Minnesota 1332 Waiver Application Extension

Minnesota Department of Commerce

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Minnesota 1332 Waiver Extension Proposal
Affordable Care Act (ACA) Waiver for State Innovation

Executive Overview

The Minnesota Department of Commerce (Commerce) respectfully submits this 1332 State Innovation Waiver Extension Application to the Center for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services (HHS), and the Department of Treasury.

The waiver extension application supports a state-based reinsurance program, the Minnesota Premium Security Plan (MPSP), for the individual market which addresses the following goals:

1. Stabilizing individual market premiums, and reducing future potential rate increases, to a level that encourages Minnesotans to purchase health coverage;
2. Encouraging consumer enrollment and ongoing participation by health insurers in Minnesota's individual market;
3. Eliminating unintended consequences for Minnesota's Basic Health Plan (BHP), known as MinnesotaCare, and federal premium tax credits (PTC); and
4. Creating a fiscally sustainable program that maximizes the positive impact of federal funding on the market.

The MPSP's funding sources are (1) savings generated by PTC that the federal government would otherwise pay to Minnesotans without the MPSP; and (2) carryover funds from the existing MPSP program, and (3) state appropriations.

To achieve the goal of reduced monthly premium rates in the individual market, Minnesota's enabling legislation established a reinsurance program, partially funded with federal dollars resulting from an approved 1332 waiver extension. Federal PTC support is applied to monthly premium payments of enrollees who do not receive full PTC to help with affordability.

Pending details of state legislation expected in the first half of 2022, this waiver application assumes that the structure of the MPSP will be similar to the current MPSP program which has been in effect since the 2018 plan year.

Commerce projects that this level of support will reduce the entire market's premiums by an average of over 15 percent from where rates would be absent the MPSP and that healthier Minnesotans will either remain in, or return to, the individual insurance market. Neither the MPSP nor this waiver request will negatively affect individuals who typically qualify and receive federal PTC support.

Minnesota's Legislature has authorized the MPSP to operate in plan year 2022 and directed Commerce to seek a continuation waiver by December 31, 2021. Minnesota's Legislature is expected to address program authorization and state funding questions during the regular 2022 legislative session which will end in May, 2022.The MPSP helps stabilize the state's individual market because:

- It has an immediate effect on premium affordability for consumers purchasing individual insurance coverage.
- It is a seamless and invisible program to enrollees and maintains access to carriers, networks, health savings accounts, and plan design choices.
- It meets the goal of maintaining preexisting condition prohibitions, a major accomplishment of the ACA.
- It fosters competition through reducing the risk of high-cost claims; this risk is a major barrier for issuers who may consider entry into this market.
- The delivery structure will be the same as for the current Minnesota reinsurance program, allowing for easy federal review and feedback. Quick dissemination and approval of the program is important, given that issuers will be making plans for 2023 participation in the individual market in early- to mid- 2022.
- It is budget neutral for the federal government. This approach ensures that the raw data used to verify the federal waiver remains intact. For example, CMS can audit the count and proportion of enrollees receiving PTCs at each carrier, ensuring no additional expenses for the federal budget.
- Many Minnesotans purchased health insurance for the first time because of the ACA. The Minnesota uninsured rate reached 4.3 percent in 2015,[1] among the lowest in the country. The current uninsured rate is estimated to be 4.7%.

Commerce estimates that the continuation of the MPSP will mean more Minnesotans will purchase individual market insurance in 2023 than would have otherwise purchased insurance in the absence of this program. This enrollment difference will continue to help stabilize and lower the uninsured rate.

In this application, Minnesota seeks to waive section 1312 (c)(1) of the Affordable Care Act. Federal funds will help support the MPSP and reduce each issuers' individual market rates.

In addition to seeking funding for reinsurance, Minnesota also seeks to secure receipt of funding equal to the amount of the forgone federal funds and assistance that would have been provided to Minnesotans without the waiver pursuant to the BHP funding formula as provided under 42 C.F.R. Part 600, Subpart G,

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[1] *Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey*, Feb 29, 2016, http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf.

also referred to as the pass-through funding under section 1332(a)(3) and subsequent guidance. Maintaining the same level of federal BHP funding that would have otherwise been available without the waiver is an essential component of this waiver request.

Minnesota proposes that this Section 1332 Waiver extension be effective starting January 1, 2023 and extend for a period of five years.

Description of the MPSP

Minnesota's enabling legislation that created the original state-based reinsurance program (MPSP) took effect on April 4, 2017. The MPSP is an attachment-point reinsurance model that had parameters of an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000. For plan year 2022, state law changed the coinsurance rate to 60 percent. For purposes of this waiver request, actuarial analysis assumes a continuation of the 2022 parameters for all projected years of the program. The current program does not explicitly specify incentives for managing health-care cost or utilization. Details on payments to carriers are provided in the actuarial report. See Attachment A for a copy of existing state law.

Implementation of the MPSP

The original MPSP enabling legislation repurposed the state's former high-risk pool, the Minnesota Comprehensive Health Association (MCHA) to administer the MPSP. Governed by a 13-member board, MCHA established operational processes and procedures subject to t Commerce approval. MCHA reimburses eligible health insurers for reinsurance-eligible expenses incurred during a plan year. Health insurers remain responsible for ongoing enrollment, notice, administration, and claims-handling.

MCHA collects data to determine reinsurance payments and disburses reinsurance payments to each eligible health carrier. Reinsurance payments are calculated with respect to an eligible health insurers' incurred claims costs for an enrollee's covered benefits in a plan year. Once an enrollee's claims exceed the attachment point, reinsurance payments are calculated as the product of the coinsurance rate and the lesser of 1) the claims cost minus the attachment point, or 2) the reinsurance cap minus the attachment point. Reinsurance payments cannot exceed the total amount paid by a health insurer for an eligible claim. Health insurers must provide data to MCHA and maintain certain records to be eligible for the reinsurance program.

For purposes of this application, Commerce assumes MCHA will propose payment parameters each year, taking into account available funding, to ensure stabilized premiums, increased market participation, improved access to providers, and mitigation of the impact of high-risk individuals. Commerce can approve or disapprove the proposed parameters. For 2022 and past plan years, the attachment point is no lower than $50,000; the coinsurance rate is no higher than 80 percent (60 percent in 2022 and assumed going

forward); and the cap is no higher than $250,000. Note that evaluations indicate the reasonability of parameters to ensure that the MPSP will have sufficient funds in time to meet its obligations. A detailed timeline of MPSP implementation is included in Attachment B.

Additional State Responsibilities Related to the MPSP

Additional duties of the Commerce Commissioner and other state agencies are specified in the legislation. MPSP funds are annually appropriated to Commerce and then granted to MCHA for operational and administrative costs and reinsurance payments.

Related to each benefit year, the Commerce Commissioner will receive a report summarizing the plan operations and receive the results of a required audit. There are no federal responsibilities related to the operations of the MPSP.

Compliance

Minnesota's 1332 waiver intends to use federal dollars to partially fund the MPSP. Under existing law, available federal funds are expended first and state dollars fund the balance.

The benefits of an approved waiver will be shared by the entire non-grandfathered individual health insurance market, without regard to enrollees' income, age, health condition, tobacco status, area of residence, race, carrier selection, network selection, or metal level selection.

Minnesota does not seek to waive any other aspect of the ACA. This waiver is designed to maintain access to comprehensive health insurance for all Minnesotans through more affordable rates. This waiver request does not herein contemplate any overall funding level changes to the state's basic health plan, MinnesotaCare, Medicaid, the state-based exchange (MNsure), federal grants, or any direct purchases. The State of Minnesota provides the following assurances:

- This waiver request meets the scope of coverage comparability requirements of Section 1332 (b)(1)(A) of the Affordable Care Act:
    - The Essential Health Benefit (EHB) coverage set (which dictates covered medical services, visit limits, and formulary) will be unaffected.
    - Coverage for vulnerable populations by health condition, age, income, geographic location, or any other demographic characteristic, will be unaffected by this waiver.

    - This waiver will not affect cost sharing parameters that could indirectly affect the scope of coverage.
- This waiver meets the affordability requirements of Section 1332 (b)(1)(B):
    - This waiver will not affect cost sharing parameters (deductible, coinsurance, copays, OOP Max, etc.), which will continue to rely on the federal Actuarial Value Calculator for annual calibration. Coverage and cost sharing protections (such as the self-only coverage limit) against excessive out-of-pocket spending will remain the same. There will be no increases in designed or effective enrollee cost sharing, whether based on parameters or premiums, due to the approval or existence of this waiver.
    - EHB coverage will be unaffected, and thus have no indirect effect on cost sharing.
    - Cost sharing for vulnerable populations by health condition, age, income, geographic location, or any other demographic characteristic will be unaffected.
- This waiver request meets the affected number of individuals requirements of Section 1332 (b)(1)(C). The state expects more, not fewer, Minnesota residents will enroll in coverage if this waiver is approved. Minnesota estimates that this waiver will result in at least 10,000 more Minnesota residents accessing health insurance, in comparison to the number expected in the absence of the MPSP.
- This waiver request meets the deficit neutrality requirement of Section 1332 (b)(1)(D). Any anticipated increase in federal spending, administrative costs or other expenses to the federal government, or reduction in federal income tax, payroll tax, excise tax, health insurance tax, PCORI assessments, or any other federal revenue is accounted for and explained in the economic and actuarial analysis.
- This waiver retains the existing scope of benefits, including requiring the provision for 10 EHBs, matching the state's benchmark plan's covered service list and minimum visit limits. Waiver approval will not result in a decrease in the number of individuals with coverage that meets the EHB, nor will approval of this waiver affect health plan coverage offered through the state's basic health plan, MinnesotaCare, Medicaid, or employers.
- This waiver meets the requirements of Section 1332(a)(3). Minnesota proposes that the savings that the federal government would have otherwise spent on PTC be used instead for broader financial support of the individual market through the MPSP. It also seeks the pass through of funding of the federal assistance that, absent this waiver, would have otherwise been spent on Minnesotans pursuant to the state's BHP, MinnesotaCare.
- This waiver requests no change or consideration of any kind to state-specific exchanges or the federal role in the exchange or Minnesota's BHP. As previously stated, this waiver requests both: (1) federal funds that, absent the waiver for the MPSP, would have otherwise been spent on Minnesotans pursuant to the BHP, be instead directed to the state to be treated as BHP trust funds for the purposes of 42 C.F.R. Part 600, Subpart H; and (2) federal PTC that would have otherwise been spent without the waiver be instead directed to the MPSP. There is a financially immaterial

effect on federal operations in terms of having existing HHS, CMS, and Office of the Actuary (OACT) staff review and approve this waiver request.

- This waiver request meets the requirements for public input and a coordinated approach under Section 1332 (a)(4) and (5). Once any legislation is passed, the proposed extension waiver will be publicly posted and public hearings will be scheduled. Public comment will be solicited in compliance with 31 §CFR 33.112 and 45 §CFR 155.1312. Online materials meet national and Minnesota accessibility standards.

Summary of Proposal

Background

Minnesota developed a reinsurance program for the individual health insurance market as a stability mechanism that provides premium relief for those who do not receive federal PTC. The number of people in the individual market not receiving federal PTC was approximately 100,000 for the first few years of the program. With the 2021 American Rescue Plan Act (ARPA) enhancement of federal PTC, the number of people in the individual market not receiving federal PTC decreased and is expected to substantially decrease following open enrollment associated with the 2022 plan year.

Goal of Waiver

This application assumes a continuation of MPSP's current program parameters. This level of support will subsidize the market's premiums by an assumed 15 percent (if the program resembles the 2022 program), or an average of around $100 per person per month in 2023.

The benefits of an approved waiver will include:

- More Minnesotans would have insurance coverage than in the absence of an approved waiver.
- Allowing for reduced premium increases and more affordable premiums to Minnesota residents, targeting 15 percent average premium reduction from where rates would otherwise be without the MPSP.
- No negative effect on plan offerings, cost sharing, and covered services.
- Potential increased health insurer participation and competition in the market.
- Promoting stability of the individual market risk pool.
- Reducing issuers' risk from high-cost claims, which reduces risk margins, which further reduces premiums.
- No increase in federal spending to support the individual market.
- No increase in federal spending to support MinnesotaCare, Minnesota's BHP.

Applicable Federal Regulations

Minnesota proposes to make alternative use of federal savings, as allowed under Section 1332 of the Affordable Care Act.

Federal funding will be deposited for use by the MPSP. The MPSP will reimburse certain high costs in Minnesota's individual market, as it has since the state's reinsurance program was introduced in 2018.

The MPSP will directly affect the price of the second lowest cost silver plan and thus the PTC available through the state's individual market, as well as federal funding for MinnesotaCare, the state's BHP. Therefore, Minnesota seeks to receive the funding equal to the amount of the forgone federal assistance that would have otherwise been spent on Minnesotans without this waiver pursuant to the BHP funding formula, under 42 C.F.R. Part 600, Subpart G, as a passthrough of funding under section 1332(a)(3) and subsequent guidance. Protecting the federal BHP funding that, without this waiver, would have otherwise been spent in support of MinnesotaCare, is an essential component of this waiver request.

Background on Minnesota's Health Insurance Market

Minnesota has long been a national leader in health care reform and efforts to address the state's uninsured rate. Through Section 1115 demonstration waivers, Minnesota has a long history of expanding and supporting public programs to cover more people in need than most other states. This includes MinnesotaCare, which operates today as a Basic Health Plan under the ACA. Prior to the ACA's implementation in 2014, Minnesota had the second oldest and largest (with approximately 26,000 members in its last year of full operation) high-risk pool in the nation.

The ACA's guarantee issue requirements and preexisting condition prohibitions increased Minnesota's individual market enrollment in 2014 and 2015[2]. Further expansion of Medicaid reduced Minnesota's uninsured rate to an all-time low (estimated at 4.3 percent) in 2015.[3]

At its highest point, the individual market covered just over 300,000 Minnesotans (2015), or approximately 5.5 percent of Minnesotans. Current enrollment is just over 160,000.

Based on rate review feedback, many people who purchase health insurance through Minnesota's individual market are self-employed, including contractors, entrepreneurs, realtors, insurance agents, farmers, and day care providers. The individual market also provides insurance for people working for very small employers who fail to provide health insurance. Market participants have identified premium affordability, access to providers and out-of-pocket expenses as critical issues driving enrollment declines.

Minnesota has nine rating areas, which are based on contiguous counties. In the Twin Cities metro area, the provider community is composed of several competitive integrated delivery systems. Many carriers have

[2] This increase is somewhat understated when compared to other states, as Minnesota residents with incomes under 200 percent of the Federal Poverty Level (FPL) are enrolled in MinnesotaCare.

[3] 4.3%, see *Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey*, Feb 29, 2016, http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf

partnered with these systems to offer narrow networks in the individual market (a common complaint from affected enrollees).

Health insurance costs are higher in Greater Minnesota relative to the Twin Cities Metropolitan Area.

Individual market participants in rating area 1 (counties near Rochester, Minnesota, where the Mayo Clinic is headquartered) have had the highest rates in Minnesota, generally 20-35% higher than rates available elsewhere.

In general, the Twin Cities (rating area 8) has the most competitive rates in Minnesota. Enrollment in the Twin Cities tends to make up about 65 percent of the Minnesota marketplace.

Minnesota elected not to allow for transition plans in the individual or small group markets.

Most individual market members have migrated to bronze and silver plans due to rate increases. Over 75 percent of Minnesotans in the individual market had purchased those tiers of plans. This migration to bronze and silver plans has occurred generally uniformly at all ages.

High-cost claimants are the predominant issue affecting affordability. About 50 percent of the aggregate claims are a result of high-cost cases. While this dynamic is not atypical in comparison to the group market, the group market has far more subsidies from employers in place to stabilize the curve to this general shape over time.

Waiver Proposal: Use of Savings

As provided by Section 1332 of the ACA, Minnesota proposes to use federal savings that, absent the MPSP, would have been paid as premium tax credits due to higher premium levels. The MPSP will reduce the cost of the applicable second lowest cost silver plan.

Due to the MPSP's reinsurance support for Minnesota's individual market, all premiums (including second-lowest silver premiums) will be less than they would have been without the MPSP. Health insurers' actuaries will be asked to certify the premium reduction amount attributable to the MPSP when developing and submitting proposed premium rates to Minnesota state regulators during the rate review process.

Minnesota proposes to receive federal savings as described in federal guidance.[4] Federal waiver funding will contribute to reducing each issuer's individual market health insurance rates.

[4] https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation

As discussed above, Minnesota also seeks to receive the federal savings attributed to the impact of lowering the second lowest silver plan on the federal BHP funding formula, as a passthrough of funding under section 1332(a)(3). These federal savings will be treated by the state as federal BHP trust funds under 42 C.F.R. 600, Subpart H, and, therefore, only available to the state for the support of the state's BHP, MinnesotaCare. Currently, MinnesotaCare is federally supported by a formula relating to the federal premium tax credits and cost sharing reduction subsidies, as provided under 42 C.F.R. Part 600, Subpart G. That funding value is the difference between the federal BHP funding with and without the 1332 waiver to support the MPSP. As illustrated in the actuarial report, the impact of the 1332 waiver to support the MPSP would be budget neutral to the federal deficit over the next 10 years.

Minnesota will provide the Federal government with all information necessary to administer the Federal waiver. This includes annual data on premium tax credits provided to Minnesotans, the second-lowest cost silver premiums, overall premiums, and enrollment.

Waiver Funding Proposal Financial Effects

As shown in the actuarial report, under the waiver scenario, the federal government will save approximately $72 million in PTCs during 2023 if ARPA enhanced PTCs are not extended into 2023) and $144 million if ARPA enhanced PTCs are extended into 2023. The required 10-year projection (see actuarial report) shows the federal government would not expect to pay more in any future years if this waiver is approved.

Minnesota has an above-national-average percentage of individual market enrollees who do not qualify for federal PTCs. The projected federal savings take into account both those who are eligible for PTCs and those who are not eligible. The MPSP will directly allow more people to afford coverage. The premium rates paid by enrollees will generally remain about the same as without the MPSP for most Minnesotans receiving PTCs. Premium rates will decrease proportionally in comparison to rates without the MPSP for Minnesotans not eligible for any PTCs as well as for those who are younger with family incomes between 300-400 percent of federal poverty level.

Description of Post-Waiver Marketplace

Individual Health Insurance Market

Approval of this waiver will not affect the existing functions of the individual market, nor its consumer experience, other than to have reduced rates available to consumers. Individuals and families can continue to apply to MNSure, where eligibility for Medicaid, MinnesotaCare, tax credits, and cost-sharing reduction plan variations are determined. In many cases, there are also individual market plans available directly through issuers' websites and insurance brokers. Assistance with plan selection is unchanged by this waiver, and may be provided by an agent, broker, navigator, or other in-person assister. Individual rates will be reduced by every issuer, whether or not the issuer sells plans through MNSure.

Small and Large Employers

This waiver does not affect health insurance available to Minnesota residents through small and large employers. Employers using the individual market as the provider of health insurance for their early-retirement plans often provide service-based subsidies to premiums and will be aided by improved stability in this market. Based on the typical employer strategy to subsidize a fixed amount of an early retiree's premium, the proposed waiver could help early retirees (versus the employer) in such employer early-retirement plans.

Medicare

This waiver does not affect health insurance available to Minnesota residents through Medicare, including Medicare Cost plans and Medicare Advantage plans. This waiver has no effect on Medicare Supplement coverage offered from commercial carriers.

Medical Assistance, Minnesota's Medicaid Program

This waiver does not affect health insurance available to Minnesota residents through Medicaid.

MinnesotaCare

Approval of this waiver request as submitted, in conjunction with the passthrough of savings to the state attributable to the BHP formula, will not affect the state's existing BHP program, MinnesotaCare, nor its consumer experience.[5] MinnesotaCare-eligible individuals and families will continue to apply through MNsure where eligibility is determined. Assistance with plan selection is unchanged by this waiver.

Number of Employers Offering Coverage Pre/Post Waiver

This waiver will not affect the number of employers offering health insurance coverage in Minnesota.

Impact on Insurance Coverage in the State

Minnesota's proposed 1332 waiver requests premium tax credit savings from the federal government, based on an amount determined by the federal government. This waiver does not affect any health insurance covered services in Minnesota. The MPSP does not affect cost sharing parameters or coverage of services for individual market health plans or MinnesotaCare. Other markets are unaffected by this waiver.

The MPSP is intended to make the individual health insurance market more viable, more affordable, and more stable. Minnesota's proposal encourages competition. If additional issuers move into, or return to, the individual market, consumers may benefit from expanded choice of plans and competitive pressure on rates. For 2021, there are six issuers offering individual health insurance. Modeling provided by the Commerce

[5] MinnesotaCare funding was impacted by federal regulators' decision on the state's original waiver application in 2017. See Governor Dayton's statement at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Approval-Letter-MN.pdf

actuarial staff assumes that an extension of the MPSP will continue to reduce the rates for all issuers in the Minnesota individual market and thus the premium amounts charged to Minnesotans, in comparison to a scenario with no state program.

Minnesota's waiver does not request any modification to benefits or design parameters. Benefit packages will contain the same essential health benefits, remaining comprehensive, and will comply with standard national metal level requirements, including out-of-pocket limitations to protect in-network point of service cost sharing. Minnesota will report on any modifications to the EHBs on an annual basis.

Under this waiver, Minnesota's insurance coverage will continue to meet the requirements of federal law.

Administrative Burden

Minnesota expects that the MPSP will result in a small increase in health insurers' administrative burden. Health insurers' actuarial, claims, and finance departments will need to report and account for high-cost claims, and many of the issuers will continue their participation on the MCHA Board. Health insurers will continue to manage rate filing requests, plan design and benefit set-up, enrollment, marketing, and claims administration in the same manner as they would without a waiver. Participation in the MPSP will be mandatory to participation in the non-grandfathered individual market.

Commerce will monitor the governance, solvency, and administration of MCHA, as well as review the actuarial work relating to the MCHA credit in issuer's rate filings. Actuarial staff participated in drafting this waiver request and actuarial study, and are be available for future inquiries from issuers, MCHA, or the federal government.

The Department of Treasury and CMS staff will have a small increased burden in determining waiver funding values as related to the individual market. The waiver does not affect the calculation of PTC or the reconciliation of PTC in terms of tax filings. Minnesota's waiver does not require operational or financial changes for MNSure.

This waiver will have no administrative impact to individuals and families, even those whose conditions are reinsured by MCHA. All individuals will continue to purchase plans in the same manner available now, including through MNSure at www.mnsure.org or through a broker, agent, navigator, or through directly contacting issuers.

Waivers Requested

The Minnesota Department of Commerce seeks to waive Section 1312 (c)(1)[6] for the individual market single risk pool in connection with a Section 1332 waiver extension to continue a state-operated reinsurance program for 2023 and future years. Currently, that requirement at Section 1312(c)(1) requires a health insurance issuer to consider "all enrollees in all health plans….offered by such issuer in the individual market…to be members of a single risk pool." To maximize the rate-lowering impact of the reinsurance program, the state would like to waive this single risk pool provision at 45 CFR 156.80 to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate.

The Department of Commerce will communicate with issuers participating on the Marketplace that issuers should include state-operated reinsurance dollars in rate setting. The reinsurance program will result in a reduction in premiums and premium tax credits which the state believes will result in pass-through funding that the state can use towards the reinsurance program. We expect the implementation of this waiver to be straightforward and consistent with implementation of the current waiver.

More on Minnesota Coverage of Services

All Minnesota individual market plans must include the 10 Essential Health Benefits (EHBs), listed below. These benefits will not change as a result of the proposed waiver.

Federally Required Essential Health Benefits (Non-grandfathered Individual and Small Group)
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care

[6] 1312 (c)(1)Individual market--A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Minnesota's state-mandated benefits can be found at the following links:

https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Minnesota-Benchmark-Summary.pdf

https://downloads.cms.gov/cciio/State%20Required%20Benefits_MN.PDF

These state-mandated benefits are summarized below:

Benefit	Name of Required Benefit	Market Applicability	Statutory Authority
Outpatient Surgery Physician/Surgical Services	Outpatient medical & surgical services	Individual, Group, HMO	62A.153 4685.0100 Subp. 5 4685.0700, Subp. 2 62D.02, Subd. 7 (Citations individually apply to specific markets) (Citations individually apply

			to specific markets) 62D.02, Subd. 7 (Citations individually apply to specific markets)
Mental/Behavioral Health Outpatient Services	Outpatient services	Qualified Plans, HMO	62E.06 Subd. 1(b)(2) 4685.0100 Subp. 5 4685.0700, Subp. 2 62D.02, Subd. 7 (Citations individually apply to specific markets)
Private-Duty Nursing	Private duty nurse	Individual, Group, HMO	62A.155 Subd. 2
Preventive Care/ Screening/ Immunization	Preventive health services	Individual, Group, HMO	62Q.46 62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)

Home Health Care Services	Home health services	Qualified Plans, HMO	62E.06 Subd. 1(b)(5)
Emergency Room Services	Emergency services	Individual, Group, HMO	62A.049 62Q.81 Subd. 4 (a) 62M.07 (b); 62Q.55 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Emergency Transportation/Ambulance	Ambulance services	All health plans	62E.06 Subd. 1(b)(14) 62J.48 4685.0100 subp. 5 62D.02, subd. 7 (Citations individually apply to specific markets)
Inpatient Hospital Services	Hospital services	Qualified Plans, HMO	62E.06 Subd. 1(b)(1) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7

			(Citations individually apply to specific markets)
Inpatient Hospital Services	Inpatient hospital services	Qualified Plans, HMO	62E.06 Subd. 1(b)(2) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Skilled Nursing Facility	Skilled nursing facility	Qualified Plans, HMO	62E.06 Subd. 1(b)(4)
Delivery and All Inpatient Services for Maternity Care	Maternity benefits	Individual, Group, HMO	62Q.81 Subd. 4(5) 62A.047 62A.041 62A.0411 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Prenatal and Postnatal Care	Pre-natal care	Individual, Group, HMO	62Q.81 Subd. 4(5)

			62A.047 62A.041 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Delivery and All Inpatient Services for Maternity Care	Minimum maternity stay	Individual, Group, HMO	62A.0411
Emergency Transportation/Ambulance	Ambulatory mental health services	Individual, Group, HMO	62A.152 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Mental/Behavioral Health Inpatient Services	Inpatient mental health benefits	Individual, Group, HMO	62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply

			to specific markets)
Substance Abuse Disorder Outpatient Services Substance Abuse Disorder Inpatient Services	Treatment for alcoholism and chemical dependency	Individual, Group, HMO	62A.149 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations apply to specific markets)
Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, Specialty Drugs	Prescription drug coverage	Qualified Plans, HMO	62E.06 Subd. 1(b)(3) 4685.0700, subp. 3 4685.0700, subp. 3A (Citations individually apply to specific markets)
Mental/Behavioral Health Outpatient Services Mental/Behavioral Health Inpatient Services	Therapeutic services	Qualified Plans, HMO	62E.06 Subd. 1 (b)(3) 4685.0700 Subd. 2E 4685.0100 Subd. 5D (Citations individually apply to specific markets)

Durable Medical Equipment	Durable medical equipment	Individual, Group, HMO	62Q. 66 62E.06 Subd. 1(b)(10) 4685.0700, subp. 2 4685.0700, subp. 3B (Citations individually apply to specific markets)
Durable Medical Equipment	Scalp-hair prostheses for alopecia areata	Individual, Group, HMO	62A.28
Durable Medical Equipment	Durable medical equipment	Individual, Group, HMO	62Q. 66 62E.06 Subd. 1(b)(10) (Citations individually apply to specific markets)
Durable Medical Equipment	Prostheses	Qualified Plans	62E.06 Subd. 1(b)(9)
Hearing Aids	Hearing aids	Individual, Group, HMO	62Q.675
Outpatient Surgery Physician/Surgical Services	Professional services, outpatient services and hospital services	Qualified Plans, HMO	62E.06 4685.0100 subp. 5 4685.0700, subp. 2

			62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive Care/ Screening/ Immunization	Well-child visits, immunizations	Individual, Group, HMO	62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive Care/ Screening/ Immunization	Routine cancer screenings (mammograms, ovarian cancer screening for women at risk , pap smears)	Individual, Group, HMO	62A.30 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive Care/ Screening/ Immunization	Prostate cancer screening	Individual, Group, HMO	62Q.50 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply

			to specific markets)
Preventive Care/ Screening/ Immunization	Preventive health services	Individual, Group, HMO	62Q.46 62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Routine Eye Exam (Adult) Routine Eye Exam for Children	Routine eye exams	HMO plans	4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7
Diagnostic Test (X-Ray and Lab Work)	Diagnostic testing	Qualified Plans, HMO	62E.06 Subd. 1(b)(11) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Radiation	Radiation therapy	Qualified Plans	62E.06 Subd. 1(b)(6)

Treatment for Temporomandibular Joint Disorders	Temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD)	Individual, Group, HMO	62A.043
Reconstructive Surgery	Reconstructive surgery	Individual, Group, HMO	62A.25
	Clinical trials	Individual, Group, HMO	62D.109, 62Q.526 (Citations individually apply to specific markets)
Diabetes Care Management	Coverage for diabetes	Individual, Group, HMO	62A.3093
Inherited Metabolic Disorder - PKU	PKU treatment	Individual, Group, HMO	62A.26
Off Label Prescription Drugs	Coverage for off-label drugs to treat cancer in certain circumstances	Individual, Group, HMO	62Q.525
Dental Anesthesia	Anesthesia and hospital charges for dental care	Individual, Group, HMO	62A.308
Diabetes Care Management	Coverage for chemical	Health plan that provides coverage	62Q.137

	dependency in corrections facilities	for chemical dependency	
Mental Health Other	Coverage for mental health medically necessary care	Individual, Group, HMO	62Q.53
Mental Health Other	Court-ordered mental health services	Individual, Group, HMO	62Q.535
Off Label Prescription Drugs	Nonformulary antipsychotic drugs	Individual, Group, HMO	62Q.527
Congenital Anomaly, including Cleft Lip/Palate	Cleft lip/cleft palate	Individual, Group, HMO	62A.042
Treatment of Lyme Disease	Lyme disease	Individual, Group, HMO	62A.265
Port-Wine Stain Removal	Port-wine stain removal	Individual, Group, HMO	62A.304
Residential Treatment for Children with Emotional Disabilities	Health insurance benefits for emotionally disabled children	All health plans	62A.151
Services to Ventilator-Dependent Persons	Coverage of services to ventilator-dependent persons	All health plans	62A.155

	Anesthetics	Qualified Plans	62E.06 Subd. 1(b)(8)
Mental/Behavioral Health Outpatient Services	Family therapy	HMO	62D.102
Outpatient Surgery Physician/Surgical Services	Oral surgery	Qualified Plans	62E.06 Subd. 1(b)(12)
	Oxygen	Qualified Plans	62E.06 Subd. 1(b)(7)
Substance Abuse Disorder Outpatient Services	Second opinions related to chemical dependency and mental health	HMO	62D.103
	Second surgical opinions	Qualified Plans	62E.06 Subd. 1(e)
Chemotherapy	Cancer Chemotherapy Treatment Coverage	All health Plans	62A.3075
	Benefits for DES Related Conditions	All health Plans	62A.154
	Conditions caused by Breast Implants	All health Plans	62A.285 Subd. 2

10-Year Waiver Budget (Budget Neutrality)

As discussed in the actuarial report, the proposed waiver will not reduce federal revenues or increase federal spending.

Ensuring Compliance, Reducing Waste and Fraud

Commerce has the responsibility for regulating and ensuring the compliance and solvency of all issuers, performing market conduct analysis and examinations, investigations, and providing consumer outreach. The Minnesota Department of Health also regulates and ensures compliance for HMOs specifically, but monitors all issuers' accreditation, quality, and network adequacy.

The State of Minnesota, MCHA, and MinnesotaCare prepare financial statements and reports annually. Financial statements are audited annually. The state's enabling legislation creates several new accounting, auditing, and reporting requirements for MCHA as part of its administration of the MPSP. The MPSP is also subject to audit by Minnesota's Legislative Auditor.

The State of Minnesota, MinnesotaCare, and MCHA are audited annually by Certified Public Accountants.

Federal staff are responsible for determining the savings calculations related to this waiver and ultimately ensuring that there are no increases to federal spending related to this waiver.

Implementation Timeline and Process

Minnesota expects implementation of the waiver can be accomplished in order to be in place for the plan year starting January 1, 2023.

An implementation timeline is included as Attachment B.

Reporting Responsibilities

As required under 45 CFR 155.1308(f)(4), Commerce will submit quarterly, annual, and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement.

In addition, Commerce proposes to include the following information in the reports:

- Evidence of compliance with public forum requirements (within six-months after waiver implementation and annually thereafter), including date, time, place, description of attendees, the substance of public comment and the state's response, if any.
- Information about any challenges the state may face in implementing and sustaining the waiver program and its plan to address the challenges.
- A description of any substantive changes in Minnesota's insurance market such as the number of insurers serving the individual market.
- Any other information consistent with the terms and conditions in the state's approved waiver.
- Information related to scope, affordability, comprehensiveness, and deficit neutrality that Commerce proposes to provide on a quarterly, annual and cumulative basis, where appropriate.

As required, Minnesota will hold public meetings annually and as otherwise required. The date, time, and location of each forum will be posted on the Commerce website. Consumers and business organizations will also be notified using existing communication channels. Each meeting will be conducted at a site that allows both in-person and virtual attendance to accommodate residents across the state, unless permission is granted from CMS to conduct the meeting in an alternative manner.

Minnesota's current enabling legislation requires MCHA to submit an annual public report summarizing plan operations for each benefit year 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.

Minnesota will provide the Federal government with all information necessary to administer the Federal waiver. This includes annual data on advanced premium tax credits provided to Minnesotans, the second-lowest cost silver premiums before and after the waiver as submitted by the carriers, overall premiums, and enrollment.

Waiver Development Process

As required under 1332(a)(1)(B)(i), Minnesota's state legislature authorized submission and implementation of the proposed waiver. This bill language can be found in Attachment A.

As required in 1332 (a)(4)(B)(i), public hearings will be scheduled in accordance with 31 CFR 33.112 and 45 CFR 155.1312, to address the state public notice requirements once the state passes final legislation.

In addition, the state has offered separate tribal consultation to Minnesota's eleven Federally-Recognized Tribal Governments in compliance with federal requirements and Commerce and DHS' agency tribal consultation policies. Commerce presented on the waiver at the Minnesota Indian Affairs Council on November 16, 2021. Additionally, the state will offer separate tribal consultation to Minnesota's eleven Federally-Recognized Tribal Governments in compliance with federal requirements and Commerce and DHS' agency tribal consultation policies once the state passes final legislation.

A summary of comments will be included as they are received.

Attachment A: Existing Legislation

2021 Special Session 1, Chapter 7, Article 15

ARTICLE 15

REINSURANCE

Section 1. Laws 2017, chapter 13, article 1, section 15, as amended by Laws 2017, First Special Session chapter 6, article 5, section 10, and Laws 2019, First Special Session chapter 9, article 8, section 19, 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, 2023 2024, 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.

Sec. 2. MINNESOTA PREMIUM SECURITY PLAN ADMINISTERED THROUGH THE 2022 BENEFIT YEAR.

(a) The Minnesota Comprehensive Health Association must administer the Minnesota premium security plan through the 2022 benefit year.

(b) Notwithstanding Minnesota Statutes, section 62E.23, the Minnesota premium security plan payment parameters for benefit year 2022 are:

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

(2) a coinsurance rate of 60 percent; and

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

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

Sec. 3. PLAN YEAR 2022 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, is July 9, 2021. 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 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.

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

Sec. 4. CONTINUATION OF STATE INNOVATION WAIVER.

The commissioner of commerce shall apply to the secretary of health and human services under United States Code, title 42, section 18052, for a continuation of the state innovation waiver previously granted to implement the Minnesota premium security plan for benefit years beginning January 1, 2023, to maximize federal funding. The commissioner must submit the application by December 31, 2021. The waiver application must clearly state that operation of the Minnesota premium security plan after the 2022 benefit year is contingent on approval of the waiver request.

Sec. 5. TRANSFERS; REINSURANCE.

(a) The commissioner of management and budget shall transfer $79,101,000 from the general fund to the health care access fund by June 30, 2023, for state basic health plan costs related to the loss of federal revenue associated with a reinsurance plan. This is a onetime transfer.

(b) The commissioner of commerce shall transfer $5,948,000 from the premium security plan account, authorized in Minnesota Statutes, section 62E.25, subdivision 1, to the health care access fund by June 30, 2023, for state basic health plan costs related to the loss of federal revenue associated with a reinsurance plan. This is a onetime transfer.

(c) The commissioner of management and budget shall transfer $3,844,000 in fiscal year 2022 from the general fund to the MNsure account established under Minnesota Statutes, section 62V.07. This is a onetime transfer.

(d) The commissioner of human services, in consultation with the commissioners of commerce and management and budget, shall review the federal funding for the state basic health plan to determine whether federal funding for the plan has been modified to account for changes in the benchmark premium due to the Minnesota premium security plan authorized in section 2 for calendar year 2022.

(e) The commissioner shall conduct the review in paragraph (d) prior to the February 2022 and November 2022 state budget forecasts. If the commissioner determines the federal funding for the state basic health plan has been modified, the commissioner shall estimate the loss of federal funding for the basic health plan after the modification. The commissioner of management and budget must adjust the February 2022 and November 2022 state budget forecasts based on the findings of this review, according to this section.

(f) If the commissioner determines that the reduction of federal funding for the basic health plan in paragraph (d) is less than $85,049,000, the commissioner of management and budget shall transfer the difference between $85,049,000 and the estimated reduction in federal funding from the health care access fund to the general fund and the premium security plan account in amounts proportional to the transfers in paragraphs (a) and (b). These transfers are onetime and must be made by June 30, 2023.

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

Sec. 6. APPROPRIATIONS; REINSURANCE.

(a) $155,000 is appropriated in fiscal year 2022 from the general fund to the commissioner of commerce to prepare and submit the state innovation waiver renewal. This is a onetime appropriation.

(b) $41,393,000 in fiscal year 2022 and $43,656,000 in fiscal year 2023 are appropriated from the health care access fund to the commissioner of human services for MinnesotaCare program costs. These are onetime appropriations.

2017, 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 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.

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.

CHAPTER 62E - COMPREHENSIVE HEALTH INSURANCE

62E.01 ….62E.08 [Not applicable to the reinsurance program.

These sections discuss another subject on special Minnesota-specific disclosers pre-dating the ACA.]

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) formulate general policies to advance the purposes of sections 62E.01 to 62E.19;

(b) supervise the creation of the Minnesota Comprehensive Health Association within the limits described in section 62E.10;

(c) approve the selection of the writing carrier by the association, approve the association's contract with the writing carrier, and approve the state plan coverage;

(d) appoint advisory committees;

(e) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;

(g) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.15, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

(h) contract with insurers and others for administrative services; and

(i) adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.19.

62E.091 [Not applicable to the reinsurance program.

These sections discuss another subject on special Minnesota-specific disclosers pre-dating the ACA.]

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.§

Subdivision 1.Creation; tax exemption. There is established a Comprehensive Health Association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternals; joint self-insurance plans regulated under chapter 62H; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; health maintenance organizations; and community integrated service networks licensed or authorized to do business in this state. The Comprehensive Health Association is exempt from the taxes imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

§ 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. §

Subd. 2a.Appeals. A person may appeal to the commissioner within 30 days after notice of an action, ruling, or decision by the board.

A final action or order of the commissioner under this subdivision is subject to judicial review in the manner provided by chapter 14.

In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.§

Subd. 3.Mandatory membership. All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, health maintenance organization, or community integrated service network business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 14.001 to 14.69.§

Subd. 4.Open meetings. All meetings of the association, its board, and any committees of the association shall comply with the provisions of chapter 13D, except that during any portion of a meeting during which an enrollee's appeal of an action of the writing carrier is being heard, that portion of the meeting must be closed at the enrollee's request.§

Subd. 5. [Repealed]§

Subd. 6.Antitrust exemption. In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325D.49 to 325D.66.§

Subd. 7.General powers. The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by section 62E.04 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) individual qualified plans, excluding group conversions;

(2) group conversions;

(3) group qualified plans with fewer than 50 employees or members; and

(4) major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses

incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.§

Subd. 8.Department of state exemption. The association is exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt rules, the association may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.§

Subd. 9.Experimental delivery method. The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.§

Subd. 10.Cost containment goals. (a) By July 1, 2001, the association shall investigate managed care delivery systems, and if cost effective, enter into contracts with third-party entities as provided in section 62E.101.

(b) By July 1, 2001, the association shall establish a system to annually identify individuals insured by the Minnesota Comprehensive Health Association who may be eligible for private health care coverage, medical assistance, state drug programs, or other state or federal programs and notify them about their eligibility for these programs.

(c) The association shall endeavor to reduce health care costs using additional methods consistent with effective patient care. At a minimum, by July 1, 2001, the association shall:

(1) develop a focused chronic disease management and case management program;

(2) develop a comprehensive program of preventive care; and

(3) implement a total drug formulary program.

The association may establish an enrollee incentive based on enrollee participation in the chronic disease management and case management program developed under this section.

62E.101-19 [Not applicable to the reinsurance program.

These sections discuss another subject on special Minnesota-specific disclosers pre-dating the ACA.]

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.

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.

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.

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.

62E.25 ACCOUNTS.

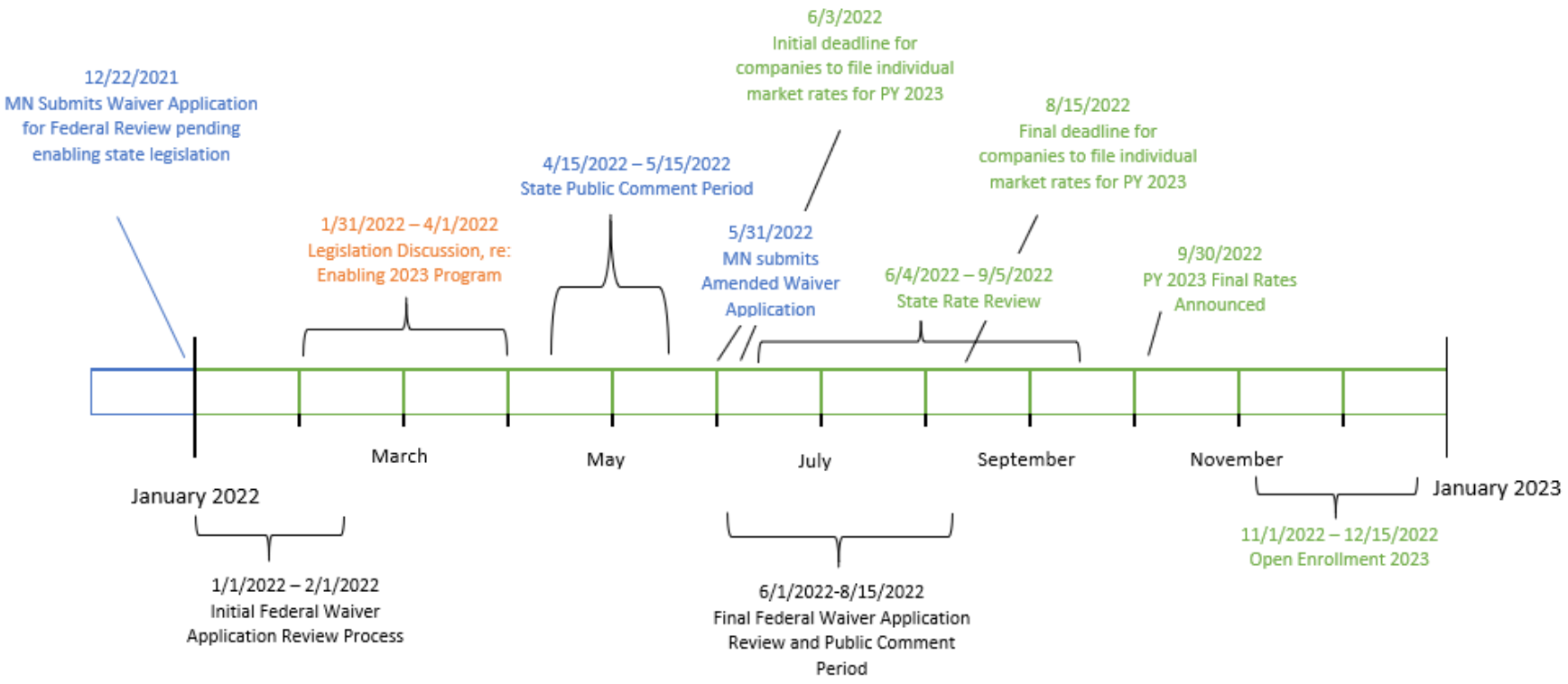
Subdivision 1. Premium security plan account. The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational 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.

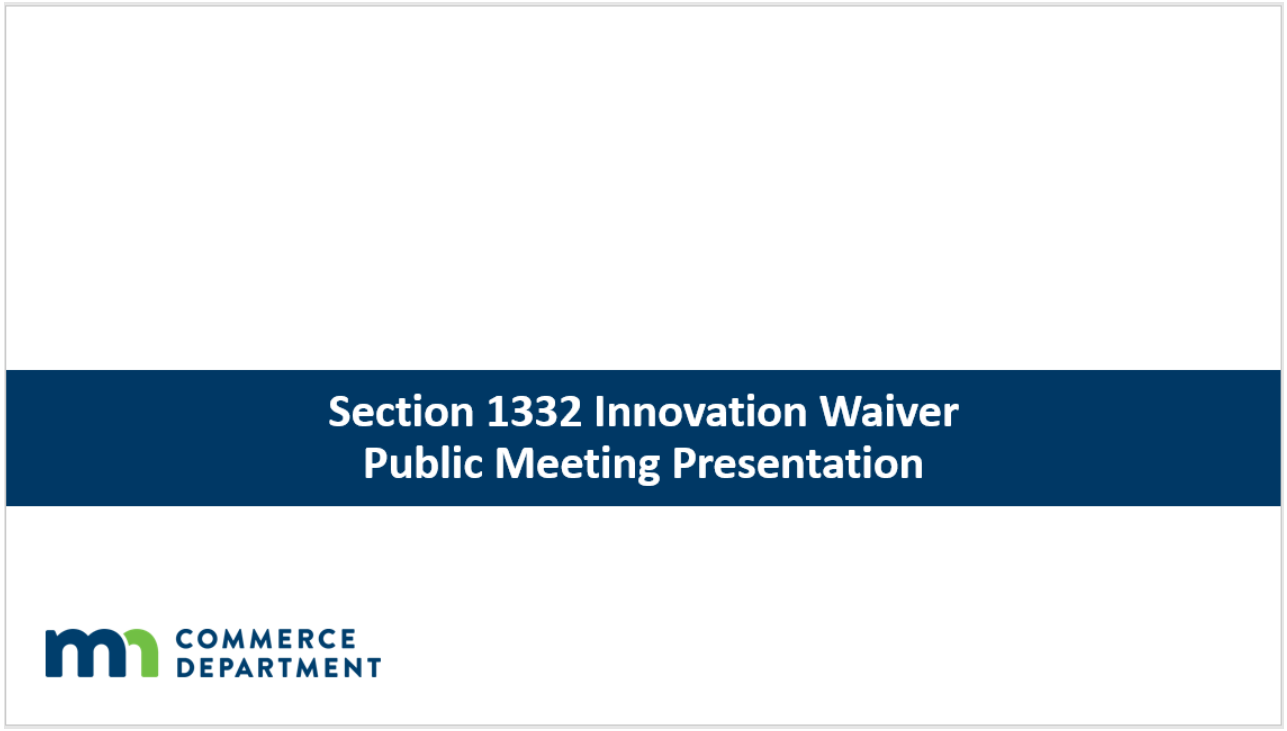
Attachment B: Timeline

Best estimate timeline for 1332 waiver extension application:



Attachment C: Slides From Public Hearings

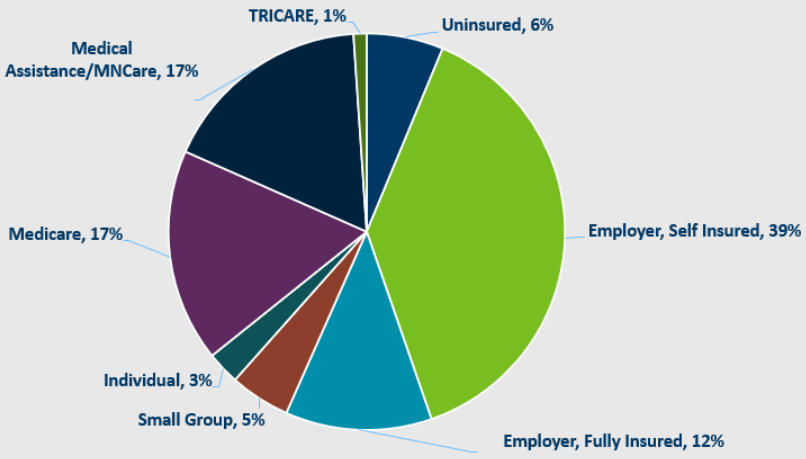
Most recent public hearing, June 24, 2021:



Presentation overview

- How Minnesotans receive their health insurance coverage
- The state of Minnesota's individual market in 2016-17
- Actions taken by the Minnesota Legislature to make coverage more affordable
- Minnesota's 1332 waiver for an individual market reinsurance program
- Reinsurance program figures, 2018-2020
- Impact of COVID-19
- Impact of American Rescue Plan Act (ARPA)
- Reinsurance status, 2022

Distribution of Minnesota Population by Primary Source of Insurance Coverage, 2017



Sources: MDH Health Economics Program; U.S. Census Bureau, Annual Estimates of the Population for July 1, 2018.
High Risk Pool ended in 2014. Individual may also be referred to as non-group market. Employer, fully insured is a residual of the MDH fully insured estimate, net of individual and small group coverage.

2016-17 individual market landscape

- Some federal programs providing individual market stability expired
- Another key Affordable Care Act aspect, premium tax credits (PTC), continued to provide stability to those with incomes below 400% of federal poverty level (FPL)
- For individual market enrollees with incomes above 400% FPL, vulnerability to instability
- Instability triggered by more participants with high-cost claims than expected

2016-17 individual market landscape, continued

- Minnesota insurance companies reacted with rate increases, enrollment cap requests, narrower provider networks and a market exit:
  - From 2014 to 2017, the gross average premium per enrollee per month rose from $206 to $526
- Worst-case example: Family in Rochester, 60-year old head of household, with $105,000 of income, paying $2,000 per month in premiums
- Market enrollment dropped significantly:
  - Enrollment peaked in 2015 with over 300,000 enrollees
  - Approximately 260,000 in 2016
  - Approximately 160,000 in 2017

Legislative initiatives around insurance affordability

- In January 2017, the legislature authorized a 25% direct premium subsidy funded by the state and administered by the health carriers
  - All individual market enrollees not receiving advanced premium tax credits from the federal government received the state discount for the remainder of 2017
  - Program ultimately cost approximately $137 Million and served approximately 118,000 Minnesotans
- In April 2017, the legislature authorized a state-based reinsurance program called the Minnesota Premium Security Plan (MPSP)
  - This law required filing for approval of a 1332 waiver program from the federal government

Minnesota's 1332 waiver application

- The reinsurance program required federal approval via Section 1332
- Commerce and DHS prepared the 1332 waiver application, working with federal agencies on language designed to ensure that the State's Basic Health Plan (BHP), MinnesotaCare, would be held harmless
- On September 22, 2017, CMS partially approved Minnesota's application, authorizing reinsurance but not holding BHP funding harmless
- Governor Dayton signed the agreement, but did not waive Minnesota's rights to the BHP funding
- 1332 waivers last up to five years

1332 waiver approval

- Minnesota's waiver, associated with the MPSP, aimed to do the following:
  - Maximize federal funding to reduce individual market premiums
  - Capture federal funds that would otherwise already come to Minnesota
    - Minnesota's 1332 waiver application showed that the program is deficit-neutral to the federal government
  - Stabilize the individual market
    - 2018 - 2021 rates were approximately 20 percent lower than they would be absent the program
    - Carriers in the market in 2017 remained in the market thereafter
    - For plan year 2021, all counties have more than one carrier offering coverage

Reinsurance administration and processes

- The Minnesota Comprehensive Health Association (MCHA) oversees the reinsurance program
  - MCHA has developed auditing, accounting and payment procedures to make 2020 reinsurance payments to carriers by August 15, 2021
- Financial cost of high-cost claims to carriers and to the state are determined as claims develop over the year
- Quarterly and annual reports are due to the federal government throughout the duration of the waiver

Reinsurance federal funding and program size, 2018-20

	2018	2019	2020
Federal funding	$130.7 million	$84.8 million	$86.1 million
Program size	$136.1 million	$149.7 million	$160.2 million

Distribution of Reinsurance Payment Dollar Amounts by Rating Area 2020

Rating Area	Reinsurance Distribution*	Enrollment Distribution**
Rating Area 1 - Rochester	11%	5%
Rating Area 2 - Duluth	6%	5%
Rating Area 3 - South Central	7%	4%
Rating Area 4 - South West	2%	3%
Rating Area 5 - West Central	4%	4%
Rating Area 6 - West	5%	4%
Rating Area 7 - Central	7%	8%
Rating Area 8 - Metro/St. Cloud	57%	66%
Rating Area 9 - North West	1%	1%
Statewide	**100%**	**100%**

*Initial 2020 Benefit Year MPSP Report, Wakely Consulting Group
**Enrollment data as of April 2019, aggregated by MN Dept of Commerce

COVID-19 reinsurance program impact

- Claims decreased in 2Q 2020 (mainly due to reduction in elective procedures)
- Claims increased later in the year
- The net result for 2020 was reinsurance costs being close to expectations.

2021 individual market landscape

- Key development: American Rescue Plan Act (federal stimulus)
  - Effective March 11, 2021
  - Substantially increased premium tax credits, including for those with over 400% FPL of income
  - Most individual market enrollees with an on-exchange plan can expect to receive more federal PTC, starting in 2021 (so retroactively).
  - Individual market enrollees have an opportunity to change plans to take advantage of increased PTC.

American Rescue Plan impact

- Previous worst-case example:
  - 60 year old couple in Rochester with $105,000 income that was paying $2,000 per month
  - What they will pay under the American Rescue Plan: $744.
- Many individual market enrollees will see substantial decreases in what they pay in premiums

American Rescue Plan impact, continued

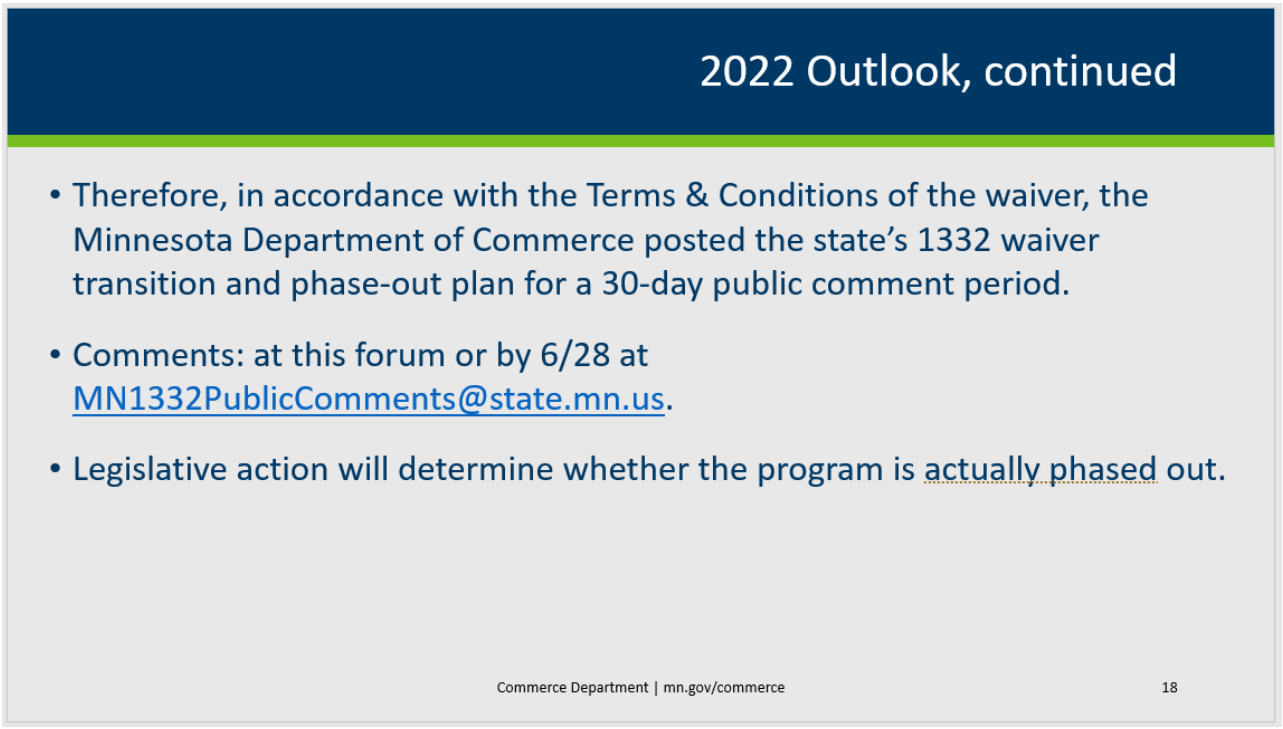
- Congress capped what people pay for benchmark coverage as a percentage of income.
- Above 400% FPL income, that percentage is 8.5%
- For lower income levels, that percentage is substantially lower
- Impact is for plans purchased on exchange
- For those in low-cost categories (low-cost regions or lower ages) with benchmark premiums below the income cap:
  - Increase PTC does not apply; these enrollees may face moderate rate increases in 2022

American Rescue Plan impact, continued

- With the new subsidies, the reinsurance program's cost related to the benefits provided to Minnesotans has shifted substantially.
- On net, we would expect ARPA to have the effect of significantly reducing overall premium costs for at least 100,000 Minnesotans in 2022.
- With the income-capped premiums, service area coverage is expected to remain stable.
- Consumer protections such as coverage for essential health benefits and pre-existing conditions will continue.

2022 Outlook

- Reinsurance was initially authorized by the legislature for two years, 2018 and 2019.
- It was subsequently re-authorized for another two years, 2020 and 2021.
- The program has not been authorized beyond that period.
- Discussions are taking place at the legislature regarding a 2022 program



Note that the legislature extended the reinsurance program into 2022 five days after the June 24, 2021 public hearing. Therefore the presentation bullets on phasing out the program are no longer applicable.

Upcoming activities

- Offer tribal consultations and other stakeholder engagement opportunities (from now until late June)
- Host public forum, including discussion of program phase-out (today)
- TBD, depending on legislative action:
  - Incorporate the public feedback into a formal notification letter to the federal Center for Medicare & Medicaid Services (CMS) (prior to July 1)
  - Submit formal notification letter and phase-out plan to CMS (by July 1)
  - Begin phase-out implementation activities (within 14 days of federal approval of plan)

Upcoming activities, continued

- Make reinsurance payments to health carriers for 2020 expenses (by August 2021)
- Submit draft annual program report to CMS (by March 31, 2022)
- Publish draft annual program report on Commerce website (within 30 days of submission to CMS)
- Submit final annual program report to CMS (within 60 days of receipt of federal comments)
- Post final annual program report on Commerce website (within 30 days of approval the report)

Upcoming activities, continued

- Host final post-award public forum (by June 30, 2022)
- Make reinsurance payments to health carriers for 2021 expenses (by August 2022)
- Regardless of the status of a 2022 program, the state will receive federal funding, as scheduled, through the end of the program, which will be used to fund a portion of the reinsurance payments.

Questions or comments?