State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 2160

04/07/2015 Authored by Anderson, S.,
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; regulating health plans; amending Minnesota Statutes 2014, sections 62A.04, subdivision 1; 62A.047; 62A.06, by adding a subdivision; 62A.21, subdivision 2a; 62A.65, by adding a subdivision; 62D.105, subdivision 1; 62Q.18, subdivision 7; 62Q.188, subdivision 2.

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

Section 1. Minnesota Statutes 2014, section 62A.04, subdivision 1, is amended to read:

Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions. Subdivision 2, clauses (4), (5), (6), (7), (8), (9), (10), and (12); subdivision 3, clauses (1), (3), (4), (5), (6), and (7); subdivision 6; and subdivision 10 do not apply to accident and sickness or accident and health insurance that are health plans as defined in section 62A.011, subdivision 3.

Sec. 2. Minnesota Statutes 2014, section 62A.047, is amended to read:

62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES.

A policy of individual or group health and accident insurance regulated under this chapter, or individual or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and

customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. Nothing in this section prohibits a health carrier that has a network of providers from imposing a deductible, co-payment, or other coinsurance or dollar limitation requirement for child health supervision services and prenatal care services that are delivered by an out-of-network provider. This section does not prohibit the use of policy waiting periods for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to ~~a commercial health insurance policy issued as a companion to a health maintenance organization contract,~~ a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage. A policy, contract, or certificate described under this section may not apply to preexisting condition limitations to individuals under 19 years of age. This section does not apply to individual coverage under a grandfathered plan.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Sec. 3. Minnesota Statutes 2014, section 62A.06, is amended by adding a subdivision to read:

Subd. 4. **Electronic applications.** Notwithstanding subdivision 1, an issuer may rely on statements provided by the insured in completing an electronic enrollment and may introduce the electronic record as evidence in any action or proceeding based upon the policy without delivering or attaching a copy of the insured's application to the policy. The falsity of any statement made in the electronic enrollment may not bar the right to

recovery unless the false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Sec. 4. Minnesota Statutes 2014, section 62A.21, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's ~~former spouse and~~ dependent children ~~upon~~ as defined in section 62Q.01, subdivision 2a, and former spouse, who were covered on the day before entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's ~~former spouse or~~ dependent ~~child~~ children and former spouse, who were covered on the day before entry of a valid decree of dissolution, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

Sec. 5. Minnesota Statutes 2014, section 62A.65, is amended by adding a subdivision to read:

Subd. 3c. **Premium rate restrictions.** (a) No grandfathered plan, as defined under section 62A.011, subdivision 1b, offered in the individual market to a Minnesota resident may be renewed unless the premium rate charged is determined in accordance with the requirements in paragraphs (b) to (j).

(b) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations

permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, 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 by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(c) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variations permitted under paragraph (b), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(d) 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.

(e) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or 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 generalized differences in expected costs between principal insureds and their spouses.

(f) In developing its index rates and 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 (b) and (c); and

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

(g) 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.

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

(i) 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, actuarially valid changes in risks associated with the enrollee populations, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

(j) An insurer 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 renewed only with premium rates and premium rating practices that comply with subdivisions 2, 3a, 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, 3a, 4, or 5. An insurer that complies with this paragraph in connection with a policy form is exempt from the requirement of prior approval by the commissioner under paragraphs (d), (g), and (i).

EFFECTIVE DATE. This section is effective for all grandfathered plans offered in the individual market renewed on or after January 1, 2014.

Sec. 6. Minnesota Statutes 2014, section 62D.105, subdivision 1, is amended to read:

Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the ~~spouse and~~ dependent children of the enrollee and spouse who were covered on the day before entry of a valid decree of dissolution shall: (1) permit the spouse and dependent children to elect to continue coverage when the enrollee becomes enrolled for benefits under title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Sec. 7. Minnesota Statutes 2014, section 62Q.18, subdivision 7, is amended to read:

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.~~

Sec. 8. Minnesota Statutes 2014, section 62Q.188, subdivision 2, is amended to read:

Subd. 2. **Flexible benefits plan.** Except for individual and small groups, notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health plan company may offer, sell, issue, and renew a health plan that is a flexible benefits plan under this section if the following requirements are satisfied:

(1) the health plan must be offered in compliance with the laws of this state, except as otherwise permitted in this section;

(2) the health plan must be designed to enable covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;

(3) the health plan may modify or exclude any or all coverages of benefits that would otherwise be required by law, except for maternity benefits and other benefits required under federal law and may modify co-pays, deductibles, out-of-pocket maximum limits, and other cost-sharing arrangements;

(4) each health plan and plan's premiums must be approved by the commissioner of health or commerce, whichever is appropriate under section 62Q.01, subdivision 2, but neither commissioner may disapprove a plan on the grounds of a modification or exclusion permitted under clause (3); and

(5) prior to the sale of the health plan, the purchaser must be given a written list of the coverages otherwise required by law that are modified or excluded in the health plan. The list must include a description of each coverage in the list and indicate whether the

coverage is modified or excluded. If coverage is modified, the list must describe the modification. The list may, but is not required to, also list any or all coverages otherwise required by law that are included in the health plan and indicate that they are included. The health plan company must require that a copy of this written list be provided, prior to the effective date of the health plan, to each enrollee or employee who is eligible for health coverage under the plan.