State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

HOUSE FILE NO. 1204

March 21, 2011
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The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to health; creating the Minnesota health benefit exchange; proposing coding for new law as Minnesota Statutes, chapter 62V.

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

Section 1. **[62V.01] TITLE.**

This act shall be known and may be cited as the Minnesota Health Benefit Exchange Act.

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

(a) For purposes of this act, the following definitions have the meanings given.

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

(c) "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(d) "Exchange" means the Minnesota health benefit exchange established under section 62V.03.

(e) "Federal act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments thereto, or regulations or guidance issued under, those acts.

(f)(1) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(2) "Health benefit plan" does not include:

(i) accident-only coverage, disability income insurance, or any combination thereof;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics; or

(viii) other similar insurance coverage, specified in federal regulations issued under Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of them; or

(iii) other similar, limited benefits specified in federal regulations issued under Public Law 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided to such an event under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(iii) similar supplemental coverage provided to coverage under a group health plan.

(g) "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an accident and sickness insurance company, a health maintenance organization, a nonprofit health service plan corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

(h) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7, paragraph (e).

(i) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the small business health options program (SHOP) exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) has its principal place of business in this state and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

(2) elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in this state.

(j) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act and section 62V.06.

(k) "Qualified individual" means an individual, including a minor, who:

(1) is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(2) resides in this state;

(3) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

(l) "Secretary" means the secretary of the federal Department of Health and Human Services.

(m) "SHOP exchange" means the small business health options program established under section 62V.05.

(n)(1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

(2) For purposes of this paragraph:

(i) all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(ii) an employer and any predecessor employer shall be treated as a single employer;

(iii) all employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(iv) if an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(v) an employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of sections 62V.01 to 62V.11 as long as it continuously makes enrollment through the SHOP exchange available to its employees.

Sec. 3. **[62V.03] ESTABLISHMENT OF EXCHANGE.**

(a) The Minnesota health benefit exchange is established as a state agency governed by a nine-member board of directors. Its members are appointed by the governor for staggered three-year terms. No member may serve for more than two consecutive full terms. No member may be affiliated with the insurance or health plan industry, including agents or brokers of either of those industries. At least six members of the board must represent individuals or groups served by the exchange, including representatives of communities of color. The commissioners of commerce, health, and human services shall administer the exchange under the guidance and direction of the board.

(b) The exchange shall:

(1) facilitate the purchase and sale of qualified health plans;

(2) provide for the establishment of a SHOP exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and

(3) meet the requirements of sections 62V.01 to 62V.11 and any associated adopted rules.

(c) The exchange may contract with an eligible entity for any of its functions described in sections 62V.01 to 62V.11. An eligible entity includes, but is not limited to, the Department of Human Services or an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the

responsibilities to be assumed by the entity, but a health carrier, an affiliate of a health carrier, or an insurance agency or insurance brokerage firm is not an eligible entity.

(d) The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under sections 62V.01 to 62V.11, provided the agreements include adequate protections for the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

Sec. 4. **[62V.04] GENERAL REQUIREMENTS.**

(a) The exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

(b)(1) The exchange shall not make available any health benefit plan that is not a qualified health plan; and

(2) the exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the federal act.

(c) Neither the exchange nor a carrier offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Sec. 5. **[62V.05] DUTIES OF EXCHANGE.**

The exchange shall:

(1) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311(c) of the federal act and section 62V.06, of health benefit plans as qualified health plans;

(2) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) provide for enrollment periods, as provided under section 1311(c)(6) of the federal act;

(4) maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(5) assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under section 1311(c)(3) of the federal act, and determine each qualified health plan's level of coverage according to regulations issued by the secretary under section 1302(d)(2)(A) of the federal act;

(6) use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under section 2715 of the federal Public Health Services Act;

(7) in accordance with section 1413 of the federal act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act, or any applicable state or local public program, and if through screening of the application by the exchange, the exchange determines that any individual is eligible for any such program, enroll or arrange for the enrollment of that individual in that program. The exchange shall serve as a portal for individuals who may be eligible for those other public programs to initiate eligibility determination and enrollment in them;

(8) establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the federal act;

(9) establish a SHOP exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage. The SHOP exchange and the exchange for individual purchasers shall be treated as a single risk pool;

(10) subject to section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(i) there is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(11) transfer to the federal secretary of the treasury the following:

(i) a list of the individuals who are issued a certification under clause (10), including the name and taxpayer identification number of each individual;

(ii) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(A) the employer did not provide minimum essential coverage; or

(B) the employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of:

(A) each individual who notifies the exchange under section 1411(b)(4) of the federal act that the individual has changed employers; and

(B) each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(12) provide to each employer the name of each employee of the employer described in clause (11), item (ii), who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(13) perform duties required of the exchange by the secretary or the secretary of the treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(14) select entities qualified to serve as navigators in accordance with section 1311(i) of the federal act, and standards developed by the secretary provided that the navigators must be employed by nonprofit community organizations that have experience working with low-income and uninsured populations. In contracting with navigators, the commissioner shall give preference to nonprofit entities serving as participating community organizations in the Minnesota community application assistance program established under section 256.962, subdivision 5;

(15) award grants to enable navigators to:

(i) conduct public education activities to raise awareness of the availability of qualified health plans;

(ii) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the federal act;

(iii) facilitate enrollment in qualified health plans;

(iv) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate state agency or agencies, for any

enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan, coverage, or a determination under that plan or coverage; and

(v) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(16) review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(17) credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the federal act, and collect the amount credited from the offering employer;

(18) consult with stakeholders relevant to carrying out the activities required under sections 62V.01 to 62V.11, including, but not limited to:

(i) educated health care consumers who are enrollees in qualified health plans;

(ii) individuals and entities with experience in facilitating enrollment in qualified health plans;

(iii) representatives of small businesses and self-employed individuals;

(iv) the Department of Human Services; and

(v) advocates for enrolling hard-to-reach populations; and

(19) meet the following financial integrity requirements:

(i) keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the secretary, the governor, the commissioner, and the legislature a report concerning the accountings;

(ii) fully cooperate with any investigation conducted by the secretary under authority of the federal act and allow the secretary, in coordination with the inspector general of the United States Department of Health and Human Services, to:

(A) investigate the affairs of the exchange;

(B) examine the properties and records of the exchange; and

(C) require periodic reports in relation to the activities undertaken by the exchange; and

(iii) in carrying out its activities under this act, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

Sec. 6. **[62V.06] HEALTH BENEFIT PLAN CERTIFICATION.**

(a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) the plan provides the essential health benefits package described in section 1302(a) of the federal act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in paragraph (e), if:

(i) the exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(ii) the carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

(2) the premium rates and contract language have been approved by the commissioner;

(3) the plan provides at least a bronze level of coverage, as determined under clause (5), unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans, and will be offered only to individuals eligible for catastrophic coverage;

(4) the plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the federal act, and if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the federal act;

(5) the health carrier offering the plan:

(i) is licensed and in good standing to offer health insurance coverage in this state;

(ii) offers at least one qualified health plan in each of the bronze, silver, gold, and platinum levels through each component of the exchange where "component" refers to the SHOP exchange and the exchange for individual coverage;

(iii) charges the same premium rate for each qualified health plan in each exchange without regard to whether the plan is offered through the exchange or is offered directly from the carrier or through an insurance producer;

(iv) does not charge any cancellation fees or penalties in violation of section 62V.04, paragraph (c);

(v) complies with the regulations developed by the secretary under section 1311(d) of the federal act and other requirements as the exchange may establish, which must include medical loss ratio standards, a comprehensive annual audit, and network adequacy for low-income and multicultural individuals, and which may include mandatory in-network inclusion requirements for providers serving communities of color; and

(vi) offers within the exchange each plan it offers outside of the exchange;

(6) the plan meets the requirements of certification as promulgated by regulation under section 62V.09 and by the secretary under section 1311(c) of the federal act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance; and

(7) the exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

(b) The exchange shall not exclude a health benefit plan:

(1) on the basis that the plan is a fee-for-service plan;

(2) through the imposition of premium price controls by the exchange, but the exchange shall comply with paragraph (f); or

(3) on the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

(c) The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) submit a justification for any premium increase, including detailed data on the product's medical loss ratio, before implementation of that increase. The carrier shall prominently post the information on its Internet Web site. The exchange shall take this information, along with the information and the recommendations provided to the exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the exchange;

(2)(i) make available to the public, in the format described in item (ii), and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of the following:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment;

(D) data on disenrollment;

(E) data on the number of claims that are denied;

(F) data on rating practices;

(G) information on cost-sharing and payments with respect to any out-of-network coverage;

(H) information on enrollee and participant rights under title I of the federal act; and

(I) other information as determined appropriate by the secretary; and

(ii) the information required in item (i) shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the federal act; and

(3) permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, co-payments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through a Web site and through other means for individuals without access to the Internet.

(d) The exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

(e)(1) The provisions of this act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans, except as modified according to clauses (2), (3), and (4) or by regulations adopted by the exchange;

(2) the carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) the plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the secretary under section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange or the secretary may specify by regulation; and

(4) carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

(f) The exchange shall be an active and selective purchaser and shall negotiate with carriers to obtain the optimal combination of price and quality, including consideration of the health benefits plan's medical loss ratio.

(g) In negotiating with health plan companies for the inclusion of health plans, the exchange shall consider the extent to which a health plan incorporates alternative health care delivery models, including but not limited to health care homes certified under section 256B.0751 and accountable care organizations, that provide incentives for the efficient and coordinated delivery of high-quality care. The commissioner shall include alternative health care delivery models in the public plan required to be offered through

the exchange under paragraph (h). Alternative health care delivery models must comply with all applicable state and federal laws in addition to the requirements of this section.

(h) The exchange shall offer at least one public plan sponsored or administered by a state entity that contracts directly with health care providers.

(i) Health carriers must disclose to the exchange and to a public entity that sponsors or administers a public plan under paragraph (h) all provider payment rates and other data required to be disclosed by health carriers under the federal act.

Sec. 7. **[62V.07] ALL-PAYER RATE SETTING.**

Subdivision 1. **Establishment.** The exchange shall establish an all-payer rate setting system to govern provider payments made under private and public sector health plans offered inside and outside the exchange. The system must include:

(1) uniform payment rates for specific health care procedures and services that do not vary by health plan or payer type or within provider type;

(2) uniform payment rates for specific health care provider types that are reimbursed under capitated or total cost of care payment methods that do not vary by health plan or payer type; and

(3) procedures for determining and approving periodic increases in provider payment rates that do not vary by health plan or payer type, and which reflect increases in costs incurred by efficient and high-quality providers.

Subd. 2. **State health care programs.** Payments under the medical assistance and MinnesotaCare programs must comply with the requirements of the all-payer rate setting system.

Subd. 3. **Advisory council.** The exchange shall establish a rate setting advisory council to assist the exchange in setting initial uniform payment rates and in determining future increases in payment rates. The advisory council must be comprised of representatives of health plan companies, health care providers, health care consumers, and state agencies and other payers. The advisory council is governed by section 15.059, except that it does not expire.

Sec. 8. **[62V.08] FUNDING; PUBLICATION OF COSTS.**

(a) The exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under sections 62V.01 to 62V.11.

(b) The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the

exchange, on an Internet Web site to educate consumers on such costs. This information must include information on money lost to waste, fraud, and abuse.

Sec. 9. **[62V.09] REGULATIONS.**

The exchange may adopt rules to implement the provisions of sections 62V.01 to 62V.11. Rules adopted under this section shall not conflict with or prevent the application of rules adopted by the secretary under the federal act.

Sec. 10. **[62V.10] FAIR HEARING.**

Any person aggrieved by a decision of the exchange about eligibility for any public program or aggrieved by a subsidy determination shall have the right to a fair hearing under section 256.045.

Sec. 11. **[62V.11] RELATION TO OTHER LAWS.**

Nothing in sections 62V.01 to 62V.10, and no action taken by the exchange under sections 62V.01 to 62V.10, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this state. Except as expressly provided to the contrary in sections 62V.01 to 62V.10, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.

Sec. 12. **EFFECTIVE DATE.**

This act is effective the day following final enactment for purposes of preparing to carry out the exchange's duties, provided that no health coverage provided under it may be effective prior to January 1, 2014.