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State of Minnesota
HOUSE OF REPRESENTATIVES

**EIGHTY-FIFTH
SESSION**

HOUSE FILE No. 3410

February 25, 2008

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

March 13, 2008

Committee Recommendation and Adoption of Report:

To Pass and re-referred to the Committee on Commerce and Labor

1.1 A bill for an act
1.2 relating to human services; reenacting a health care purchasing alliance
1.3 stop-loss fund repealed in 2007; extending its existence and adjusting eligibility;
1.4 appropriating money; proposing coding for new law in Minnesota Statutes,
1.5 chapter 256.

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

1.7 Section 1. **[256.9561] PURCHASING ALLIANCE STOP-LOSS FUND.**

1.8 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
1.9 this subdivision have the meaning given.

1.10 (b) "Commissioner" means the commissioner of human services.

1.11 (c) "Health plan" means a policy, contract, or certificate issued by a health plan
1.12 company to a qualifying purchasing alliance. Any health plan issued to the members of a
1.13 qualifying purchasing alliance must meet the requirements of chapter 62L.

1.14 (d) "Health plan company" means:

1.15 (1) a health carrier as defined under section 62A.011, subdivision 2;

1.16 (2) a community integrated service network operating under chapter 62N; or

1.17 (3) an accountable provider network operating under chapter 62T.

1.18 (e) "Qualifying employer" means an employer who:

1.19 (1) is a member of a qualifying purchasing alliance;

1.20 (2) has at least one employee but no more than 49 employees at the time of initial
1.21 membership to a qualifying purchasing alliance or is a sole proprietor or farmer;

1.22 (3) did not offer employer-subsidized health care coverage to its employees for at
1.23 least 12 months prior to joining the purchasing alliance; and

1.24 (4) is offering health coverage through the purchasing alliance to all employees who
1.25 work at least 20 hours per week unless the employee is eligible for Medicare. For purposes

2.1 of this subdivision, "employer-subsidized health coverage" means health coverage for
2.2 which the employer pays at least 50 percent of the cost of coverage for the employee.

2.3 (f) "Qualifying enrollee" means an employee of a qualifying employer or the
2.4 employee's dependent covered by a health plan.

2.5 (g) "Qualifying purchasing alliance" means a purchasing alliance as defined in
2.6 section 62T.01, subdivision 2, that:

2.7 (1) meets the requirements of chapter 62T;

2.8 (2) services a geographic area located in outstate Minnesota; and

2.9 (3) is registered with the Department of Health as a health care purchasing alliance
2.10 on April 1, 2008.

2.11 Subd. 2. **Creation of account.** (a) A purchasing alliance stop-loss fund account
2.12 is established in the general fund. The commissioner shall use the money to establish
2.13 a stop-loss fund from which a health plan company may receive reimbursement for
2.14 claims paid for qualifying enrollees. The account consists of money appropriated by the
2.15 legislature. Money from the account must be used for the stop-loss fund.

2.16 (b) The commissioner may accept grants from public or private entities for the
2.17 purpose of expanding the stop-loss fund. Any money received by the commissioner must
2.18 be deposited in the account and distributed in accordance with this section.

2.19 Subd. 3. **Reimbursement.** (a) A health plan company may receive reimbursement
2.20 from the fund for 90 percent of the payments made, less any third-party recoveries, for
2.21 claims incurred in a calendar year for a qualifying enrollee for services that in aggregate
2.22 exceed \$30,000 but not of the payments that exceed \$100,000.

2.23 (b) Claims shall be reported and funds shall be distributed on a calendar-year basis.
2.24 Claims incurred by a qualifying enrollee are eligible for reimbursement for a two-year
2.25 period beginning from the date of enrollment. During this two-year period, claims shall be
2.26 eligible for reimbursement only for the calendar year in which the claims were incurred.

2.27 (c) Once claims incurred on behalf of a qualifying enrollee reach \$100,000 in a
2.28 given calendar year, no further claims may be submitted for reimbursement on behalf of
2.29 that enrollee in that calendar year.

2.30 (d) If a health plan company collects third-party recoveries for a claim after the
2.31 health plan company has received reimbursement for the claim from the stop-loss fund
2.32 account, the health plan company must reimburse the account with the amount that would
2.33 have been subtracted from the payment under this subdivision. The health plan company
2.34 shall not be required to reimburse the account for more than the amount received by the
2.35 health plan company for that claim as calculated under subdivision 5.

3.1 Subd. 4. **Request process.** (a) Each health plan company must submit a request
 3.2 for reimbursement from the fund on a form prescribed by the commissioner. Requests
 3.3 for payment must be submitted no later than April 1 following the end of the calendar
 3.4 year for which the reimbursement request is being made.

3.5 (b) The commissioner may require a health plan company to submit claims data as
 3.6 needed in connection with the reimbursement request.

3.7 Subd. 5. **Distribution.** (a) The commissioner shall calculate the total claims
 3.8 reimbursement amount for all qualifying health plan companies for the calendar year for
 3.9 which claims are being reported and shall distribute the stop-loss funds before June 30
 3.10 of the following calendar year.

3.11 (b) In the event that the total amount requested for reimbursement by the health plan
 3.12 companies for a calendar year exceeds the funds available for distribution for claims
 3.13 paid by all health plan companies during the same calendar year, the commissioner shall
 3.14 provide for the pro rata distribution of the available funds. Each health plan company
 3.15 shall be eligible to receive only a proportionate amount of the available funds as the
 3.16 health plan company's total eligible claims paid compares to the total eligible claims
 3.17 paid by all health plan companies.

3.18 (c) In the event that funds available for distribution for claims paid by all health plan
 3.19 companies during a calendar year exceed the total amount requested for reimbursement
 3.20 by all health plan companies during the same calendar year, any excess funds shall be
 3.21 reallocated for distribution in the next calendar year and may carry over into the next
 3.22 biennium.

3.23 Subd. 6. **Data.** Upon the request of the commissioner, each health plan company
 3.24 shall furnish data the commissioner deems necessary to administer the fund. The
 3.25 commissioner may require that the data be submitted on a per enrollee, aggregate, or
 3.26 categorical basis. Any data submitted under this section shall be classified as private data
 3.27 or nonpublic data as defined in section 13.02.

3.28 Subd. 7. **Delegation.** The commissioner may delegate any or all of the
 3.29 commissioner's administrative duties to another state agency or to a private contractor.

3.30 Subd. 8. **Expiration.** This section expires January 1, 2013.

3.31 **EFFECTIVE DATE.** This section is effective July 1, 2008.

3.32 Sec. 2. **APPROPRIATION.**

3.33 \$...... is appropriated in fiscal year 2009 from the health care access fund to the
 3.34 commissioner of human services for the purpose of Minnesota Statutes, section 256.9561.
 3.35 The funds are available until spent.