HOUSE RESEARCH

Bill Summary

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Overview

This bill establishes the Minnesota health insurance exchange, requires certain employers to offer section 125 plans, establishes a health care transformation task force, and contains other provisions related to health care payment reform, health care reporting, and claims processing.

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Article 1: Health Insurance Exchange; Section 125 Plans

1 **Premium rate restrictions.** Amends § 62A.65, subd. 3. Provides that premium rates for children under the age of 19 may not vary by age in the individual market, regardless of whether the child is covered as a dependent or as a primary insured.

2 **Minnesota health insurance exchange.** Adds § 62A.67.

Subd. 1. Title; citation. States that this section may be cited as the "Minnesota Health Insurance Exchange."

Subd. 2. Creation; tax exemption. States that the exchange is created to provide individuals with greater access, choice, portability, and affordability of health insurance products. Provides that the exchange is a not-for-profit corporation under chapter 317A and section 501(c) of the Internal Revenue Code.

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Subd. 3. Definitions. Defines terms. "Commissioner" is defined as the commissioner of commerce for health insurers subject to the jurisdiction of that commissioner, and the commissioner of health for health insurers subject to the jurisdiction of that commissioner.

Subd. 4. Insurer and health plan participation. Requires all plans issued or renewed in the individual market to participate in the exchange, and prohibits these plans from being issued or renewed outside of the exchange. Prohibits group health plans from being offered through the exchange. Provides that health plans offered through MCHA are offered through the exchange as determined by MCHA, and that health plans offered through MinnesotaCare are offered through the exchange as determined by the commissioner of human services.

Subd. 5. Approval of health plans. Prohibits a health plan from being offered through the exchange unless the commissioner has certified that the insurer is licensed to issue health insurance in the state, the health plan meets the requirements of this section, and the health plan and insurer are in compliance with all other applicable laws.

Subd. 6. Individual market health plans. Provides that individual market plans offered through the exchange continue to be regulated by the commissioner as provided in other law and must include the following provisions: (1) premiums for children under age 19 shall not vary by age; and (2) premiums for children under age 19 must excluded from the individual market rating factor requirements related to age in section 62A.65, subdivision 3, paragraph (b).

Subd. 7. Individual participation and eligibility. Allows individuals to purchase health plans directly through the exchange or an employer section 125 plan. States that this section does not require guaranteed issue of individual market health plans offered through the exchange. Provides that individuals are eligible to purchase individual market plans through the exchange by meeting one or more of the following qualifications: (1) the individual is a Minnesota resident; (2) the individual is a student attending an institution outside of Minnesota and maintains Minnesota residency; (3) the individual is not a Minnesota resident but is employed by an employer located in the state, and the employer is required to offer a section 125 plan; (4) the individual is not a Minnesota resident but is self-employed and the principal place of business is in the state; or (5) the individual is a dependent of an eligible individual.

Subd. 8. Continuation of coverage. Allows enrollment in a health plan to be cancelled for nonpayment of premiums, fraud, or changes in MinnesotaCare eligibility. Prohibits enrollment in an individual plan from being cancelled or not renewed due to a change in employer or employment status, marital status, health status, age, residence, or any other change that does not affect eligibility.

Subd. 9. Responsibilities of the exchange. Requires the exchange to serve as the sole entity for enrollment and collection and transfer of premium payments for health

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plans offered through the exchange. Requires the exchange to: (1) publicize the exchange; (2) provide assistance to employers in setting up a section 125 plan; (3) provide education and assistance to employers; (4) create a system to allow individuals to compare and enroll in health plans; (5) create a system to collect and transmit premium payments and other contributions to applicable plans; (6) refer individuals interested in MinnesotaCare to DHS to determine eligibility; (7) establish a mechanism with DHS to transfer MinnesotaCare premiums and subsidies to qualify for federal matching payments; (8) upon request, issue certificates of previous coverage; (9) establish procedures to account for all funds received and disbursed; and (10) make available to the public, at the end of each calendar year, an independent audit.

Subd. 10. Powers of the exchange. Grants the exchange the power to: (1) contract with insurance vendors to perform functions assigned to the exchange; (2) contract with employers to collect premiums through section 125 plans; (3) establish and assess fees on premiums to fund the cost of administration; (4) seek and receive grants; (5) establish and administer rules and procedures to govern operations; (6) establish one or more service centers within the state; (7) sue or be sued and take legal action; (8) establish bank accounts and borrow money; and (9) enter into any necessary agreements with state agencies.

Subd. 11. Dispute resolution. Requires the exchange to establish procedures to resolve disputes concerning individual eligibility to participate in the exchange. Provides that the exchange does not have the authority or responsibility to intervene in disputes between an individual and a health plan or insurer. Requires the exchange to refer complaints from participants to the commissioner of human services to be resolved according to the complaint resolution procedures that apply to health plan companies.

Subd. 12. Governance. Provides that the exchange is governed by an 11-member board of directors. Requires the board to convene on or before July 1, 2007. Specifies initial board membership.

Subd. 13. Subsequent board membership. Specifies ongoing membership of the board, effective July 1, 2010.

Subd. 14. Operations of the board. Specifies procedures for board operation.

Subd. 15. Operations of the exchange. Requires the board to appoint an exchange director, and specifies duties of the director.

Subd. 16. Insurance producers. Allows health plans to pay producer commissions.

Subd. 17. Implementation. Specifies that health plan coverage through the exchange begins January 1, 2009. Requires the exchange to be operational to provide assistance to individuals and employers by September 1, 2008, and prepared for enrollment by December 1, 2008. Provides that enrollees of individual market plans,

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MinnesotaCare, and MHCA as of December 2, 2008, are automatically enrolled in the exchange on January 1, 2009, in the same health plan and at the same premium, subject to this section. Requires enrollees to make premium payments to the exchange as of January 1, 2009.

3 **Section 125 plans.** Adds § 62A.68.

Subd. 1. Definitions. Defines terms.

Subd. 2. Section 125 plan requirement. Effective January 1, 2009, requires all employers with 11 or more employees to offer a section 125 plan through the exchange, to allow their employees to pay for health insurance premiums with pretax dollars. Exempts from the requirement employers that offer a group insurance plan, are self-insured, and those with fewer than 11 employees (but allows these employers to voluntarily offer a section 125 plan). Allows employers that offer a section 125 plan to enter into an agreement with the exchange to administer the plan.

Subd. 3. Tracking compliance. Requires the exchange, in consultation with specified agency commissioners, to establish a method to track employer compliance with the section 125 plan requirement.

Subd. 4. Employer requirements. Requires employers offering a section 125 plan to:

(1) allow employees to purchase an individual market plan for themselves and their dependents through the exchange;

(2) deduct premium amounts on a pretax basis, upon the request of the employee; and

(3) provide notice that individual market plans purchased through the exchange are not employer-sponsored.

Subd. 5. Section 125 eligible health plans. Allows individuals eligible for the exchange through a section 125 plan to enroll in any health plan offered through the exchange for which the individual is eligible.

4 **Inclusion in employer-sponsored plan.** Amends § 6E.141. Limits the prohibition on employees eligible for employer coverage enrolling in or continuing enrollment in an MCHA plan to enrollees eligible for a group plan.

5 **Exceptions.** Amends § 62L.12, subd. 2. States that nothing in chapter 62L restricts the offer, sale, issuance or renewal of an individual health plan through the Minnesota Health Insurance Exchange.

Article 2: Health Care Payment Reform

1 **Cost containment duties.** Amends § 62J.04, subd. 3. Requires the commissioner of health to report annually to the legislature on whether statewide cost containment goals for health care spending were achieved, and if not, what action should be taken to ensure that the goals are achieved in the future. Provides an effective date of July 1, 2007.

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2 **Required disclosure of estimated payment.** Amends § 62J.81, subd. 1. Clarifies provisions that require health care providers and health plan companies to provide information to consumers on payments received or provided and enrollee costs. Changes terminology from "reimbursement" to "allowable payment" and also requires information on the amount due from the enrollee and enrollee out-of-pocket expenses to be provided. Also specifies in more detail the information that must be provided when consumers have no applicable public or private coverage. Provides an August 1, 2007, effective date.

3 **Definition.** Amends § 62Q.165, subd. 1. States that it is the commitment of the state to achieve universal coverage by 2010 (current law contains this commitment, with no date). Provides a July 1, 2007, effective date.

4 **Goal.** Amends § 62Q.165, subd. 2. States that it is the goal of the state to reduce the number of Minnesotans who do not have health coverage, so that by January 1, 2010, all Minnesota residents have access to affordable health care. (Deletes language that set the state goal as reducing the percentage of Minnesotans without health coverage to less than 4 percent by January 1, 2000.) Provides a July 1, 2007, effective date.

5 **Approval.** Amends § 62Q.80, subd. 3. Strikes language that allows the commissioner to only approve a community-based health care coverage program awarded a community access program grant from the U.S. Department of Health and Human Services.

6 **Establishment.** Amends § 62Q.80, subd. 4. Eliminates a reference to the initiative using money collected from premium payments to capture federal funds.

7 **Report.** Amends § 62Q.80, subd. 13. Delays by one year, from January 15, 2007, to January 15, 2008, the date on which the initiative must submit its first quarterly status report. Also delays by one year, from January 15, 2009, to January 15, 2010, the date by which an evaluation of the program must be submitted to the commissioners of health and commerce and the legislature.

8 **Sunset.** Amends § 62Q.80, subd. 14. Extends the sunset of the statutory language authorizing the initiative by one year, from December 31, 2011 to December 31, 2012.

9 **Yearly reports.** Amends § 144.698, subd. 1. Requires nonprofit hospitals to annually report on community benefits, beginning with hospital fiscal year 2009. Provides a definition of community benefit.

10 **Annual reports on community benefit, community care amounts, and state program underfunding.** Amends § 144.699, by adding subd. 5. For each hospital reporting health care cost information under section 144.698 or 144.702, requires the commissioner of health to report annually on the hospital's community benefit, community care, and underpayment for state public health care programs.

11 **Performance payments.** Amends § 256.01, subd. 2b. The amendment to paragraph (a) requires the commissioner of human services to provide performance payments to clinics as well as medical groups that demonstrate optimum care in serving individuals with chronic diseases. Also requires performance payments to be paid to medical groups that implement effective medical home models of patient care and to medical groups and clinics that provide feedback on provider practice patterns.

A new paragraph (b) requires the commissioner to develop and implement a patient incentive program for state health care program enrollees who meet personal health goals established with their provider to manage a chronic disease or condition. Provides a July 1, 2007, effective date.

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(c) A new paragraph (c) allows the commissioner to receive any federal match made available through MA for managed care oversight, for purposes of the pay-for-performance system for medical groups serving persons with chronic diseases.

12 **Provider-directed care coordination services.** Amends § 256B.0625, by adding subd. 49. Requires the commissioner to develop and implement a provider-directed care coordination program for MA recipients receiving services under fee-for-service. Requires the program to pay primary care clinics for care coordination for persons who have complex and chronic medical conditions.

13 **Health care payment system reform.**

Subd. 1. Payment reform plan. Requires the commissioners of employee relations, human services, commerce, and health to develop a plan to promote and facilitate changes in payment rates and methods of paying for health care, in order to: reward cost-effective primary and preventive care; reward evidence-based care; discourage underutilization, overuse, and misuse; reward the use of the most cost effective settings, drugs, devices, providers, and treatments; and encourage consumers to maintain good health and use the health care system appropriately.

Subd. 2. Report. Requires the commissioners to present a report on and proposed legislation for the plan to the legislature by December 15, 2007.

Provides a July 1, 2007 effective date.

14 **Community collaborative pilot projects to cover the uninsured.**

Subd. 1. Community collaboratives. Requires the commissioner of human services to provide grants to up to three community collaboratives. Requires a collaborative to include one or more of the following: counties, hospitals, employers, health clinics or physician groups, and a third-party payer.

Subd. 2. Pilot project requirements. Requires community collaborative projects to: (1) identify and enroll persons who are uninsured and who have or are at risk of developing a chronic condition; (2) assist uninsured persons in obtaining private sector or public sector health coverage; (3) assist uninsured persons to retain employment or become employable; (4) ensure that each person has a medical home; (5) coordinate services; and (6) be coordinated with the state's Q-Care initiative and meet other quality objectives. States that projects are not insurance and are not subject to mandated benefits or insurance regulations.

Subd. 3. Criteria. Requires proposals to be evaluated as to whether they would produce a positive return on investment. Specifies criteria to be used by the commissioner in awarding grants.

Subd. 4. Grants. Requires the commissioner to provide implementation grants of up to one-half of a collaborative's costs for planning, administration, and evaluation. Also requires the commissioner to provide grants to collaboratives to pay up to 50 percent of the cost of services provided to the uninsured; requires the remaining costs to be paid for through other sources or by agreement of the health care provider to

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contribute the cost as charity care.

Subd. 5. Evaluation. Requires the commissioner of human services to evaluate the effectiveness of each collaborative, and to require collaboratives to provide all information necessary for this evaluation.

Provides an effective date of July 1, 2007.

15 Health care payment reform pilot projects.

Subd. 1. Pilot projects. Requires the commissioners of health, human services, and employee relations to develop and administer payment reform pilot projects for state employees and MA, MinnesotaCare, and GAMC enrollees. States that the purpose of the projects is to promote and facilitate changes in payment rates and methods to: (1) reward the provision of cost-effective primary and preventive care; (2) reward the use of evidence-based care; (3) reward coordination of care for patients with chronic conditions; (4) discourage overuse and misuse; (5) reward cost-effective practice; and (6) encourage consumers to maintain good health and use the health care system appropriately.

(b) Requires the projects to use designated care professionals and clinics to serve as a patient's medical home and coordinate services. Requires the projects to evaluate different payment reform models and to coordinate with the Minnesota senior health options program, the Minnesota disability health options program, and with initiatives of other purchasers.

Subd. 2. Payment methods and incentives. Requires the commissioners to modify existing payment methods and rates to provide incentives for proper care, and allows the commissioner to create financial incentives for patients to select a medical home and to require patients to remain with their medical home for a specified period. Sets other requirements for payment methods.

Subd. 3. Requirements. Specifies requirements that health care professionals or clinics must meet to be designated a medical home under the pilot project.

Subd. 4. Evaluation. Requires projects to be evaluated based on patient and provider satisfaction, clinical process and outcome measures, program costs and savings, and economic impact on health care providers. Lists other criteria for evaluation.

Subd. 5. Rulemaking. Exempts the commissioners from rulemaking requirements. Requires public comment on the request for proposals.

Subd. 6. Regulatory and payment barriers. Requires the commissioners to study state and federal statutory and regulatory barriers to the creation of medical homes, and to report to the legislature by December 15, 2007.

16 Health care system consolidation. Requires the commissioner of health to study the effect of health care provider and health plan company consolidation in the four metropolitan statistical areas on costs, quality, and access, and report to the legislature by December 15,

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17 **Repealer.** Repeals § 62J.052, subd. 1 (requirement that health care providers provide specified information on payments and charges).

Article 3: Health Insurance

1 **Health information technology and infrastructure.** Amends § 62J.495. Requires all hospitals and health care providers, by January 15, 2012, to have in place an interoperable electronic health records system. Requires the commissioner of health, in consultation with the health information technology and infrastructure advisory committee, to develop a statewide plan to meet this goal, including uniform standards. Requires uniform standards to be developed by January 1, 2009, with a status report on their development to be submitted to the legislature by January 15, 2008. Extends the expiration date of the section, from June 30, 2009, to June 30, 2012.

2 **Electronic health record system; revolving account and loan program.** Adds § 62J.496.

Subd. 1. Account establishment. Requires the commissioner of finance to establish and implement a revolving account to provide loans to physicians or physician group practices to install or support an interoperable health record system.

Subd. 2. Eligibility. Requires applicants to submit a loan application to the commissioner of health and specifies requirements for the application.

Subd. 3. Loans. (a) Requires the commissioner of health to make no interest loans on a first-come, first-served basis and places an unspecified limit on the amount of the loan. Gives the commissioner discretion over the size and number of loans made.

(b) Allows the commissioner to prescribe forms, establish an application process, and impose an application fee.

(c) Requires repayment of the principal no later than two years from the date of the loan, and requires amortization within 15 years from the date of the loan.

(d) Credits repayments to the account.

3 **Uniform electronic transactions and implementation guide standards.** Adds § 62J.536

Subd. 1. Electronic claims and eligibility transactions required. (a) Beginning January 15, 2009, requires group purchasers to accept from health care providers the eligibility for a health plan transaction described in specified federal regulations, and beginning July 15, 2009, requires group purchasers to accept from health care providers the health care claims or equivalent encounter information transaction described in specified federal regulations.

(b) Beginning January 15, 2009, requires group purchasers to transmit to providers the eligibility for a health plan transaction, and beginning December 1, 2009, requires group purchasers to transmit to providers the health care payment and remittance

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advice transaction.

(c) Beginning January 15, 2009, requires health care providers to submit to group purchasers the eligibility for a health plan transaction, and beginning July 15, 2009, requires health care providers to submit to group purchasers the health care claims or equivalent encounter transaction.

(d) Beginning January 15, 2009, requires health care providers to accept from group purchasers the eligibility for a health plan transaction, and beginning December 15, 2009, requires health care providers to accept from group purchasers the health care payment and remittance advice transaction.

(e) Requires each transaction to require use of a single, uniform guide to the implementation guides.

(f) Requires all group purchasers and health care providers to exchange claims and eligibility information electronically, and prohibits group purchasers from imposing any fee for use of the transactions.

(g) Provides that the subdivision does not prohibit group purchasers and health care providers from using a direct data entry, Web-based methodology.

Subd. 2. Establishing uniform, standard companion guides. (a) Requires the commissioner of health to adopt rules at least 12 months prior to the timelines in subdivision 1, establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides.

(b) Requires the commissioner to consult with the Minnesota Administrative Uniformity Committee on development of the companion guides.

(c) Prohibits group purchasers and health care providers from adding to or modifying the companion guides.

(d) Prohibits the commissioner, in adopting rules, from requiring data that is not essential for the purposes of subdivision 1.

4 **Distribution of funds.** Amends § 62J.692, subd. 4. Requires the distribution of MERC funds under the public program factor to be based on charges submitted, rather than revenue received, and makes related changes.

5 **Hospital information reporting disclosure.** Amends § 62J.82. Requires the Minnesota Hospital Association to include on their public web-based system information on hospital specific performance on measures of care related to acute myocardial infarction, heart failure, and pneumonia. Beginning January 1, 2009, requires inclusion of hospital-specific performance measures for hospital-acquired infections. Requires the commissioner of health to provide a link to the reported information on the MDH web site. Allows the commissioner to take action against the license of a hospital that does not provide the required information.

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6 **Health care transformation task force.** Adds § 62J.84.

Subd. 1. Task force. Requires the governor to convene a health care transformation task force, comprised of: (1) four House members and four Senate members, with two members of each body from the majority party and two members of each body from the minority party; (2) four representatives of the governor and state agencies, appointed by the governor; (3) at least four persons appointed by the governor who have demonstrated leadership in health care; and (4) at least two persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement, at least one of whom must be from a labor organization.

Subd. 2. Public input. Requires the commissioner of health to review research and conduct surveys, focus groups, and other activities to determine Minnesotan's values and views on health care issues, and to report findings to the task force.

Subd. 3. Inventory and assessment of existing activities. Requires the task force to complete an inventory and assessment of all public and private activities, coalitions, and collaboratives working on health system improvement.

Subd. 4. Action plan. Requires the governor, with the advice and assistance of the task force, to develop and present to the legislature by December 15, 2007, a statewide action plan for transforming the health care system to improve affordability, quality, and access. Requires the action plan to include specific and measurable goals and deadlines for: (1) actions to slow the rate of increase in health care costs to the CPI plus two percentage points, plus an additional percentage based on added costs necessary to implement legislation enacted in 2007; (2) actions to increase affordable health coverage options for the uninsured and underinsured, to ensure that all Minnesotans have health coverage by January 2010; (3) actions to improve the quality and safety of health care and reduce health disparities; (4) actions to reduce the rate of preventable chronic illness; (5) proposed changes to state health care purchasing and payment strategies to achieve specified health goals; (6) actions to promote the appropriate and cost-effective investment in new facilities, technologies, and drugs; (7) actions to reduce administrative costs; and (8) the results of the inventory completed under subdivision 3 and recommendations for coordinating and improving these activities.

Subd. 5. Options for small employers. Requires the task force to study and report back to the legislature by December 15, 2008, on options for serving small employers and their employees and self-employed individuals.

7 **Dependent.** Amends § 62L.02, subd. 11. For purposes of the individual, small group, and large group markets, expands the definition of dependent to include an unmarried child under the age of 25, regardless of enrollment in an educational institution. Provides a January 1, 2008, effective date.

8 **Gross individual or gross family income.** Amends § 256L.01, subd. 4. Modifies the MinnesotaCare definition of gross income for the farm self-employed, by eliminating the

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requirement that depreciation be added back in. Provides a July 1, 2007, effective date.