SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 2303

(SENATE AUTHORS: ABELER and by request)

DATE	D-PG	OFFICIAL STATUS
03/11/2019		Introduction and first reading
		Referred to Commerce and Consumer Protection Finance and Policy

A bill for an act

relating to health insurance; establishing a premium subsidy program administered by MNsure; providing a sunset for the Minnesota premium security plan; modifying calculation of loss ratios to reflect reinsurance payments; appropriating money; amending Minnesota Statutes 2018, sections 62A.021, by adding a subdivision; 62E.23, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 62V; repealing Laws 2017, chapter 13, article 1, sections 1; 2; 3; 4; 5; 6.

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

Section 1. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 4. **Minnesota premium security plan and loss ratio calculations.** (a) When demonstrating compliance with this section in its rate filing, a health carrier must subtract from incurred claims or incurred health expenses all reinsurance payments applied for or received under section 63E.23 for benefit years 2018 and 2019.

(b) When reviewing a health carrier rate filing, the commissioner must verify the health carrier complies with this subdivision.

Sec. 2. Minnesota Statutes 2018, section 62E.23, subdivision 1, is amended to read:

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and

ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(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) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, through August 15, 2020, the association must disburse all applicable reinsurance payments to an eligible health carrier.

(h) The association must disburse applicable reinsurance payments for claims costs incurred by eligible health carriers through December 31, 2019. Reinsurance payments are not available to eligible health carriers for claims costs incurred after December 31, 2019.

Sec. 3. **[62V.12] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 62V.12 to 62V.15, the following terms have the meanings given.

Subd. 2. **Eligible individual.** (a) "Eligible individual" means a Minnesota resident who:

(1) is not receiving an advance premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, in a month in which the eligible individual's coverage is effective;

(2) is not enrolled in public program coverage under section 256B.055 or 256L.04;

(3) purchased a qualified health plan through MNsure; and

(4) has a household income that does not exceed 800 percent of the federal poverty guidelines, calculated using a modified adjusted gross income methodology.

(b) "Eligible individual" includes a person required to repay an advanced premium tax credit because the person's income was subsequently determined to exceed 400 percent of

the federal poverty guidelines, provided the person would have met the income limit in paragraph (a), clause (4), during the time period when the advanced premium tax credit must be repaid.

Subd. 3. **Gross premium.** "Gross premium" means the amount billed for a health plan purchased by an eligible individual prior to a premium subsidy in a calendar year.

Subd. 4. **Net premium.** "Net premium" means the gross premium less the premium subsidy.

Subd. 5. **Premium subsidy.** "Premium subsidy" means a payment:

(1) made on behalf of eligible individuals to promote general welfare and not as compensation for any services; and

(2) equal to (i) 25 percent of the monthly gross premium otherwise paid by or on behalf of the eligible individual for coverage purchased through MNsure, that covers the eligible individual and the eligible individual's spouse and dependents, or (ii) the percentage established by the commissioner under section 62V.13, subdivision 3, paragraph (c).

Sec. 4. **[62V.13] PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE INDIVIDUALS.**

Subdivision 1. **Program established.** The board of directors of MNsure, in consultation with the commissioners of commerce and human services, must establish and administer the premium subsidy program authorized by this section to help eligible individuals pay for coverage through MNsure, beginning January 1, 2020.

Subd. 2. **Premium subsidy provided.** (a) Health carriers must provide a premium subsidy to each eligible individual who purchases a qualified health plan through MNsure for each month the net premium is paid. An eligible individual must pay the net premium amount to the health carrier.

(b) The premium subsidy must be excluded from any calculation used to determine eligibility within any Department of Human Services programs.

Subd. 3. **Payments to health carriers.** (a) The board must make payments to health carriers on behalf of eligible individuals effectuating coverage for a calendar year, for the months in that year for which the individual has paid the net premium amount to the health carrier. Payments to health carriers must be based on the premium subsidy available to eligible individuals in the individual market, regardless of the cost of the coverage purchased.

The board must not withhold payments because a health carrier cannot prove an enrollee is an eligible individual.

(b) In order to be eligible for payment, health carriers seeking reimbursement from the board must submit an invoice and supporting information to the board, using a form developed by the board. The board must finalize the form by November 1, 2019.

(c) Total state payments to health carriers must be made within the limits of the available appropriation. The board must reimburse health carriers at the full requested amount up to the level of the appropriation. The board, by July 15 of each calendar year, must determine whether the available appropriation is sufficient to provide premium subsidies equal to 25 percent of the gross premium for the period September 1 through December 31 of the calendar year. If the board determines the available appropriation is not sufficient, the board must reduce the premium subsidy percentage, beginning September 1 and through the remainder of the calendar year, by an amount sufficient to ensure that the total amount of premium subsidies provided for the calendar year does not exceed the available appropriation. The board must notify health carriers of any reduced premium subsidy percentage within five days of making a determination. Health carriers must provide enrollees with at least 30 days' notice of any reduction in the premium subsidy percentage.

(d) The board must consider health carriers as vendors under section 16A.124, subdivision 3, and each monthly invoice must represent the completed delivery of the service.

(e) With each November forecast, the board must certify the extent to which appropriations exceed forecast obligations under this subdivision.

Subd. 4. **Retroactive payments to individuals.** (a) The board must make retroactive subsidy payments directly to individuals for any month the individual is required to repay an advanced premium tax credit because the individual's income exceeded 400 percent of the federal poverty guidelines. In order to qualify for retroactive subsidy payments for the month, the individual must have met the income limit in section 62V.12, subdivision 2, clause (4), for that month.

(b) Retroactive subsidy payments to individuals must be adjusted by the board to the same extent that payments to health carriers are adjusted under subdivision 3.

Subd. 5. **Data practices.** (a) The definitions in section 13.02 apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

Subd. 6. **Data sharing.** (a) Notwithstanding any law to the contrary, government entities are permitted to share or disseminate data as follows:

(1) the commissioner of human services must share data on public program enrollment under sections 256B.055 and 256L.04 with the board; and

(2) the board must disseminate data on an enrollee's public program coverage enrollment under sections 256B.055 and 256L.04 to health carriers to the extent the board determines is necessary to determine the enrollee's eligibility for the premium subsidy program authorized by this section.

(b) Data shared under this subdivision may be collected, stored, or used only to administer the premium subsidy program authorized by this section, and must not be further shared or disseminated except as otherwise provided by law.

Subd. 7. **Intent.** The legislature intends to repeal sections 62V.12 to 62V.15 upon the enactment of future legislation to stabilize the individual insurance market and ensure premium affordability in that market. Repeal of these sections is effective only if the sections are repealed through the enactment of future legislation.

Sec. 5. **[62V.14] AUDITS.**

(a) The legislative auditor must annually audit the health carriers' supporting data, as prescribed by the board, to determine whether payments align with criteria established in sections 62V.12 and 62V.13. The commissioner of human services must provide data as necessary to the legislative auditor to complete the audit. The board must withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 62V.12 and 62V.13, as determined by the audit.

(b) The legislative auditor must annually audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements specified in section 62V.12, subdivision 2. The legislative auditor must report to the board the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. The board, in consultation with the commissioners of commerce and human services, must develop and implement a process to recover from health carriers the premium subsidies received for enrollees the legislative auditor determines are ineligible for premium subsidies.

(c) The legislative auditor must annually audit the extent to which the board provided retroactive subsidy payments to individuals meeting the eligibility requirements specified in section 62V.12, subdivision 2, and 62V.13, subdivision 3. The legislative auditor must

report to the board the amount of retroactive subsidy payments provided by the board to persons that are not eligible for retroactive subsidy payments. The board, in consultation with the commissioners of commerce and human services, must develop and implement a process to recover from individuals the amount of retroactive subsidy payments that were incorrectly provided.

Sec. 6. **[62V.15] APPLICABILITY OF GROSS PREMIUM.**

Notwithstanding premium subsidies provided under section 62V.13, subdivision 2, the premium base to calculate any applicable premium taxes under chapter 297I is the gross premium for health plans purchased by eligible individuals in the individual market.

Sec. 7. **TRANSFER.**

Effective August 16, 2020, any remaining balance in the premium security plan account established under Minnesota Statutes, section 62E.25, is transferred to the general fund.

Sec. 8. **APPROPRIATIONS.**

(a) $..... is appropriated from the general fund to the board for the biennium beginning July 1, 2019, for premium assistance under Minnesota Statutes, section 62V.13.

(b) $..... is appropriated from the general fund to the legislative auditor for the biennium beginning July 1, 2019, for audits under Minnesota Statutes, section 62V.14.

Sec. 9. **REPEALER.**

Laws 2017, chapter 13, article 1, sections 1; 2; 3; 4; 5; and 6, are repealed effective August 16, 2020.

Laws 2017, chapter 13, article 1, section 1

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~~ 13 members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; two directors selected by the commissioner of human services, one of whom must represent hospitals and one of whom must represent health care providers; 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,~~ enrollees in the individual market 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. 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.~~

Laws 2017, chapter 13, article 1, section 2

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

Subdivision 1. **Application.** 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" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(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. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.
Laws 2017, chapter 13, article 1, section 3

Sec. 3. **[62E.22] DUTIES OF COMMISSIONER.**

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.
Laws 2017, chapter 13, article 1, section 4

Sec. 4. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(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) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan; and

(6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is 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 reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in article 1, section 8.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance 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 benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and 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 reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "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 5, paragraph (c).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

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

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. 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.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six 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 reinsurance payment requests.

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

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its

contractors, subcontractors, or agents 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 provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) implement the approved plan; and

(3) provide the association with written documentation of the corrective action once taken.

Subd. 6. **Data.** Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivisions 9 or 12.
Laws 2017, chapter 13, article 1, section 5

Sec. 5. **[62E.24] ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.**

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

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

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

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** The board must submit to the commissioner and make available to the public a report summarizing the plan operations for each benefit year by posting the summary on the Minnesota Comprehensive Health Association Web site and making the summary otherwise available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

Subd. 3. **Legislative auditor.** The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. **Independent external audit.** (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; 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 the results of the audit;

(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 in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association Web site and making the audit results otherwise available.

Subd. 5. **Actions on audit findings.** (a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association 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 corrective action plan; and

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

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.
Laws 2017, chapter 13, article 1, section 6

Sec. 6. **[62E.25] ACCOUNTS.**

Subdivision 1. **Premium security plan account.** The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. **Deposits.** Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. **Basic health plan trust account.** Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.