2017 Minnesota Session Laws

Key: (1) ~~language to be deleted~~ (2) new language

CHAPTER 2--S.F.No. 1

An act relating to health care coverage; providing a temporary program to help pay for health insurance premiums; requiring audits by the legislative auditor; modifying requirements for health maintenance organizations; modifying provisions governing health insurance; authorizing agricultural cooperative health plans; modifying a tax provision; authorizing transition of care coverage for 2017; requiring reports; transferring funds; appropriating money; amending Minnesota Statutes 2016, sections 60A.08, subdivision 15; 60A.235, subdivision 3; 60A.236; 62D.02, subdivision 4; 62D.03, subdivision 1; 62D.05, subdivision 1; 62D.06, subdivision 1; 62D.19; 62E.02, subdivision 3; 62K.10, by adding a subdivision; 62L.12, subdivision 2; 297I.05, subdivision 12; proposing coding for new law in Minnesota Statutes, chapters 62H; 62Q; repealing Minnesota Statutes 2016, section 62D.12, subdivision 9; Laws 2007, chapter 147, article 12, section 14, as amended; Laws 2010, chapter 384, section 99; Laws 2013, chapter 135, article 1, section 9.

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

ARTICLE 1

PREMIUM SUBSIDY PROGRAM

Section 1. **DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 1 to 6, the follo terms have the meanings given.

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

Subd. 3. **Eligible individual.** "Eligible individual" means a Mir resident who:

(1) is not receiving a premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, as of the date their coverage is effectuated;

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

(3) purchased an individual health plan from a health carrier in the individual market.

Subd. 4. **Gross premium.** "Gross premium" means the amount for a health plan purchased by an eligible individual prior to a premium subsidy in a calendar year.

Subd. 5. **Health carrier.** "Health carrier" has the meaning giver Minnesota Statutes, section 62A.011, subdivision 2.

Subd. 6. **Individual health plan.** "Individual health plan" has tl meaning given in Minnesota Statutes, section 62A.011, subdivision 4.

Subd. 7. **Individual market.** "Individual market" has the meani given in Minnesota Statutes, section 62A.011, subdivision 5.

Subd. 8. **Net premium.** "Net premium" means the gross premiu

the premium subsidy.

Subd. 9. **Premium subsidy.** "Premium subsidy":

(1) is a payment made on behalf of eligible individuals for the promotion of general welfare, and is not compensation for any services;

(2) is equal to 25 percent of the monthly gross premium otherwise paid by or on behalf of the eligible individual for coverage purchased in the individual market, that covers the eligible individual and the eligible individual's spouse and dependents, or the percentage established by the commissioner under section 2, subdivision 3, paragraph (c); and

(3) is excluded from any calculation used to determine eligibility within any of the Department of Human Services programs.

Sec. 2. **PAYMENT TO HEALTH CARRIERS ON BEHALF OF ELIGIBLE INDIVIDUALS.**

Subdivision 1. **Program established.** The commissioner of Mi Management and Budget, in consultation with the commissioner of commerce and the commissioner of human services, shall establish and administer the premium subsidy program authorized by this act, to help eligible individuals pay for coverage in the individual market in 2017.

Subd. 2. **Premium subsidy provided.** As soon as practicable, b later than April 30, 2017, health carriers shall begin paying a premium subsidy to each eligible individual who purchases a health plan in the individual market, for all the months for which the net premium is paid. An eligible individual shall pay the net premium amount to the health carrier.

Subd. 3. **Payments to health carriers.** (a) The commissioner sl make payments to health carriers on behalf of eligible individuals effectuating coverage for calendar year 2017, for the months in that

year for which the individual has paid the net premium amount to the health carrier. Payments to health carriers shall be based on the premium subsidy available to eligible individuals in the individual market, regardless of the cost of coverage purchased. The commissioner shall not withhold payments because a health carrier cannot prove an enrollee is an eligible individual.

(b) Health carriers seeking reimbursement from the commissioner must submit an invoice and supporting information to the commissioner, using a form developed by the commissioner, in order to be eligible for payment. The commissioner shall finalize the form by March 1, 2017.

(c) Total state payments to health carriers must be made within the limits of the available appropriation. The commissioner shall reimburse health carriers at the full requested amount up to the level of the appropriation. The commissioner, by July 15, 2017, shall determine whether the available appropriation will be sufficient to provide premium subsidies equal to 25 percent of the gross premium for the period September 1, 2017, through December 31, 2017. If the commissioner determines that the available appropriation is not sufficient, the commissioner shall reduce the premium subsidy percentage, beginning September 1, 2017, 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 commissioner shall notify health carriers of any reduced premium subsidy percentage within five days of making a determination. Health carriers shall provide enrollees with at least 30 days' notice of any reduction in the premium subsidy percentage.

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

Subd. 4. **Data practices.** (a) The definitions in Minnesota Statu

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.

(c) Notwithstanding Minnesota Statutes, section 138.17, government data on an enrollee or health carrier under this section must be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later.

Sec. 3. **AUDITS.** (a) The legislative auditor shall conduct audits of the health carriers' supporting data, as prescribed by the commissioner, to determine whether payments align with criteria established in sections 1 and 2. The commissioner of human services shall provide data as necessary to the legislative auditor to complete the audit. The commissioner shall withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 1 and 2, as determined by the audit.

(b) The legislative auditor shall audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements specified in section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. The commissioner, in consultation with the commissioners of commerce and health, shall develop and implement a process to recover from health carriers the amount of premium subsidies received for enrollees determined to be ineligible for premium subsidies by the legislative auditor. The legislative auditor, when conducting the required audit, and the commissioner, when determining the amount of premium subsidy to be recovered, may take into account the extent to which a health carrier makes use of the Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision 1.

Sec. 4. **APPLICABILITY OF GROSS PREMIUM.**

Notwithstanding premium subsidies provided under section 2, the premium base for calculating the amount of any applicable premium taxes under Minnesota Statutes, chapter 297I, shall be the gross premium for health plans purchased by eligible individuals in the individual market.

Sec. 5. **SUNSET.**

This article sunsets June 30, 2018.

Sec. 6. **TRANSFER.**

$326,945,000 in fiscal year 2017 is transferred from the budget reserve account in Minnesota Statutes, section 16A.152, subdivision 1a, to the general fund.

Sec. 7. **APPROPRIATIONS.**

(a) $311,788,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget for premium assistance under section 2. This appropriation is onetime and is available through June 30, 2018.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor for purposes of section 3. This appropriation is onetime.

(c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018, shall be transferred on July 1, 2018, from the general fund to the budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

Sec. 8. **EFFECTIVE DATE.** Sections 1 to 7 are effective the day following final enactment.

ARTICLE 2

INSURANCE MARKET REFORMS

Section 1. Minnesota Statutes 2016, section 60A.08, subdivision 15, is amended to read:

Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related information filed with the commissioner under section 61A.02 shall be nonpublic data until the filing becomes effective.

(b) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic data until the filing becomes effective.

(c) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

(d) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic data until the filing becomes effective.

(e) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic data until the filing becomes effective.

(f) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under section 2794 of the Public Health Services Act and any amendments to, or regulations, or guidance issued under the act that are filed with the commissioner on or after September 1, 2011, the commissioner:

(1) may acknowledge receipt of the information;

(2) may acknowledge that the corresponding rate filing is pending review;

(3) must provide public access from the Department of Commerce's Web site to parts I and II of the Preliminary Justifications of the rate increases subject to review; and

(4) must provide notice to the public on the Department of Commerce's Web site of the review of the proposed rate, which must

include a statement that the public has 30 calendar days to submit written comments to the commissioner on the rate filing subject to review.

(g) Notwithstanding paragraphs (b) and (c), for all proposed premium rates filed with the commissioner for individual health plans, as defined in section 62A.011, subdivision 4, and small group health plans, as defined in section 62K.03, subdivision 12, the commissioner must provide public access on the Department of Commerce's Web site to compiled data of the proposed changes to rates, separated by health plan and geographic rating area, within ten business days after the deadline by which health carriers, as defined in section 62A.011, subdivision 2, must submit proposed rates to the commissioner for approval.

EFFECTIVE DATE. This section is effective 30 days following enactment.

Sec. 2. Minnesota Statutes 2016, section 60A.235, subdivision 3, is amended to read:

Subd. 3. **Health plan policies issued as stop loss coverage.** (a) An insurance company or health carrier issuing or renewing an insurance policy or other evidence of coverage, that provides coverage to an employer for health care expenses incurred under an employer-sponsored plan provided to the employer's employees, retired employees, or their dependents, shall issue the policy or evidence of coverage as a health plan if the policy or evidence of coverage:

(1) has a specific attachment point for claims incurred per individual that is lower than $20,000; or

~~(2) has an aggregate attachment point, for groups of 50 or fewer, that is lower than the greater of:~~

~~(i) $4,000 times the number of group members;~~

~~(ii) 120 percent of expected claims; or~~

~~(iii) $20,000; or~~

~~(3)~~ (2) has an aggregate attachment point ~~for groups of 51 or more~~ that is lower than 110 percent of expected claims.

(b) An insurer shall determine the number of persons in a group, for the purposes of this section, on a consistent basis, at least annually. Where the insurance policy or evidence of coverage applies to a contract period of more than one year, the dollar amounts set forth in paragraph (a), ~~clauses~~ clause (1) ~~and (2)~~, must be multiplied by the length of the contract period expressed in years.

~~(c) The commissioner may adjust the constant dollar amounts provided in paragraph (a), clauses (1), (2), and (3), on January 1 of any year, based upon changes in the medical component of the Consumer Price Index (CPI). Adjustments must be in increments of $100 and must not be made unless at least that amount of adjustment is required. The commissioner shall publish any change in these dollar amounts at least six months before their effective date.~~

~~(d)~~ (c) A policy or evidence of coverage issued by an insurance company or health carrier that provides direct coverage of health care expenses of an individual including a policy or evidence of coverage administered on a group basis is a health plan regardless of whether the policy or evidence of coverage is denominated as stop loss coverage.

EFFECTIVE DATE. This section is effective June 1, 2017, and applies to policies or evidence of coverage offered, issued, or renewed to an employer on or after that date.

Sec. 3. Minnesota Statutes 2016, section 60A.236, is amended to read:

60A.236 STOP LOSS REGULATION; SMALL EMPLOYER COVERAGE.

A contract providing stop loss coverage, issued or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan

sponsored by a small employer, must include a claim settlement period no less favorable to the small employer or plan than ~~coverage of all~~ the following:

(1) claims incurred during the contract period ~~regardless of when the claims are~~; and

(2) paid by the plan during the contract period or within three months after expiration of the contract period.

EFFECTIVE DATE. This section is effective June 1, 2017, and applies to policies or evidence of coverage offered, issued, or renewed to an employer on or after that date.

Sec. 4. 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 f enactment.

Sec. 5. 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 f enactment.

Sec. 6. 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 f enactment.

Sec. 7. 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 f enactment.

Sec. 8. 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 f enactment.

Sec. 9. 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 f enactment.

Sec. 10. **[62H.18] AGRICULTURAL COOPERATIVE HEALTH PLAN.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivisio apply to this section.

(b) "Agricultural cooperative" means a cooperative

organized under chapter 308A or 308B that meets the requirements of subdivision 2.

(c) "Broker" means an insurance agent engaged in brokerage business according to section 60K.49.

(d) "Employee Retirement Income Security Act" means the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq.

(e) "Enrollee" means a natural person covered by a joint self-insurance plan operating under this section.

(f) "Insurance agent" has the meaning given to insurance agent in section 60A.02, subdivision 7.

(g) "Joint self-insurance plan" or "plan" means a plan or any other arrangement established for the benefit of two or more entities authorized to transact business in the state, in order to jointly self-insure through a single employee welfare benefit plan funded through a trust, to provide health, dental, or other benefits as permitted under the Employee Retirement Income Security Act.

(h) "Service plan administrator" means a vendor of risk management services licensed under section 60A.23.

(i) "Trust" means a trust established to accept and hold assets of the joint self-insurance plan in trust and use and disperse funds in accordance with the terms of the written trust document and joint self-insurance plan for the sole purposes of providing benefits and defraying reasonable administrative costs of providing the benefits.

Subd. 2. **Exemption.** A joint self-insurance plan, its service plan administrator, stop loss carrier, and any broker assisting the agricultural cooperative are exempt from sections 62H.01 to 62H.17, and are governed by the requirements of this section, if the joint self-insurance plan is administrated through a trust established by an agricultural cooperative that:

(1) has members who (i) actively work in production agriculture in Minnesota and file either Form 1065 or Schedule F with the member's income tax return; or (ii) provide direct services to production agriculture in Minnesota;

(2) specifies criteria for membership in the agricultural cooperative in their articles of organization or bylaws, however criteria cannot be based on health status factors of the individuals to be covered through the joint self-insurance plan; and

(3) grants at least 51 percent of the aggregate voting power on matters for which all members may vote to members who satisfy clause (1) and any additional criteria in the agricultural cooperative's articles of organization and bylaws.

Subd. 3. **Plan requirements.** A joint self-insurance plan operati under this section must:

(1) offer health coverage to members of the agricultural cooperative that establishes the plan and their dependents, to employees of members of the agricultural cooperative that establishes the plan and their dependents, or to employees of the agricultural cooperative that establishes the plan and their dependents. Health coverage may be offered only to those individuals who meet certain criteria described in the joint self-insurance plan governing documents, however the criteria cannot be based on health status factors of the individuals to be covered through the joint self-insurance plan;

(2) include stop-loss coverage with an individual attachment point not lower than $20,000 and an aggregate attachment point not lower than 110 percent of expected claims, issued by an insurance company licensed in Minnesota;

(3) establish a reserve fund, certified by an actuary to be sufficient to cover unpaid claim liability for incurred but not reported liabilities in the event of plan termination. Certification from the actuary must include all maximum funding requirements for plan

fixed cost requirements and current claims liability requirements, and must include a calculation of the reserve levels needed to fund all incurred but not reported liabilities in the event of member or plan termination. These reserve funds must be held in a trust;

(4) be governed by a board elected by agricultural cooperative members that participate in the plan;

(5) contract for services with a service plan administrator; and

(6) satisfy the requirements of the Employee Retirement Income Security Act that apply to employee welfare benefit plans.

Subd. 4. **Submission of documents to commissioner of comm** A joint self-insurance plan operating under this section must submit to the commissioner of commerce copies of all filings and reports that are submitted to the United States Department of Labor according to the Employee Retirement Income Security Act. Members participating in the joint self-insurance plan may designate an agricultural cooperative that establishes the plan as the entity responsible for satisfying the reporting requirements of the Employee Retirement Income Security Act and for providing copies of these filings and reports to the commissioner of commerce.

Subd. 5. **Participation; termination of participation.** If a men chooses to participate in a joint self-insurance plan under this section, the member must participate in the plan for at least three consecutive years. If a member terminates participation in the plan before the end of the three-year period, a financial penalty may be assessed under the plan, not to exceed the amount contributed by the member to the plan reserves.

Subd. 6. **Single risk pool.** The enrollees of a joint self-insuranc operating under this section shall be members of a single risk pool. The plan shall provide benefits as a single, self-insured plan with the size of the plan based on the total enrollees in the risk pool.

Subd. 7. **Promotion, marketing, sale of coverage.** (a) Coverag joint self-insurance plan operating under this section may be promoted, marketed, and sold by insurance agents and brokers to members of the agricultural cooperative sponsoring the plan and their dependents, employees of members of the agricultural cooperative sponsoring the plan and their dependents, and employees of the agricultural cooperative sponsoring the plan and their dependents.

(b) Coverage in a joint self-insurance plan operating under this section may be promoted and marketed by a cooperative organized under chapter 308A or 308B to persons who may be eligible to participate in the joint self-insurance plan.

Subd. 8. **Taxation.** Joint self-insurance plans are exempt from t taxation imposed under section 297I.05, subdivision 12.

Subd. 9. **Compliance with other laws.** A joint self-insurance pl operating under this section:

(1) is exempt from providing the mandated health benefits in chapters 62A and 62Q, if the plan otherwise provides the benefits required under the Employee Retirement Income Security Act;

(2) is exempt from the continuation requirements in sections 62A.146, 62A.16, 62A.17, 62A.20, and 62A.21, if the plan complies with the continuation requirements under the Employee Retirement Income Security Act; and

(3) must comply with all requirements of the Affordable Care Act, as defined in section 62A.011, subdivision 1a, to the extent that they apply to such plans.

EFFECTIVE DATE. This section is effective the day following 1 enactment.

Sec. 11. Minnesota Statutes 2016, section 62K.10, is amended by adding a subdivision to read:

Subd. 5a. **Appeal of waiver of network adequacy requiremer**

If a health carrier receives a waiver under subdivision 5 applicable to a health plan's provider network, a provider who is in the service area served by the health plan and who is aggrieved by the issuance of the waiver may appeal the commissioner's decision using the contested case procedures in sections 14.57 to 14.62. A contested case proceeding must be initiated within 60 days after the date on which the commissioner grants a waiver, except that a proceeding regarding a waiver in effect as of January 1, 2017, must be initiated within 60 days after the effective date of this subdivision. The commissioner must provide timely notice of an appeal under this subdivision to the health carrier that received the waiver that is subject to the appeal. After considering the appeal, the administrative law judge must either uphold or nullify the waiver of network adequacy requirements. The prevailing party in the contested case proceeding may seek an award of expenses and fees from the nonprevailing party by applying to the administrative law judge using the procedure in section 15.472, paragraph (b). The administrative law judge shall award fees and expenses to the prevailing party if the administrative law judge finds that the position of the nonprevailing party was not substantially justified. For purposes of this paragraph, "substantially justified" has the meaning given in section 15.471, subdivision 8.

(b) The decision of the administrative law judge constitutes the final decision regarding the waiver. A party aggrieved by the administrative law judge's decision may seek judicial review of the decision as provided in chapter 14. If the waiver is nullified and no judicial review is sought, the health carrier must comply with the network adequacy requirements in subdivisions 2, 3, and 4, within 30 days after the deadline for seeking judicial review in section 14.63.

(c) This subdivision expires December 31, 2018.

EFFECTIVE DATE. This section is effective the day following f enactment, and applies to network adequacy waivers in effect on or after January 1, 2017.

Sec. 12. 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, section 18001.

EFFECTIVE DATE. This section is effective the day following 1 enactment.

Sec. 13. **[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; or

(2) 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.

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

(c) The services described in paragraph (a), clause (2), 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.** (a) An enrollee's financial responsibility f unauthorized provider services shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.

(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a

list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the department of health's Web Site, and update the list as appropriate.

(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.

EFFECTIVE DATE. This section is effective 90 days following enactment and applies to provider services provided on or after that date.

Sec. 14. Minnesota Statutes 2016, section 297I.05, subdivision 12, is amended to read:

Subd. 12. **Other entities.** (a) A tax is imposed equal to two percent of:

(1) gross premiums less return premiums written for risks resident or located in Minnesota by a risk retention group;

(2) gross premiums less return premiums received by an attorney in fact acting in accordance with chapter 71A;

(3) gross premiums less return premiums received pursuant to assigned risk policies and contracts of coverage under chapter 79; and

(4) the direct funded premium received by the reinsurance association under section 79.34 from self-insurers approved under section 176.181 and political subdivisions that self-insure.

(b) A tax is imposed on a joint self-insurance plan operating under chapter 60F. The rate of tax is equal to two percent of the total amount of claims paid during the fund year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance.

(c) A tax is imposed on a joint self-insurance plan operating under chapter 62H, except as provided in section 62H.18, subdivision 8. The rate of tax is equal to two percent of the total amount of claims paid during the fund's fiscal year, with no deduction for claims wholly or partially reimbursed through stop-loss insurance.

(d) A tax is imposed equal to the tax imposed under section 297I.05, subdivision 5, on the gross premiums less return premiums on all coverages received by an accountable provider network or agents of an accountable provider network in Minnesota, in cash or otherwise, during the year.

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

Sec. 15. **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.** 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, within 45 days before an involuntary termination of coverage, 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.

Subd. 4. **Limitations.** (a) Subdivision 3 applies only if the enro 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; 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 to the extent that the records and other documentation are relevant to a determination regarding the existence of a condition under subdivision 3, paragraph (a). 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.

Subd. 6. **Reimbursement.** (a) The commissioner of manageme budget must reimburse the enrollee's new health plan company for the cost of claims that the health plan company certifies as eligible for reimbursement under this subdivision. The cost eligible for reimbursement under this subdivision is the difference between the in-network level of benefits under the enrollee's health plan and the out-of-network level of benefits under the enrollee's health plan. The health plan company must seek reimbursement for the cost of claims from the commissioner 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 subdivision are subject to the limits of the available appropriation and the commissioner may prorate equally across all claims paid as necessary. In the event that funding for reimbursements to health plan companies is not sufficient to fully reimburse health plan companies for the costs of claims for reimbursement for services authorized under this section, health plan companies must continue to cover services authorized under this section.

(b) For any service provided under this section, the enrollee shall not owe the provider more than the cost-sharing amount the enrollee would be required to pay if the services were performed by an in-network provider under the enrollee's new health plan.

EFFECTIVE DATE. This section is effective for health plans iss 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. 16. **COSTS RELATED TO IMPLEMENTATION OF**

THIS ACT.

A state agency that incurs administrative costs to implement any provision in this act and does not receive an appropriation for administrative costs in this act, must implement the act within the limits of existing appropriations.

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

Sec. 17. **INSURANCE MARKET OPTIONS.**

The commissioner of commerce shall report by March 1, 2017, to the standing committees of the legislature having jurisdiction over insurance and health on the past and future use of Minnesota Statutes 2005, section 62L.056, and Minnesota Statutes, section 62Q.188, including:

(1) rate and form filings received, approved, or withdrawn;

(2) barriers to current utilization, including federal and state laws; and

(3) recommendations for allowing or increasing the offering of health plans compliant with Minnesota Statutes, section 62Q.188.

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

Sec. 18. **APPROPRIATION.**

$15,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of management and budget to reimburse health plan companies for costs of claims eligible for reimbursement for coverage of transition of care services. Of this amount, $272,400 is available to the commissioner for purposes of administering reimbursement for coverage of transition of care services and administering the premium subsidy program in article 1. This is a onetime appropriation and is available until June 30, 2018. Any funds remaining from this appropriation after June 30, 2018, shall

be transferred on July 1, 2018, from the general fund to the budget reserve account in Minnesota Statutes, section 16A.152, subdivision 1a.

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

Sec. 19. **REPEALER.**

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

(b) Laws 2007, chapter 147, article 12, section 14, as amended by Laws 2010, chapter 344, section 4, Laws 2010, chapter 384, section 99, Laws 2013, chapter 135, article 1, section 9; Laws 2010, chapter 384, section 99; and Laws 2013, chapter 135, article 1, section 9, are repealed effective the day following final enactment.

Presented to the governor January 26, 2017

Signed by the governor January 26, 2017, 7:21 p.m.