A bill for an act

relating to insurance; specifying geographical considerations in regard to implementing and adjusting the Affordable Care Act in this state; appropriating money; amending Minnesota Statutes 2013 Supplement, sections 62A.65, subdivision 3; 62K.10, subdivisions 2, 3.

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

Section 1. Minnesota Statutes 2013 Supplement, 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 contain populations that do not vary from each other by more than 400 percent and be composed of no fewer than seven counties that create a contiguous region, except that the two largest counties in the state by population may constitute one entire 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~~.~~; and

(4) the maximum aggregate premium ratio of the highest cost geographic region to the lowest cost geographic region does not exceed 1.5.

(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.

EFFECTIVE DATE. This section is effective May 1, 2014, or upon federal approval, whichever is later.

Sec. 2. Minnesota Statutes 2013 Supplement, section 62K.10, subdivision 2, is amended to read:

Subd. 2. **Primary care; mental health services; general hospital services.** (a) The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services.

(b) In any geographic region, as defined by section 62A.65, subdivision 3, where the average aggregate premiums exceeded those available in the lowest cost region by at least 50 percent in 2014, the maximum travel distance or time may be the lesser of 75 miles or 75 minutes to the nearest in-network or contracted provider of each of the following services: primary care services, mental health services, and general hospital services.

(c) A health plan may offer a qualified health plan under paragraph (b) only if it also offers at least one qualified health plan in the same region that complies with the requirements of paragraph (a).

EFFECTIVE DATE. This section is effective May 1, 2014.

Sec. 3. Minnesota Statutes 2013 Supplement, section 62K.10, subdivision 3, is amended to read:

Subd. 3. **Other health services.** (a) The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

(b) In any geographic region, as defined by section 62A.65, subdivision 3, where the average aggregate premiums exceeded those available in the lowest cost region by at least 50 percent in 2014, the maximum travel distance or time shall be the lesser of 100 miles or 100 minutes to the nearest in-network or contracted provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

(c) A health plan may offer a qualified health plan under paragraph (b) only if it also offers at least one qualified health plan in the same region that complies with the requirements of paragraph (a).

EFFECTIVE DATE. This section is effective May 1, 2014.

Sec. 4. **EVALUATION OF ALL-PAYER RATE SETTING SYSTEM.**

(a) No later than December 15, 2014, the commissioners of health, commerce, and human services shall issue a report to the legislature evaluating the potential costs and benefits of an all-payer rate setting system to determine provider payments made under all private and public sector health plans. The evaluation report must analyze the impact of establishing:

(1) uniform payment rates for specific health care procedures and services that do not vary by health plan or payer type or within provider type;

(2) uniform payment rates for specific health care provider types that are reimbursed under capitated or total cost of care payment methods that do not vary by health plan or payer type; and

(3) procedures for determining and approving periodic increases in provider payment rates that do not vary by health plan or payer type, and that reflect increases in costs incurred by efficient and high-quality providers.

(b) As part of the evaluation report in paragraph (a), the commissioner of human services shall estimate the fiscal impact to payments under the medical assistance and MinnesotaCare programs as a result of the implementation of an all-payer rate setting system.

(c) As part of the evaluation report in paragraph (a), the commissioner of commerce shall estimate the impact on private insurance market premium rates as a result of the implementation of an all-payer rate setting system.

(d) In conducting this evaluation, the commissioners must consult with representatives of health plan companies, health care providers, a sample set of typical health care consumers, and state agencies and other payers. Any written responses received from these stakeholders must be included as an appendix to the report.

Sec. 5. **NETWORK ADEQUACY STANDARDS PROPOSAL.**

No later than December 15, 2014, the commissioner of health shall investigate and propose to the legislature a set of revised standards for provider network adequacy, as defined by section 62K.10. The revised standards shall assess the impact of any such revision on regional provider pricing disparities for identical treatments and services, health insurance product premiums, and the affordability of health insurance for consumers.

Sec. 6. **SINGLE GEOGRAPHIC RATE AREA STUDY.**

As part of the public release of rates for qualified health plans available starting January 1, 2015, the commissioner of commerce shall report the likely impact on premium rates in each region as a result of establishing a single geographic rating area for the entire state of Minnesota for plans available starting January 1, 2016.

Sec. 7. **APPROPRIATION.**

$450,000 in fiscal year 2015 is appropriated from the general fund, of which $..... is appropriated to the commissioner of health, $..... to the commissioner of commerce, and $..... to the commissioner of human services, for the evaluation reports described in section 4.