# SENATE
## STATE OF MINNESOTA
## NINETIETH SESSION

# S.F. No. 1593

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| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 03/01/2017 | | Introduction and first reading<br>Referred to Commerce and Consumer Protection Finance and Policy |

A bill for an act

relating to insurance; health; creating a state-based individual health plan reinsurance program; appropriating money; amending Minnesota Statutes 2016, section 13.7191, by adding a subdivision; proposing coding for new law as Minnesota Statutes, chapter 62W; repealing Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6.

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

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 that qualifies claims for the person to be submitted by a member for reinsurance payments under the program.

Subd. 5. **Health carrier.** "Health carrier" has the meaning given 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" has the meaning given in section 62A.011, subdivision 4.

Subd. 8. **Individual market.** "Individual market" has the meaning given 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 subsidization 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 May 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 actuarial analysis takes 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 12 members as follows: six directors selected by members, subject to approval by the commissioner, one of whom must be a health actuary and one of whom must be a medical director of a health system; six public directors selected by the commissioner, five 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 the seven-county metropolitan area.

(b) In determining voting rights to elect directors at the member's meeting, each member may vote in person or by proxy. The vote shall be a weighted vote based on 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 shall be reimbursed by 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 the 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 are exempt from sections 14.001 to 14.69.

Subd. 5. **Open meetings.** All meetings of the board and any committees shall comply with 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 are exempt from 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 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, it 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.** 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.

Subd. 2. **Payment to members.** 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.

Subd. 3. **Payment from reinsurance association account.** Reinsurance payments from the association to members must be paid from the reinsurance association account.

Subd. 4. **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) health conditions that qualify a natural person to be an eligible individual;

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

(3) 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, including data necessary for the association to determine a member's eligibility for reinsurance payments;

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

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

(6) requirements for the processing of reports received under clause (5) by the association;

(7) requirements for conducting audits in compliance with section 62W.09; and

(8) 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. 5. **Use of premium payments.** The association must retain all premiums received 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. All premiums received by the association must be deposited in the reinsurance association account.

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 having paid a claim for the individual that indicates through the use of a diagnosis code that the individual is eligible for the program. Reinsurance by the program is effective as of the date the claim is incurred 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 member has paid a claim of an eligible individual for a qualifying health condition;

(2) is currently paying the claims of an 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 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 under paragraph (a), clause (4), within 30 days of receiving the pharmacy rebate.

Subd. 3. **Duties; members.** (a) A member must comply with the plan of operation created under section 62W.06, subdivision 4, to receive reinsurance payments under the program.

(b) A member must continue to administer and manage an eligible individual's individual health plan according to 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 the premium paid by an eligible individual based on whether the risk and cost associated with an eligible individual has been transferred to the program.

(d) Premium rates for eligible individuals must be determined in compliance with section 62A.65.

(e) After the risk and cost of an eligible individual has been transferred to the program, the risk and cost will remain with the program until the eligible individual ceases coverage with the member.

(f) 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] CARE COORDINATION.**

A member is eligible for reinsurance payments to reimburse the member for claims of an eligible individual if the member implements:

(1) a system for care coordination for eligible individuals in which an eligible individual selects a health care home certified under section 256B.0751 and receives care coordination

services through the health care home. Services provided by a health care home include the services specified in section 256B.0757, subdivision 3; and

(2) a model for payment of health care providers who serve eligible individuals in which the provider agrees to provide services to an eligible individual for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The payment model must include payment for care coordination services provided by an individual's health care home.

Sec. 10. **[62W.09] 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 according to 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 shall 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 according to 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) crediting 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, the Centers for Medicare and Medicaid Services, and the 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.

(c) All amounts received by the association under this subdivision must be deposited in the reinsurance association account.

Sec. 11. **[62W.10] REINSURANCE ASSOCIATION ACCOUNT.**

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

Sec. 12. **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 Health Reinsurance Association and health reinsurance program under Minnesota Statutes, chapter 62W, for plan years beginning on or after January 1, 2018. The waiver application submitted must request that:

(1) the Minnesota Health Reinsurance Association receive federal funding in an amount equal to the amount the federal government has not paid in advance premium tax credits under United States Code, title 29, section 36B, due to reinsurance payments made by the Minnesota Health Reinsurance Association; and

(2) MinnesotaCare continue 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 commissioners of human services and 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 for 30 days prior to submission. 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.

Sec. 13. **MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION BOARD.**

(a) Notwithstanding Minnesota Statutes, chapter 62W, the commissioner of commerce must offer all members of the board of directors and current employees of the Minnesota Comprehensive Health Association, as defined in Minnesota Statutes, section 62E.02, subdivision 14, that are in service as of April 1, 2017, positions on the board of directors of the Minnesota Health Reinsurance Association, as defined in Minnesota Statutes, section 62W.02, subdivision 2, or employment positions in service of the association, as applicable.

(b) When a director of the Minnesota Health Reinsurance Association vacates a position, the commissioner of commerce must ensure that the director is replaced in accordance with Minnesota Statutes, section 62W.05, subdivision 2.

Sec. 14. **TRANSFER.**

$..... in fiscal year 2018 and $..... in fiscal year 2019 are transferred from the health care access fund to the reinsurance association account in the special revenue fund for the payment of reinsurance payments and the operational and administrative costs of the Minnesota Health Reinsurance Association, as provided under Minnesota Statutes, chapter 62W.

Sec. 15. **REPEALER.**

Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, is repealed.

Sec. 16. **EFFECTIVE DATE.**

Sections 1 to 15 are effective the day following final enactment and apply to individual health plans providing coverage on or after January 1, 2018.

***Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6***

Sec. 97. **REPEALER.**

Subd. 6. **MinnesotaCare provider taxes.** Minnesota Statutes 2010, sections 13.4967, subdivision 3; 295.50, subdivisions 1, 1a, 2, 2a, 3, 4, 6, 6a, 7, 9b, 9c, 10a, 10b, 12b, 13, 14, and 15; 295.51, subdivisions 1 and 1a; 295.52, subdivisions 1, 1a, 2, 3, 4, 4a, 5, 6, and 7; 295.53, subdivisions 1, 2, 3, and 4a; 295.54; 295.55; 295.56; 295.57; 295.58; 295.581; 295.582; and 295.59, are repealed effective for gross revenues received after December 31, 2019.