SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 1523

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
03/09/2015	610	Introduction and first reading Referred to Commerce
03/18/2015	917a	Comm report: To pass as amended
	962	Second reading
04/30/2015		Special Order: Amended Third reading Passed

A bill for an act

relating to commerce; regulating health coverages; modifying coverages; amending Minnesota Statutes 2014, sections 62A.3075; 62A.65, subdivision 3; 62L.05, subdivision 9; 62L.08, by adding a subdivision; 62Q.18; 62Q.73, subdivision 3.

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

Section 1. Minnesota Statutes 2014, section 62A.3075, is amended to read:

62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.

(a) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(c) Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

(e) <u>For health plans that have a multi-tier benefit structure for prescription drugs,</u> a health plan company is in compliance with this section if it does not include orally

administered anticancer medication in the ~~fourth~~ coverage tier of its pharmacy benefit with the highest cost-sharing.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 2. Minnesota Statutes 2014, 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) Premium rates may vary based upon tobacco use, in accordance with the provisions of the Affordable Care Act.

(d) 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

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

(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) changes in age, as provided in paragraph (a);

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

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

(6) 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.

(k) The provisions of Minnesota Statutes 2012, section 62A.65, subdivision 3, apply to grandfathered plans.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2014.

Sec. 3. Minnesota Statutes 2014, section 62L.05, subdivision 9, is amended to read:

Subd. 9. **Dependent coverage.** Other state law and rules applicable to health plan coverage of newborn infants, dependent children ~~who do not reside with the eligible employee~~, disabled dependent children ~~and dependents~~, and adopted children apply to a small employer plan. Health benefit plans that provide dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Sec. 4. Minnesota Statutes 2014, section 62L.08, is amended by adding a subdivision to read:

Subd. 12. **Grandfathered plans.** The provisions of Minnesota Statutes 2012, section 62L.08, apply to grandfathered plans.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2014.

Sec. 5. Minnesota Statutes 2014, section 62Q.18, is amended to read:

62Q.18 PORTABILITY OF COVERAGE.

Subdivision 1. **Definition.** For purposes of this section,

(1) "continuous coverage" has the meaning given in section 62L.02, subdivision 9;

(2) "guaranteed issue" means:

(i) for individual health plans, that a health plan company shall not decline an application by an individual for any individual health plan offered by that health plan company, including coverage for a dependent of the individual to whom the health plan has been or would be issued; and

(ii) for group health plans, that a health plan company shall not decline an application by a group for any group health plan offered by that health plan company and shall not decline to cover under the group health plan any person eligible for coverage under the group's eligibility requirements, including persons who become eligible after initial issuance of the group health plan;

(3) "large employer" means an entity that would be a small employer, as defined in section 62L.02, subdivision 26, except that the entity has more than 50 current employees, based upon the method provided in that subdivision for determining the number of current employees;

(4) "preexisting condition" has the meaning given in section 62L.02, subdivision 23; and

(5) "qualifying coverage" has the meaning given in section 62L.02, subdivision 24.

Subd. 7. **Portability of coverage.** Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage and who qualify under the group's eligibility requirements:

(1) make coverage available on a guaranteed issue basis;

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or preexisting condition exclusion; and

(3) with respect to a group health plan offered, sold, issued, or renewed to a large employer, impose preexisting condition limitations or preexisting condition exclusions except to the extent that would be permitted under chapter 62L if the group sponsor were a small employer as defined in section 62L.02, subdivision 26.

To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. ~~An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L.~~

Subd. 10. **Guaranteed issue.** No health plan company shall offer, sell, or issue any health plan that does not make coverage available on a guaranteed issue basis in accordance with the Affordable Care Act.

Sec. 6. Minnesota Statutes 2014, section 62Q.73, subdivision 3, is amended to read:

Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. No enrollee may be subject to filing fees totaling more than $75 during a plan year for group coverage or policy year for individual coverage.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

(d) The enrollee must request external review within ~~six~~ 9 months from the date of the adverse determination.