plan payments to be made for the applicable plan year no later than June 30 of the year following the applicable plan year.

(b) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(c) The board must provide each eligible health carrier on a quarterly basis during the applicable plan year with the calculation of total plan payment requests.

Subd. 6. **Disbursement.** The association must:

(1) collect data from an eligible health carrier that are necessary to determine plan payments, according to the data requirements under subdivision 4; and

(2) make plan payments to the eligible health carrier after receiving a valid claim for payment from that eligible health carrier by August 15 of the year following the applicable plan year.

Subd. 7. **Data.** Data collected, created, or maintained by the association for the purpose of providing plan payments to eligible health carriers is classified as private data on individuals, as defined under section 13.02, subdivision 12; nonpublic data, as defined under section 13.02, subdivision 9; or not public data, as defined under section 13.02, subdivision 8a.

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

Sec. 6. **[62E.25] ACCOUNTING, REPORTS, AND AUDITS.**

Subdivision 1. **Accounting.** The board must keep an accounting for each plan year of all:

(1) funds appropriated for plan payments and administrative expenses;

(2) claims for plan payments received from eligible health carriers;

(3) plan payments made to eligible health carriers; and

(4) administrative expenses incurred for the plan.

Subd. 2. **Report.** The board must submit to the commissioner and make available to the public a report summarizing the plan operations for each plan year by November 1 of the year following the applicable plan year or 60 calendar days following the final disbursement of plan payments for the applicable plan year, whichever is later.

Subd. 3. **Audits.** The commissioner may conduct a financial or programmatic audit of the plan to assess its compliance with the requirements of sections 62E.21 to 62E.25. The board must cooperate and comply with any audit.

Subd. 4. **Independent external audit.** (a) The board must engage an independent qualified auditor to perform a financial and programmatic audit for each plan year of the plan in accordance with generally accepted auditing standards. The audit must:

(1) address compliance with section 62E.24, subdivision 2, paragraph (d); and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner with the results of the audit, in a form and manner acceptable to the commissioner;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency; and

(3) make available to the public a summary of the results of the audit, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency.

Subd. 5. **Actions on audit findings.** If an audit results in a finding of material weakness or significant deficiency with respect to compliance with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the plan described in clause (1); and

(3) provide the commissioner with written documentation of the corrective actions taken.

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

Sec. 7. **STATE INNOVATION WAIVER.**

Subdivision 1. **Submission of waiver application.** The commissioner of commerce shall apply to the secretary of health and human services under United States Code, title 42, section 18052, for a state innovation waiver to implement the Minnesota premium security plan for plan years beginning on or after January 1, 2018, in a manner that maximizes federal funding for the state. The waiver application submitted must ensure that upon implementation of the Minnesota premium security plan:

(1) eligible Minnesotans will continue to receive advanced premium tax credits and cost-sharing reductions; and

(2) MinnesotaCare continues to operate and receive federal funding as a basic health program.

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

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, and the board of directors of the Minnesota Comprehensive Health Association of any federal actions regarding the waiver request.

Subd. 4. **Board review; contingent report.** The board of directors of the Minnesota Comprehensive Health Association shall review the decision of the secretary of health and human services regarding the request for a state innovation waiver. If the waiver is rejected, in whole or in part, the board shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance and health care on the projected impact of the federal decision on the overall health insurance market, health plan affordability, and basic health plan funding for MinnesotaCare. The board shall submit this report within 60 calendar days of receipt of the federal decision.

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

Sec. 8. **APPROPRIATION.**

$..... for the 2018-2019 biennium is appropriated from the health care access fund to the commissioner of commerce for transfer to the board of directors of the Minnesota Comprehensive Health Association to administer the Minnesota premium security plan under Minnesota Statutes, sections 62E.21 to 62E.25. Any unexpended funds in fiscal year 2018 do not cancel and are available in fiscal year 2019.