State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 3717

02/24/2022 Authored by Stephenson
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy
03/07/2022 Adoption of Report: Amended and re-referred to the Committee on Health Finance and Policy
03/10/2022 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to state government; modifying the comprehensive health association; modifying the Minnesota premium security plan; modifying provisions governing health insurance; requiring certain additional coverage under health plans; establishing a Mental Health Parity and Substance Abuse Accountability Office; requiring a proposal for a public option; requiring a report; transferring money; appropriating money; amending Minnesota Statutes 2020, sections 62E.10, by adding a subdivision; 62E.23, subdivision 3; 62K.06, subdivision 2; 62Q.81, by adding a subdivision; 256B.0625, by adding a subdivision; 256L.03, subdivision 5; Laws 2017, chapter 13, article 1, section 15, as amended; Laws 2021, First Special Session chapter 7, article 15, section 3; proposing coding for new law in Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 2020, section 62E.10, subdivision 2.

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

Section 1. Minnesota Statutes 2020, section 62E.10, is amended by adding a subdivision to read:

Subd. 1a. **Board of directors; organization.** The board of directors of the association shall be made up of 19 members as follows:

(1) the commissioner of commerce or a designee;

(2) the commissioner of health or a designee;

(3) the chief executive officer of MNsure or a designee;

(4) one director selected by the speaker of the house and one director selected by the house minority leader;

(5) one director selected by the senate majority leader and one director selected by the senate minority leader;

(6) two directors selected by the commissioner of human services, one of whom must represent hospitals and one of whom must represent health care providers;

(7) five directors selected by contributing members, each representing a different contributing member and subject to approval by the commissioner of commerce, one of whom must be a health actuary; and

(8) five public directors selected by the commissioner of commerce, at least two of whom must be 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.

Sec. 2. Minnesota Statutes 2020, section 62E.23, subdivision 3, is amended to read:

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.

(c) Notwithstanding paragraph (a), the payment parameters for benefit ~~year 2020~~ years 2023 through 2027 are:

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

(2) a coinsurance rate of 80 percent; and

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

EFFECTIVE DATE. This section is effective upon federal approval of the continuation of the state innovation waiver described in Laws 2021, First Special Session chapter 7, article 15, section 4. The commissioner of commerce shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2020, section 62K.06, subdivision 2, is amended to read:

Subd. 2. **Minimum levels.** (a) A health carrier that offers a catastrophic plan or a bronze level health plan within a service area in either the individual or small group market must also offer a silver level ~~and~~, a gold level, and a platinum level health plan in that market and within that service area.

(b) A health carrier with less than five percent market share in the respective individual or small group market in Minnesota is exempt from paragraph (a), until January 1, 2017, unless the health carrier offers a qualified health plan through MNsure. If the health carrier offers a qualified health plan through MNsure, the health carrier must comply with paragraph (a).

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 4. **[62Q.521] POSTNATAL CARE.**

(a) For purposes of this section, "comprehensive postnatal visit" means a visit with a health care provider that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

(b) A health plan must provide coverage for the following:

(1) a comprehensive postnatal visit with a health care provider not more than three weeks from the date of delivery;

(2) any postnatal visits recommended by a health care provider between three and 11 weeks from the date of delivery; and

(3) a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery.

(c) The requirements of this section are separate from and cannot be met by a visit made pursuant to section 62A.0411.

EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 5. Minnesota Statutes 2020, section 62Q.81, is amended by adding a subdivision to read:

Subd. 6. **Prescription drug benefits.** (a) A health plan company that offers individual health plans must ensure that no fewer than 25 percent of the individual health plans the company offers in each geographic area that the health plan company services at each level of coverage described in subdivision 1, paragraph (b), clause (3), that the health plan company offers, apply a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(b) A health plan company that offers small group health plans must ensure that no fewer than 25 percent of the small group health plans the company offers in each geographic area that the health plan company services at each level of coverage described in subdivision 1, paragraph (b), clause (3), that the health plan company offers, apply a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(c) The highest allowable co-payment for the highest cost drug tier for health plans offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket maximum for an individual.

(d) The flat-dollar amount co-payment tier structure for prescription drugs under this subdivision must be graduated and proportionate.

(e) All individual and small group health plans offered pursuant to this subdivision must be:

(1) clearly and appropriately named to aid the purchaser in the selection process;

(2) marketed in the same manner as other health plans offered by the health plan company; and

(3) offered for purchase to any individual or small group.

(f) This subdivision does not apply to catastrophic plans, grandfathered plans, large group health plans, health savings accounts, qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(g) Neither a health plan company nor a pharmacy benefit manager, as defined in section 62W.02, subdivision 15, shall delay or divide payment to a pharmacy or pharmacy provider, as defined in section 62W.02, subdivision 14, because of the co-payment structure of a health plan offered pursuant to this subdivision.

(h) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

EFFECTIVE DATE. This section is effective January 1, 2024, and applies to individual and small group health plans offered, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 3i. **Postnatal care.** Medical assistance covers comprehensive postnatal visits, as defined in section 62Q.521, and coverage must meet the requirements of section 62Q.521.

EFFECTIVE DATE. This section is effective January 1, 2023.

Sec. 7. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit ~~to~~ at no less than 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

Sec. 8. Laws 2017, chapter 13, article 1, section 15, as amended by Laws 2017, First Special Session chapter 6, article 5, section 10, Laws 2019, First Special Session chapter 9, article 8, section 19, and Laws 2021, First Special Session chapter 7, article 15, section 1, is amended to read:

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 remaining state funds not used for the Minnesota premium security plan by June 30, ~~2024~~ 2029, 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.

(c) 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.

EFFECTIVE DATE. This section is effective upon federal approval of the continuation of the state innovation waiver described in Laws 2021, First Special Session chapter 7, article 15, section 4. The commissioner of commerce shall notify the revisor of statutes when federal approval is obtained.

Sec. 9. Laws 2021, First Special Session chapter 7, article 15, section 3, is amended to read:

Sec. 3. **PLAN YEAR ~~2022~~ 2023 PROPOSED RATE FILINGS FOR THE INDIVIDUAL MARKET.**

The rate filing deadline for individual health plans, as defined in Minnesota Statutes, section 62E.21, subdivision 9, to be offered, issued, sold, or renewed on or after January 1, ~~2022~~ 2023, and before January 1, 2024, is July 9, ~~2021~~ 2022. Eligible health carriers under Minnesota Statutes, section 62E.21, subdivision 8, filing individual health plans to be offered, issued, sold, or renewed for benefit ~~year 2022~~ years 2023 through 2027 shall include the impact of the Minnesota premium security plan payment parameters in the proposed individual health plan rates. Notwithstanding Minnesota Statutes, section 60A.08, subdivision 15, paragraph (g), the commissioner must provide public access on the Department of Commerce's website to compiled data of the proposed changes to rates for individual health plans and small group health plans, as defined in Minnesota Statutes, section 62K.03, subdivision 12, separated by health plan and geographic rating area, no later than July 23, ~~2021~~ 2022.

EFFECTIVE DATE. This section is effective upon federal approval of the continuation of the state innovation waiver described in Laws 2021, First Special Session chapter 7, article 15, section 4. The commissioner of commerce shall notify the revisor of statutes when federal approval is obtained.

Sec. 10. **MENTAL HEALTH PARITY AND SUBSTANCE ABUSE ACCOUNTABILITY OFFICE.**

The Mental Health Parity and Substance Abuse Accountability Office is established within the Department of Commerce to create and execute effective strategies for implementing the requirements of Minnesota Statutes, section 62Q.47; federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts. The Mental Health Parity and Substance Abuse Accountability Office may oversee compliance reviews, conduct and lead stakeholder engagement, review consumer and provider complaints, and serve as a resource for ensuring health plan compliance with mental health and substance abuse requirements.

Sec. 11. **DELIVERY REFORM ANALYSIS REPORT.**

(a) The commissioner of human services shall present to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2024, a report comparing service delivery and payment system models for delivering services to medical assistance enrollees for whom income eligibility is determined using the modified adjusted gross income methodology under Minnesota Statutes, section 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible under Minnesota Statutes, chapter 256L. The report must compare the current delivery model with at least two alternative models. The alternative models must include a state-based model in which the state holds the plan risk as the insurer and may contract with a third-party administrator for claims processing and plan administration. The alternative models may include but are not limited to:

(1) expanding the use of integrated health partnerships under Minnesota Statutes, section 256B.0755;

(2) delivering care under fee-for-service through a primary care case management system; and

(3) continuing to contract with managed care and county-based purchasing plans for some or all enrollees under modified contracts.

(b) The report must include:

(1) a description of how each model would address:

(i) racial and other inequities in the delivery of health care and health care outcomes;

(ii) geographic inequities in the delivery of health care;

(iii) the provision of incentives for preventive care and other best practices;

(iv) reimbursing providers for high-quality, value-based care at levels sufficient to sustain or increase enrollee access to care; and

(v) transparency and simplicity for enrollees, health care providers, and policymakers;

(2) a comparison of the projected cost of each model; and

(3) an implementation timeline for each model that includes the earliest date by which each model could be implemented if authorized during the 2024 legislative session and a discussion of barriers to implementation.

Sec. 12. **PROPOSAL FOR A PUBLIC OPTION.**

(a) The commissioner of human services shall consult with the Centers for Medicare and Medicaid Services, the Internal Revenue Service, and other relevant federal agencies to develop a proposal for a public option program. The proposal may consider multiple public option structures, at least one of which must be through expanded enrollment into MinnesotaCare. Each option must:

(1) allow individuals with incomes above the maximum income eligibility limit under Minnesota Statutes, section 256L.04, subdivision 1 or 7, the option of purchasing coverage through the public option;

(2) allow undocumented noncitizens the option of purchasing through the public option;

(3) establish a small employer public option that allows employers with 50 or fewer employees to offer the public option to the employer's employees and contribute to the employees' premiums;

(4) allow the state to:

(i) receive the maximum pass through of federal dollars that would otherwise be used to provide coverage for eligible public option enrollees if the enrollees were instead covered

through qualified health plans with premium tax credits, emergency medical assistance, or other relevant programs; and

(ii) continue to receive basic health program payments for eligible MinnesotaCare enrollees; and

(5) be administered in coordination with the existing MinnesotaCare program to maximize efficiency and improve continuity of care, consistent with the requirements of Minnesota Statutes, sections 256L.06, 256L.10, and 256L.11.

(b) Each public option proposal must include:

(1) a premium scale for public option enrollees that at least meets the Affordable Care Act affordability standard for each income level;

(2) an analysis of the impact of the public option on MNsure enrollment and the consumer assistance program and, if necessary, a proposal to ensure that the public option has an adequate enrollment infrastructure and consumer assistance capacity;

(3) actuarial and financial analyses necessary to project program enrollment and costs; and

(4) an analysis of the cost of implementing the public option using current eligibility and enrollment technology systems and, at the option of the commissioner, an analysis of alternative eligibility and enrollment systems that may reduce initial and ongoing costs and improve functionality and accessibility.

(c) The commissioner shall incorporate into the design of the public option mechanisms to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse financial impacts to MNsure. These mechanisms must minimize: (1) adverse selection; (2) state financial risk and expenditures; and (3) potential impacts on premiums in the individual and group insurance markets.

(d) The commissioner shall present the proposal to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 15, 2023. The proposal must include recommendations on any legislative changes necessary to implement the public option. Any implementation of the proposal that requires a state financial contribution must be contingent on legislative approval.

Sec. 13. **TRANSFER.**

The commissioner of management and budget shall transfer $42,465,000 from the general fund to the health care access fund by June 30, 2024, for state basic health plan costs related

to the loss of federal revenue associated with the extension of the premium security plan through plan year 2023. This is a onetime transfer.

EFFECTIVE DATE. This section is effective January 1, 2023, but only if the continuation of the state innovation waiver described in Laws 2021, First Special Session chapter 7, article 15, section 4, is approved and results in a loss of federal revenue for the state basic health plan for plan year 2023. The commissioner of management and budget shall notify the revisor of statutes upon this occurrence.

Sec. 14. **APPROPRIATION.**

$500,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of commerce to create and operate the Mental Health Parity and Substance Abuse Accountability Office.

Sec. 15. **REPEALER.**

Minnesota Statutes 2020, section 62E.10, subdivision 2, is repealed.

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.

Subd. 2. **Board of directors; organization.** The board of directors of the association shall be made up of 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 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. 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.