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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. **3719**

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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 human services; modifying requirements for county-based purchasing
1.3 plans; removing exemptions from the premium tax and provider surcharge;
1.4 requiring a study of county-based purchasing and taxpayer risk; amending
1.5 Minnesota Statutes 2006, sections 256.9657, subdivision 3; 256B.692,
1.6 subdivisions 1, 2, 5; 297I.05, subdivision 5.

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

1.8 Section 1. Minnesota Statutes 2006, section 256.9657, subdivision 3, is amended to
1.9 read:

1.10 Subd. 3. **Surcharge on ~~HMOs~~ health maintenance organizations, county-based**
1.11 **purchasing plans, and community integrated service networks.** (a) Effective October
1.12 1, 1992, each health maintenance organization with a certificate of authority issued
1.13 by the commissioner of health under chapter 62D, each county-based purchasing plan
1.14 under section 256B.692, and each community integrated service network licensed by the
1.15 commissioner under chapter 62N shall pay to the commissioner of human services a
1.16 surcharge equal to six-tenths of one percent of the total premium revenues of the health
1.17 maintenance organization, county-based purchasing plan, or community integrated
1.18 service network as reported to the commissioner of health according to the schedule in
1.19 subdivision 4.

1.20 (b) For purposes of this subdivision, total premium revenue means:

1.21 (1) premium revenue recognized on a prepaid basis from individuals and groups
1.22 for provision of a specified range of health services over a defined period of time which
1.23 is normally one month, excluding premiums paid to a health maintenance organization
1.24 or community integrated service network from the Federal Employees Health Benefit
1.25 Program;

2.1 (2) premiums from Medicare wrap-around subscribers for health benefits which
2.2 supplement Medicare coverage;

2.3 (3) Medicare revenue, as a result of an arrangement between a health maintenance
2.4 organization, county-based purchasing plan, or a community integrated service network
2.5 and the Centers for Medicare and Medicaid Services of the federal Department of Health
2.6 and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue
2.7 that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title
2.8 XVIII of the federal Social Security Act, codified as United States Code, title 42, sections
2.9 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to
2.10 time; and

2.11 (4) medical assistance revenue, as a result of an arrangement between a health
2.12 maintenance organization, county-based purchasing plan, or community integrated service
2.13 network and a Medicaid state agency, for services to a medical assistance beneficiary.

2.14 If advance payments are made under clause (1) or (2) to the health maintenance
2.15 organization or community integrated service network for more than one reporting period,
2.16 the portion of the payment that has not yet been earned must be treated as a liability.

2.17 (c) When a health maintenance organization or community integrated service
2.18 network merges or consolidates with or is acquired by another health maintenance
2.19 organization or community integrated service network, the surviving corporation or the
2.20 new corporation shall be responsible for the annual surcharge originally imposed on
2.21 each of the entities or corporations subject to the merger, consolidation, or acquisition,
2.22 regardless of whether one of the entities or corporations does not retain a certificate of
2.23 authority under chapter 62D or a license under chapter 62N.

2.24 (d) Effective July 1 of each year, the surviving corporation's or the new corporation's
2.25 surcharge shall be based on the revenues earned in the second previous calendar year by
2.26 all of the entities or corporations subject to the merger, consolidation, or acquisition
2.27 regardless of whether one of the entities or corporations does not retain a certificate of
2.28 authority under chapter 62D or a license under chapter 62N until the total premium
2.29 revenues of the surviving corporation include the total premium revenues of all the merged
2.30 entities as reported to the commissioner of health.

2.31 (e) When a health maintenance organization or community integrated service
2.32 network, which is subject to liability for the surcharge under this chapter, transfers,
2.33 assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability
2.34 for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer
2.35 of the health maintenance organization or community integrated service network.

3.1 (f) In the event a health maintenance organization or community integrated service
3.2 network converts its licensure to a different type of entity subject to liability for the
3.3 surcharge under this chapter, but survives in the same or substantially similar form, the
3.4 surviving entity remains liable for the surcharge regardless of whether one of the entities
3.5 or corporations does not retain a certificate of authority under chapter 62D or a license
3.6 under chapter 62N.

3.7 (g) The surcharge assessed to a health maintenance organization, county-based
3.8 purchasing plan, or community integrated service network ends when the entity ceases
3.9 providing services for premiums and the cessation is not connected with a merger,
3.10 consolidation, acquisition, or conversion.

3.11 Sec. 2. Minnesota Statutes 2006, section 256B.692, subdivision 1, is amended to read:

3.12 Subdivision 1. **In general.** County boards or groups of county boards may elect
3.13 to purchase or provide health care services on behalf of persons eligible for medical
3.14 assistance and general assistance medical care who would otherwise be required to or
3.15 may elect to participate in the prepaid medical assistance or prepaid general assistance
3.16 medical care programs according to sections 256B.69 and 256D.03. Counties that elect to
3.17 purchase or provide health care under this section must provide all services included in
3.18 prepaid managed care programs according to sections 256B.69, subdivisions 1 to 22, and
3.19 256D.03. County-based purchasing under this section is governed by section 256B.69,
3.20 unless otherwise provided for under this section. A county, or a group of counties in the
3.21 case of a multicounty arrangement, to the extent it operates a county-based purchasing
3.22 program under this section, may be described as a county-based purchasing plan.

3.23 Sec. 3. Minnesota Statutes 2006, section 256B.692, subdivision 2, is amended to read:

3.24 Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D
3.25 and 62N, a county that elects to purchase medical assistance and general assistance
3.26 medical care in return for a fixed sum without regard to the frequency or extent of services
3.27 furnished to any particular enrollee is not required to obtain a certificate of authority
3.28 under chapter 62D or 62N. The county board of commissioners is the governing body of
3.29 a county-based purchasing program. In a multicounty arrangement, the governing body
3.30 is a joint powers board established under section 471.59.

3.31 (b) A county that elects to purchase medical assistance and general assistance
3.32 medical care services under this section must satisfy the commissioner of health that
3.33 the requirements for assurance of consumer protection, provider protection, and fiscal
3.34 solvency of chapter 62D, applicable to health maintenance organizations, or chapter 62N,

4.1 applicable to community integrated service networks, will be met. The commissioner of
4.2 health shall impose the same reserve requirements on a county-based purchasing plan
4.3 as required for a health maintenance organization, and shall not permit a county-based
4.4 purchasing plan to use a guarantee to meet these requirements. The commissioner also
4.5 shall subject county-based purchasing plans to section 62D.19, related to unreasonable
4.6 expenses. In the event that a county-based purchasing plan receives revenue that exceeds
4.7 its expenses, the surplus shall only be used to meet its obligations for sufficient reserves
4.8 under this section or to fund programs or services that would be permitted under chapter
4.9 62D. A county shall be considered a major participating entity under section 62D.02,
4.10 subdivision 13, with respect to any county-based purchasing plan in which it participates
4.11 under this section, such that the commissioner shall apply provisions under chapter 62D
4.12 regarding major participating entities to county-based purchasing plans, including but not
4.13 limited to the filing and reporting of contracts and payments between a county-based
4.14 purchasing plan and a county.

4.15 (c) A ~~county~~ county-based purchasing plan must also assure the commissioner of
4.16 health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to
4.17 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055;
4.18 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43;
4.19 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

4.20 (d) All enforcement and rulemaking powers available under chapters 62D, 62J,
4.21 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to
4.22 counties that purchase medical assistance and general assistance medical care services
4.23 under this section.

4.24 (e) The commissioner, in consultation with county government, shall develop
4.25 administrative and financial reporting requirements for county-based purchasing programs
4.26 relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31,
4.27 and other sections as necessary, that are specific to county administrative, accounting, and
4.28 reporting systems and consistent with other statutory requirements of counties.

4.29 (f) If permitted by federal law, the commissioner may certify to the Centers for
4.30 Medicare and Medicaid Services that a county-based purchasing plan is authorized to
4.31 sell or offer specialized Medicare Advantage plans for special needs individuals only
4.32 if the commissioner determines that the county-based purchasing plan meets the same
4.33 state regulatory requirements that apply to health maintenance organizations selling or
4.34 offering such plans.

4.35 Sec. 4. Minnesota Statutes 2006, section 256B.692, subdivision 5, is amended to read:

5.1 Subd. 5. **County proposals.** (a) On or before September 1, 1997, a county board
5.2 that wishes to purchase or provide health care under this section must submit a preliminary
5.3 proposal that substantially demonstrates the county's ability to meet all the requirements of
5.4 this section in response to criteria for proposals issued by the department on or before July
5.5 1, 1997. Counties submitting preliminary proposals must establish a local planning process
5.6 that involves input from medical assistance and general assistance medical care recipients,
5.7 recipient advocates, providers and representatives of local school districts, labor, and tribal
5.8 government to advise on the development of a final proposal and its implementation.

5.9 (b) The county board must submit a final proposal on or before July 1, 1998, that
5.10 demonstrates the ability to meet all the requirements of this section, including beginning
5.11 enrollment on January 1, 1999, unless a delay has been granted under section 256B.69,
5.12 subdivision 3a, paragraph (g).

5.13 (c) After January 1, 1999, for a county in which the prepaid medical assistance
5.14 program is in existence, the county board must submit a preliminary proposal at least 15
5.15 months prior to termination of health plan contracts in that county and a final proposal
5.16 six months prior to the health plan contract termination date in order to begin enrollment
5.17 after the termination. Nothing in this section shall impede or delay implementation
5.18 or continuation of the prepaid medical assistance and general assistance medical care
5.19 programs in counties for which the board does not submit a proposal, or submits a
5.20 proposal that is not in compliance with this section.

5.21 (d) The commissioner is not required to terminate contracts for the prepaid medical
5.22 assistance and prepaid general assistance medical care programs that begin on or after
5.23 September 1, 1997, in a county for which a county board has submitted a proposal under
5.24 this paragraph, until two years have elapsed from the date of initial enrollment in the
5.25 prepaid medical assistance and prepaid general assistance medical care programs.

5.26 (e) To ensure federal compliance and require choice for recipients, the commissioner
5.27 shall not solicit or accept any proposals, execute any contracts or amendments, or take any
5.28 other action which could have the effect of expanding county-based purchasing to other
5.29 counties on a single-plan or sole-source basis for any state health care program.

5.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

5.31 Sec. 5. Minnesota Statutes 2006, section 297I.05, subdivision 5, is amended to read:

5.32 Subd. 5. **Health maintenance organizations, nonprofit health service plan**
5.33 **corporations, county-based purchasing plans, and community integrated service**
5.34 **networks.** (a) A tax is imposed on health maintenance organizations, community
5.35 integrated service networks, county-based purchasing plans operating under section

6.1 256B.692, and nonprofit health care service plan corporations. The rate of tax is equal to
6.2 one percent of gross premiums less return premiums on all direct business received by
6.3 the organization, plan, network, or corporation or its agents in Minnesota, in cash or
6.4 otherwise, in the calendar year.

6.5 (b) The commissioner shall deposit all revenues, including penalties and interest,
6.6 collected under this chapter from health maintenance organizations, community integrated
6.7 service networks, county-based purchasing plans, and nonprofit health service plan
6.8 corporations in the health care access fund. Refunds of overpayments of tax imposed
6.9 by this subdivision must be paid from the health care access fund. There is annually
6.10 appropriated from the health care access fund to the commissioner the amount necessary
6.11 to make any refunds of the tax imposed under this subdivision.

6.12 Sec. 6. **ACTUARIAL REPORT ON TAXPAYER RISK FROM COUNTY-BASED**
6.13 **PURCHASING.**

6.14 The state auditor shall contract with an independent actuary to describe and evaluate
6.15 the potential impact on property taxes and county fund balances caused by counties
6.16 assuming financial risk for health care expenses for public health care program recipients
6.17 when operating as county-based purchasing or prepaid health plans under Minnesota
6.18 Statutes, section 256B.692. The state auditor shall submit a report containing the actuary's
6.19 evaluation to the legislature by January 1, 2009.