State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2216

02/13/2012 Authored by Hoppe, Davids, Sanders and Abeler
The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform
02/23/2012 Adoption of Report: Pass and Read Second Time

A bill for an act

relating to insurance; the Minnesota Comprehensive Health Association; permitting flexibility in premium rate-setting process; permitting closing enrollment in two plans; permitting flexibility in benefits; amending Minnesota Statutes 2010, sections 62E.08, subdivisions 1, 3; 62E.091; 62E.12.

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

Section 1. Minnesota Statutes 2010, section 62E.08, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The association shall establish the following maximum premiums to be charged for membership in the comprehensive health insurance plan:

(a) the premium for the number one qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $1,000 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a $1,000 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(b) the premium for the number two qualified plan shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $500 annual deductible individual plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage with a $500 annual deductible which are in force in Minnesota; and

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(c) the premiums for the plans with a $2,000, $5,000, or $10,000 annual deductible shall range from a minimum of 101 percent to a maximum of 125 percent of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) $2,000, $5,000, or $10,000 annual deductible individual plans, respectively, in force in Minnesota; and

(2) individual health maintenance organization contracts of coverage with a $2,000, $5,000, or $10,000 annual deductible, respectively, which are in force in Minnesota; or

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles;

(d) the premium for each type of Medicare supplement plan required to be offered by the association pursuant to section 62E.12 shall ~~range from a minimum of 101 percent to a maximum of 125 percent of~~ be determined by calculating and applying the weighted average of ~~rates charged by those insurers and~~ the rate increases approved for the period for which the association premiums are to be effective for the three insurers or health maintenance organizations with the most individuals enrolled in:

(1) Medicare supplement plans in force in Minnesota;

(2) health maintenance organization Medicare supplement contracts of coverage which are in force in Minnesota; ~~and~~ or

(3) other plans of coverage similar to plans offered by the association based on generally accepted actuarial principles; and

(e) the charge for health maintenance organization coverage shall be based on generally accepted actuarial principles.

The list of insurers and health maintenance organizations whose rates are used to establish the premium for coverage offered by the association pursuant to paragraphs (a) to (d) shall be established by the commissioner on the basis of information which shall be provided to the association by all insurers and health maintenance organizations annually at the commissioner's request. This information shall include the number of individuals covered by each type of plan or contract specified in paragraphs (a) to (d) that is sold, issued, and renewed by the insurers and health maintenance organizations, including those plans or contracts available only on a renewal basis. The information shall also include the rates charged for each type of plan or contract.

In establishing premiums pursuant to this section, the association shall utilize generally accepted actuarial principles, provided that the association shall not discriminate

in charging premiums based upon sex. In order to compute a weighted average for each type of plan or contract specified under paragraphs (a) to (d), the association shall, using the information collected pursuant to this subdivision, list insurers and health maintenance organizations in rank order of the total number of individuals covered by each insurer or health maintenance organization. The association shall then compute a weighted average of the rates charged for coverage by all the insurers and health maintenance organizations by:

(1) multiplying the numbers of individuals covered by each insurer or health maintenance organization by the rates charged for coverage;

(2) separately summing both the number of individuals covered by all the insurers and health maintenance organizations and all the products computed under clause (1); and

(3) dividing the total of the products computed under clause (1) by the total number of individuals covered.

The association may elect to use a sample of information from the insurers and health maintenance organizations for purposes of computing a weighted average. In no case, however, may a sample used by the association to compute a weighted average include information from fewer than the two insurers or health maintenance organizations highest in rank order.

(f) Notwithstanding the provisions of this section, in calculating premiums to be effective January 1, 2014, and thereafter, the association may utilize rates for individual plans of insurance, individual health maintenance organization contracts, and other individual plans of coverage that are similar to plans offered by the association based upon generally accepted actuarial principles, so long as such plans and contracts have been filed with the Department of Commerce and are reasonably anticipated to be in force and individuals are reasonably anticipated to be enrolled in them during the period for which the association premiums are to be effective, regardless of whether they are in force in Minnesota or have individuals enrolled in them at the time the association is engaged in the rate-setting process mandated by this section and section 62E.091. For purposes of determining a weighted average under paragraph (e), the association shall use generally accepted actuarial principles to project potential enrollment in plans of coverage for the period for which the association's premiums will be effective and for which no individuals have enrolled at the time the association engages in the premium setting process.

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

Sec. 2. Minnesota Statutes 2010, section 62E.08, subdivision 3, is amended to read:

Subd. 3. **Determination of rates.** Premium rates under this section must be determined annually. These rates are effective July 1 of each year and must be based on a survey of approved rates of insurers and health maintenance organizations in effect, or to be in effect, on April 1 of the same calendar year. These rates may be trended to ~~July 1~~ the midpoint of the period for which the premium rates will apply in order to reflect economic and inflationary changes. Notwithstanding the provisions of this subdivision, the association may set rates to be effective for the 18-month period July 1, 2012, through December 31, 2013. For calendar years beginning January 1, 2014, and thereafter, premium rates shall be determined annually and effective January 1 of each year. Premium rates shall be prospective and trended forward to the midpoint of the period for which the premium rates apply to ensure that the association's rates are based upon individual market rates for insurers and health maintenance organizations that will be in effect during the period for which the association's rates will be effective.

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

Sec. 3. Minnesota Statutes 2010, section 62E.091, is amended to read:

62E.091 APPROVAL OF STATE PLAN PREMIUMS.

The association shall submit to the commissioner any premiums it proposes to become effective for coverage under the comprehensive health insurance plan, pursuant to section 62E.08, subdivision 3. No later than 45 days before the effective date for premiums specified in section 62E.08, subdivision 3, the commissioner shall approve, modify, or reject the proposed premiums on the basis of the following criteria:

(a) whether the association has complied with the provisions of section 62E.11, subdivision 11;

(b) whether the association has submitted the proposed premiums in a manner which provides sufficient time for individuals covered under the comprehensive insurance plan to receive notice of any premium increase no less than 30 days prior to the effective date of the increase;

(c) the degree to which the association's computations and conclusions are consistent with section 62E.08;

(d) the degree to which any sample used to compute a weighted average by the association pursuant to section 62E.08 reasonably reflects circumstances ~~existing~~ projected to exist in the private marketplace for individual coverage through the use of accepted actuarial principles during the period to which the association's rates will apply;

(e) the degree to which a weighted average computed pursuant to section 62E.08 that uses information pertaining to individual coverage available only on a renewal basis reflects the circumstances ~~existing~~ projected to exist through the use of accepted actuarial principles, in the private marketplace for individual coverage during the period to which the association's rates will apply;

(f) a comparison of the proposed increases with increases in the cost of medical care and increases ~~experienced~~ projected to occur through the use of accepted actuarial principles in the private marketplace for individual coverage during the period to which the association's rates will apply;

(g) the financial consequences to enrollees of the proposed increase;

(h) the actuarially projected effect of the proposed increase upon both total enrollment in, and the nature of the risks assumed by, the comprehensive health insurance plan;

(i) the relative solvency of the contributing members; and

(j) other factors deemed relevant by the commissioner.

In no case, however, may the commissioner approve premiums for those plans of coverage described in section 62E.08, subdivision 1, paragraphs (a) to (d), that are lower than 101 percent or greater than 125 percent of the weighted averages computed by the association pursuant to section 62E.08. The commissioner shall support a decision to approve, modify, or reject any premium proposed by the association with written findings and conclusions addressing each criterion specified in this section. If the commissioner does not approve, modify, or reject the premiums proposed by the association sooner than 45 days before the effective date for premiums specified in section 62E.08, subdivision 3, the premiums proposed by the association under this section become effective.

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

Sec. 4. Minnesota Statutes 2010, section 62E.12, is amended to read:

62E.12 MINIMUM BENEFITS OF COMPREHENSIVE HEALTH INSURANCE PLAN.

(a) The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan and a number two qualified plan, except that the maximum lifetime benefit on these plans shall be $5,000,000; and an extended basic Medicare supplement plan and a basic Medicare supplement plan as described in sections 62A.3099 to 62A.44. The association may also offer a plan that is identical to a number one and number two qualified plan except that it has a $2,000

annual deductible and a $5,000,000 maximum lifetime benefit. The association, subject to the approval of the commissioner, may also offer plans that are identical to the number one or number two qualified plan, except that they have annual deductibles of $5,000 and $10,000, respectively; have limitations on total annual out-of-pocket expenses equal to those annual deductibles and therefore cover 100 percent of the allowable cost of covered services in excess of those annual deductibles; and have a $5,000,000 maximum lifetime benefit. The association, subject to approval of the commissioner, may also offer plans that meet all other requirements of state law except those that are inconsistent with high deductible health plans as defined in sections 220 and 223 of the Internal Revenue Code and supporting regulations. As of January 1, 2006, the association shall no longer be required to offer an extended basic Medicare supplement plan.

(b) The requirement that a policy issued by the association must be a qualified plan is satisfied if the association contracts with a preferred provider network and the level of benefits for services provided within the network satisfies the requirements of a qualified plan. If the association uses a preferred provider network, payments to nonparticipating providers must meet the minimum requirements of section 72A.20, subdivision 15.

(c) The association shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

(d) Notwithstanding the provisions of section 62E.06 and unless those charges are billed by a provider that is part of the association's preferred provider network, the state plan shall exclude coverage of services of a private duty nurse other than on an inpatient basis and any charges for treatment in a hospital or other inpatient facility located outside of the state of Minnesota in which the covered person is receiving treatment for a mental or nervous disorder, unless similar treatment for the mental or nervous disorder is medically necessary, unavailable in Minnesota and provided upon referral by a licensed Minnesota medical practitioner.

(e) Notwithstanding the provisions of this section, the association may cease offering a number one qualified plan and a number two qualified plan on or after January 1, 2013.

(f) Beginning January 1, 2014, and for calendar years thereafter, the association may offer one or more plans containing the essential health benefits described in United States Code, title 42, section 18022, as amended.

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