WEEKLY SESSION UPDATE

January 27, 2017

Premium Relief Bill Signed into Law

Last night Governor Mark Dayton signed the health insurance premium relief bill, SF 1, into law, just hours after it passed out of the House 108-19 and the Senate 47-19. The bill will provide $326 million in premium relief to Minnesotans who buy coverage on the individual market. As many as 120,000 people could start seeing significant drops in their health insurance premiums. Relief dollars will be spent throughout 2017 and will retroactively reduce enrollee premiums by approximately 25%. Some other provisions included are not controversial, including $15 million that will help people with serious medical conditions keep their doctors into 2017 even if they have lost their old plan's network. Others are more controversial, such as allowing for-profit companies to operate as HMOs in Minnesota. For decades, HMOs in Minnesota have been required to be nonprofits.

Key provisions in the bill include:

Surprise Billing Language

- For care provided at an in-network facility, patients will not have to pay out-of-network rates when they receive care from a non-network physician or other provider without their advance understanding or ability to choose. This is expected to affect specialties like anesthesia, pathology, and radiology if they are not part of a patient's insurance network and are practicing in an in-network hospital or surgery center. A disclosure provision applies to specimens collected by a physician and referred to an external lab, pathologist or other testing facility. The bill as passed directs physicians and health plans to negotiate the out-of-network rate. If they can't reach an agreement, either side can seek review by an independent arbitrator. The Commissioner of Health must develop a list of arbitrators to address these disputes. To determine reimbursement, arbitrators will reference a number of sources, including a health plan company's payments to other non-participating providers for the same services and a national database gathered by an independent, nonprofit that tracks all payers to determine a usual, customary and reasonable payment for physicians.

HMOs

- Minnesota will now allow for-profit HMOs to operate in the state. During floor debate, Senate Democrats tried to get this issue removed but didn't have enough votes.

Agriculture Co-ops

- Language permitting the creation of an agricultural cooperative program was included. This allows farmers and others in the agriculture industry to pool together and purchase health insurance as a group in an effort to lower their costs.

Narrow Networks

- To address increasing concerns about narrow networks, the bill allows physicians and other

providers the ability to appeal a waiver of network adequacy requirements granted to a health plan by the health department. Under current law, the health department may grant waivers of network requirements, including access within 30 minutes/30 miles to primary care physicians, general hospital, and mental health services, and 60 minutes/60 miles for specialty practices. If the health plan demonstrates with specific data that the network requirements are not feasible in a particular area. For 2017, appeals must be filed within 60 days of enactment of the law (approximately March 26). Appeals will take place before an administrative law judge.

Continuity of Care

- The bill also provides some limited continuity of care coverage to individuals who purchase coverage on their own on the individual market and if their health plan pulled out of the market in 2017. Physicians and other providers who had been treating a patient, but are no longer in the patient's new health plan network, can provide - at in-network rates - up to 120 days of care if the patient was being treated for: an acute condition; a life-threatening mental or physical illness; pregnancy beyond the first trimester of pregnancy; a physical or mental disability defined as an inability to engage in one or more major life activities, provided the disability has lasted or can be expected to last for at least one year or can be expected to result in death, or a disabling or chronic condition that is in an acute phase; or, for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or fewer.

Provisions dropped from the final bill:

Mandate Repeal

- A House amendment that would have allowed insurers to sell bare-bones coverage in Minnesota. This proposal would have allowed insurers to sell policies that would not have to, for example, cover preventive care, immunizations, mental health coverage, and maternity care to name a few.

High Risk Pool

- A proposal to reinstate a high-risk pool, similar to the former Minnesota Comprehensive Health Association, was removed. The issue of risk pooling and re-insurance may come up in separate legislation.

Attached, please find a letter to conference committee members with concerns over several elements in the original bill.

Below is the final language for unauthorized provider services contained in the bill.

Sec. 13. **[62Q.556] UNAUTHORIZED PROVIDER SERVICES.**

Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph (c), unauthorized provider services occur when an enrollee receives services:

(1) from a nonparticipating provider at a participating hospital or ambulatory surgical center, when the services are rendered:

(i) due to the unavailability of a participating provider;

(ii) by a nonparticipating provider without the enrollee's knowledge; or

(iii) due to the need for unforeseen services arising at the time the services are being rendered; or

(2) from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility.

(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.

(c) The services described in paragraph (a), clause (2), are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized provider services shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.

(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the department of health's Web Site, and update the list as appropriate.

(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.

EFFECTIVE DATE. This section is effective 90 days following final enactment and applies to provider services provided on or after that date.

Sec. 14. Minnesota Statutes 2016, section 297I.05, subdivision 12, is amended to read:

Subd. 12. **Other entities.** (a) A tax is imposed equal to two percent of: