State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 107

01/09/2017 Authored by Hoppe and Lueck
The bill was read for the first time and referred to the Committee on State Government Finance
01/11/2017 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to government operation; providing a temporary program to help pay for health insurance premiums; providing transition of care coverage; appropriating money.

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

ARTICLE 1

PREMIUM ASSISTANCE

Section 1. **PREMIUM ASSISTANCE PROGRAM ESTABLISHED.**

The commissioner of Minnesota Management and Budget, in consultation with the commissioner of commerce and the commissioner of revenue, shall establish and administer a premium assistance program to help eligible individuals pay expenses for qualified health coverage in 2017.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. **DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 1 to 5, the following terms have the meanings given, unless the context clearly indicates otherwise.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of Minnesota Management and Budget.

Subd. 3. **Eligible individual.** "Eligible individual" means an individual who:

(1) is a resident of Minnesota;

(2) purchased qualified health coverage for calendar year 2017;

(3) meets the income eligibility requirements under section 3, subdivision 3;

(4) is not receiving a premium assistance credit under section 36B of the Internal Revenue Code for calendar year 2017; and

(5) is approved by the commissioner as qualifying for premium assistance.

Subd. 4. **Health plan.** "Health plan" has the meaning provided in Minnesota Statutes, section 62A.011, subdivision 3.

Subd. 5. **Health plan company.** "Health plan company" means a health carrier, as defined in Minnesota Statutes, section 62A.011, subdivision 2, that provides qualified health coverage in the individual market through MNsure or outside of MNsure to Minnesota resident individuals in 2017.

Subd. 6. **Individual market.** "Individual market" means the individual market as defined in Minnesota Statutes, section 62A.011, subdivision 5.

Subd. 7. **Internal Revenue Code.** "Internal Revenue Code" means the Internal Revenue Code as amended through December 31, 2016.

Subd. 8. **Modified adjusted gross income.** "Modified adjusted gross income" means the modified adjusted gross income for taxable year 2016, as defined in section 36B(d)(2)(B) of the Internal Revenue Code.

Subd. 9. **Premium assistance.** "Premium assistance," "assistance amount," or "assistance" means the amount allowed to an eligible individual as determined by the commissioner under section 3 as a percentage of the qualified premium.

Subd. 10. **Program.** "Program" means the premium assistance program established under section 1.

Subd. 11. **Qualified health coverage.** "Qualified health coverage" means health coverage provided under a qualified health plan, as defined in Minnesota Statutes, section 62V.02, subdivision 11, or provided under a health plan that meets the standards of a qualified health plan except that it is not purchased through MNsure, and is:

(1) offered to individuals in the individual market;

(2) not a grandfathered health plan, as defined in section 36B of the Internal Revenue Code; and

(3) provided by a health plan company through MNsure or outside of MNsure.

Subd. 12. **Qualified premium.** "Qualified premium" means the premium for qualified health coverage purchased by an eligible individual.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. **PREMIUM ASSISTANCE AMOUNT.**

Subdivision 1. **Applications by individuals; notification of eligibility.** (a) An eligible individual may apply to the commissioner to receive premium assistance under this section at any time after purchase of qualified health coverage, but no later than January 31, 2018. The commissioner shall prescribe the manner and form for applications, including requiring any information the commissioner considers necessary or useful in determining whether an applicant is eligible and the assistance amount allowed to the individual under this section. The commissioner shall make application forms available on the agency's Web site.

(b) The commissioner shall notify applicants of their eligibility status under the program, including, for applicants determined to be eligible, their premium assistance amount.

Subd. 2. **Health plan companies.** (a) By the first of each month, and any other times the commissioner requires, each health plan company shall provide to the commissioner an effectuated coverage list with the following information for each individual for whom it provides qualified health coverage:

(1) name, address, and age of each individual covered by the health plan, and any other identifying information that the commissioner determines appropriate to administer the program;

(2) the qualified premium for the coverage;

(3) whether the coverage is individual or family coverage;

(4) whether the individual is receiving advance payment of the credit under section 36B of the Internal Revenue Code; and

(5) any additional information the commissioner determines appropriate to administer the program.

(b) A health plan company must notify the commissioner of coverage terminations of eligible individuals within ten business days.

(c) Each health plan company shall make the application forms developed by the commissioner under subdivision 1 available on the company's Web site, and shall include application forms with premium notices for individual health coverage.

Subd. 3. **Income eligibility rules.** (a) Individuals with incomes that meet the requirements of this subdivision satisfy the income eligibility requirements for the program. For purposes of this subdivision, "poverty line" has the meaning used in section 36B of the Internal Revenue Code, except that modified adjusted gross income, as reported on the individual's federal income tax return for tax year 2016, must be used instead of household income. For married separate filers claiming eligibility for family coverage, modified adjusted gross income equals the sum of that income reported by both spouses on their returns.

(b) Individuals are eligible for premium assistance if their modified adjusted gross income is greater than 300 percent but does not exceed 800 percent of the poverty line.

Subd. 4. **Determination of assistance amounts.** (a) For the period January 1, 2017, through December 31, 2017, eligible individuals qualify for premium assistance equal to 25 percent of the qualified premium for effectuated coverage.

(b) The commissioner shall determine premium assistance amounts as provided under this subdivision so that the estimated sum of all premium assistance for eligible individuals does not exceed the appropriation for this purpose. The commissioner may adjust premium assistance amounts using a sliding scale based on income, if this is necessary to remain within the limits of the appropriation.

Subd. 5. **Provision of premium assistance to eligible individuals.** (a) The commissioner shall provide the premium assistance amount calculated under subdivision 4 on a monthly basis to each eligible individual. The commissioner shall provide each eligible individual with the option of receiving premium assistance through direct deposit to a financial institution.

(b) If the commissioner, for administrative reasons, is unable to provide an eligible individual with the premium assistance owed for one or more months for which the eligible individual had effectuated coverage, the commissioner shall include the premium assistance owed for that period with the premium assistance payment for the first month for which the commissioner is able to provide premium assistance in a timely manner.

(c) The commissioner may require an eligible individual to provide any documentation and substantiation of payment of the qualified premium that the commissioner considers appropriate.

Subd. 6. **Contracting.** The commissioner may contract with a third-party administrator to determine eligibility for and administer premium assistance under this section.

Subd. 7. **Verification.** The commissioner shall verify that persons applying for premium assistance are residents of Minnesota. The commissioner may access information from the Department of Employment and Economic Development and the Minnesota Department of Revenue when verifying residency.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. **AUDIT AND PROGRAM INTEGRITY.**

Subdivision 1. **Audit.** The legislative auditor shall audit implementation of the premium assistance program by the commissioner to determine whether premium assistance payments align with the criteria established in sections 2 and 3. The legislative auditor shall present a report summarizing findings of the audit to the legislative committees with jurisdiction over insurance and health by June 1, 2018.

Subd. 2. **Program integrity.** The commissioner of revenue shall ensure that only eligible individuals, as defined in section 2, subdivision 3, have received premium assistance. The commissioner of revenue shall review information available from Minnesota Management and Budget, the Department of Human Services, MNsure, and the most recent Minnesota tax records to identify ineligible individuals who received premium assistance. The commissioner of revenue shall recover the amount of any premium assistance paid on behalf of an ineligible individual from the ineligible individual, in the manner provided by law for the collection of unpaid taxes or erroneously paid refunds of taxes.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. **TRANSFER.**

$300,157,000 in fiscal year 2017 is transferred from the budget reserve account in Minnesota Statutes, section 16A.152, subdivision 1a, to the general fund.

Sec. 6. **APPROPRIATIONS.**

(a) $285,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of Minnesota Management and Budget for purposes of providing premium assistance under section 3. No more than three percent of this appropriation is available to the commissioner for administrative costs. This is a onetime appropriation and is available until June 30, 2018.

(b) $157,000 in fiscal year 2017 is appropriated from the general fund to the legislative auditor to conduct the audit required by section 4. This is a onetime appropriation and is available until expended.

ARTICLE 2

TRANSITION OF CARE COVERAGE

Section 1. **TRANSITION OF CARE COVERAGE FOR CALENDAR YEAR 2017; INVOLUNTARY TERMINATION OF COVERAGE.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Enrollee" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 2b.

(c) "Health plan" has the meaning given in Minnesota Statutes, section 62Q.01, subdivision 3.

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

(e) "Individual market" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 5.

(f) "Involuntary termination of coverage" means the termination of a health plan due to a health plan company's refusal to renew the health plan in the individual market because the health plan company elects to cease offering individual market health plans in all or some geographic rating areas of the state.

Subd. 2. **Application.** This section applies to an enrollee who is subject to a change in health plans in the individual market due to an involuntary termination of coverage from a health plan in the individual market after October 31, 2016, and before January 1, 2017, and who enrolls in a new health plan in the individual market for all or a portion of calendar year 2017 that goes into effect after December 31, 2016, and before March 2, 2017.

Subd. 3. **Change in health plans; transition of care coverage.** (a) If an enrollee satisfies the criteria in subdivision 2, the enrollee's new health plan company must provide, upon request of the enrollee or the enrollee's health care provider, authorization to receive services that are otherwise covered under the terms of the enrollee's calendar year 2017 health plan from a provider who provided care on an in-network basis to the enrollee during calendar year 2016 but who is out of network in the enrollee's calendar year 2017 health plan:

(1) for up to 120 days if the enrollee has received a diagnosis of, or is engaged in a current course of treatment for, one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

(b) For all requests for authorization under this subdivision, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria in paragraph (a) or subdivision 2.

(c) The commissioner of Minnesota Management and Budget must reimburse the enrollee's new health plan company for costs attributed to services authorized under this subdivision. Costs eligible for reimbursement under this paragraph are the difference between the health plan company's reimbursement rate for in-network providers for a service authorized under this subdivision and its rate for out-of-network providers for the service. The health plan company must seek reimbursement from the commissioner for costs attributed to services authorized under this subdivision, in a form and manner mutually agreed upon by the commissioner and the affected health plan companies. Total state reimbursements to health plan companies under this paragraph are subject to the limits of the available appropriation. In the event that funding for reimbursements to health plan companies is not sufficient to fully reimburse health plan companies for the costs attributed to services authorized under this subdivision, health plan companies must continue to cover services authorized under this subdivision.

Subd. 4. **Limitations.** (a) Subdivision 3 applies only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of:

(i) the health plan company's reimbursement rate for in-network providers for the same or similar service; or

(ii) the provider's regular fee for that service;

(2) request authorization for services in the form and manner specified by the enrollee's new health plan company, if the provider chooses to request authorization; and

(3) provide the enrollee's new health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 5. **Request for authorization.** The enrollee's health plan company may require medical records and other supporting documentation to be submitted with a request for authorization under subdivision 3. If authorization is denied, the health plan company must explain the criteria used to make its decision on the request for authorization and must explain the enrollee's right to appeal the decision. If an enrollee chooses to appeal a denial, the enrollee must appeal the denial within five business days of the date on which the enrollee receives the denial. If authorization is granted, the health plan company must provide the enrollee, within five business days of granting the authorization, with an explanation of how transition of care will be provided.

EFFECTIVE DATE. This section is effective for health plans issued after December 31, 2016, and before March 2, 2017, and that are in effect for all or a portion of calendar year 2017. This section expires June 30, 2018.

Sec. 2. **APPROPRIATION; COVERAGE FOR TRANSITION OF CARE.**

$15,000,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of Minnesota Management and Budget to reimburse health plan companies for costs attributed to coverage of transition of care services under section 1. No more than three percent of this appropriation is available to the commissioner for administrative costs. This is a onetime appropriation and is available until expended.

EFFECTIVE DATE. This section is effective the day following final enactment.

APPENDIX
Article locations in H0107-1