HOUSE RESEARCH

Bill Summary

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Subject: Creation of health insurance exchange

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Overview

This bill would create a health insurance exchange to operate in Minnesota as required by the federal health reform bill (Affordable Care Act, abbreviated "ACA") enacted in 2010. A health insurance exchange is a primarily electronic marketplace at which individuals and small employers who wish to buy health insurance can connect with health plan companies that sell it, and buy it through the exchange. Exchanges are also required to determine whether applicants for coverage are eligible for federal premium and tax subsidies or for Medical Assistance and other public programs. Federal law requires each state to have an exchange ready to perform all required functions by January 1, 2014. If a state misses that deadline, the federal law requires the federal government to design, create, and operate an exchange in that state. The federal law has some specific requirements that apply to all state exchanges, but allows states flexibility on other aspects of the state's exchange. Products can be offered both inside and outside the exchange. Insurance coverage will still be able to be purchased and sold in the private market outside of the exchange. This bill would put into place the aspects of a health insurance exchange required at this time to be on track to meet the federally-required timetable for creation of a fully-functioning exchange by 2014. Some decisions on what Minnesota's exchange will be like can be made in 2012 or maybe 2013.

1 **Citation.** Says this chapter of law (a new chapter 62V) may be known and cited as the Minnesota Exchange Act.

2 **Definitions.** Defines 13 terms used in this bill.

3 **Exchange.**

Subd. 1. Creates the exchange and exempts it from Minnesota state taxes, including income and sales taxes.

Subd. 2. Board of directors; organization. Specifies that the initial board of directors will consist of nine members - three each appointed by the speaker of the house, the Subcommittee on Committees of the Senate Rules Committee, and the governor. Specifies that future board members will be chosen by the board members serving at the time. Lists areas of expertise that the board must have among its members. Requires that of the three initial members appointed by each legislative body, one or two must be from outside of the seven-county metro area.

Subd. 3. Election of board. Requires that the initial board members be appointed by January 1, 2012.

Beginning in 2014, regular (non-initial) board members will be elected by board members already serving.

Subd. 4. Term of office. For (non-initial) directors, the term of office will be three years, with a two-term limit. Service on the initial board does not count for that purpose.

Subd. 5. Resignation and removal. Specifies how directors may resign or be removed.

Subd. 6. Quorum. Specifies that a majority of the board is a quorum.

Subd. 7. Approval by the board. Majority rule governs on the board, unless this act requires a two-thirds vote on the decision.

Subd. 8. Open meetings. Requires that meetings of the board, its committees, and its advisory group be open to the public, with three types of exceptions.

Subd. 9. Antitrust exemption. Exempts directors from antitrust liability in connection with their duties as board members.

Subd. 10. Conflict of interest. Requires board members to recuse themselves when they have a conflict of interest as defined in this subdivision.

Subd. 11. Advisory group. Requires the board to convene and regularly use an advisory group to advise the board on certain subjects listed in the subdivision.

4 **Establishment of exchange; powers.**

Subd. 1. Establishment of exchange. Creates the exchange as a nonprofit entity that has the 22 powers listed in the subdivision. The powers listed are modeled on those granted in the Minnesota Nonprofit Corporations Act (chapter 317A), with some modifications to conform to the purposes of this unique nonprofit entity.

Subd. 2. Exempt from administrative procedure act. Exempts the exchange from chapter 14 (Administrative Procedures Act), except as otherwise provided in this act.

Subd. 3. Plan of operation. Requires the exchange to develop a plan of operations. Lists what the plan must cover. (A plan of operations is similar to corporate bylaws and deals with the internal operating procedures of the company.)

Subd. 4. Purpose of exchange. States three purposes of the exchange as follows: (1) facilitate access to qualified health plans; (2) assist small employers in getting their employees covered; and (3) meet the other requirements of this act and any rules adopted under it.

Subd. 5. Data sharing. As required by federal law, permits the exchange to enter into information-sharing agreements with state and federal agencies and other state exchanges as needed to carry out the exchange's duties, provided the agreements protect confidentiality. Requires the exchange to handle data responsibly. Authorizes employers and health plan companies to share with the exchange information the exchange needs, without getting consent from the employees and other covered persons. Notes that the exchange is required to help employers enroll their employees in health coverage, and therefore permits the exchange to share information between the employer and the employee where necessary.

Subd. 6. Data on individuals. Classifies data on individuals seeking coverage through the exchange as private data on individuals or nonpublic.

5 **General requirements.** (a) Requires the exchange to provide coverage to individuals and employers beginning January 1, 2014. Requires the exchange to provide access only to health plans that meet federal requirements. Permits the exchange to offer "limited scope dental plans" if the plans meet the federal requirements for pediatric dental benefits.

(b) Prohibits the exchange and health plan companies from charging an enrollee a fee for early termination of coverage, if the enrollee terminated the plan because of becoming able to enroll in another type of plan.

(c) Requires the exchange to treat all health plans uniformly. Points out that the ACA does not prohibit sale of health plans outside of an exchange.

(d) Requires health plan companies selling through the exchange to pay insurance agents commissions that match what they pay agents for selling identical plans outside of the exchange. Says that this act is not intended to limit commissions paid to agents for sales outside the exchange.

(e) Limits health plan companies selling through the exchange to just one version of each of the four levels of enrollee cost-sharing (bronze, gold, silver, and platinum) specified in federal law.

(f) Requires that all plans a company offers in the exchange be also offered outside of the exchange.

6 **Duties of the exchange.**

Subd. 1. Certification of health plans. Requires the exchange to "certify, recertify, and decertify" health plans as to whether they meet federal and state requirements.

Subd. 2. Individuals. Lists the services an exchange must provide to individuals looking for health coverage, including a toll-free telephone hotline, enrollment periods, a Web site providing standardized comparative information, a standardized format for information, determination of eligibility for public health coverage programs, and an electronic Web-based calculator allowing people to know the amount, if any, of federal premium tax credit or federal cost-sharing reduction for which the person qualifies, based on income level.

Subd. 3. Employers. Lists the services the exchange must provide to employers, which are crediting to employees the free choice vouchers provided by the employee's employer and notifying the employer if the employee drops coverage. (A free choice voucher is an opportunity the exchange provides in which the employer decides what percent of the premium the employer is willing to pay toward a certain level of coverage in the exchange (bronze, gold, etc.), and the employee can then choose which plan sold through the exchange at that coverage level the employee wants to buy, and the exchange will apply the employer contribution toward the employee's enrollment in that coverage. It is basically an employer-subsidized individual type of coverage, as contrasted with an employer-sponsored group insurance plan.)

Subd. 4. Plan rating; benefit levels. Requires the exchange to assign a rating to each plan it offers using federal criteria, rate each plan in terms of the level of enrollee cost-sharing required as a bronze, gold, silver, or platinum, establish a process for the free-choice voucher approach as described in the summary of subdivision 3 above, and determine whether an individual is exempt from the federal individual mandate to have coverage.

Subd. 5. Tax matters. Requires the exchange to provide to the IRS tax-relevant information on people the exchange finds to be exempt from the individual mandate, eligible for a premium tax credit, or to have changed employers or dropped coverage. Requires the exchange to perform duties required by the HHS Secretary or the IRS related to premium tax credits, reduced cost-sharing, or individual mandate exemptions.

Subd. 6. Navigators. Navigators are described in the ACA as entities that receive grants from the exchange to give advice without charge to consumers about health insurance. Requires that individuals giving advice through navigators must be health insurance agents licensed in Minnesota. Lists the requirements for navigators required in the ACA in items (1) to (5). Prohibits navigator grants to any governmental unit.

Subd. 7. Group market definition. Requires the exchange to develop by January 15, 2016, a recommendation on whether to offer exchange coverage to employers that are larger than small employers (which at that time will mean employers larger than 100 eligible employees).

Subd. 8. Stakeholders. Lists categories of stakeholders with whom the exchange must consult in general.

Subd. 9. Financial integrity. Lists four things the exchange must do to demonstrate its financial integrity.

Subd. 10. Records of exchange. Describes in general terms the exchange's records requirements. Allows the commissioner of commerce access to them.

Subd. 11. Enrollment through insurance producers. (a) Requires the exchange to allow insurance agents to enroll people in the exchange from day one and to help people apply for premium tax credits and cost-sharing reductions for use in the exchange.

(b) Provides that only licensed insurance agents can perform the functions that insurance agents are licensed to perform, when enrolling an individual in a qualified health plan.

7 **Health plan certification.**

Subd. 1. Qualified health plan. Specifies the requirements for the exchange to certify a health plan as a "qualified health plan." They are (1) that it provide the "essential benefits package" required under the ACA; (2) the premium rates and policy forms have been approved by the commissioner of commerce (that is already required in MN); (3) that it provide at least the "bronze" level of coverage specified in the ACA (covers 60 percent of the cost of care on average), unless the plan qualifies as a "catastrophic plan" under the ACA and will only be offered to customers qualified for that type of plan; (4) satisfies the ACA's cost-sharing limits; (5) the health plan company is licensed in MN, offers through the exchange at least one silver and one gold plan, charges premium rates that are the same inside and outside the exchange, and without regard to whether the plan is sold through an agent or directly by the health plan company; does not charge cancellation fees; the health plan meets certification requirements in state and federal rules; and the exchange determines that offering the plan benefits individuals and employers.

Subd. 2. Health plan exclusion. (a) Prohibits the exchange from excluding a health plan because it is fee-for-service (non-managed care), through premium price controls imposed by the exchange, or on the basis that it covers end-of-life care the exchange considers inappropriate or too costly.

(b) Requires the exchange to deny entry to the exchange until 2015 for a health plan not offered in the exchange as of the January 1, 2014, start date for the exchange, unless the exchange decides that making an exception will benefit individuals or employers.

Subd. 3. Reentry provision. Specifies the circumstances under which a health plan company may reenter the exchange after leaving it.

Subd. 4. Data required. Lists the data health plan companies must provide to the exchange and to the public about plans it offers through the exchange.

Subd. 5. State licensure. Prohibits the exchange from exempting a health plan company from state licensure or state financial solvency requirements.

Subd. 6. Dental plans. Specifies how this act applies to dental plans.

Subd. 7. Administrative Procedure Act. Allows a health plan company to appeal a decision by the exchange in a contested case hearing under chapter 14.

8 **Funding; publication of costs.** (a) Permits the exchange to generate funding to cover its costs. Any user fee charged by the exchange must be collected directly from the individual or employer that buys the coverage (not from the health plan company).

(b) Requires the exchange to publish its administrative and operations costs on the Web. Says what information must be provided.

9 **Duties of the commissioner.**

Subd. 1. Duties. Requires the commissioner of commerce to supervise the exchange subject to limits

described in this act; monitor compliance of the exchange with this act, including investigating, examining records and property, and requiring periodic reporting by the exchange; and coordinate with the commissioner of health's role in overseeing the health-related (as opposed to insurance-related) aspects of health coverage.

Subd. 2. Consistent and uniform regulation. Requires the commissioners of commerce and health to make sure that health coverage is regulated consistently inside and outside of the exchange, except where contrary to the ACA or this act.

Subd. 3. Licensure. Prohibits the commissioner of commerce from requiring a health plan company to offer a health plan through the exchange as a condition of the company's licensure.

10 **Relation to other laws.** Says that nothing in this act and no action taken by the exchange may be interpreted as preempting or superseding the commissioner of commerce's authority under state law to regulate insurance. Requires all health plan companies that offer health coverage in the state to comply with the laws of this state and with the commissioner's rules and orders.

11 **Sunset.** Makes this act sunset 30 days after the federal repeal, or invalidation by a court decision, of the section of the ACA that requires states to have health insurance exchanges, or of the section of the ACA that provides federal premium tax credits, unless the legislature takes action to extend this act.

12 **Effective date.** Makes this act effective the day following final enactment (subject of course to the later dates specified in this act.)