State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2739

03/07/2012 Authored by Murphy, E.; Liebling; Moran; Fritz; Allen and others
The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform

A bill for an act

relating to insurance; creating the Minnesota Health Benefits Exchange and specifying its functions and duties; 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] CITATION.**

This act must be known and may be cited as the Minnesota Health Benefits Act.

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

It is the intent of the legislature to create a Minnesota Health Benefits Exchange for the purposes of improving the health of Minnesotans, providing individuals and small businesses with a variety of high-quality health insurance options that fit their needs, streamlining public programs in Minnesota to assure ease of accessibility and full continuity of coverage, and ensuring that individuals who will be eligible for health insurance coverage and financial assistance through the exchange obtain that coverage and assistance to the fullest extent possible under the Minnesota Health Benefits Exchange.

Sec. 3. **[62V.03] DEFINITIONS.**

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

(b) "Advisory committee" means those advisory committees established by the board as specified under section 62V.06, paragraph (d), clauses (12) and (13).

(c) "Board" means the board of directors as specified under section 62V.05.

(d) "Commissioner" means the commissioner of commerce for health plans or health plan companies regulated by that commissioner and the commissioner of health for health plans or health plan companies regulated by that commissioner.

(e) "Exchange" means the Minnesota Health Benefits Exchange created in this act.

(f) "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 thereunder.

(g) "Health plan company" has the meaning given in section 62Q.01, subdivision 4.

(h) "No-wrong-door policy" means a policy that provides a system for individuals seeking coverage that will ensure: (1) access to the exchange through multiple entry points that are culturally and linguistically appropriate for all populations served; (2) screenings for all available public and private health coverage options and any state public benefit programs or public services; and (3) an enrollment process that does not require additional application forms or multiple eligibility determinations for each program or plan.

(i) "Secretary" means the United States Secretary of Health and Human Services.

Sec. 4. **[62V.04] ESTABLISHMENT OF EXCHANGE.**

(a) The Minnesota Health Benefits Exchange is established as an independent public entity under section 15.012, paragraph (a).

(b) The exchange shall pursue available federal funding for operation of the exchange and shall promulgate rules necessary to obtain federal recognition of the exchange as a certified exchange under the federal act.

(c) The exchange may accept gifts, grants, and bequests, contract with other persons, and enter into memoranda of understanding with other governmental agencies to carry out any of its functions, including agreements with other states to perform administrative functions.

(d) The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this act, provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations. Notwithstanding any law to the contrary, the exchange shall have access to private and nonpublic data on providers, health carriers, and third-party administrators that is maintained by the commissioners of health and commerce and needed by the exchange for risk adjustment, monitoring adverse selection, and health plan quality. The definitions in section 13.02 apply to data practices by the exchange.

(e) The exchange shall be subject to review by the legislative auditor under section 3.971.

Sec. 5. **[62V.05] EXCHANGE BOARD OF DIRECTORS.**

(a) The operation of the exchange shall be governed by a board of directors.

(b) The board shall consist of 19 members. Initial members of the board shall serve staggered terms not to exceed four years. Members appointed thereafter shall serve three-year terms.

(c) The board membership shall reflect the diversity of individuals who receive coverage through the exchange, including diversity of ethnicity, geography, and gender, and consist of the following:

(1) four members shall represent the interests of individual consumers served by the exchange. Those members shall be appointed by the governor;

(2) four members shall represent the interests of individual consumers, small business employees, and small employers, with at least one seat for each of the three categories. The Subcommittee on Committees of the Committee on Rules and Administration of the senate shall appoint one member recommended by the majority and one member recommended by the minority, and the speaker of the house shall appoint one member recommended by the majority and one member recommended by the minority;

(3) four members shall have demonstrated expertise and knowledge in the areas of public health, health disparities, health care administration and finance, health benefits administration, health plan purchasing, or health policy issues. The governor, commissioner of human services, commissioner of health, and commissioner of commerce shall each appoint one member;

(4) four members shall demonstrate knowledge of and experience with the health care needs of underserved or low-income populations, Minnesota Indian tribes, mental health and substance abuse, individuals with disabilities, children or youth, or health-related disorders or illnesses. Those members shall be appointed by the governor;

(5) the commissioner of commerce;

(6) the commissioner of health; and

(7) the commissioner of human services.

(d) Section 15.0597 applies to all appointments, except the commissioners.

(e) No board member may be appointed if the person's participation in the decisions of the board could benefit the person's own financial interests or the financial interests of an entity the person represents. No board member may be or become affiliated with the

health insurance or plan industry, including agents or brokers, employees, representatives, consultants to or members of the board of directors of either industry.

(f) A board member who develops an affiliation or a conflict of interest prohibited under this section shall act in accordance with section 10A.07 and proceed with resignation voluntarily or be removed from the board. Removal from the board in such circumstances shall be provided following notice, a hearing, and a two-thirds vote of the board.

(g) All board members, officers, or employees are subject to section 10A.071.

(h) Board members may be compensated in accordance with section 15.0575.

(i) All meetings of the board shall comply with the open meeting law in chapter 13D, except meetings regarding labor negotiations and contract negotiations at the discretion of the board and meetings regarding private, not public, nonpublic, or trade-secret information or data.

(j) A board member, an officer, or an employee of the exchange is not liable for an act or omission when acting in the person's official capacity in connection with the administration, management, or conduct of this act if the act or omission was conducted in good faith and without the intent to defraud.

Sec. 6. **[62V.06] DUTIES OF THE EXCHANGE.**

(a) In partnership with the Departments of Commerce, Health, and Human Services, the exchange shall operate a consumer-friendly marketplace that provides consumers with the ability to choose among qualified insurance products, facilitates enrollment in certified health plans, administers financial assistance to those who are eligible, negotiates with health plans to achieve high value for consumers, and achieves goals of reducing health disparities, generating health equity, and ensuring improved health for Minnesotans.

(b) The exchange shall also fulfill the requirements under the federal act, including any related amendments, regulations, or guidance.

(c) Laws governing public agencies apply to the exchange unless otherwise specified in this act.

(d) To fulfill these duties, the exchange shall perform, but not be limited to, the following:

(1) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the secretary under section 1311, paragraph (c), of the federal act, of health benefit plans as qualified health plans, as well as additional guidelines established by the exchange board;

(2) base certification of a health benefit plan on requirements promulgated by the secretary under section 1311, paragraph (c), of the federal act, as well as additional

standards promulgated by the exchange that shall include the achievement of goals for health outcomes, network adequacy, essential community providers in underserved areas, accreditation, uniform enrollment forms and descriptions of coverage, and other standards promulgated by the exchange. The exchange shall further determine whether making the plan available through the exchange is in the interest of qualified individuals and employers in this state. The exchange shall not exclude a health benefit plan on the basis that the plan is a fee-for-service plan;

(3) be active as an active purchaser to negotiate with health plan companies to obtain the optimal combination of price and quality for plans offered through the exchange;

(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, paragraph (c), clause (3), of the federal act, as well as additional standards promulgated by the exchange, and determine each qualified health plan's level of coverage according to regulations issued by the secretary under section 1302, paragraph (d), clause (2), subitem (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) perform duties required of the exchange by the secretary or the United States secretary of the treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(9) select entities qualified to serve as navigators in accordance with section 1311, paragraph (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;

(10) establish a no-wrong-door policy for the exchange with a protocol for monitoring and evaluating the effectiveness of the policy on access to the exchange;

(11) develop strategies to prevent adverse selection and report on those strategies to the board;

(12) create an advisory committee of experts, consisting of five members with demonstrated and acknowledged expertise in health insurance, actuarial science, adverse selection and risk management, or benefit plan administration to allow for the views and expertise of the health care industry and other stakeholders to be heard in the operation of the exchange;

(13) establish other advisory committees to seek technical advice or expertise when necessary to execute the powers and duties included in this act;

(14) consult with the Indian Affairs Council, established under section 3.922, to assist with access to, enrollment in, and coverage through the exchange; and

(15) submit a report to the legislature by March 15, 2013, on the progress of establishing the exchange in accordance with this chapter, and an annual report by January 15 of each year thereafter, that includes a report on the performance of the exchange operations and on meeting the exchange duties, health outcome goals, and an accounting of the marketplace budget activities.

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

The exchange may adopt rules to implement the provisions of this act. Rules adopted under this section must not conflict with or prevent the application of rules adopted by the secretary under the federal act.

Sec. 8. **[62V.08] FAIR HEARING.**

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

Sec. 9. **[62V.09] RELATION TO OTHER LAWS.**

Nothing in this act, and no action taken by the exchange under this act, 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 this act, all health plan companies 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. 10. **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.