CHAPTER 13--H.F.No. 5

An act relating to insurance; health; creating the Minnesota premium security plan; providing funding; establishing a legislative working group; regulating health care provider system access; modifying premium subsidy program provisions; appropriating money; amending Minnesota Statutes 2016, sections 62E.10, subdivision 2; 62K.10, by adding a subdivision; Laws 2013, chapter 9, section 15; Laws 2017, chapter 2, article 1, sections 1, subdivision 3; 2, subdivision 4, by adding a subdivision; 3; article 2, section 13; proposing coding for new law in Minnesota Statutes, chapter 62E.

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

ARTICLE 1

MINNESOTA PREMIUM SECURITY PLAN

Section 1. Minnesota Statutes 2016, section 62E.10, subdivision 2, is amended to read:

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of ~~eleven~~ 13 members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; two directors selected by the commissioner of human services, one of whom must represent hospitals and one of whom must represent health care providers; five public directors selected by the commissioner, at least two of whom must be ~~plan enrollees, two of whom are covered under an individual plan subject to assessment under section 62E.11 or group plan offered by an employer subject to assessment under section 62E.11,~~ enrollees in the individual market and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. ~~The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, health maintenance contract payment, or community integrated service network payment derived from or on behalf of Minnesota residents in the previous calendar year, as determined by the commissioner.~~ In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. ~~The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.~~

Sec. 2. **[62E.21] DEFINITIONS.**

Subdivision 1. **Application.** For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. **Affordable Care Act.** "Affordable Care Act" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. **Attachment point.** "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. **Benefit year.** "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. **Board.** "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. **Coinsurance rate.** "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 8. **Eligible health carrier.** "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D.

Subd. 9. **Individual health plan.** "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. **Individual market.** "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. **Minnesota Comprehensive Health Association or association.** "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. **Minnesota premium security plan or plan.** "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. **Payment parameters.** "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. **Reinsurance cap.** "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. **Reinsurance payments.** "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

Sec. 3. **[62E.22] DUTIES OF COMMISSIONER.**

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

Sec. 4. **[62E.23] MINNESOTA PREMIUM SECURITY PLAN.**

Subdivision 1. **Administration of plan.** (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. **Payment parameters.** (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan; and

(6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in article 1, section 8.

Subd. 3. **Operation.** (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

Subd. 5. **Eligible carrier requests for reinsurance payments.** (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

(b) An eligible health carrier must make requests for reinsurance payments in accordance with any requirements established by the board.

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(f) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) implement the approved plan; and

(3) provide the association with written documentation of the corrective action once taken.

Subd. 6. **Data.** Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivisions 9 or 12.

Sec. 5. **[62E.24] ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.**

Subdivision 1. **Accounting.** The board must keep an accounting for each benefit year of all:

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

(3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. **Reports.** The board must submit to the commissioner and make available to the public a report summarizing the plan operations for each benefit year by posting the summary on the Minnesota Comprehensive Health Association Web site and making the summary otherwise available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

Subd. 3. **Legislative auditor.** The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. **Independent external audit.** (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association Web site and making the audit results otherwise available.

Subd. 5. **Actions on audit findings.** (a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

Sec. 6. **[62E.25] ACCOUNTS.**

Subdivision 1. **Premium security plan account.** The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. **Deposits.** Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. **Basic health plan trust account.** Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.

Sec. 7. Laws 2013, chapter 9, section 15, is amended to read:

Sec. 15. **MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION TERMINATION.**

(a) The commissioner of commerce, in consultation with the board of directors of the Minnesota Comprehensive Health Association, has the authority to develop and implement the phase-out and eventual appropriate termination of coverage provided by the Minnesota Comprehensive Health Association under Minnesota Statutes, chapter 62E. The phase-out of coverage shall begin no sooner than January 1, 2014, or upon the effective date of the operation of the Minnesota Insurance Marketplace and the ability to purchase qualified health plans through the Minnesota Insurance Marketplace, whichever is later, and shall, to the extent practicable, ensure the least amount of disruption to the enrollees' health care coverage. The member assessments established under Minnesota Statutes, section 62E.11, shall take into consideration any phase-out of coverage implemented under this section.

(b) Nothing in paragraph (a) applies to the Minnesota premium security plan, as defined in Minnesota Statutes, section 62E.21, subdivision 12.

Sec. 8. **STATE INNOVATION WAIVER.**

Subdivision 1. **Submission of waiver application.** The commissioner of commerce shall apply to the secretary of health and human services under United States Code, title 42, section 18052, for a state innovation waiver to implement the Minnesota premium security plan for benefit years beginning January 1, 2018, and future years, to maximize federal funding. The waiver application must clearly state that operation of the Minnesota premium security plan is contingent on approval of the waiver request.

Subd. 2. **Consultation.** In developing the waiver application, the commissioner shall consult with the commissioner of human services, the commissioner of health, and the MNsure board.

Subd. 3. **Application timelines; notification.** The commissioner shall submit the waiver application to the secretary of health and human services on or before June 15, 2017. The commissioner shall make a draft application available for public review and comment by May 15, 2017. The commissioner shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance, and the board of directors of the Minnesota Comprehensive Health Association of any federal actions regarding the waiver request.

Sec. 9. **COSTS RELATED TO IMPLEMENTATION OF THIS ACT.**

A state agency that incurs administrative costs to implement any provision of this act and does not receive an appropriation for administrative costs of this act must implement the act within the limits of existing appropriations.

Sec. 10. **PREMIUM SECURITY PLAN CONTINGENT ON FEDERAL WAIVER.**

If the state innovation waiver request in article 1, section 8, is not approved, the Minnesota Comprehensive Health Association and its board of directors shall not administer the Minnesota premium security plan and provide reinsurance payments to eligible health carriers.

Sec. 11. **PAYMENT PARAMETERS FOR 2018.**

(a) Notwithstanding Minnesota Statutes, section 62E.23, and subject to paragraph (b), the Minnesota premium security plan payment parameters for benefit year 2018 are:

(1) an attachment point of $50,000;

(2) a coinsurance rate of 80 percent; and

(3) a reinsurance cap of $250,000.

(b) The board of directors of the Minnesota Comprehensive Health Association may alter the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in article 1, section 8.

Sec. 12. **DEPOSIT OF FUNDS.**

(a) Within ten days of the effective date of this section, the Minnesota Comprehensive Health Association, as defined in Minnesota Statutes, section 62E.02, subdivision 14, shall deposit all money, including monetary reserves, the association holds into the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1.

(b) Notwithstanding paragraph (a), the Minnesota Comprehensive Health Association may retain funds necessary to fulfill medical needs and contractual obligations in place for former Minnesota Comprehensive Health Association enrollees until December 31, 2018.

Sec. 13. **DISPOSITION AND SETTLEMENTS.**

Notwithstanding Minnesota Statutes, section 62E.09, and any other law to the contrary, the board of directors of the Minnesota Comprehensive Health Association, as defined in Minnesota Statutes, section 62E.02, subdivision 14, shall have authority:

(1) over the disposition and settlement of all funds held by the association, including prior assessments, to the extent funds have not been transferred pursuant to article 1, section 12; and

(2) to settle and make determinations regarding litigation pending on the effective date of this act, including litigation that impacts funds held by the association.

Sec. 14. **LEGISLATIVE WORKING GROUP.**

A legislative working group is established consisting of the chairs and ranking minority members of the senate committees with jurisdiction over commerce, health and human services finance and policy, and

human services reform finance and policy and the chairs and ranking minority members of the house of representatives committees with jurisdiction over commerce and regulatory reform, health and human services finance, and health and human services reform. The purpose of the working group is to advise the board of the Minnesota Comprehensive Health Association on the adoption of payment parameters and other elements of a reinsurance plan for benefit year 2019. The commissioner of commerce must provide technical assistance for the working group, and must review and monitor the following to serve as a resource for the working group:

(1) the effectiveness of reinsurance models adopted in Alaska and other states in stabilizing premiums in the individual market and the related costs thereof;

(2) the effect of federal health reform legislation on the Minnesota premium security plan, including but not limited to funding for the plan; and

(3) the status of the health care access fund, and issues relating to its potential continued use as a source of funding for the Minnesota premium security plan.

Sec. 15. **MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

(a) The Minnesota Comprehensive Health Association shall fund the operational and administrative costs and reinsurance payments of the Minnesota security plan and association using the following amounts deposited in the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1, in the following order:

(1) any federal funding available;

(2) funds deposited under article 1, sections 12 and 13;

(3) any state funds from the health care access fund; and

(4) any state funds from the general fund.

(b) The association shall transfer from the premium security plan account any general fund amount not used for the Minnesota premium security plan by June 30, 2021, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the general fund.

(c) The association shall transfer from the premium security plan account any health care access fund amount not used for the Minnesota premium security plan by June 30, 2021, to the commissioner of commerce. Any amount transferred to the commissioner of commerce shall be deposited in the health care access fund in Minnesota Statutes, section 16A.724.

(d) The Minnesota Comprehensive Health Association may not spend more than $271,000,000 for benefit year 2018 and not more than $271,000,000 for benefit year 2019 for the operational and administrative costs of, and reinsurance payments under, the Minnesota premium security plan.

Sec. 16. **TRANSFERS.**

(a) The commissioner of management and budget shall transfer $200,000,000 in fiscal year 2018 and $200,000,000 in fiscal year 2019 from the health care access fund to the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This is a onetime transfer.

(b) The commissioner of management and budget shall transfer $71,000,000 in fiscal year 2018 and $71,000,000 in fiscal year 2019 from the general fund to the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This is a onetime transfer.

EFFECTIVE DATE. This section is effective upon federal approval of the state innovation request in article 1, section 8. The commissioner of commerce shall inform the revisor of statutes when federal approval is obtained.

Sec. 17. **TRANSFER; 2018.**

The commissioner of management and budget shall transfer $750,000 in fiscal year 2018 from the health care access fund to the premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This is a onetime transfer.

Sec. 18. **APPROPRIATION.**

$155,000 in fiscal year 2018 is appropriated from the general fund to the commissioner of commerce to prepare and submit the state innovation waiver in article 1, section 8.

Sec. 19. **EFFECTIVE DATE.**

Sections 1 to 15, 17, and 18 are effective the day following final enactment.

ARTICLE 2

HEALTH POLICY

Section 1. Minnesota Statutes 2016, section 62K.10, is amended by adding a subdivision to read:

Subd. 1a. **Health care provider system access.** For those counties in which a health carrier actively markets an individual health plan, the health carrier must offer, in those same counties, at least one individual health plan with a provider network that includes in-network access to more than a single health care provider system. This subdivision is applicable only for the year in which the health carrier actively markets an individual health plan.

EFFECTIVE DATE. This section is effective January 1, 2018, and applies to individual health plans offered, issued, or renewed on or after that date.

Sec. 2. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

Subd. 3. **Eligible individual.** "Eligible individual" means a Minnesota resident who:

(1) is not receiving ~~a~~ an advance premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, ~~as of the date~~ in a month in which their coverage is ~~effectuated~~ effective;

(2) is not enrolled in public program coverage under Minnesota Statutes, section 256B.055, or 256L.04; and

(3) purchased an individual health plan from a health carrier in the individual market.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 3. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

Subd. 4. **Data practices.** (a) The definitions in Minnesota Statutes, section 13.02, apply to this subdivision.

(b) Government data on an enrollee or health carrier under this section are private data on individuals or nonpublic data, except that the total reimbursement requested by a health carrier and the total state payment to the health carrier are public data.

(c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on an enrollee or health carrier under this section must be destroyed by June 30, 2018, or upon completion by the legislative auditor of the audits required by section 3, whichever is later. This paragraph does not apply to data maintained by the legislative auditor.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 4. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to read:

Subd. 5. **Data sharing.** (a) Notwithstanding any law to the contrary, government entities are permitted to share or disseminate data as follows:

(1) the commissioner of human services and the board of directors of MNsure must share data on public program enrollment under Minnesota Statutes, sections 256B.055 and 256L.04, as well as data on an enrollee's receipt of a premium tax credit under Code of Federal Regulations, title 26, section 1.36B-2, with the commissioner of management and budget; and

(2) the commissioner of management and budget must disseminate data on an enrollee's public program coverage enrollment under Minnesota Statutes, sections 256B.055 and 256L.04, to health carriers to the extent the commissioner determines is necessary for determining the enrollee's eligibility for the premium subsidy program authorized by this act.

(b) Data shared under this subdivision may be collected, stored, or used only for the purposes of administration of the premium subsidy program authorized by this act and may not be further shared or disseminated except as otherwise provided by law.

(c) By June 30, 2018, a health carrier must destroy any data it received pursuant to this subdivision.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 5. Laws 2017, chapter 2, article 1, section 3, is amended to read:

Sec. 3. **AUDITS.**

(a) The legislative auditor shall conduct audits of the health carriers' supporting data, as prescribed by the commissioner, to determine whether payments align with criteria established in sections 1 and 2. The commissioner of human services shall provide data as necessary to the legislative auditor to complete the audit. The commissioner shall withhold or charge back payments to the health carriers to the extent they do not align with the criteria established in sections 1 and 2, as determined by the audit.

(b) The legislative auditor shall audit the extent to which health carriers provided premium subsidies to persons meeting the residency and other eligibility requirements specified in section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount of premium subsidies provided by each health carrier to persons not eligible for a premium subsidy. The commissioner, in consultation with the commissioners of commerce and ~~health~~ human services, shall develop and implement a process to recover from health carriers the amount of premium subsidies received for enrollees determined to be ineligible for premium subsidies by the legislative auditor. The legislative auditor, when conducting the required audit, and the commissioner, when determining the amount of premium subsidy to be recovered, may take into account the extent to which a health carrier makes use of the Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision 1.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Sec. 6. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~90 days following final enactment~~ January 1, 2018, and applies to provider services provided on or after that date.

EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Presented to the governor March 30, 2017

Became law without the governor's signature April 4, 2017