62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.

Subdivision 1. **Rate restrictions.** Premium rates for all health benefit plans sold or issued to small employers are subject to the restrictions specified in this section.

Subd. 2. **General premium variations.** Beginning July 1, 1993, each health carrier must offer premium rates to small employers that are no more than 25 percent above and no more than 25 percent below the index rate charged to small employers for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this subdivision must be based only on health status, claims experience, industry of the employer, and duration of coverage from the date of issue. For purposes of this subdivision, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined to be actuarially valid and approved by the commissioner. Variations permitted under this subdivision must not be based upon age or applied differently at different ages. This subdivision does not prohibit use of a constant percentage adjustment for factors permitted to be used under this subdivision.

Subd. 2a. **Renewal premium increases limited.** (a) Beginning January 1, 2003, the percentage increase in the premium rate charged to a small employer for a new rating period must not exceed the sum of the following:

(1) the percentage change in the index rate measured from the first day of the prior rating period to the first day of the new rating period;

(2) an adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of the employer; and

(3) any adjustment due to change in coverage or in the case characteristics of the employer.

(b) This subdivision does not apply if the employer, employee, or any applicant provides the health carrier with false, incomplete, or misleading information.

Subd. 3. **Age-based premium variations.** Beginning July 1, 1993, each health carrier may offer premium rates to small employers that vary based upon the ages of the eligible employees and dependents of the small employer only as provided in this subdivision. In addition to the variation permitted by subdivision 2, each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

Subd. 4. **Geographic premium variations.** A health carrier may request approval by the commissioner to establish separate geographic regions determined by the health carrier and to

establish separate index rates for each such region. The commissioner shall grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(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 index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

Subd. 5. **Gender-based rates prohibited.** Beginning July 1, 1993, no health carrier may determine premium rates through a method that is in any way based upon the gender of eligible employees or dependents. Rates must not in any way reflect marital status or generalized differences in expected costs between employees and spouses.

Subd. 6. **Rate cells permitted.** Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based on the number of adults and children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect marital status or differences in expected costs between employees and spouses.

Subd. 7. **Index and premium rate development.** (a) In developing its index rates and premiums, a health carrier may take into account only the following factors:

(1) actuarially valid differences in benefit designs of health benefit plans;

(2) actuarially valid differences in the rating factors permitted in subdivisions 2 and 3;

(3) actuarially valid geographic variations if approved by the commissioner as provided in subdivision 4.

(b) All premium variations permitted under this section must be based upon actuarially valid differences in expected cost to the health carrier of providing coverage. The variation must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All premium variations are subject to approval by the commissioner.

Subd. 7a. [Repealed, 1995 c 234 art 7 s 28]

Subd. 8. **Filing requirement.** A health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description

of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates. The rates shall 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, actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Subd. 9. **Effect of assessments.** Premium rates must comply with the rating requirements of this section, notwithstanding the imposition of any assessments or premiums paid by health carriers as provided under sections 62L.13 to 62L.22.

Subd. 10. **Rating report.** Beginning January 1, 1995, and annually thereafter, the commissioners of health and commerce shall provide a joint report to the legislature on the effect of the rating restrictions required by this section and the appropriateness of proceeding with additional rate reform. Each report must include an analysis of the availability of health care coverage due to the rating reform, the equitable and appropriate distribution of risk and associated costs, the effect on the self-insurance market, and any resulting or anticipated change in health plan design and market share and availability of health carriers.

Subd. 11. **Loss ratio standards.** Notwithstanding section 62A.02, subdivision 3, relating to loss ratios, each policy or contract form used with respect to a health benefit plan offered, or issued in the small employer market, is subject, beginning July 1, 1993, to section 62A.021. The commissioner of health has, with respect to carriers under that commissioner's jurisdiction, all of the powers of the commissioner of commerce under that section.

History: *1992 c 549 art 2 s 8,23; 1993 c 345 art 7 s 11,12; 1994 c 625 art 10 s 40-46,50; 1Sp1995 c 3 art 13 s 2; 1997 c 7 art 1 s 18; 1997 c 225 art 2 s 63; 2002 c 330 s 26; 2005 c 77 s 3; 2006 c 255 s 29*