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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. 578

February 5, 2007

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The bill was read for the first time and referred to the Committee on Health and Human Services

1.1 A bill for an act
1.2 relating to health care access; establishing the MinnesotaCare CMF program;
1.3 providing coverage through medical benefit accounts and high-deductible health
1.4 plans; establishing health insurance exchanges; amending Minnesota Statutes
1.5 2006, section 62L.03, subdivision 3; proposing coding for new law in Minnesota
1.6 Statutes, chapter 256L; proposing coding for new law as Minnesota Statutes,
1.7 chapter 62U.

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

1.9 **ARTICLE 1**
1.10 **MINNESOTACARE CMF PROGRAM**

1.11 Section 1. **[256L.20] MINNESOTACARE CARE FOR MORE FAMILIES**
1.12 **PROGRAM.**

1.13 The commissioner shall establish the MinnesotaCare Care for More Families (CMF)
1.14 program. The commissioner shall implement the program on January 1, 2008, or upon
1.15 federal approval, whichever is later.

1.16 Sec. 2. **[256L.22] ELIGIBILITY.**

1.17 Subdivision 1. **General requirements.** Families and children meeting the eligibility
1.18 requirements of this section are eligible for the MinnesotaCare CMF program. Enrollment
1.19 in the program is voluntary. For purposes of the program, a child is an individual under
1.20 age 19.

1.21 Subd. 2. **Income limit.** Families and children with family income equal to or less
1.22 than 300 percent of the federal poverty guidelines for the applicable family size are
1.23 eligible for the MinnesotaCare CMF program.

2.1 Subd. 3. **No other health coverage.** (a) Families and children must have no other
 2.2 health coverage at the time of application, except that families and children that contribute
 2.3 15 percent or more of their gross income toward the cost of employer-sponsored coverage
 2.4 are eligible for the program.

2.5 (b) Families and children eligible to enroll in the medical assistance program are not
 2.6 eligible for the MinnesotaCare CMF program.

2.7 (c) Families and children enrolled in the MinnesotaCare program under section
 2.8 256L.04, subdivision 1, may voluntarily enroll in the MinnesotaCare CMF program.

2.9 Subd. 4. **Other MinnesotaCare eligibility requirements.** (a) To be eligible for
 2.10 MinnesotaCare CMF, families and children must comply with the citizenship requirement
 2.11 in section 256L.04, subdivision 10, and the residency requirement in section 256L.09.

2.12 (b) Section 256L.07, subdivisions 2 and 3, do not apply to enrollment under the
 2.13 MinnesotaCare CMF program.

2.14 **Sec. 3. [256L.24] PROGRAM ADMINISTRATION.**

2.15 Unless otherwise specified, the commissioner shall administer the MinnesotaCare
 2.16 CMF program using the procedures and methods used to administer the MinnesotaCare
 2.17 program for persons enrolled under section 256L.04, subdivision 1.

2.18 **Sec. 4. [256L.26] COVERED SERVICES.**

2.19 Covered services under the MinnesotaCare CMF program consist of all
 2.20 comprehensive health maintenance services covered under a standard HMO contract, as
 2.21 defined under section 62D.02, subdivision 7, and Minnesota Rules, chapter 4685, or
 2.22 their actuarial equivalent.

2.23 **Sec. 5. [256L.28] HIGH-DEDUCTIBLE HEALTH PLAN.**

2.24 Subdivision 1. **Purchase required.** Enrollees shall purchase a high-deductible
 2.25 health plan through a health insurance exchange established under section 62U.02. For
 2.26 purposes of this requirement, a high-deductible health plan is a health plan with an
 2.27 annual deductible equal to \$1,000 for individuals and \$2,000 for families, indexed by the
 2.28 Consumer Price Index (CPI-urban). The health plan purchased may be either a family or
 2.29 individual policy, at the option of the enrollee. Enrollees who receive premium subsidies
 2.30 must select the least costly high-deductible health plan available to the enrollee.

2.31 Subd. 2. **Plan coverage.** High-deductible health plans must provide coverage for
 2.32 all services required to be covered under section 256L.26.

3.1 Subd. 3. **Cost-sharing.** High-deductible plans shall have no enrollee cost-sharing,
 3.2 beyond the deductible.

3.3 **Sec. 6. [256L.30] MEDICAL BENEFIT ACCOUNT.**

3.4 Subdivision 1. **Establishment of account.** Each enrollee shall manage a medical
 3.5 benefit account. A medical benefit account is a trust established and owned by the state of
 3.6 Minnesota for the sole benefit of the MinnesotaCare CMF enrollee, that may be used to
 3.7 pay for health care services subject to a deductible, other qualified medical expenses, and
 3.8 qualified educational expenses of the enrollee. The medical benefit account shall consist
 3.9 of a deductible account and a freedom account.

3.10 Subd. 2. **Deductible account.** The deductible account shall be funded by the
 3.11 enrollee and the state, to the value of the annual deductible of the high-deductible health
 3.12 plan. Expenditures from the deductible account are limited to medical expenses that count
 3.13 toward the deductible, according to the terms of the high-deductible health plan.

3.14 Subd. 3. **Freedom account.** The freedom account shall be funded with money
 3.15 rolled over from the enrollee's previous year's unspent deductible account dollars,
 3.16 investment gains, and any additional private contributions. Money in the freedom account
 3.17 may be spent on:

3.18 (1) all qualified medical expenses, as defined in section 213(d) of the Internal
 3.19 Revenue Code;

3.20 (2) qualified education expenses; and

3.21 (3) private sector health plan premiums, for persons who lose eligibility for or are no
 3.22 longer enrolled in MinnesotaCare CMF.

3.23 For purposes of this subdivision, "qualified educational expenses" means tuition and fees
 3.24 at postsecondary educational institutions. Money in the freedom account may be invested
 3.25 by the enrollee, using the procedures that apply to individual retirement accounts.

3.26 Subd. 4. **Administration.** Any organization qualified to administer individual
 3.27 retirement accounts may administer the medical benefit account, subject to any restrictions
 3.28 specified in the trust documents. Funds in the medical benefits account must be accessible
 3.29 through a debit card. Charges on the debit card must be limited to allowed expenditures.

3.30 Subd. 5. **Additional contributions.** Enrollees, and employers and other third
 3.31 parties, may contribute additional funds to the medical benefit account. These funds are
 3.32 subject to the same spending restrictions as contributions by the enrollee and the state.

3.33 Subd. 6. **Continued access to account.** Individuals who become ineligible for or
 3.34 leave the MinnesotaCare CMF program shall continue to have access to money in the
 3.35 medical benefit account, if they had been enrolled in the MinnesotaCare CMF program for

4.1 at least 12 consecutive months. Medical benefit account funds for persons enrolled in the
 4.2 MinnesotaCare CMF program for less than 12 consecutive months shall be forfeited by
 4.3 the person and deposited into the general fund.

4.4 **Sec. 7. [256L.32] PREMIUMS.**

4.5 Subdivision 1. **Requirement.** Families and children shall pay a premium based
 4.6 on the sliding scale specified in section 256L.15, as modified to include the percentage
 4.7 increase effective October 1, 2003, for higher income enrollees, except that the
 4.8 commissioner shall extend the sliding scale to require children and families with income
 4.9 greater than 275 percent but not exceeding 300 percent of the federal poverty guidelines to
 4.10 pay 10.8 percent of gross income. All other provisions of section 256L.15 shall apply to
 4.11 premium administration and collection under the MinnesotaCare CMF program, unless
 4.12 otherwise specified in this section. Families and children with incomes that exceed the
 4.13 income limit for the MinnesotaCare CMF program may remain on the program, but must
 4.14 pay the full cost of the high-deductible premium and must fully fund the deductible
 4.15 account without any state subsidy.

4.16 Subd. 2. **Premiums applied first to deductible account.** The commissioner
 4.17 shall fully fund each enrollee's deductible account at the time of initial enrollment and
 4.18 at the start of each plan year, and shall use the required premium contributions from the
 4.19 enrollee to pay back the cost of fully funding the deductible. The commissioner shall
 4.20 apply the premiums collected under this section to the cost of premium payments for the
 4.21 high-deductible health plan policy only if the enrollee still has a premium obligation
 4.22 after fully funding the deductible account.

4.23 Subd. 3. **Payment to exchange.** The commissioner shall require families and
 4.24 children to pay sliding scale premiums to the health insurance exchange from which the
 4.25 MinnesotaCare CMF high-deductible health plan is purchased.

4.26 **Sec. 8. [256L.34] WAIVERS AND FEDERAL APPROVAL.**

4.27 The commissioner shall seek all necessary federal waivers and approvals to
 4.28 implement the MinnesotaCare CMF program and to use federal medical assistance and
 4.29 state children's health insurance program dollars to pay for health care services covered
 4.30 under the MinnesotaCare CMF program.

4.31 **ARTICLE 2**
 4.32 **HEALTH INSURANCE EXCHANGES**

4.33 Section 1. Minnesota Statutes 2006, section 62L.03, subdivision 3, is amended to read:

5.1 Subd. 3. **Minimum participation and contribution.** (a) A small employer that has
 5.2 at least 75 percent of its eligible employees who have not waived coverage participating in
 5.3 a health benefit plan and that contributes at least 50 percent toward the cost of coverage
 5.4 of each eligible employee must be guaranteed coverage on a guaranteed issue basis
 5.5 from any health carrier participating in the small employer market. The participation
 5.6 level of eligible employees must be determined at the initial offering of coverage and
 5.7 at the renewal date of coverage. A health carrier must not increase the participation
 5.8 requirements applicable to a small employer at any time after the small employer has been
 5.9 accepted for coverage. For the purposes of this subdivision, waiver of coverage includes
 5.10 only waivers due to: (1) coverage under another group health plan; (2) coverage under
 5.11 Medicare Parts A and B; (3) coverage under MCHA permitted under section 62E.141; ~~or~~
 5.12 (4) coverage under medical assistance under chapter 256B or general assistance medical
 5.13 care under chapter 256D; or (5) coverage under the employer's plan requiring an employee
 5.14 contribution of 15 percent or more of the employee's gross employment income.

5.15 (b) If a small employer does not satisfy the contribution or participation requirements
 5.16 under this subdivision, a health carrier may voluntarily issue or renew individual health
 5.17 plans, or a health benefit plan which must fully comply with this chapter. A health carrier
 5.18 that provides a health benefit plan to a small employer that does not meet the contribution
 5.19 or participation requirements of this subdivision must maintain this information in its files
 5.20 for audit by the commissioner. A health carrier may not offer an individual health plan,
 5.21 purchased through an arrangement between the employer and the health carrier, to any
 5.22 employee unless the health carrier also offers the individual health plan, on a guaranteed
 5.23 issue basis, to all other employees of the same employer. An arrangement permitted under
 5.24 section 62L.12, subdivision 2, paragraph (k), is not an arrangement between the employer
 5.25 and the health carrier for purposes of this paragraph.

5.26 (c) Nothing in this section obligates a health carrier to issue coverage to a small
 5.27 employer that currently offers coverage through a health benefit plan from another health
 5.28 carrier, unless the new coverage will replace the existing coverage and not serve as one
 5.29 of two or more health benefit plans offered by the employer. This paragraph does not
 5.30 apply if the small employer will meet the required participation level with respect to
 5.31 the new coverage.

5.32 Sec. 2. **[62U.01] DEFINITIONS.**

5.33 (a) For purposes of this chapter, the terms defined in this section have the meanings
 5.34 given.

5.35 (b) "Commissioner" means the commissioner of commerce.

6.1 (c) "Eligible individual" means an individual who is a resident of this state.

6.2 (d) "Health insurance exchange" or "exchange" means an entity licensed under
6.3 this chapter.

6.4 (e) "Health plan" means a health plan as defined under section 62A.011, subdivision
6.5 3.

6.6 (f) "Health plan company" means a health carrier as defined under section 62A.011,
6.7 subdivision 2, and includes the Minnesota Comprehensive Health Association created
6.8 under section 62E.10.

6.9 (g) "MinnesotaCare CMF program" means the program created under section
6.10 256L.20.

6.11 **Sec. 3. [62U.02] HEALTH INSURANCE EXCHANGES PERMITTED.**

6.12 Subdivision 1. **Health insurance exchanges permitted.** Any corporation
6.13 authorized to do business in this state may establish and operate a health insurance
6.14 exchange to do business in this state under this chapter.

6.15 Subd. 2. **Establishment of exchange.** A corporation wishing to establish a health
6.16 insurance exchange must first apply for and obtain a health insurance exchange license
6.17 from the commissioner.

6.18 Subd. 3. **Licensing criteria.** The commissioner shall approve an application for a
6.19 license under this chapter if the applicant establishes to the commissioner's satisfaction
6.20 that the applicant:

6.21 (1) has sufficient knowledge of health insurance, the market for health insurance,
6.22 and the federal and Minnesota laws that are relevant to health insurance;

6.23 (2) has the managerial and technical capability to handle a large number of
6.24 transactions, keep data secure and confidential, and respond promptly to telephone, e-mail,
6.25 mail, and other contacts with employers, insurers, individuals who are potential or existing
6.26 customers of the exchange, and the commissioner; and

6.27 (3) has the ability and trustworthiness to receive and transmit large amounts of
6.28 money with no risk of loss to the persons who make payments to, or receive payments
6.29 from, the applicant as shown in part by the applicant having obtained a bond in the amount
6.30 of at least \$10,000,000, or a larger amount if required by the commissioner, conditioned
6.31 upon the faithful execution of transactions with no loss to participants.

6.32 Subd. 4. **Regulation.** An exchange is subject to the enforcement authority available
6.33 to the commissioner under chapter 45 and the insurance laws of this state.

6.34 **Sec. 4. [62U.03] FUNCTIONS OF HEALTH INSURANCE EXCHANGE.**

7.1 A health insurance exchange shall:

7.2 (1) establish and maintain one or more master health plans, that provide a choice
7.3 of several health plans within the master plan. The master plans must comply with all
7.4 applicable requirements for employer-sponsored health plans under the federal Employee
7.5 Retirement Income Security Act, other relevant federal laws, and the laws of this state.
7.6 Health plans offered within a master plan must be individual health plans that comply with
7.7 all federal and Minnesota laws that govern individual health plans;

7.8 (2) permit public sector and private sector employers to adopt the exchange's master
7.9 health plan as a plan through which they will sponsor, and to which they may make
7.10 contributions toward the cost of, health coverage for their employees, their employees'
7.11 dependents, and other persons, including retirees and independent contractors, included
7.12 as eligible under the employer's plan. An exchange must accept payments from a plan
7.13 created by an employer under section 125 of the Internal Revenue Code;

7.14 (3) permit eligible individuals to enroll in the master plan and select a health plan
7.15 from among the offerings available within the master plan, and permit those individuals
7.16 to make payments to the exchange toward the cost of the health plan selected by the
7.17 individual;

7.18 (4) permit the commissioner of human services to enroll individuals eligible for the
7.19 MinnesotaCare CMF program under section 256L.20 and permit that commissioner to
7.20 make payments to the exchange as contributions toward the coverage of those eligible
7.21 individuals;

7.22 (5) review and accept or reject applications from health plan companies for inclusion
7.23 in the health plans that enrollees may choose within the exchange's master plan;

7.24 (6) receive payments from individuals, employers, and the commissioner of human
7.25 services to be credited toward the coverage of an individual enrollee and transmit the
7.26 amounts received for that individual to the health plan company that provides the health
7.27 plan chosen by that individual from among those offered within the master plan;

7.28 (7) collect an administrative charge approved by the commissioner for its services
7.29 from the premiums received;

7.30 (8) administer an annual open enrollment period within which an individual may
7.31 enroll in a different health plan within the exchange, subject to approval of the health plan
7.32 company that offers the health plan; and

7.33 (9) operate on a statewide basis.

7.34 **Sec. 5. [62U.04] RELATIONSHIP WITH HEALTH PLAN COMPANIES.**

8.1 (a) Participation in an exchange by a health plan company is voluntary, except that
8.2 the Minnesota Comprehensive Health Association must offer all of its plans, except for
8.3 its Medicare supplement plans, through each exchange.

8.4 (b) A health plan company that participates in the exchange may offer through
8.5 the exchange only health plans that comply with all applicable federal and Minnesota
8.6 laws, including all underwriting and rating laws of this state that apply to the individual
8.7 market. A health plan company may reject any applicant for coverage and may charge any
8.8 premium permitted under the underwriting and rating laws that apply in the individual
8.9 market in this state.

8.10 (c) All health plans provided through an exchange must be individual (nongroup)
8.11 coverage and must offer both self-only and family coverage.

8.12 (d) A health plan company that participates in an exchange must offer within the
8.13 exchange a health plan that meets the requirements for the MinnesotaCare CMF program.

8.14 (e) All premium payments for health plan coverage through the exchange must be
8.15 made by the exchange to the health plan company, but the exchange shall not make any
8.16 premium payment for which it has not received sufficient contributions.

8.17 **Sec. 6. COMMISSIONER TO CREATE EXCHANGE IF NECESSARY.**

8.18 If fewer than two health insurance exchanges are licensed under Minnesota Statutes,
8.19 chapter 62U, by October 1, 2007, the commissioner of commerce shall contract with
8.20 an appropriate private entity to operate an exchange under the supervision of the
8.21 commissioner, until at least two exchanges have been licensed under Minnesota Statutes,
8.22 chapter 62U.

8.23 **Sec. 7. EFFECTIVE DATE.**

8.24 Sections 1 to 6 are effective the day following final enactment, provided that a health
8.25 insurance exchange may not provide coverage that begins prior to January 1, 2008.