State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 2901

February 11, 2010
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The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight

A bill for an act

relating to human services; implementing governor's health care reform; creating interstate health insurance choice; creating a flexible benefit plan and repealing the small employer flexible benefits plan; creating primary provider care tiering for Minnesota health care programs; creating a MinnesotaCare modern benefit plan; authorizing rulemaking; amending Minnesota Statutes 2008, sections 256B.0754, by adding subdivisions; 256L.12, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62L; 256L; proposing coding for new law as Minnesota Statutes, chapter 62V; repealing Minnesota Statutes 2008, section 62L.056; Minnesota Statutes 2009 Supplement, section 256B.032.

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

ARTICLE 1

HEALTH INSURANCE CHOICE

Section 1. **[62V.01] CITATION AND PURPOSE.**

This chapter may be cited as the "Health Insurance Choice Act."

Sec. 2. **[62V.02] DEFINITIONS.**

Subdivision 1. **Application.** The definitions in this section apply to this chapter.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 3. **Covered person.** "Covered person" means an individual, whether a policyholder, subscriber, enrollee, or member of a health plan who is entitled to health care services provided, arranged for, paid for, or reimbursed pursuant to a health plan.

Subd. 4. **Domestic health insurer.** "Domestic health insurer" means an insurer licensed to sell, offer, or provide health plans in Minnesota.

Subd. 5. **Foreign health plan.** "Foreign health plan" means a health plan that was filed for use in any other state.

Subd. 6. **Hazardous financial condition.** "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a foreign health insurer is unlikely to be able to meet obligations to policyholders with respect to known claims or to any other obligations in the normal course of business.

Subd. 7. **Health plan.** "Health plan" means an arrangement for the delivery of health care, on an individual basis, in which an insurer undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person that is in accordance with the laws of any state. Health plan does not include short-term health coverage, accident only, limited or specified disease, long-term care or individual conversion policies or contracts, nor policies or contracts designed for issuance to persons eligible for coverage under title XVIII of the federal Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

Subd. 8. **Health care services.** "Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

Subd. 9. **Health care provider or provider.** "Health care provider" or "provider" means any hospital, physician, or other person authorized by statute, licensed, or certified to furnish health care services.

Subd. 10. **Insurer.** "Insurer" means any entity that is authorized to sell, offer, or provide a health plan, including an entity providing a plan of health insurance, health benefits or health services, an accident and sickness insurance company, a health maintenance organization, a corporation offering a health plan, a fraternal benefit society, a community integrated service network, or any other entity that provides health plans subject to state insurance regulation, or a health carrier described in section 62A.011, subdivision 2.

Subd. 11. **Resident.** "Resident" means an individual whose primary residence is in Minnesota and who is present in Minnesota for at least six months of the calendar year.

Sec. 3. **[62V.03] FOREIGN HEALTH PLANS TO MINNESOTA RESIDENTS.**

Subdivision 1. **Eligibility.** (a) Notwithstanding any other law, rule, or regulation to the contrary, a health insurer may sell, offer, or provide a foreign health plan to residents in Minnesota, if the following requirements are met:

(1) the foreign health plan must be in compliance with all applicable laws, regulations, and other requirements of that other state applicable to the content of the policy;

(2) the foreign health plan shall not be issued, nor any application, rider, or endorsement be used in connection with the plan, until the form has received prior approval in the state in which it was filed;

(3) the offering insurer must have a certificate of authority to do business in Minnesota pursuant to section 60A.07; and

(4) the foreign health plan shall participate, on a nondiscriminatory basis, in the Minnesota Life and Health Insurance Guaranty Association created under chapter 61B.

(b) The provisions of section 62A.02, subdivision 2, shall not apply to plans issued under this section.

(c) The commissioner of commerce, in consultation with the commissioner of health, shall draft rules that identify the states whose health plans can be marketed to Minnesota residents. In adopting those rules, the commissioners shall focus on identifying states that have:

(1) an acceptable degree of consumer protection;

(2) competitive marketplaces;

(3) good clinical outcomes; and

(4) cost containment measures.

Subd. 2. **Exemption.** Except as provided in this chapter, a foreign health plan sold, offered, or provided by a health insurer in Minnesota in accordance with the provisions of this chapter is not subject to laws applicable to the sale, offering, or provision of accident and sickness insurance or health plans including, but not limited to, requirements imposed by chapters 62A, 62E, and 62Q.

EFFECTIVE DATE. Subdivision 1, paragraph (c), is effective July 1, 2011.

Sec. 4. **[62V.04] CERTIFICATE OF AUTHORITY TO OFFER FOREIGN HEALTH PLANS.**

Subdivision 1. **Issuance of certificate.** A health insurer may apply for a certificate that authorizes the health insurer to offer foreign health insurance plans in Minnesota, using a form prescribed by the commissioner. Upon application, the commissioner shall issue a certificate to the health insurer unless the commissioner determines that the foreign health insurer:

(1) will not provide a health plan in compliance with the provisions of this chapter;

(2) is in a hazardous financial condition, as determined by an examination by the commissioner conducted in accordance with the Financial Analysis Handbook of the National Association of Insurance Commissioners; or

(3) has not adopted procedures to ensure compliance with all applicable laws governing the confidentiality of its records with respect to providers and covered persons.

Subd. 2. **Validity.** A certificate of authority issued pursuant to this section is valid for three years from the date of issuance by the commissioner.

Subd. 3. **Rulemaking authority.** The commissioner shall adopt rules that include:

(1) procedures for a foreign health insurer to renew a certificate of authority, consistent with the provisions of this chapter; and

(2) certificate of authority application and renewal fees, the amount of which shall be no greater than is reasonably necessary to enable the commissioner of commerce to carry out the provisions of this chapter.

Subd. 4. **Applicability of certain statutory requirements.** A health insurer offering health plans pursuant to this chapter shall comply with:

(1) protections for covered persons from unfair trade practices applicable to accident and sickness insurance or health plans pursuant to chapter 72A;

(2) the capital and surplus requirements for licensure specified in chapter 60A, as determined applicable to foreign health insurers by the commissioner;

(3) applicable requirements of this chapter and sections 297I.05, subdivision 12, and 62E.11, pertaining to taxes and assessments imposed on health insurers selling individual health insurance policies in Minnesota; and

(4) applicable requirements of chapter 60A regarding the obtaining of authority to transact business in Minnesota.

Sec. 5. **[62V.05] REQUIRED DISCLOSURE.**

(a) Each foreign health plan provided by a health insurer to a resident of Minnesota, and each application for the plan, shall disclose in plain language the following:

(1) the differences between the benefits of the foreign health plan and a health plan issued under the laws of Minnesota, using at least 14-point bold type to describe the differences that relate to mandated health benefits, underwriting standards, premium rating, preexisting conditions, renewability, portability, and cancellation; and

(2) an explanation of which state's laws govern the issuance of, and requirements under, the health plan offered under this chapter.

(b) A health insurer shall not offer a foreign health plan to a resident of Minnesota until the commissioner determines that the disclosures required by paragraph (a) are provided.

Sec. 6. **[62V.06] REVOCATION OF CERTIFICATE OF AUTHORITY; MARKETING MATERIALS.**

Subdivision 1. **Revocation.** The commissioner may deny, revoke, or suspend, after notice and opportunity to be heard, a certificate of authority issued to a health insurer pursuant to this chapter for a violation of the provisions of this chapter, including any finding by the commissioner that a health insurer is no longer in compliance with any of the conditions for issuance of a certificate of authority set forth in section 60A.07, or the administrative rules adopted pursuant to this chapter. The commissioner shall provide for an appropriate and timely right of appeal for the foreign health insurer whose certificate is denied, revoked, or suspended.

Subd. 2. **Fair marketing standards.** The commissioner shall establish fair marketing standards for marketing materials used by foreign health insurers to market health plans to residents in Minnesota, which standards shall be consistent with those applicable to health plans offered by a domestic health insurer pursuant to chapter 72A.

Subd. 3. **Nondiscrimination.** The procedures and standards established under subdivision 2 shall be applied on a nondiscriminatory basis so as not to place greater responsibilities on foreign health insurers than the responsibilities placed on domestic health insurers doing business in Minnesota.

Sec. 7. **[62V.07] RULES.**

(a) The commissioner shall adopt rules to effectuate the purposes of this chapter. The rules must not:

(1) directly or indirectly require an insurer offering foreign health plans to, directly or indirectly, modify coverage or benefit requirements, or restrict underwriting requirements or premium ratings, in any way that conflicts with the insurer's domiciliary state's laws or regulations;

(2) provide for regulatory requirements that are more stringent than those applicable to carriers providing Minnesota health plans; or

(3) require any foreign health plan issued by the health insurer to be countersigned by an insurance agent or broker residing in Minnesota.

ARTICLE 2

FLEXIBLE BENEFIT PLANS

Section 1. **[62L.0561] FLEXIBLE BENEFITS PLANS.**

Subdivision 1. **Definitions.** For the purposes of this section, the terms used in this section have the meaning defined in section 62Q.01, except that "health plan" includes individual and group coverage.

Subd. 2. **Flexible benefits plan.** Notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health plan company may offer, sell, issue, and renew a health plan that is a flexible benefits plan under this section if the following requirements are satisfied:

(1) the health plan must be offered in compliance with the laws of this state, except as otherwise permitted in this section;

(2) the health plan must be designed to enable covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;

(3) the health plan may modify or exclude any or all coverages of benefits that would otherwise be required by law, except for maternity benefits and other benefits required under federal law;

(4) each health plan and plan's premiums must be approved by the commissioner of health or commerce, whichever is appropriate under section 62Q.01, subdivision 2, but neither commissioner may disapprove a plan on the grounds of a modification or exclusion permitted under clause (3); and

(5) prior to sale of the health plan, the purchaser must be given a written list of the coverages otherwise required by law that are modified or excluded in the health plan. The list must include a description of each coverage in the list and indicate whether the coverage is modified or excluded. If coverage is modified, the list must describe the modification. The list may, but is not required to, also list any or all coverages otherwise required by law that are included in the health plan and indicate that they are included. The health plan company must require that a copy of this written list be provided, prior to the effective date of the health plan, to each enrollee or employee who is eligible for health coverage under the plan.

Subd. 3. **Employer health plan.** An employer may provide a health plan permitted under this section to its employees, the employees' dependents, and other persons eligible for coverage under the employer's plan, notwithstanding chapter 363A or any other law to the contrary.

EFFECTIVE DATE. This section is effective January 1, 2012.

Sec. 2. **REPEALER.**

Minnesota Statutes 2008, section 62L.056, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2012.

ARTICLE 3

PROVIDER TIERING

Section 1. Minnesota Statutes 2008, section 256B.0754, is amended by adding a subdivision to read:

Subd. 3. **Primary care provider tiering.** (a) The commissioner shall establish a tiering system for all providers participating in Minnesota health care programs. The tiering system must differentiate providers on the basis of their ability to provide cost-effective, quality care and must incorporate the provider peer grouping measures established under section 62U.04. The tier assignments must be established annually based on the most recent peer grouping measures available. Differentiation of tier assignments must be statistically valid. The commissioner may set specific quality standards for providers designated as high-performing providers under this subdivision.

(b) The commissioner may adjust the rates paid to providers within each tier group established under paragraph (a) on an annual basis. Adjustments across provider rates made under this subdivision must be cost-neutral, adjusted for the number of enrollees, and compared to provider payments made during the previous year. Adjustments to rates shall not include the rate paid for care coordination services to certified health care homes (HCH) under section 256B.0753. Providers designated high-performing providers under paragraph (c) are not eligible for rate increases unless the provider also meets the cost and quality criteria associated with that tier level.

(c) Health care homes certified under section 256B.0751, rural health clinics, and federally qualified health care clinics are designated as high-performing providers under this subdivision.

(d) Providers reimbursed on a cost basis are not subject to rate adjustments under this section.

(e) The commissioner may phase in the tiering system by service type. The tiering system must be implemented first with primary care providers.

EFFECTIVE DATE. This section is effective one year from the public release of provider peer grouping measures under Minnesota Statutes, section 62U.04, or upon federal approval, whichever is later.

Sec. 2. Minnesota Statutes 2008, section 256B.0754, is amended by adding a subdivision to read:

Subd. 4. **Provider tiering patient incentives.** The commissioner shall seek federal approval to allow incentives for enrollees to choose high-performing providers established under subdivision 1. The incentives may include an enrollee credit used to pay for co-pays on prescription drugs. Enrollees choosing a high-performing provider as their primary care provider (PCP) shall be eligible for the credit for their enrollment period. The enrollee would be eligible for the same credit in the next enrollment period if they continue to designate a high-performing PCP.

EFFECTIVE DATE. This section is effective upon federal approval.

Sec. 3. **REPEALER.**

Minnesota Statutes 2009 Supplement, section 256B.032, is repealed.

ARTICLE 4

MINNESOTACARE MODERN BENEFIT PLAN

Section 1. Minnesota Statutes 2008, section 256L.12, subdivision 1, is amended to read:

Subdivision 1. **Selection of vendors.** (a) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

(b) The commissioner shall consider proposals by vendors to provide services for adults who qualify for MinnesotaCare modern benefit plan described in section 256L.28. The commissioner shall use the criteria described in paragraph (a). The commissioner shall limit the number of vendors selected to a maximum of three.

Sec. 2. **[256L.29] MINNESOTACARE MODERN BENEFIT PLAN.**

Subdivision 1. **Eligibility.** Beginning January 1, 2012, or upon federal approval, adults who qualify for MinnesotaCare under section 256L.04, subdivision 1, with family gross income that exceeds 133 percent of the federal poverty guidelines, and who are not pregnant, may voluntarily enroll in the MinnesotaCare modern benefit plan as described in this section. All provisions of sections 256L.01 to 256L.18 shall continue to apply to adults enrolled in the MinnesotaCare modern benefit plan unless otherwise specified.

Subd. 2. **Covered services; deductible; co-payments.** The MinnesotaCare modern benefit plan shall include all covered services and co-payments under section 256L.03. In addition to the enrollee cost sharing described in section 256L.03, subdivision 5, adults enrolled in the MinnesotaCare modern benefit plan shall be subject to a $..... annual deductible each calendar year. All covered services and co-payments described in this section are subject to the enrollee's annual deductible. Enrollees may use their health savings account (HSA) described in section 256L.03, subdivision 5c, to pay for covered services and co-payments.

Subd. 3. **Enrollment.** (a) Adults who qualify for the MinnesotaCare modern benefit plan may enroll during an annual open enrollment period. MinnesotaCare modern benefits will begin each year on January 1, following the open enrollment period.

(b) Adults enrolled in the MinnesotaCare modern benefit plan who are disenrolled from the MinnesotaCare program and then reapply, may not enroll in the MinnesotaCare modern benefit plan until the next annual open enrollment period. Upon disenrollment, any unused funds in the enrollee's HSA under subdivision 5c will not roll over to the next calendar year.

Subd. 4. **MinnesotaCare modern health savings accounts (HSAs).** Beginning January 1, 2012, or upon federal approval, the commissioner shall establish a health savings account (HSA) for each adult enrolled in the MinnesotaCare modern benefit plan. The HSA shall be available to the enrollee to pay for covered services and co-payments described under subdivision 2, up to the amount of the annual deductible. The state shall contribute $..... per calendar year to each enrollee's HSA to pay for covered services and co-payments. Any funds that remain in an enrollee's HSA at the end of a calendar year shall be available to the enrollee the following calendar year. Enrollees are responsible for costs of health services incurred in excess of the state's contribution up to the amount of the annual deductible.

Subd. 5. **Premium discount for MinnesotaCare modern enrollees.** Beginning January 1, 2012, or upon federal approval, each adult enrolled in the MinnesotaCare modern benefit plan under section 256L.28, shall qualify for a monthly premium discount of $..... The discount shall be applied to the family premium determined according to section 256L.15, subdivision 2, beginning with the premium for the first month of coverage under the MinnesotaCare modern plan.