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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1129

02/13/2017 Authored by Liebling; Schultz; Quam; Dean, M.; Sauke and others
The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform

A bill for an act

relating to insurance; making the state of Minnesota a single geographic rating area for individual health plans; allowing enrollees access to out-of-network referral centers; amending Minnesota Statutes 2016, section 62A.65, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. Minnesota Statutes 2016, section 62A.65, subdivision 3, is amended to read:

Subd. 3. **Premium rate restrictions.** No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates may vary based upon the ages of covered persons in accordance with the provisions of the Affordable Care Act.

~~(b) Premium rates may vary based upon geographic rating area. The commissioner shall grant approval if the following conditions are met:~~

~~(1) the areas are established in accordance with the Affordable Care Act;~~

~~(2) each geographic region must be composed of no fewer than seven counties that create a contiguous region; and~~

~~(3) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in premium rates for each area, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.~~

~~(c)~~ (b) Premium rates may vary based upon tobacco use, in accordance with the provisions of the Affordable Care Act.

~~(d)~~ (c) In developing its premiums for a health plan, a health carrier shall take into account only ~~the following factors:~~

~~(1)~~ actuarially valid differences in rating factors permitted under paragraphs (a) and ~~(c);~~ ~~and~~ (b).

~~(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (b).~~

(d) The state of Minnesota shall constitute a single geographic rating area for purposes of setting premium rates.

(e) The premium charged with respect to any particular individual health plan shall not be adjusted more frequently than annually or January 1 of the year following initial enrollment, except that the premium rates may be changed to reflect:

(1) changes to the family composition of the policyholder;

~~(2) changes in geographic rating area of the policyholder, as provided in paragraph (b);~~

~~(3)~~ (2) changes in age, as provided in paragraph (a);

~~(4)~~ (3) changes in tobacco use, as provided in paragraph ~~(c)~~ (b);

~~(5)~~ (4) transfer to a new health plan requested by the policyholder; or

~~(6)~~ (5) other changes required by or otherwise expressly permitted by state or federal law or regulations.

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) The rates must not be approved, unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in effect and actuarially valid changes in risks associated with the enrollee populations.

(i) A health carrier may, as part of a minimum lifetime loss ratio guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee as provided in this paragraph. The rating practices guarantee must be in writing and must guarantee that the

policy form will be offered, sold, issued, and renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5. The rating practices guarantee must be accompanied by an actuarial memorandum that demonstrates that the premium rates and premium rating system used in connection with the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any excess premiums to policyholders charged premiums that exceed those permitted under subdivision 2, 3, 4, or 5. A health carrier that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs ~~(b),~~ (f)~~,~~ and (h).

(j) The commissioner may establish regulations to implement the provisions of this subdivision.

EFFECTIVE DATE. This section is effective for health plans offered, issued, or renewed on or after January 1, 2018.

Sec. 2. **[62Q.581] ACCESS TO OUT-OF-NETWORK REFERRAL CENTER.**

Subdivision 1. **Definition.** For purposes of this section, "out-of-network referral center" means a referral center that is not part of a health plan company's network and is:

(1) a hospital operated at two campus locations in Rochester, Minnesota, and owned and operated by a health system that has its principal place of business in Rochester, Minnesota;

(2) a clinic or physician practice for physicians who practice at one or both of the hospital campus locations in clause (1);

(3) a hospital or children's hospital owned by a health system and affiliated with the University of Minnesota; or

(4) a nonprofit clinical practice organization for the faculty of the University of Minnesota School of Medicine.

Subd. 2. **Enrollee access.** (a) A health plan company must allow an enrollee to request access to an out-of-network referral center, at in-network cost sharing, including any deductible, co-pay, or coinsurance, where there is a clinical need identified by the enrollee's referring provider and there are no available in-network referral centers for that clinical need.

(b) A health plan company must review requests and make a determination of whether an enrollee may access an out-of-network referral center within 72 hours for urgent care, and within 15 calendar days for nonurgent care. If no contractual arrangement exists between

the health plan company and out-of-network referral center, the health plan company shall reimburse the out-of-network referral center at a rate determined by the amounts generally billed calculation for the services rendered in section 501(r)(5) of the Internal Revenue Code of 1986, as amended through December 31, 2016.

EFFECTIVE DATE. This section is effective for health plans offered, issued, or renewed on or after January 1, 2018.