State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 3030

03/14/2016 Authored by Murphy, E.,
The bill was read for the first time and referred to the Committee on Government Operations and Elections Policy

A bill for an act

relating to state employee benefits; requiring the commissioner of management and budget to set network standards for the use of health care homes when contracting for employee health benefits; amending Minnesota Statutes 2014, section 43A.23, subdivision 1.

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

Section 1. Minnesota Statutes 2014, section 43A.23, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The commissioner is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the benefit plans. Contracts entered into are not subject to the requirements of sections 16C.16 to 16C.19. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. The commissioner shall require carriers to demonstrate a capacity to serve eligible employees and other eligible persons, who are chronically ill, through a statewide network of certified health care homes. Each benefit contract must be for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. A carrier licensed under chapter 62A is exempt from the taxes imposed by chapter 297I on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured, including chapters 62J, 62M, and 62Q. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall

comply with section 62D.123 and geographic access standards for health maintenance organizations adopted by the commissioner of health in rule under chapter 62D.

(c) Notwithstanding paragraph (b), a self-insured hospital and medical product offered under sections 43A.22 to 43A.30 is required to extend dependent coverage to an eligible employee's child to the full extent required under chapters 62A and 62L. Dependent child coverage must, at a minimum, extend to an eligible employee's dependent child to the limiting age as defined in section 62Q.01, subdivision 9, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren to the extent required in sections 62A.042 and 62A.302.

(d) Beginning January 1, 2010, the health insurance benefit plans offered in the commissioner's plan under section 43A.18, subdivision 2, and the managerial plan under section 43A.18, subdivision 3, must include an option for a health plan that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code.

EFFECTIVE DATE. This section is effective January 1, 2017.