CHAPTER 62E

HEALTH CARE

62E.08 STATE PLAN PREMIUM.

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) number one individual qualified plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage which are in force in Minnesota and which are, or are adjusted to be, actuarially equivalent to number one individual qualified plans; and

(3) individual policies and individual health maintenance organization contracts of coverage which are in force in Minnesota, are not qualified under section 62E.06, are, or are adjusted to be, actuarially equivalent to number one individual qualified plans, and do not fall under clause (2);

(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) number two individual qualified plans of insurance in force in Minnesota;

(2) individual health maintenance organization contracts of coverage which are in force in Minnesota and which are, or are adjusted to be, actuarially equivalent to number two individual qualified plans; and

(3) individual policies and individual health maintenance organization contracts of coverage which are in force in Minnesota, are not qualified under section 62E.06, are, or are adjusted to be, actuarially equivalent to number two individual qualified plans, and do not fall under clause (2);

(c) the premium for each type of qualified 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 the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in:

(1) qualified Medicare supplement plans in force in Minnesota;

(2) health maintenance organization Medicare supplement contracts of coverage which are in force in Minnesota and which are, or are adjusted to be, actuarially equivalent to qualified Medicare supplement plans; and

(3) Medicare supplement policies and health maintenance organization Medicare supplement contracts of coverage which are in force in Minnesota, are not qualified under section 62E.07, are, or are adjusted to be, actuarially equivalent to qualified Medicare supplement plans, and do not fall under clause (2); and

(d) 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 (c) 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 num-

ber of individuals covered by each type of plan or contract specified in paragraphs (a) to (c) 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 (c), 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. If the association so elects, the sample of information from insurers and health maintenance organizations shall, at a minimum, include information from those insurers and health maintenance organizations which, according to their order of ranking from the largest number of individuals covered to the smallest number, account for at least the first 51 percent of all individuals covered. 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.

Subd. 2. **Self-supporting.** Subject to subdivision 1, the schedule of premiums for coverage under the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

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.

History: *1993 c 324 s 1*

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) Formulate general policies to advance the purposes of sections 62E.01 to 62E.16;

(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.16, 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.16. The commissioner may until December 31, 1978 adopt emergency rules.

History: *1993 c 324 s 2*

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 in the private marketplace for individual coverage;

(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 in the private marketplace for individual coverage;

(f) a comparison of the proposed increases with increases in the cost of medical care and increases experienced in the private marketplace for individual coverage;

(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 (c), 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.

History: *1993 c 324 s 3*

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.

[For text of subds 1 to 8, see M.S.1992]

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.

History: *1993 c 324 s 4*

62E.11 OPERATION OF COMPREHENSIVE PLAN.

[For text of subds 1 to 11, see M.S.1992]

Subd. 12. **Funding.** Notwithstanding subdivision 5, the claims expenses and operating and administrative expenses of the association incurred on or after January 1, 1994, to the extent that they exceed the premiums received, shall be paid from the health care access account established in section 16A.724, to the extent appropriated for that purpose by the legislature. Any such expenses not paid from that account shall be paid as otherwise provided in this section. All contributing members shall adjust their premium rates to fully reflect funding provided under this subdivision. The commissioner of commerce or the commissioner of health, as appropriate, shall require contributing members to prove compliance with this rate adjustment requirement.

History: *1993 c 345 art 8 s 5*