State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 978

02/28/2013 Authored by Huntley and Atkins
The bill was read for the first time and referred to the Committee on Commerce and Consumer Protection Finance and Policy

A bill for an act

relating to health plan regulation; regulating policy and contract coverages; conforming state law to federal requirements; amending Minnesota Statutes 2012, sections 13.7191, subdivision 12; 43A.23, subdivision 1; 43A.317, subdivision 6; 60A.08, subdivision 15; 62A.011, subdivision 3, by adding subdivisions; 62A.02, by adding a subdivision; 62A.03, subdivision 1; 62A.04, subdivision 2; 62A.047; 62A.049; 62A.136; 62A.149, subdivision 1; 62A.17, subdivisions 2, 6; 62A.21, subdivision 2b; 62A.28, subdivision 2; 62A.302; 62A.615; 62A.65, subdivisions 3, 5, 6, 7; 62C.14, subdivision 5; 62C.142, subdivision 2; 62D.02, by adding a subdivision; 62D.07, subdivision 3; 62D.095; 62D.12, by adding a subdivision; 62D.181, subdivision 7; 62D.30, subdivision 8; 62E.02, by adding a subdivision; 62E.04, subdivision 4; 62E.06, subdivision 1; 62E.09; 62E.10, subdivision 7; 62H.04; 62L.02, subdivisions 11, 14a, 26, by adding a subdivision; 62L.03, subdivisions 1, 3, 4, 6; 62L.045, subdivisions 2, 4; 62L.05, subdivision 10; 62L.06; 62L.08; 62L.12, subdivision 2; 62M.05, subdivision 3a; 62M.06, subdivision 1; 62Q.01, by adding subdivisions; 62Q.021; 62Q.17, subdivision 6; 62Q.18, by adding a subdivision; 62Q.19, by adding a subdivision; 62Q.23; 62Q.43, subdivision 2; 62Q.47; 62Q.52; 62Q.55; 62Q.68, subdivision 1; 62Q.69, subdivision 3; 62Q.70, subdivisions 1, 2; 62Q.71; 62Q.73; 62Q.75, subdivision 1; 62Q.80, subdivision 2; 72A.20, subdivision 35; 471.61, subdivision 1a; proposing coding for new law in Minnesota Statutes, chapters 62A; 62Q; 72A; repealing Minnesota Statutes 2012, sections 62A.65, subdivision 6; 62E.02, subdivision 7; 62E.16; 62E.20; 62L.02, subdivisions 4, 18, 19, 23; 62L.05, subdivisions 1, 2, 3, 4, 4a, 5, 6, 7, 11, 12, 13; 62L.081; 62L.10; 62Q.37, subdivision 5.

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

Section 1. Minnesota Statutes 2012, section 13.7191, subdivision 12, is amended to read:

Subd. 12. **~~Small employer insurance reform.~~** ~~(a)~~ **Health carrier data.** ~~Data received by the commissioner from health carriers under chapter 62L are classified under section 62L.10, subdivision 3.~~

~~(b)~~ **Small employer reinsurance association data.** Patient identifying data held by the reinsurance association are classified under section 62L.16, subdivision 6.

Sec. 2. Minnesota Statutes 2012, section 43A.23, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The commissioner is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the benefit plans. Contracts entered into are not subject to the requirements of sections 16C.16 to 16C.19. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. Each benefit contract must be for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party. A carrier licensed under chapter 62A is exempt from the taxes imposed by chapter 297I on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured, including chapters 62J, 62M, and 62Q. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall comply with section 62D.123 and geographic access standards for health maintenance organizations adopted by the commissioner of health in rule under chapter 62D.

(c) Notwithstanding paragraph (b), a self-insured hospital and medical product offered under sections 43A.22 to 43A.30 is ~~not~~ required to extend dependent coverage to an eligible employee's ~~unmarried~~ child ~~under the age of 25~~ to the full extent required under chapters 62A and 62L. Dependent <u>child</u> coverage must, at a minimum, extend to an eligible employee's ~~unmarried~~ <u>dependent</u> child ~~who is under the age of 19 or an unmarried child under the age of 25 who is a full-time student. A person who is at least 19 years of age but who is under the age of 25 and who is not a full-time student must be permitted to be enrolled as a dependent of an eligible employee until age 25 if the person:~~ <u>to the limiting age as defined in section 62Q.01, subdivision 10, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren to the extent required in sections 62A.042 and 62A.302.</u>

~~(1) was a full-time student immediately prior to being ordered into active military service, as defined in section 190.05, subdivision 5b or 5c;~~

~~(2) has been separated or discharged from active military service; and~~

~~(3) would be eligible to enroll as a dependent of an eligible employee, except that the person is not a full-time student.~~

~~The definition of "full-time student" for purposes of this paragraph includes any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this definition of "full-time student."~~

(d) Beginning January 1, 2010, the health insurance benefit plans offered in the commissioner's plan under section 43A.18, subdivision 2, and the managerial plan under section 43A.18, subdivision 3, must include an option for a health plan that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code.

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

Sec. 3. Minnesota Statutes 2012, section 43A.317, subdivision 6, is amended to read:

Subd. 6. **Individual eligibility.** (a) **Procedures.** The commissioner shall establish procedures for eligible employees and other eligible individuals to apply for coverage through the program.

(b) **Employees.** An employer shall determine when it applies to the program the criteria its employees must meet to be eligible for coverage under its plan. An employer may subsequently change the criteria annually or at other times with approval of the commissioner. The criteria must provide that new employees become eligible for coverage after a probationary period of at least 30 days, but no more than 90 days.

(c) **Other individuals.** An employer may elect to cover under its plan:

(1) the spouse, dependent children to the limiting age as defined in section 62Q.01, subdivision 10, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren ~~of a covered employee~~ to the extent required in sections 62A.042 and 62A.302;

(2) a retiree who is eligible to receive a pension or annuity from the employer and a covered retiree's spouse, dependent children to the limiting age as defined in section 62Q.01, subdivision 10, disabled children to the extent required in sections 62A.14 and 62A.141, and dependent grandchildren to the extent required in sections 62A.042 and 62A.302;

(3) the surviving spouse, dependent children to the limiting age as defined in section 62Q.01, subdivision 10, disabled children, and dependent grandchildren of a deceased

employee or retiree, if the spouse, children, or grandchildren were covered at the time of the death;

(4) a covered employee who becomes disabled, as provided in sections 62A.147 and 62A.148; or

(5) any other categories of individuals for whom group coverage is required by state or federal law.

An employer shall determine when it applies to the program the criteria individuals in these categories must meet to be eligible for coverage. An employer may subsequently change the criteria annually, or at other times with approval of the commissioner. The criteria for dependent children to the limiting age as defined in section 62Q.01, subdivision 10, disabled children, and dependent grandchildren may be no more inclusive than the criteria under section 43A.18, subdivision 2. This paragraph shall not be interpreted as relieving the program from compliance with any federal and state continuation of coverage requirements.

(d) **Waiver and late entrance.** An eligible individual may waive coverage at the time the employer joins the program or when coverage first becomes available. The commissioner may establish a preexisting condition exclusion of not more than 18 months for late entrants as defined in section 62L.02, subdivision 19.

(e) **Continuation coverage.** The program shall provide all continuation coverage required by state and federal law.

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

Sec. 4. Minnesota Statutes 2012, section 60A.08, subdivision 15, is amended to read:

Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related information filed with the commissioner under section 61A.02 shall be nonpublic data until the filing becomes effective.

(b) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic data until the filing becomes effective.

(c) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

(d) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic data until the filing becomes effective.

(e) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic data until the filing becomes effective.

(f) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under section 2794 of the Public Health Services Act and underlying regulations that are filed with the commissioner on or after September 1, 2011, the commissioner:

(1) may acknowledge receipt of the information;

(2) may acknowledge that the corresponding rate filing is pending review;

(3) must provide public access from the Department of Commerce's Web site to parts I and II of the Preliminary Justifications of the rate increases subject to review; and

(4) must provide notice to the public on the Department of Commerce's Web site of the review of the proposed rate, which must include a statement that the public has 30 calendar days to submit written comments to the commissioner on the rate filing subject to review.

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

Sec. 5. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and applicable regulations.

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

Sec. 6. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1b. **Covered person.** "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

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

Sec. 7. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1c. **Grandfathered plan coverage.** "Grandfathered plan coverage" means a health benefit plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act. Unless otherwise specified, grandfathered plan coverage includes both individual and group health plans.

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

Sec. 8. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 1d. **Group health plan.** "Group health plan" means a policy or certificate issued to an employer or an employee organization that is both:

(1) a health plan as defined in subdivision 3; and

(2) an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1002, if the plan provides payment for medical care to employees, including both current and former employees, or their dependents, directly or through insurance, reimbursement, or otherwise.

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

Sec. 9. Minnesota Statutes 2012, section 62A.011, subdivision 3, is amended to read:

Subd. 3. **Health plan.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) ~~supplemental~~ liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, including coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance, if the benefits are provided under a separate policy, certificate, or contract for insurance; there is no coordination between the provision of benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor;

(5) credit accident and health insurance as defined in section 62B.02;

(6) designed solely to provide hearing, dental, or vision care;

(7) blanket accident and sickness insurance as defined in section 62A.11;

(8) accident-only coverage;

(9) a long-term care policy as defined in section 62A.46 or 62S.01;

(10) issued as a supplement to Medicare, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended;

(11) workers' compensation insurance; ~~or~~

(12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan~~.~~;

(13) coverage for on-site medical clinics; or

(14) coverage supplemental to the coverage provided under United States Code, title 10, chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

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

Sec. 10. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 4. **Individual health plan.** "Individual health plan" means a health plan as defined in subdivision 3 that is offered to individuals in the individual market as defined in subdivision 5, but does not mean short-term coverage as defined in section 62A.65, subdivision 7. For purposes of this chapter, a health carrier shall not be deemed to be offering individual health plan coverage solely because the carrier offers a conversion policy in connection with a group health plan.

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

Sec. 11. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision to read:

Subd. 5. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

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

Sec. 12. Minnesota Statutes 2012, section 62A.02, is amended by adding a subdivision to read:

Subd. 8. **Filing by insurers for purposes of complying with the certification requirements of the Minnesota Insurance Marketplace.** No health plan shall be offered for sale through the Minnesota Insurance Marketplace until a copy of its form and the premium rates pertaining to the form have been filed with the commissioner and the commissioner has reviewed the health plan for compliance with the certification requirements of the Minnesota Insurance Marketplace in accordance with agreement between the commissioners of commerce and health and the Minnesota Insurance Marketplace.

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

Sec. 13. Minnesota Statutes 2012, section 62A.03, subdivision 1, is amended to read:

Subdivision 1. **Conditions.** No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:

(1) **Premium.** The entire money and other considerations therefor are expressed therein.

(2) **Time effective.** The time at which the insurance takes effect and terminates is expressed therein.

(3) **One person.** It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:

(a) husband,

(b) wife,

(c) dependent children as described in sections 62A.302 and 62A.303, or

~~(d) any children under a specified age of 19 years or less, or~~

~~(e)~~ (d) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lowercase unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) **Description of policy.** The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate

statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) **Exceptions in policy.** The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) **Form number.** Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) **No incorporation by reference.** It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

(9) **Medical benefits.** If the policy contains a provision for medical expense benefits, the term "medical benefits" or similar terms as used therein includes treatments by all licensed practitioners of the healing arts unless, subject to the qualifications contained in clause (10), the policy specifically states the practitioners whose services are covered.

(10) **Osteopath, optometrist, chiropractor, or registered nurse services.** With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of the policy, if it contains a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, the person entitled to benefits or person performing services under the policy is entitled to reimbursement on an equal basis for the service, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, licensed under the laws of this state.

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

Sec. 14. Minnesota Statutes 2012, section 62A.04, subdivision 2, is amended to read:

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this

section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) Except as required for health plans by the Affordable Care Act, a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision,

subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

All policies required to comply with the Affordable Care Act must include a grace period provision no less restrictive than the grace period required by the Affordable Care Act as defined under section 62A.011, subdivision 1a.

(4) A provision as follows:

REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. For health plans described in section 62A.011, subdivision 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the policy, if the insured applies for reinstatement no later than 60 days after the due date for the premium payment, unless:

(1) the insured has in the interim left the state or the insurer's service area; or

(2) the insured has applied for reinstatement on two or more prior occasions.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due

date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(7) A provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests

otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

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

Sec. 15. Minnesota Statutes 2012, 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 ~~or preexisting condition limitations~~ 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 policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or non-expense-incurred basis, or a policy that provides only accident coverage. A policy, contract, or certificate described under this section may not apply preexisting condition limitations to individuals under 19 years of age. This section does not apply to individual coverage that is grandfathered plan coverage, as defined in section 62A.011, subdivision 1c.

"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.

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

Sec. 16. Minnesota Statutes 2012, section 62A.049, is amended to read:

62A.049 LIMITATION ON PREAUTHORIZATIONS; EMERGENCIES.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or

part of the insured's benefits. ~~This provision does not apply to admissions for treatment of chemical dependency and nervous and mental disorders.~~

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

Sec. 17. Minnesota Statutes 2012, section 62A.136, is amended to read:

62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.

The following provisions do not apply to health plans as defined in section 62A.011, subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17, subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; and 62A.3093~~; and 62E.16~~.

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

Sec. 18. Minnesota Statutes 2012, section 62A.149, subdivision 1, is amended to read:

Subdivision 1. **Application.** The provisions of this section apply to all group policies of accident and health insurance and group subscriber contracts offered by nonprofit health service plan corporations regulated under chapter 62C, and to a plan or policy that is individually underwritten or provided for a specific individual and family members as a nongroup policy ~~unless the individual elects in writing to refuse benefits under this subdivision in exchange for an appropriate reduction in premiums or subscriber charges under the policy or plan~~, when the policies or subscriber contracts are issued or delivered in Minnesota or provide benefits to Minnesota residents enrolled thereunder.

This section does not apply to policies designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage.

Every insurance policy or subscriber contract included within the provisions of this subdivision, upon issuance or renewal, shall provide coverage that complies with the requirements of section 62Q.47, paragraphs (b) and (c), for the treatment of alcoholism, chemical dependency or drug addiction to any Minnesota resident entitled to coverage.

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

Sec. 19. Minnesota Statutes 2012, section 62A.17, subdivision 2, is amended to read:

Subd. 2. **Responsibility of employee.** Every covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued

coverage. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the employee 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. If the policy, contract, or health care plan is administered by a trust, every covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until the employee becomes covered under another group health plan, or for a period of 18 months after the termination of or lay off from employment, whichever is shorter. For an individual age 19 or older, if the employee becomes covered under another group policy, contract, or health plan and the new group policy, contract, or health plan contains any preexisting condition limitations, the employee may, subject to the 18-month maximum continuation limit, continue coverage with the former employer until the preexisting condition limitations have been satisfied. The new policy, contract, or health plan is primary except as to the preexisting condition. In the case of a newborn child who is a dependent of the employee, the new policy, contract, or health plan is primary upon the date of birth of the child, regardless of which policy, contract, or health plan coverage is deemed primary for the mother of the child.

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

Sec. 20. Minnesota Statutes 2012, section 62A.17, subdivision 6, is amended to read:

Subd. 6. **Conversion to individual policy.** ~~A group insurance policy that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a covered employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium.~~

~~The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. A health maintenance contract issued by a health maintenance organization that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a former employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided in subdivision 2 to obtain from the health maintenance organization, at the former employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual health maintenance contract. Effective January 1, 1985, enrollees who have become nonresidents of the health maintenance organization's service area shall be given the option, to be arranged by the health maintenance organization, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3. This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage.~~

~~A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the optional coverage otherwise required by this subdivision.~~

~~The~~ An individual policy or contract issued as a conversion policy prior to January 1, 2014, shall be renewable at the option of the individual as long as the individual is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar conversion policies issued by the insurer.

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

Sec. 21. Minnesota Statutes 2012, section 62A.21, subdivision 2b, is amended to read:

Subd. 2b. **Conversion privilege.** ~~Every policy described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an insured, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage required under subdivision 2a or sections 62A.146 and 62A.20, conversion coverage providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The~~ An individual policy or contract issued as a conversion policy prior to

January 1, 2014 shall be renewable at the option of the covered person as long as the covered person is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar conversion policies issued by the insurer.

~~A policy providing reduced benefits at a reduced premium rate may be accepted by the covered person in lieu of the optional coverage otherwise required by this subdivision.~~

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

Sec. 22. Minnesota Statutes 2012, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract~~, and is limited to a maximum of $350 in any benefit year~~ and may be limited to one prostheses per benefit year.

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

Sec. 23. Minnesota Statutes 2012, section 62A.302, is amended to read:

62A.302 COVERAGE OF DEPENDENTS.

Subdivision 1. **Scope of coverage.** This section applies to:

(1) a health plan as defined in section 62A.011; and

~~(2) coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10); and~~

~~(3)~~ (2) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

Subd. 2. **Required coverage.** Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section 62L.02.

Subd. 3. **No additional restrictions permitted.** Every health plan in subdivision 1 that makes available dependent coverage of children shall make that coverage available for children until attainment of 26 years of age. Plans may not place restrictions on this coverage and must comply with the following requirements:

(1) with respect to a child who has not attained 26 years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant or spouse of the plan participant, and, in the individual market, primary subscriber or spouse of the primary subscriber;

(2) a health carrier shall not deny or restrict coverage for a child who has not attained 26 years of age based on (i) the presence or absence of the child's financial dependency upon the participant, primary subscriber, or any other person; (ii) residency with the participant and in the individual market the primary subscriber, or with any other person; (iii) marital status; (iv) student status; (v) employment; or (vi) any combination of those factors; and

(3) a health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in subdivision 5.

Subd. 4. **Grandchildren.** Nothing in this section requires a health carrier to make coverage available for a grandchild, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild or unless the grandchild meets the requirements of section 62A.042. For grandchildren included under a grandparent's policy pursuant to section 62A.042, coverage for the grandchild may terminate if the grandchild does not continue to reside with the covered grandparent continuously from birth, if the grandchild does not remain financially dependent upon the covered grandparent, or when the grandchild reaches age 25, except as provided in section 62A.14 or if coverage is continued under section 62A.20.

Subd. 5. **Terms of coverage of dependents.** The terms of coverage in a health plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are 26 years of age or older.

Subd. 6. **Opportunity to enroll.** A health carrier shall comply with all provisions of the Affordable Care Act in regards to providing an opportunity to enroll in coverage to any child whose coverage ended, or who was denied coverage, or was not eligible for coverage under a group health plan or individual health plan because, under the terms of the coverage, the availability of dependent coverage of a child ended before age 26. This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act. The commissioner shall enforce this section.

Subd. 7. **Grandfathered plan coverage.** (a) For plan years beginning before January 1, 2014, a group health plan that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible

employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

(b) For plan years beginning on or after January 1, 2014, a group health plan that is grandfathered plan coverage shall comply with all requirements of this section.

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

Sec. 24. **[62A.3021] COVERAGE OF DEPENDENTS BY PLANS OTHER THAN HEALTH PLANS.**

Subdivision 1. **Scope of coverage.** This section applies to coverage described in section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10).

Subd. 2. **Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 25 years, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A child also includes grandchildren as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.

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

Sec. 25. Minnesota Statutes 2012, section 62A.615, is amended to read:

62A.615 PREEXISTING CONDITIONS DISCLOSED AT TIME OF APPLICATION.

No insurer may cancel or rescind a health insurance policy for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice. No insurer may restrict coverage for a preexisting condition of which the application or other information provided by the insured reasonably gave the insurer notice unless the coverage is restricted at the time the policy is issued and the restriction is disclosed in writing to the insured at the time the policy is issued. In addition, no health plan may restrict coverage for a preexisting condition for an individual who is under 19 years of age. This section does not apply to individual coverage that is grandfathered plan coverage as defined in section 62A.011, subdivision 1c.

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

Sec. 26. Minnesota Statutes 2012, 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 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.~~

~~(b)~~ (a) Premium rates may vary based upon the ages of covered persons ~~only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate~~ except that the rate shall not vary by more than three to one for adults in accordance with the provisions of the Affordable Care Act.

~~(c) 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.~~

(b) Premium rates may vary based upon geographic rating area. The commissioner shall grant approval if the following conditions are met:

(1) ~~the geographic regions must be applied uniformly by the health carrier~~ the areas are established in accordance with the Affordable Care Act;

(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~~ premium rates for each area, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

~~(d) 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.~~

(c) Premium rates may vary based upon tobacco use, except that the rate shall not vary by more than 1.5 to 1.

~~(c)~~ (d) 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 (a) and ~~(b)~~ (c); and

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

(e) The premium charged with respect to any particular health plan or individual market health insurance coverage shall not be adjusted more frequently than annually, 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) changes to the health plan requested by the policyholder; or

(6) other changes required by federal law or regulations or otherwise expressly permitted by state law.

(f) A health carrier shall consider all enrollees in all health plans, other than grandfathered health plan coverage, offered by the carrier in the individual market, including those enrollees who do not enroll in such plans through an exchange, as established under section 1311 of the Affordable Care Act, to be members of a single risk pool.

(g) The commissioner may establish regulations to implement the provisions of this section.

(h) In connection with the offering for sale of individual market health insurance coverage under this act, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) the provisions of the coverage concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates; and

(2) a listing of and descriptive information, including benefits and premiums, about all health plans offered by the carrier that provide individual market health insurance coverage and the availability of the health plans for which the individual is qualified.

(i) 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)~~ (j) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

~~(h)~~ (k) 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~~, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549~~.

~~(i)~~ (l) 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 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. 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 (c), (f), and (h).

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

Sec. 27. Minnesota Statutes 2012, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, 2014, no individual health plan may be offered, sold, issued, or ~~with respect to children age 18 or under~~ renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider~~,~~ ~~unless the limitation or exclusion is permitted under this subdivision and under chapter 62L, provided that, except for children age 18 or under, underwriting restrictions may be retained on individual contracts that are issued without evidence of insurability as a replacement for prior individual coverage that was sold before May 17, 1993. The~~ An individual age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014, unless the individual has

maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. During plan years beginning prior to January 1, 2014, an individual who is age 19 or older and who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual who is age 19 or older must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior coverage, so long as the individual maintains continuous coverage as defined in section 62L.02. The prohibition on preexisting condition limitations for children age 18 or under does not apply to an individual health plan that is a grandfathered plan, as defined in section 62A.011, subdivision 1c. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014 does not apply to individual health plans that are grandfathered plans as defined in section 62A.011, subdivision 1c.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan. The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources

of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. ~~An individual health plan offered under this paragraph to a person satisfies the health carrier's obligation to offer conversion coverage under section 62E.16, with respect to that person.~~ Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph.

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

Sec. 28. Minnesota Statutes 2012, section 62A.65, subdivision 6, is amended to read:

Subd. 6. **Guaranteed issue not required.** (a) Nothing in this section requires a health carrier to initially issue a health plan to a Minnesota resident who is age 19 or older on the date the health plan becomes effective if the effective date is prior to January 1, 2014, except as otherwise expressly provided in subdivision 4 or 5.

(b) Guaranteed issue is required for all health plans, except grandfathered plans, beginning January 1, 2014.

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

Sec. 29. Minnesota Statutes 2012, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of 185 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of 365 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The 365-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the 365-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the 365-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

~~(e) Time spent under short-term coverage counts as time spent under a preexisting condition limitation for purposes of group or individual health plans, other than short-term coverage, subsequently issued to that person, or to cover that person, by any health carrier, if the person maintains continuous coverage as defined in section 62L.02. Short-term coverage is a health plan and is qualifying coverage as defined in section 62L.02. Notwithstanding any other law to the contrary, a health carrier is not required under any circumstances to provide a person covered by short-term coverage the right to obtain coverage on a guaranteed issue basis under another health plan offered by the health carrier, as a result of the person's enrollment in short-term coverage.~~

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

Sec. 30. **[62A.67] COMPREHENSIVE HEALTH INSURANCE COVERAGE REQUIREMENTS.**

Subdivision 1. **Generally.** Health carriers offering health plans providing individual market health insurance coverage shall ensure that the coverage:

(1) includes the essential health benefits package required under section 1302(a) of the Affordable Care Act;

(2) limits cost-sharing for such coverage in accordance with section 1302(c) of the Federal Act, as described in subdivision 2; and

(3) subject to subdivision 3, provides bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the Affordable Care Act as follows:

(i) a health plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan;

(ii) a health plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan;

(iii) a health plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan; and

(iv) a health plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

Subd. 2. **Coverage for enrollees under the age of 21.** If a health carrier offers health insurance coverage in any level of coverage specified under section 1302(d) of the Affordable Care Act, as described in subdivision 1, clause (3), the carrier shall also offer such coverage in that level as a health plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of 21 years.

Subd. 3. **Alternative compliance for catastrophic plans.** A health plan not providing a bronze, silver, gold, or platinum level of coverage, as described in subdivision 1, clause (3), shall be treated as meeting the requirements of section 1302(d) of the Affordable Care Act with respect to any policy year if it provides a catastrophic plan that meets the requirements of section 1302(e) of the Affordable Care Act.

This section shall not apply to a dental plan described in section 1311(d)(2)(B)(ii) of the Affordable Care Act.

Subd. 4. **Essential health benefit package benefits package; definition.** For purposes of this section, "essential health benefits package" means coverage that:

(1) provides for the essential health benefits. "Essential health benefits" include:

(i) ambulatory patient services;

(ii) emergency services;

(iii) hospitalization;

(iv) laboratory services;

(v) maternity and newborn care;

(vi) mental health and substance abuse disorder services, including behavioral health treatment;

(vii) pediatric services, including oral and vision care;

(viii) prescription drugs;

(ix) preventative and wellness services and chronic disease management; and

(x) rehabilitative and habilitative services and devices.

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

Sec. 31. Minnesota Statutes 2012, section 62C.14, subdivision 5, is amended to read:

Subd. 5. **Disabled dependents.** A subscriber's individual contract or any group contract delivered or issued for delivery in this state and providing that coverage of a dependent child of the subscriber or a dependent child of a covered group member shall terminate upon attainment of a specified limiting age as defined in section 62Q.01, subdivision 10, shall also provide in substance that attainment of that age shall not terminate coverage while the child is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability, and (b) chiefly dependent upon the subscriber or employee for support and maintenance, provided proof of incapacity and dependency is furnished by the subscriber within 31 days of attainment of the limiting age as defined in section 62Q.01, subdivision 10, and subsequently as required by the corporation, but not more frequently than annually after a two-year period following attainment of the age. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

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

Sec. 32. Minnesota Statutes 2012, section 62C.142, subdivision 2, is amended to read:

Subd. 2. **Conversion privilege.** ~~Every subscriber contract, other than a contract whose continuance is contingent upon continued employment or membership, which~~

~~contains a provision for termination of coverage of the spouse upon dissolution of marriage shall contain a provision allowing a former spouse and dependent children of a subscriber, without providing evidence of insurability, to obtain from the corporation at the expiration of any continuation of coverage required under subdivision 2a or section 62A.146, or upon termination of coverage by reason of an entry of a valid decree of dissolution which does not require the insured to provide continued coverage for the former spouse, an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the corporation within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate fee. A subscriber contract providing reduced benefits at a reduced fee may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The~~ An individual subscriber contract issued as conversion coverage shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4. Any revisions in the table of rate for the individual subscriber contract shall apply to the former spouse's original age at entry and shall apply equally to all similar contracts issued as conversion coverage by the corporation.

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

Sec. 33. Minnesota Statutes 2012, section 62D.02, is amended by adding a subdivision to read:

Subd. 17. **Health care services.** "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

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

Sec. 34. Minnesota Statutes 2012, section 62D.07, subdivision 3, is amended to read:

Subd. 3. **Required provisions.** Contracts and evidences of coverage shall contain:

(a) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which are untrue, misleading, or deceptive as defined in section 62D.12, subdivision 1;

(b) a clear, concise and complete statement of:

(1) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health maintenance contract;

(2) any exclusions or limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or co-payment feature and requirements for referrals, prior authorizations, and second opinions;

(3) where and in what manner information is available as to how services, including emergency and out of area services, may be obtained;

(4) the total amount of payment and co-payment, if any, for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) a description of the health maintenance organization's method for resolving enrollee complaints and a statement identifying the commissioner as an external source with whom complaints may be registered; and

(c) on the cover page of the evidence of coverage and contract, a clear and complete statement of enrollees' rights. The statement must be in bold print and captioned "Important Enrollee Information and Enrollee Bill of Rights" and must include but not be limited to the following provisions in the following language or in substantially similar language approved in advance by the commissioner, except that paragraph (8) does not apply to prepaid health plans providing coverage for programs administered by the commissioner of human services:

ENROLLEE INFORMATION

(1) COVERED SERVICES: Services provided by (name of health maintenance organization) will be covered only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Your contract fully defines what services are covered and describes procedures you must follow to obtain coverage.

(2) PROVIDERS: Enrolling in (name of health maintenance organization) does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of (name of health maintenance organization), you must choose among remaining (name of the health maintenance organization) providers.

(3) REFERRALS: Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non-(name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).

(4) EMERGENCY SERVICES: Emergency services from providers who are not affiliated with (name of health maintenance organization) will be covered ~~only if proper procedures are followed~~. Your contract explains the procedures and benefits associated with emergency care from (name of health maintenance organization) and non-(name of health maintenance organization) providers.

(5) EXCLUSIONS: Certain services or medical supplies are not covered. You should read the contract for a detailed explanation of all exclusions.

(6) CONTINUATION: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

(7) CANCELLATION: Your coverage may be canceled by you or (name of health maintenance organization) only under certain conditions. Your contract describes all reasons for cancellation of coverage.

(8) NEWBORN COVERAGE: If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating (name of health maintenance organization) providers or authorized by (name of health maintenance organization). Certain services are covered only upon referral. (Name of health maintenance organization) will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify (name of health maintenance organization) of the infant's birth and that you would like coverage. If your contract requires an additional premium for each dependent, (name of health maintenance organization) is entitled to all premiums due from the time of the infant's birth until the time you notify (name of health maintenance organization) of the birth. (Name of health maintenance organization) may withhold payment of any health benefits for the newborn infant until any premiums you owe are paid.

(9) PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT: Enrolling in (name of health maintenance organization) does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year.

ENROLLEE BILL OF RIGHTS

(1) Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week;

(2) Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;

(3) Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law;

(4) Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers;

(5) Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force;

(6) Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law; and

(7) Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

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

Sec. 35. Minnesota Statutes 2012, section 62D.095, is amended to read:

62D.095 ENROLLEE COST SHARING.

Subdivision 1. **General application.** A health maintenance contract may contain enrollee cost-sharing provisions as specified in this section. Co-payment and deductible provisions in a group contract must not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the health plan. During an open enrollment period in which all offered health plans fully participate without any underwriting restrictions, co-payment and deductible provisions must not discriminate on the basis of preexisting health status.

Subd. 2. **Co-payments.** (a) A health maintenance contract may impose a co-payment ~~as authorized under Minnesota Rules, part 4685.0801, or under this section~~ and coinsurance consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

~~(b) A health maintenance organization may impose a flat fee co-payment on outpatient office visits not to exceed 40 percent of the median provider's charges for similar services or goods received by the enrollees as calculated under Minnesota Rules, part 4685.0801. A health maintenance organization may impose a flat fee co-payment on outpatient prescription drugs not to exceed 50 percent of the median provider's charges~~

~~for similar services or goods received by the enrollees as calculated under Minnesota Rules, part 4685.0801.~~

~~(c) If a health maintenance contract is permitted to impose a co-payment for preexisting health status under sections 62D.01 to 62D.30, these provisions may vary with respect to length of enrollment in the health plan.~~

Subd. 3. **Deductibles.** (a) A health maintenance contract ~~issued by a health maintenance organization that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association may impose deductibles not to exceed $3,000 per person, per year and $6,000 per family, per year. For purposes of the percentage calculation, a health maintenance organization's assessments include those of its affiliates~~ may impose a deductible consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

~~(b) All other health maintenance contracts may impose deductibles not to exceed $2,250 per person, per year and $4,500 per family, per year.~~

Subd. 4. **Annual out-of-pocket maximums.** ~~(a)~~ A health maintenance contract ~~issued by a health maintenance organization that is assessed less than three percent of the total annual amount assessed by the Minnesota comprehensive health association must include a limitation not to exceed $4,500 per person and $7,500 per family on total annual out-of-pocket enrollee cost-sharing expenses. For purposes of the percentage calculation, a health maintenance organization's assessments include those of its affiliates~~ may impose an annual out-of-pocket maximum consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

~~(b) All other health maintenance contracts must include a limitation not to exceed $3,000 per person and $6,000 per family on total annual out-of-pocket enrollee cost-sharing expenses.~~

Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive health care services ~~as described in Minnesota Rules, part 4685.0801, subpart 8~~ consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

Subd. 6. **Public programs.** This section does not apply to the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance program, the federal Medicare program, or the health plans provided through any of those programs.

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

Sec. 36. Minnesota Statutes 2012, section 62D.12, is amended by adding a subdivision to read:

Subd. 2b. **Rescission of coverage.** A health maintenance organization shall not rescind individual or group coverage except for an act or practice that constitutes fraud or intentional misrepresentation of material fact as prohibited by the plan or coverage. A health maintenance organization shall provide 30 days' prior written notice to the enrollee of the intended rescission.

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

Sec. 37. Minnesota Statutes 2012, section 62D.181, subdivision 7, is amended to read:

Subd. 7. **Replacement coverage; limitations.** The association is not obligated to offer replacement coverage under this chapter ~~or conversion coverage under section 62E.16~~ at the end of the periods specified in subdivision 6. Any continuation obligation arising under this chapter or chapter 62A will cease at the end of the periods specified in subdivision 6.

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

Sec. 38. Minnesota Statutes 2012, section 62D.30, subdivision 8, is amended to read:

Subd. 8. **Rural demonstration project.** (a) The commissioner may permit demonstration projects to allow health maintenance organizations to extend coverage to a health improvement and purchasing coalition located in rural Minnesota, comprised of the health maintenance organization and members from a geographic area. For purposes of this subdivision, rural is defined as greater Minnesota excluding the seven-county metropolitan area of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. The coalition must be designed in such a way that members will:

(1) become better informed about health care trends and cost increases;

(2) be actively engaged in the design of health benefit options that will meet the needs of their community;

(3) pool their insurance risk;

(4) purchase these products from the health maintenance organization involved in the demonstration project; and

(5) actively participate in health improvement decisions for their community.

(b) The commissioner must consider the following when approving applications for rural demonstration projects:

(1) the extent of consumer involvement in development of the project;

(2) the degree to which the project is likely to reduce the number of uninsured or to maintain existing coverage; and

(3) a plan to evaluate and report to the commissioner and legislature as prescribed by paragraph (e).

(c) For purposes of this subdivision, the commissioner must waive compliance with the following statutes and rules: the cost-sharing restrictions under section 62D.095, subdivisions 2, 3, and 4, and Minnesota Rules, part 4685.0801, subparts 1 to 7; for a period of at least two years, participation in government programs under section 62D.04, subdivision 5, in the counties of the demonstration project if that compliance would have been required solely due to participation in the demonstration project and shall continue to waive this requirement beyond two years if the enrollment in the demonstration project is less than 10,000 enrollees; ~~small employer marketing under section 62L.05, subdivisions 1 to 3;~~ and small employer geographic premium variations under section 62L.08, subdivision 4. The commissioner shall approve enrollee cost-sharing features desired by the coalition that appropriately share costs between employers, individuals, and the health maintenance organization.

(d) The health maintenance organization may make the starting date of the project contingent upon a minimum number of enrollees as cited in the application, provide for an initial term of contract with the purchasers of a minimum of three years, and impose a reasonable penalty for employers who withdraw early from the project. For purposes of this subdivision, loss ratios are to be determined as if the policies issued under this section are considered individual or small employer policies pursuant to section 62A.021, subdivision 1, paragraph (f). The health maintenance organization may consider businesses of one to be a small employer under section 62L.02, subdivision 26. The health maintenance organization may limit enrollment and establish enrollment criteria for businesses of one. Health improvement and purchasing coalitions under this subdivision are not associations under section 62L.045, subdivision 1, paragraph (a).

(e) The health improvement and purchasing coalition must report to the commissioner and legislature annually on the progress of the demonstration project and, to the extent possible, any significant findings in the criteria listed in clauses (1), (2), and (3) for the final report. The coalition must submit a final report five years from the starting date of the project. The final report must detail significant findings from the project and must include, to the extent available, but should not be limited to, information on the following:

(1) the extent to which the project had an impact on the number of uninsured in the project area;

(2) the effect on health coverage premiums for groups in the project's geographic area, including those purchasing health coverage outside the health improvement and purchasing coalition; and

(3) the degree to which health care consumers were involved in the development and implementation of the demonstration project.

(f) The commissioner must limit the number of demonstration projects under this subdivision to five projects.

(g) Approval of the application for the demonstration project is deemed to be in compliance with section 62E.06, subdivisions 1, paragraph (a), 2, and 3.

(h) Subdivisions 2 to 7 apply to demonstration projects under this subdivision. Waivers permitted under subdivision 1 do not apply to demonstration projects under this subdivision.

(i) If a demonstration project under this subdivision works in conjunction with a purchasing alliance formed under chapter 62T, that chapter will apply to the purchasing alliance except to the extent that chapter 62T is inconsistent with this subdivision.

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

Sec. 39. Minnesota Statutes 2012, section 62E.02, is amended by adding a subdivision to read:

Subd. 2a. **Essential health benefits.** "Essential health benefits" has the meaning given under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations. Essential health benefits include:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance abuse disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) other services defined as essential health benefits under the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

Sec. 40. Minnesota Statutes 2012, section 62E.04, subdivision 4, is amended to read:

Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirmatively offer coverage of major medical expenses to every applicant who applies to the insurer or fraternal for a new unqualified policy, which has a lifetime benefit limit of less than $1,000,000, at the time of application and annually to every holder of such an unqualified policy of accident and health insurance renewed by the insurer or fraternal. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $5,000 or more within a calendar year for services covered in section 62E.06, subdivision 1, benefits shall be payable, subject to any co-payment authorized by the commissioner, ~~up to a maximum lifetime limit of not less than $1,000,000~~ and shall not contain a lifetime maximum on essential health benefits. The offer of coverage of major medical expenses may consist of the offer of a rider on an existing unqualified policy or a new policy which is a qualified plan.

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

Sec. 41. Minnesota Statutes 2012, section 62E.06, subdivision 1, is amended to read:

Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by chapters 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in Minnesota, and meets or exceeds the following minimum standards:

(a) The minimum benefits for a covered individual shall, subject to the other provisions of this subdivision, be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this subdivision. The coverage shall not be subject to a ~~maximum lifetime benefit of not less than $1,000,000~~ lifetime maximum on essential health benefits.

The prohibition on lifetime maximums for essential health benefits and $3,000 limitation on total annual out-of-pocket expenses ~~and the $1,000,000 maximum lifetime benefit~~ shall not be subject to change or substitution by use of an actuarially equivalent benefit.

(b) Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) hospital services;

(2) professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a physician or at the physician's direction;

(3) drugs requiring a physician's prescription;

(4) services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;

(5) services of a home health agency if the services would qualify as reimbursable services under Medicare;

(6) use of radium or other radioactive materials;

(7) oxygen;

(8) anesthetics;

(9) prostheses other than dental but including scalp hair prostheses worn for hair loss suffered as a result of alopecia areata;

(10) rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

(11) diagnostic x-rays and laboratory tests;

(12) oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

(13) services of a physical therapist;

(14) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment; and

(15) services of an occupational therapist.

(c) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) any charge for care for injury or disease either (i) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance, Medicare, or any other governmental program except as otherwise provided by section 62A.04, subdivision 3, clause (4);

(2) any charge for treatment for cosmetic purposes other than for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician;

(3) care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;

(4) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be 90 percent of its lowest private room charge;

(5) that part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(d) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1, 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations.

(e) Effective July 1, 1979, the minimum benefits of a qualified plan shall include, in addition to those benefits specified in clause (a), a second opinion from a physician on all surgical procedures expected to cost a total of $500 or more in physician, laboratory, and hospital fees, provided that the coverage need not include the repetition of any diagnostic tests.

(f) Effective August 1, 1985, the minimum benefits of a qualified plan must include, in addition to the benefits specified in clauses (a), (d), and (e), coverage for special dietary treatment for phenylketonuria when recommended by a physician.

(g) Outpatient mental health coverage is subject to section 62A.152, subdivision 2.

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

Sec. 42. Minnesota Statutes 2012, section 62E.09, is amended to read:

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) formulate general policies to advance the purposes of sections 62E.01 to 62E.19;

(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~~ 62E.15, 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.19.

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

Sec. 43. Minnesota Statutes 2012, section 62E.10, subdivision 7, is amended to read:

Subd. 7. **General powers.** The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by ~~sections~~ section 62E.04 ~~and 62E.16~~ by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) individual qualified plans, excluding group conversions;

(2) group conversions;

(3) group qualified plans with fewer than 50 employees or members; and

(4) major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for

assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.

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

Sec. 44. Minnesota Statutes 2012, section 62H.04, is amended to read:

62H.04 COMPLIANCE WITH OTHER LAWS.

(a) A joint self-insurance plan is subject to the requirements of chapters 62A, 62E, 62L, and 62Q, and sections 72A.17 to 72A.32 unless otherwise specifically exempt. A joint self-insurance plan must pay assessments made by the Minnesota Comprehensive Health Association, as required under section 62E.11.

(b) A joint self-insurance plan is exempt from providing the mandated health benefits described in chapters 62A, 62E, 62L, and 62Q if it otherwise provides the benefits required under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et seq., for all employers and not just for the employers with 50 or more employees who are covered by that federal law.

(c) A joint self-insurance plan is exempt from section 62L.03, subdivision 1, if the plan offers an annual open enrollment period of no less than 15 days during which all employers that qualify for membership may enter the plan without preexisting condition limitations or exclusions except those permitted under chapter 62L.

(d) A joint self-insurance plan is exempt from sections 62A.146, 62A.16, 62A.17, 62A.20, 62A.21, and 62A.65, subdivision 5, paragraph (b), ~~and 62E.16~~ if the joint self-insurance plan complies with the continuation requirements under the Employee Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et

seq., for all employers and not just for the employers with 20 or more employees who are covered by that federal law.

(e) A joint self-insurance plan must provide to all employers the maternity coverage required by federal law for employers with 15 or more employees.

(f) A joint self-insurance plan must comply with all the provisions and requirements of the Affordable Care Act as defined under section 62A.011, subdivision 1a, to the extent that they apply to such plans.

EFFECTIVE DATE. This section is effective the day following final enactment, except that the amendment made to paragraph (d) is effective January 1, 2014.

Sec. 45. Minnesota Statutes 2012, section 62L.02, subdivision 11, is amended to read:

Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse, ~~unmarried child who is under the age of 25 years~~ dependent child to the limiting age as defined in section 62Q.01, subdivision 10, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a dependent child to the limiting age as defined in section 62Q.01, subdivision 10, includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A child also means a grandchild as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.

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

Sec. 46. Minnesota Statutes 2012, section 62L.02, subdivision 14a, is amended to read:

Subd. 14a. **Guaranteed issue.** "Guaranteed issue" means that a health carrier shall not decline an application by a small employer for any health benefit plan offered by that health carrier and shall not decline to cover under a health benefit plan any eligible employee or eligible dependent, including persons who become eligible employees or eligible dependents after initial issuance of the health benefit plan~~, subject to the health carrier's right to impose preexisting condition limitations permitted under this chapter~~.

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

Sec. 47. Minnesota Statutes 2012, section 62L.02, is amended by adding a subdivision to read:

Subd. 17a. **Individual health plan.** "Individual health plan" means a health plan as defined under section 62A.011, subdivision 3, that is offered to individuals in the individual market, other than conversion policies or short-term coverage. Small group market health plans offered though the Minnesota Insurance Marketplace to employees of a small employer are not considered individual health plans, regardless of whether the plan is purchased using a defined contribution from the employer.

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

Sec. 48. Minnesota Statutes 2012, section 62L.02, subdivision 26, is amended to read:

Subd. 26. **Small employer.** (a) "Small employer" means, with respect to a calendar year and a plan year, a person, firm, corporation, partnership, association, or other entity actively engaged in business in Minnesota, including a political subdivision of the state, that employed an average of ~~no fewer than two nor~~ at least one, not including a sole proprietor, but not more than 50 current employees on business days during the preceding calendar year and that employs at least ~~two~~ one current ~~employees~~ employee, not including a sole proprietor, on the first day of the plan year. ~~If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan.~~ A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two current employees. Entities that are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single employer for purposes of determining the number of current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based upon the average number of current employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For purposes of this definition, the term employer includes any predecessor of the employer. An employer that has more than 50 current employees but has 50 or fewer employees, as "employee" is defined under United States Code, title 29, section 1002(6), is a small employer under this subdivision.

(b) Where an association, as defined in section 62L.045, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers,

the association and health benefit plans it provides to small employers, are subject to section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

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

Sec. 49. Minnesota Statutes 2012, section 62L.03, subdivision 1, is amended to read:

Subdivision 1. **Guaranteed issue and reissue.** (a) Every health carrier shall, as a condition of authority to transact business in this state in the small employer market, affirmatively market, offer, sell, issue, and renew any of its health benefit plans, on a guaranteed issue basis, to any small employer, including a small employer covered by paragraph (b), that meets the participation and contribution requirements of subdivision 3, as provided in this chapter.

(b) A small employer that ~~has its~~ no longer meets the definition of small employer because of a reduction in workforce ~~reduced to one employee~~ may continue coverage as a small employer for 12 months from the date the group is reduced to one employee.

(c) Notwithstanding paragraph (a), a health carrier may, at the time of coverage renewal, modify the health coverage for a product offered in the small employer market if the modification is consistent with state law, approved by the commissioner, and effective on a uniform basis for all small employers purchasing that product other than through a qualified association in compliance with section 62L.045, subdivision 2.

~~Paragraph (a) does not apply to a health benefit plan designed for a small employer to comply with a collective bargaining agreement, provided that the health benefit plan otherwise complies with this chapter and is not offered to other small employers, except for other small employers that need it for the same reason. This paragraph applies only with respect to collective bargaining agreements entered into prior to August 21, 1996, and only with respect to plan years beginning before the later of July 1, 1997, or the date~~

~~upon which the last of the collective bargaining agreements relating to the plan terminates determined without regard to any extension agreed to after August 21, 1996.~~

~~(d) Every health carrier participating in the small employer market shall make available both of the plans described in section 62L.05 to small employers and shall fully comply with the underwriting and the rate restrictions specified in this chapter for all health benefit plans issued to small employers.~~

~~(e)~~ (d) A health carrier may cease to transact business in the small employer market as provided under section 62L.09.

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

Sec. 50. Minnesota Statutes 2012, section 62L.03, subdivision 3, is amended to read:

Subd. 3. **Minimum participation and contribution.** (a) A small employer that has at least 75 percent of its eligible employees who have not waived coverage participating in a health benefit plan and that contributes at least 50 percent toward the cost of coverage of each eligible employee must be guaranteed coverage on a guaranteed issue basis from any health carrier participating in the small employer market. The participation level of eligible employees must be determined at the initial offering of coverage and at the renewal date of coverage. A health carrier must not increase the participation requirements applicable to a small employer at any time after the small employer has been accepted for coverage. For the purposes of this subdivision, waiver of coverage includes only waivers due to: (1) coverage under another group health plan; (2) unaffordability as specified by the Affordable Care Act as defined under section 62A.011, subdivision 1a; (3) coverage under Medicare Parts A and B; or ~~(3)~~ (4) coverage under medical assistance under chapter 256B or general assistance medical care under chapter 256D.

(b) If a small employer does not satisfy the contribution or participation requirements under this subdivision, a health carrier may voluntarily issue or renew individual health plans, or a health benefit plan which must fully comply with this chapter. A health carrier that provides a health benefit plan to a small employer that does not meet the contribution or participation requirements of this subdivision must maintain this information in its files for audit by the commissioner. A health carrier may not offer an individual health plan, purchased through an arrangement between the employer and the health carrier, to any employee unless the health carrier also offers the individual health plan, on a guaranteed issue basis, to all other employees of the same employer. An arrangement permitted under section 62L.12, subdivision 2, paragraph (k), is not an arrangement between the employer and the health carrier for purposes of this paragraph.

~~(c) Nothing in this section obligates a health carrier to issue coverage to a small employer that currently offers coverage through a health benefit plan from another health carrier, unless the new coverage will replace the existing coverage and not serve as one of two or more health benefit plans offered by the employer. This paragraph does not apply if the small employer will meet the required participation level with respect to the new coverage.~~

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

Sec. 51. Minnesota Statutes 2012, section 62L.03, subdivision 4, is amended to read:

Subd. 4. **Underwriting restrictions.** ~~(a) Health carriers may apply underwriting restrictions to coverage for health benefit plans for small employers, including any preexisting condition limitations, only as expressly permitted under this chapter. For purposes of this section, "underwriting restrictions" means any refusal of the health carrier to issue or renew coverage, any premium rate higher than the lowest rate charged by the health carrier for the same coverage, any preexisting condition limitation, preexisting condition exclusion, or any exclusionary rider.~~

~~(b)~~ Health carriers may collect information relating to the case characteristics and demographic composition of small employers, as well as health status and health history information about employees, and dependents of employees, of small employers.

~~(c) Except as otherwise authorized for late entrants, preexisting conditions may be excluded by a health carrier for a period not to exceed 12 months from the enrollment date of an eligible employee or dependent, but exclusionary riders must not be used. Late entrants may be subject to a preexisting condition limitation not to exceed 18 months from the enrollment date of the late entrant, but must not be subject to any exclusionary rider or preexisting condition exclusion. When calculating any length of preexisting condition limitation, a health carrier shall credit the time period an eligible employee or dependent was previously covered by qualifying coverage, provided that the individual maintains continuous coverage. The credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. Section 60A.082, relating to replacement of group coverage, and the rules adopted under that section apply to this chapter, and this chapter's requirements are in addition to the requirements of that section and the rules adopted under it. A health carrier shall, at the time of first issuance or renewal of a health benefit plan on or after July 1, 1993, credit against any preexisting condition limitation or exclusion permitted under this section, the time period prior to July 1, 1993, during~~

~~which an eligible employee or dependent was covered by qualifying coverage, if the person has maintained continuous coverage.~~

~~(d) Health carriers shall not use pregnancy as a preexisting condition under this chapter.~~

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

Sec. 52. Minnesota Statutes 2012, section 62L.03, subdivision 6, is amended to read:

Subd. 6. **MCHA enrollees.** Health carriers shall offer coverage to any eligible employee or dependent enrolled in MCHA at the time of the health carrier's issuance or renewal of a health benefit plan to a small employer. The health benefit plan must require that the employer permit MCHA enrollees to enroll in the small employer's health benefit plan as of the first date of renewal of a health benefit plan occurring on or after July 1, 1993, and as of each date of renewal after that, or, in the case of a new group, as of the initial effective date of the health benefit plan and as of each date of renewal after that. ~~Unless otherwise permitted by this chapter,~~ Health carriers must not impose any underwriting restrictions, including any preexisting condition limitations or exclusions, on any eligible employee or dependent previously enrolled in MCHA and transferred to a health benefit plan ~~so long as continuous coverage is maintained, provided that the health carrier may impose any unexpired portion of a preexisting condition limitation under the person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee has maintained continuous coverage~~.

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

Sec. 53. Minnesota Statutes 2012, section 62L.045, subdivision 2, is amended to read:

Subd. 2. **Qualified associations.** (a) A qualified association, as defined in this section, and health coverage offered by it, to it, or through it, to a small employer in this state must comply with the requirements of this chapter regarding guaranteed issue, guaranteed renewal, preexisting condition limitations, ~~credit against preexisting condition limitations for continuous coverage,~~ treatment of MCHA enrollees, and the definition of dependent, and with section 62A.65, subdivision 5, paragraph (b). They must also comply with all other requirements of this chapter not specifically exempted in paragraph (b) or (c).

(b) A qualified association and a health carrier offering, selling, issuing, or renewing health coverage to, or to cover, a small employer in this state through the qualified association, may, but are not, in connection with that health coverage, required to:

(1) offer the two small employer plans described in section 62L.05; and

(2) offer to small employers that are not members of the association, health coverage offered to, by, or through the qualified association.

~~(c) A qualified association, and a health carrier offering, selling, issuing, and renewing health coverage to, or to cover, a small employer in this state must comply with section 62L.08, except that:~~

~~(1) a separate index rate may be applied by a health carrier to each qualified association, provided that:~~

~~(i) the premium rate applied to participating small employer members of the qualified association is no more than 25 percent above and no more than 25 percent below the index rate applied to the qualified association, irrespective of when members applied for health coverage; and~~

~~(ii) the index rate applied by a health carrier to a qualified association is no more than 20 percent above and no more than 20 percent below the index rate applied by the health carrier to any other qualified association or to any small employer. In comparing index rates for purposes of this clause, the 20 percent shall be calculated as a percent of the larger index rate; and~~

~~(2) a qualified association described in subdivision 1, paragraph (a), clauses (2) to (4), providing health coverage through a health carrier, or on a self-insured basis in compliance with section 471.617 and the rules adopted under that section, may cover small employers and other employers within the same pool and may charge premiums to small employer members on the same basis as it charges premiums to members that are not small employers, if the premium rates charged to small employers do not have greater variation than permitted under section 62L.08. A qualified association operating under this clause shall annually prove to the commissioner of commerce that it complies with this clause through a sampling procedure acceptable to the commissioner. If the qualified association fails to prove compliance to the satisfaction of the commissioner, the association shall agree to a written plan of correction acceptable to the commissioner. The qualified association is considered to be in compliance under this clause if there is a premium rate that would, if used as an index rate, result in all premium rates in the sample being in compliance with section 62L.08. This clause does not exempt a qualified association or a health carrier providing coverage through the qualified association from the loss ratio requirement of section 62L.08, subdivision 11.~~

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

Sec. 54. Minnesota Statutes 2012, section 62L.045, subdivision 4, is amended to read:

Subd. 4. **Principles; association coverage.** (a) This subdivision applies to associations as defined in this section, whether qualified associations or not, and is intended to clarify subdivisions 1 to 3.

(b) This section applies only to associations that provide health coverage to small employers.

(c) ~~A health carrier is not required under this chapter to comply with guaranteed issue and guaranteed renewal with respect to its relationship with the association itself.~~ An arrangement between the health carrier and the association, once entered into, must comply with guaranteed issue and guaranteed renewal with respect to members of the association that are small employers and persons covered through them.

(d) When an arrangement between a health carrier and an association has validly terminated, the health carrier has no continuing obligation to small employers and persons covered through them, except as otherwise provided in:

(1) section 62A.65, subdivision 5, paragraph (b);

(2) any other continuation or conversion rights applicable under state or federal law; and

(3) section 60A.082, relating to group replacement coverage, and rules adopted under that section.

(e) When an association's arrangement with a health carrier has terminated and the association has entered into a new arrangement with that health carrier or a different health carrier, the new arrangement is subject to section 60A.082 and rules adopted under it, with respect to members of the association that are small employers and persons covered through them.

(f) An association that offers its members more than one plan of health coverage may have uniform rules restricting movement between the plans of health coverage, if the rules do not discriminate against small employers.

(g) This chapter does not require or prohibit separation of an association's members into one group consisting only of small employers and another group or other groups consisting of all other members. The association must comply with this section with respect to the small employer group.

(h) For purposes of this section, "member" of an association includes an employer participant in the association.

(i) For purposes of this section, health coverage issued to, or to cover, a small employer includes a certificate of coverage issued directly to the employer's employees and dependents, rather than to the small employer.

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

Sec. 55. Minnesota Statutes 2012, section 62L.05, subdivision 10, is amended to read:

Subd. 10. **Medical expense reimbursement.** Health carriers may reimburse or pay for medical services, supplies, or articles provided under a small employer plan in accordance with the health carrier's provider contract requirements including, but not limited to, salaried arrangements, capitation, the payment of usual and customary charges, fee schedules, discounts from fee-for-service, per diems, diagnosis-related groups (DRGs), and other payment arrangements. Nothing in this chapter requires a health carrier to develop, implement, or change its provider contract requirements for a small employer plan. Coinsurance, deductibles, and out-of-pocket maximums~~, and maximum lifetime benefits~~ must be calculated and determined in accordance with each health carrier's standard business practices.

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

Sec. 56. Minnesota Statutes 2012, section 62L.06, is amended to read:

62L.06 DISCLOSURE OF UNDERWRITING RATING PRACTICES.

When offering or renewing a health benefit plan, health carriers shall disclose in all solicitation and sales materials:

(1) ~~the case characteristics and other rating factors used to determine initial and renewal rates;~~

~~(2) the extent to which premium rates for a small employer are established or adjusted based upon actual or expected variation in claim experience;~~

~~(3)~~ provisions concerning the health carrier's right to change premium rates ~~and the factors other than claim experience that affect changes in premium rates~~;

~~(4)~~ (2) provisions relating to renewability of coverage;

~~(5) the use and effect of any preexisting condition provisions, if permitted;~~

~~(6)~~ (3) the application of any provider network limitations and their effect on eligibility for benefits; and

~~(7)~~ (4) the ability of small employers to insure eligible employees and dependents currently receiving coverage from the Comprehensive Health Association ~~through health benefit plans~~.

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

Sec. 57. Minnesota Statutes 2012, section 62L.08, is amended to read:

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.~~ Premium rates may vary based upon the ages of covered persons except that the rate shall not vary by more than three to one for adults in accordance with the provisions of the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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~~ Premium rates may vary based on geographic rating areas set by the commissioner. 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**~~ **Tobacco rating.** ~~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~~ Premium rates may vary based upon tobacco use, except that the rate shall not vary by more that 1.5 to 1.

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; and

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

~~(3)~~ (2) 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. 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, and 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.

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

Sec. 58. Minnesota Statutes 2012, section 62L.12, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage under section 62D.104 as a result of leaving a health maintenance organization's service area.

(b) A health carrier may sell, issue, or renew individual conversion policies to eligible employees otherwise eligible for conversion coverage as a result of the expiration of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21, 62C.142, 62D.101, and 62D.105.

(c) A health carrier may sell, issue, or renew conversion policies ~~under section 62E.16~~ to eligible employees.

(d) A health carrier may sell, issue, or renew individual continuation policies to eligible employees as required.

(e) A health carrier may sell, issue, or renew individual health plans if the coverage is appropriate due to an unexpired preexisting condition limitation or exclusion applicable to the person under the employer's group health plan or due to the person's need for health care services not covered under the employer's group health plan.

(f) A health carrier may sell, issue, or renew an individual health plan, if the individual has elected to buy the individual health plan not as part of a general plan to substitute individual health plans for a group health plan nor as a result of any violation of subdivision 3 or 4.

(g) A health carrier may sell, issue, or renew an individual health plan if coverage provided by the employer is determined to be unaffordable under the provisions of the Affordable Care Act as defined in section 62A.011, subdivision 1a.

(h) Nothing in this subdivision relieves a health carrier of any obligation to provide continuation or conversion coverage otherwise required under federal or state law.

~~(h)~~ (i) Nothing in this chapter restricts the offer, sale, issuance, or renewal of coverage issued as a supplement to Medicare under sections 62A.3099 to 62A.44, or policies or contracts that supplement Medicare issued by health maintenance organizations, or those contracts governed by sections 1833, 1851 to 1859, 1860D, or 1876 of the federal Social Security Act, United States Code, title 42, section 1395 et seq., as amended.

~~(i)~~ (j) Nothing in this chapter restricts the offer, sale, issuance, or renewal of individual health plans necessary to comply with a court order.

~~(j)~~ (k) A health carrier may offer, issue, sell, or renew an individual health plan to persons eligible for an employer group health plan, if the individual health plan is a high deductible health plan for use in connection with an existing health savings account, in compliance with the Internal Revenue Code, section 223. In that situation, the same or a different health carrier may offer, issue, sell, or renew a group health plan to cover the other eligible employees in the group.

~~(k)~~ (l) A health carrier may offer, sell, issue, or renew an individual health plan to one or more employees of a small employer if the individual health plan is marketed directly to all employees of the small employer and the small employer does not contribute directly or indirectly to the premiums or facilitate the administration of the individual health plan. The requirement to market an individual health plan to all employees does not require the health carrier to offer or issue an individual health plan to any employee. For purposes of this paragraph, an employer is not contributing to the premiums or facilitating the administration of the individual health plan if the employer does not contribute to the

premium and merely collects the premiums from an employee's wages or salary through payroll deductions and submits payment for the premiums of one or more employees in a lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5, paragraph (b), ~~or 62E.16,~~ at the request of an employee, the health carrier may bill the employer for the premiums payable by the employee, provided that the employer is not liable for payment except from payroll deductions for that purpose. If an employer is submitting payments under this paragraph, the health carrier shall provide a cancellation notice directly to the primary insured at least ten days prior to termination of coverage for nonpayment of premium. Individual coverage under this paragraph may be offered only if the small employer has not provided coverage under section 62L.03 to the employees within the past 12 months.

~~The employer must provide a written and signed statement to the health carrier that the employer is not contributing directly or indirectly to the employee's premiums. The health carrier may rely on the employer's statement and is not required to guarantee-issue individual health plans to the employer's other current or future employees.~~

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

Sec. 59. Minnesota Statutes 2012, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure

electronic mailbox within one working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

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

Sec. 60. Minnesota Statutes 2012, section 62M.06, subdivision 1, is amended to read:

Subdivision 1. **Procedures for appeal.** A utilization review organization must have written procedures for appeals of determinations not to certify. The right to appeal must be available to the enrollee and to the attending health care professional. The enrollee shall be allowed to review the enrollee's file, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process.

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

Sec. 61. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

Sec. 62. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 1b. **Bona fide association.** "Bona fide association" means an association that meets all of the following criteria:

(1) serves a single profession that requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession;

(2) has been actively in existence for five years;

(3) has a constitution and bylaws or other analogous governing documents;

(4) has been formed and maintained in good faith for purposes other than obtaining insurance;

(5) is not owned or controlled by a health plan company or affiliated with a health plan company;

(6) does not condition membership in the association on any health status related factor;

(7) has at least 1,000 members if it is a national association, 500 members if it is a state association, or 200 members if it is a local association;

(8) all members and dependents of members are eligible for coverage regardless of any health status related factor;

(9) does not make health plans offered through the association available other than in connection with a member of the association;

(10) is governed by a board of directors and sponsors annual meeting of its members; and

(11) produces only market association memberships, accepts applications for membership, or signs up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the association.

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

Sec. 63. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 2b. **Health care professional.** "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law.

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

Sec. 64. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 2c. **Health care services.** "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

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

Sec. 65. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 7. **Life-threatening condition.** "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

Sec. 66. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 8. **Network.** "Network" means the group of participating health care professionals providing services in association with a managed care organization.

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

Sec. 67. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 9. **Participating health care professional.** "Participating health care professional" means a health care professional who, under a contract with the health plan company or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, co-payments, or deductibles, directly or indirectly from the health plan company.

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

Sec. 68. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 10. **Primary care provider.** "Primary care provider" means a health care professional designated by a covered person to supervise, coordinate, or provide initial care or continuing care to the covered person, and who may be required by the health plan

company to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

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

Sec. 69. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision to read:

Subd. 11. **Dependent child to the limiting age.** For purposes of chapters 43A, 60A, and 62A to 62U, the term "dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status. For coverage under plans offered by the Minnesota Comprehensive Health Association, dependent to the limiting age means dependent as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

(1) eligibility requirements regarding the absence of other health plan coverage as permitted by the Affordable Care Act as defined in section 62A.011, subdivision 1a, for grandfathered plan coverage as defined in section 62A.011, subdivision 1c; or

(2) an age greater than 26 in its policy, contract, or certificate of coverage.

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

Sec. 70. Minnesota Statutes 2012, section 62Q.021, is amended to read:

62Q.021 FEDERAL ACT; COMPLIANCE REQUIRED.

Subdivision 1. **Compliance with 1996 federal law.** Each health plan company shall comply with the federal Health Insurance Portability and Accountability Act of 1996, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this ~~section~~ subdivision.

Subd. 2. **Compliance with 2010 federal law.** Each health plan company shall comply with the federal Affordable Care Act as defined in section 62A.011, subdivision 1a, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any

provision of the federal act before the effective date provided for that provision in the federal act. The commissioner shall enforce this subdivision.

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

Sec. 71. **[62Q.022] ELIGIBILITY FOR COVERAGE REQUIREMENTS.**

The sponsor of a group health plan shall not take into consideration total hourly or annual salary of a full-time employee in determining eligibility for coverage in the health plan or establish eligibility rules that discriminate in favor of higher paid employees.

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

Sec. 72. Minnesota Statutes 2012, section 62Q.17, subdivision 6, is amended to read:

Subd. 6. **Employer-based purchasing pools.** Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups. ~~Pools may decide to create tiers within the pool, based on experience of group members. These tiers must be designed within the requirements of section 62L.08. The governing structure may establish criteria limiting movement between tiers. Tiers must be phased out within two years of the pool's creation.~~

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

Sec. 73. Minnesota Statutes 2012, section 62Q.18, is amended by adding a subdivision to read:

Subd. 8. **Guaranteed issue.** No health plan company shall offer, sell, or issue any health plan that does not make coverage available on a guaranteed issue basis.

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

Sec. 74. Minnesota Statutes 2012, section 62Q.19, is amended by adding a subdivision to read:

Subd. 8. **Essential community providers.** Health plans offered in the individual and small group market shall comply with section 62K.06 requirements to include a number and geographic distribution of essential community providers.

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

Sec. 75. Minnesota Statutes 2012, section 62Q.23, is amended to read:

62Q.23 GENERAL SERVICES.

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children ~~who do not reside with a covered person~~ to the limiting age as defined in section 62Q.01, subdivision 10, disabled ~~children and dependents~~ dependent children, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

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

Sec. 76. Minnesota Statutes 2012, section 62Q.43, subdivision 2, is amended to read:

Subd. 2. **Access requirement.** Every closed-panel health plan must allow enrollees ~~who are full-time students~~ under the age of ~~25~~ 26 years to change their designated clinic or physician at least once per month, as long as the clinic or physician is part of the health plan company's statewide clinic or physician network. A health plan company shall not charge enrollees who choose this option higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days' written notice of intent to change their designated clinic or physician.

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

Sec. 77. **[62Q.46] PREVENTIVE ITEMS AND SERVICES.**

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" means:

(1) evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force as of September 23, 2010, with respect to the individual involved. For purposes of this paragraph, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current;

(2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after is has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents; and

(4) evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration for women.

(b) A health plan must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

(c) A health plan is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) after the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered.

(d) Nothing prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

(e) This section does not apply to grandfathered plan coverage, as defined in section 62A.011, subdivision 1c. This section does not apply to plans offered by the Minnesota Comprehensive Health Association.

Subd. 2. **Coverage for office visits in conjunction with preventive items and services.** (a) A health plan may impose cost-sharing requirements with respect to an office visit if a preventive item or service is billed separately or is tracked as individual encounter data separately from the office visit.

(b) A health plan must not impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked as

individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the preventive item or service.

(c) A health plan may impose cost-sharing requirements with respect to an office visit if a preventive item or service is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.

Subd. 3. **Additional services not prohibited.** Nothing in these sections prohibits a health plan company from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A health plan company may impose cost-sharing requirements for a treatment not described in subdivision 1 even if the treatment results from an item or service described in subdivision 1.

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

Sec. 78. Minnesota Statutes 2012, section 62Q.47, is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204, Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Affordable Care Act, and any amendments thereto, or guidance and regulations issued under those acts.

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

Sec. 79. Minnesota Statutes 2012, section 62Q.52, is amended to read:

62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC SERVICES.

Subdivision 1. **Direct access.** (a) Health plan companies shall allow female enrollees direct access to ~~obstetricians and gynecologists~~ providers who specialize in obstetrics and gynecology for the following services:

(1) ~~annual preventive health examinations, which shall include a gynecologic examination, and any subsequent obstetric or gynecologic visits determined to be medically necessary by the examining obstetrician or gynecologist, based upon the findings of the examination~~ evaluation and necessary treatment for obstetric conditions or emergencies;

(2) maternity care; and

(3) evaluation and necessary treatment for ~~acute~~ gynecologic conditions or emergencies, including annual preventive health examinations.

(b) For purposes of this section, "direct access" means that a female enrollee may obtain the obstetric and gynecologic services specified in paragraph (a) from ~~obstetricians and gynecologists~~ providers who specialize in obstetrics and gynecology in the enrollee's network without a referral from, or prior approval through a primary care provider, another physician, the health plan company, or its representatives.

The health plan company shall treat the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services, pursuant to paragraph (a), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of a primary care health-care professional.

For purposes of this section, a health-care professional who specializes in obstetrics or gynecology means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.

The health plan company may require the health-care professional to agree to otherwise adhere to the health plan company's policies and procedures, including procedures for obtaining prior authorization and provide services in accordance with a treatment plan, if any, approved by the health plan company.

(c) Health plan companies shall not require higher co-payments, coinsurance, deductibles, or other enrollee cost-sharing for direct access.

(d) This section applies only to services described in paragraph (a) that are covered by the enrollee's coverage, but coverage of a preventive health examination for female enrollees must not exclude coverage of a gynecologic examination.

(e) This section does not:

(1) waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of obstetrical or gynecological care; or

(2) preclude the health plan company involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health plan company of treatment decisions.

Subd. 2. **Notice.** A health plan company shall provide notice to covered persons of the provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act. This commissioner shall enforce this section.

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

Sec. 80. **[62Q.526] COVERAGE FOR PARTICIPATION IN APPROVED CLINICAL TRIALS.**

Subdivision 1. **Definitions.** As used in this section, the following definitions apply:

(a) "Approved clinical trial" means phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and must be:

(1) conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA);

(2) exempt from obtaining an investigational new drug application; or

(3) approved or funded by:

(i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention; the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperating group or center of any of the entities described in this item;

(ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;

(iii) a qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants; or

(iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to:

(A) be comparable to the system of peer review of studies and investigations used by the NIH; and

(B) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

(b) "Qualified individual" means an individual with health plan coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because:

(1) the referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or

(2) the individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.

(c)(1) "Routine patient costs" includes all items and services covered by the health benefit plan of individual market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.

(2) Routine patient costs does not include:

(i) an investigational item, device, or service that is part of the trial;

(ii) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient;

(iii) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(iv) an item or service customarily provided and paid for by the sponsor of a trial.

Subd. 2. **Prohibited acts.** A health plan company that offers a health plan to a Minnesota resident may not:

(1) deny participation by a qualified individual in an approved clinical trial;

(2) deny, limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or

(3) discriminate against an individual on the basis of an individual's participation in an approved clinical trial.

Subd. 3. **Network plan conditions.** A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that

is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

Subd. 4. **Application to clinical trials outside of the state.** This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.

Subd. 5. **Construed.** (a) This section shall not be construed to require a health plan company offering health plan coverage through a network plan to provide benefits for route patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

(b) This section shall be construed to limit a health plan company's coverage with respect to clinical trials.

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

Sec. 81. Minnesota Statutes 2012, section 62Q.55, is amended to read:

62Q.55 EMERGENCY SERVICES.

Subdivision 1. **Access to emergency services.** (a) Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. The health plan company shall inform its enrollees how to obtain emergency care ~~and, if prior authorization for emergency services is required, shall make available a toll-free number, which is answered 24 hours a day, to answer questions about emergency services and to receive reports and provide authorizations, where appropriate,~~ for treatment of emergency medical conditions. Emergency services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan company's service area. In reviewing a denial for coverage of emergency services, the health plan company shall take the following factors into consideration:

(1) a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;

(2) the time of day and day of the week the care was provided;

(3) the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis;

(4) the enrollee's efforts to follow the health plan company's established procedures for obtaining emergency care; and

(5) any circumstances that precluded use of the health plan company's established procedures for obtaining emergency care.

(b) The health plan company may require enrollees to notify the health plan company of nonreferred emergency care as soon as possible, but not later than 48 hours, after the emergency care is initially provided. However, emergency care which would have been covered under the contract had notice been provided within the set time frame must be covered.

(c) Notwithstanding paragraphs (a) and (b), a health plan company, health insurer, or health coverage plan that is in compliance with the rules regarding accessibility of services adopted under section 62D.20 is in compliance with this section.

Subd. 2. **Emergency medical condition.** As used in this section, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii), of section 1867(e)(1)(A) of the Social Security Act.

Subd. 3. **Emergency services.** As used in this section, "emergency services" means, with respect to an emergency medical condition:

(1) a medical screening examination, as required under section 1867 of the Social Security Act, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the act to stabilize the patient.

Subd. 4. **Stabilize.** As used in this section, "stabilize" means, with respect to an emergency medical condition in subdivision 3, has the meaning given in section 1867(e)(3) of the Social Security Act, United States Code, title 42, section 1395dd(e)(3).

Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network.

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

Sec. 82. **[62Q.57] DESIGNATION OF PRIMARY CARE PROVIDER.**

Subdivision 1. **Choice of primary care provider.** If a health plan company offering a group health plan as defined in section 62A.011, subdivision 1d, or an individual health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan coverage as defined in section 62A.011, subdivision 1c, requires or provides for the designation by a covered person of a participating primary health care professional, the health plan company shall permit each covered person to:

(i) designate any participating primary care health-care professional who is available to accept the covered person; and

(ii) for a child, designate any participating physician who specializes in pediatrics as the child's primary care health-care professional and is available to accept the child.

This section does not waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of pediatric care.

Subd. 2. **Notice.** A health plan company shall provide notice to covered persons of the provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act. The commissioner shall enforce this section.

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

Sec. 83. **[62Q.646] REQUIRED ADDITIONAL INFORMATION.**

All individual and group health plans must submit the following information to the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the Department of Health and Human Services under the Affordable Care Act.

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

Sec. 84. **[62Q.677] LIFETIME AND ANNUAL LIMITS.**

Subdivision 1. **Applicability and scope.** Except as provided in subdivision 2, these sections apply to a health plan company providing coverage under an individual or group health plan.

Subd. 2. **Grandfathered plan coverage limits.** (a) The prohibition on lifetime limits applies to grandfathered plan coverage providing individual health insurance coverage or group health insurance coverage as defined in section 62A.011, subdivision 1c.

(b) The prohibition and limits on annual limits applies to grandfathered plan coverage providing group health insurance coverage, but it does not apply to grandfathered plan coverage providing individual health insurance coverage.

Subd. 3. **Prohibition on lifetime and annual limits.** Except as provided in subdivisions 4 and 5, a health plan company offering group or individual health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.

Except as provided in subdivisions 4, 5, and 6, a health plan company shall not establish any annual limit on the dollar amount of essential health benefits for any individual.

Subd. 4. **Nonessential benefits.** Subdivision 3 does not prevent a health plan company from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits as defined in section 62E.02 to the extent that the limits are otherwise permitted under applicable federal or state law.

Subd. 5. **Excluded benefits.** This section does not prohibit a health plan company from excluding all benefits for a given condition.

Subd. 6. **Annual limits prior to January 1, 2014.** For plan or policy years beginning before January 1, 2014, for any individual, a health plan may establish an annual limit on the dollar amount of benefits that are essential health benefits provided the limit is no less than the following:

(1) for a plan or policy year beginning after September 22, 2010, but before September 23, 2011, $750,000;

(2) for a plan or policy year beginning after September 22, 2011, but before September 23, 2012, $1,250,000; and

(3) for a plan or policy year beginning after September 22, 2012, but before January 1, 2014, $2,000,000.

In determining whether an individual has received benefits that meet or exceed the allowable limits, a health carrier shall take into account only essential health benefits.

Subd. 7. **Waivers.** For plan or policy years beginning before January 1, 2014, a health plan is exempt from the annual limit requirements if the plan is approved for a

waiver from the requirements by the United States Department of Health and Human Services, but the exemption only applies for the specified period of time that the waiver from the United States Department of Health and Human Services is applicable.

Subd. 8. **Notices.** (a) At the time a health plan receives a waiver from the United States Department of Health and Human Services, the health plan shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.

(b) At the time the waiver expires or is otherwise no longer in effect, the health plan shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.

Subd. 9. **Reinstatement.** A health plan company shall comply with all provisions of the Affordable Care Act in regards to reinstatement of coverage for individuals whose coverage or benefits under a health plan ended by reason of reaching a lifetime dollar limit on the dollar value of all benefits for the individual. This section does not require compliance with any provision of the federal act before the effective date provided for that provision in the Affordable Care Act. The commissioner shall enforce this section.

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

Sec. 85. Minnesota Statutes 2012, section 62Q.68, subdivision 1, is amended to read:

Subdivision 1. **Application.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage. For purposes of sections 62Q.69 through 62Q.73, the term "health plan company" does not include the Comprehensive Health Association created under chapter 62E. Section 62Q.70 does not apply to individual coverage. However, a health plan company offering individual coverage that is grandfathered plan coverage as defined in section 62A.011, subdivision 1c, may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow the process outlined in section 62Q.70.

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

Sec. 86. Minnesota Statutes 2012, section 62Q.69, subdivision 3, is amended to read:

Subd. 3. **Notification of complaint decisions.** (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30-day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.

(b) For group coverage, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(c) For individual coverage, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to submit the complaint decision to the external review process described in section 62Q.73 and the procedure for initiating the external process. Notwithstanding the provisions in this subdivision, a health plan company offering individual coverage that is grandfathered plan coverage as defined in section 62A.011, subdivision 1c, may instead follow the process for group coverage outlined in paragraph (b).

~~(c)~~ (d) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner.

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

Sec. 87. Minnesota Statutes 2012, section 62Q.70, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section. This section applies only to group coverage. However, a health plan company offering individual coverage that is grandfathered plan coverage as defined in section 62A.011, subdivision 1c, may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow the process outlined in this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the enrollee to review the enrollee's file and the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

(d) The enrollee must be allowed to receive continued coverage pending the outcome of the appeals process.

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

Sec. 88. Minnesota Statutes 2012, section 62Q.70, subdivision 2, is amended to read:

Subd. 2. **Procedures for filing an appeal.** The health plan company must provide notice to enrollees of its internal appeals process, in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act. If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

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

Sec. 89. Minnesota Statutes 2012, section 62Q.71, is amended to read:

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in ~~sections 62Q.69 and~~ section 62Q.70 if applicable, or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll-free telephone number of the appropriate commissioner; and

(6) of the right, for individual and group coverage, to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised~~.~~, including that under most circumstances an enrollee must exhaust the internal complaint or appeal process prior to external review. However, an enrollee may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

(i) the health plan company waives the exhaustion requirement;

(ii) the health plan company is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or

(iii) the enrollee has applied for an expedited external review at the same time the enrollee qualifies for and has applied for an expedited internal review under chapter 62M.

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

Sec. 90. Minnesota Statutes 2012, section 62Q.73, is amended to read:

62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) for individual coverage, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant;

(2) individual coverage offered by a health plan that is grandfathered plan coverage as defined in section 62A.011, subdivision 1c, may instead apply the definition of adverse determination for group coverage in clause (3);

(3) for group coverage, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

~~(2)~~ (4) any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify; ~~or~~

~~(3)~~ (5) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary~~.~~; or

(6) the enrollee has met the requirements of subdivision 6, paragraph (e).

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. **Exception.** (a) This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, the demonstration project for people with disabilities, and the federal Medicare program.

(b) In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045.

(c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.

Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. No enrollee may be subject to filing fees totaling more than $75 during a plan year for group coverage or policy year for individual coverage.

(b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.

(c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.

(d) The enrollee must request external review within six months from the date of the adverse determination.

Subd. 4. **Contract.** Pursuant to a request for proposal, the commissioner of administration, in consultation with the commissioners of health and commerce, shall contract with ~~an organization~~ at least three organizations or business ~~entity~~ entities to provide independent external reviews of all adverse determinations submitted for external review. The contract shall ensure that the fees for services rendered in connection with the reviews ~~be~~ are reasonable.

Subd. 5. **Criteria.** ~~(a)~~ The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company ~~or~~, utilization review organization, or a trade organization of health care providers;

(2) an expertise in dispute resolution;

(3) an expertise in health-related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to maintain written records, for at least three years, regarding reviews conducted and provide data to the commissioners of health and commerce upon request on reviews conducted; ~~and~~

(6) an ability to ensure confidentiality of medical records and other enrollee information.;

(7) accreditation by nationally recognized private accrediting organization; and

(8) the ability to provide an expedited external review process.

~~(b) The commissioner of administration shall take into consideration, in awarding the contract according to subdivision 4, any national accreditation standards that pertain to an external review entity.~~

Subd. 6. **Process.** (a) Upon receiving a request for an external review, the commissioner shall assign an external review entity on a random basis. The assigned external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review, the health plan company and the enrollee must provide the assigned external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. The assigned external review entity must furnish to the health plan company any additional information submitted by the enrollee within one business day of receipt. An enrollee may be assisted or represented by a person of the enrollee's choice.

(b) As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

(c) An external review shall be made as soon as practical but in no case later than ~~40~~ 45 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and the commissioner who is responsible for regulating the health plan company.

(d) The external review entity and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with:

(1) the health plan company that is the subject of the external review;

(2) the enrollee, or any parties related to the enrollee, whose treatment is the subject of the external review;

(3) any officer, director, or management employee of the health plan company;

(4) a plan administrator, plan fiduciaries, or plan employees;

(5) the health care provider, the health care provider's group, or practice association recommending treatment that is the subject of the external review;

(6) the facility at which the recommended treatment would be provided; or

(7) the developer or manufacturer of the principle drug, device, procedure, or other therapy being recommended.

(e)(1) An expedited external review must be provided if the enrollee requests it after receiving:

(i) an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal;

(ii) an adverse determination that concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services but has not been discharged from a facility; or

(iii) an adverse determination that involves a medical condition for which the standard external review time would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function.

(2) The external review entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee and the health plan company of the determination.

(3) If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.

Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

(c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including medical records the attending physician or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Subd. 8. **Effects of external review.** A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 9. **Immunity from civil liability.** A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.

Subd. 10. **Data reporting.** The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.

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

Sec. 91. Minnesota Statutes 2012, section 62Q.75, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given to them.

(b) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. A special circumstance may include, but is not limited to, a claim held pending payment of an overdue premium for the time period during which the expense was incurred as allowed by the Affordable Care Act. Nothing in this section alters an enrollee's obligation to disclose information as required by law.

(c) "Third-party administrator" means a third-party administrator or other entity subject to section 60A.23, subdivision 8, and Minnesota Rules, chapter 2767.

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

Sec. 92. Minnesota Statutes 2012, section 62Q.80, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization as defined in section 256B.692.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or ~~unmarried~~ child who is under the age of ~~19~~ 26 years.

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

Sec. 93. **[62Q.81] COMPREHENSIVE HEALTH INSURANCE COVERAGE REQUIREMENTS.**

Subdivision 1. **Essential health benefits.** All health plans shall include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in this subdivision.

The essential health benefits package means coverage that:

(a) provides essential health benefits as outlined in the Affordable Care Act. Essential health benefits include:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance abuse disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) other services defined as essential health benefits under the Affordable Care Act as defined in section 62A.011, subdivision 1a;

(b) limits cost-sharing for such coverage in accordance with section 1302(c) of the Affordable Care Act, as described in subdivision 2; and

(c) subject to subdivision 3, provides bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the Affordable Care Act as follows:

(1) a health plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan;

(2) a health plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan;

(3) a health plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan; and

(4) a health plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

Subd. 2. **Young adults.** If a health carrier offers health insurance coverage in any level of coverage specified under section 1302(d) of the Affordable Care Act, as described in subdivision 1, paragraph (c), above, the carrier shall also offer such coverage in that level as a health benefit plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of 21 years.

Subd. 3. **Catastrophic plan coverage.** A health plan not providing a bronze, silver, gold, or platinum level of coverage, as described in subdivision 1, paragraph (c), above, shall be treated as meeting the requirements of section 1302(d) of the Affordable Care Act with respect to any policy year if it provides a catastrophic plan that meets the requirements of section 1302(e) of the Affordable Care Act.

Subd. 4. **Nonapplication to dental plans.** This section does not apply to a dental plan described in section 1311(d)(2)(B)(ii) of the Affordable Care Act.

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

Sec. 94. **[62Q.82] BENEFITS AND COVERAGE EXPLANATION.**

Subdivision 1. **Summary.** Health plan companies offering health plans shall provide a summary of benefits and coverage explanation as required by the Affordable Care Act to:

(1) an applicant at the time of application;

(2) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(3) a policyholder at the time of issuance of the policy.

Subd. 2. **Compliance.** A health plan company described in subdivision 1 shall be deemed to have complied with subdivision 1 if the summary of benefits and coverage is provided in paper or electronic form.

Subd. 3. **Notice of modification.** Except in connection with a policy renewal or reissuance, if a health plan company makes any material modifications in any of the terms of the coverage, as defined for purposes of section 102 of the federal Employee Retirement Income Security Act of 1974, as amended, that is not reflected in the most recently provided summary of benefits and coverage, the health plan company shall provide notice of the modification to covered persons not later than 60 days prior to the date on which the modification will become effective.

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

Sec. 95. Minnesota Statutes 2012, section 72A.20, subdivision 35, is amended to read:

Subd. 35. **Determination of health plan policy limits.** Any health plan under section 62A.011, subdivision 3, that includes a specific policy limit within its insurance policy, certificate, or subscriber agreement shall calculate the policy limit by using the amount actually paid on behalf of the insured, subscriber, or dependents for services covered under the policy, subscriber agreement, or certificate unless the amount paid is greater than the billed charge. This provision does not permit the application of a specific policy limit within a plan where such a limit is prohibited under the Affordable Care Act as defined in section 62A.011, subdivision 1a.

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

Sec. 96. **[72A.328] PROHIBITION ON RESCISSIONS OF HEALTH PLAN.**

Subdivision 1. **Definitions.** (a) "Rescission" means a cancellation or discontinuance of coverage under a health plan that has a retroactive effect.

(b) "Rescission" does not include:

(1) a cancellation or discontinuance of coverage under a health benefit plan if:

(i) the cancellation or discontinuance of coverage has only a prospective effect; or

(ii) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage; or

(2) when the health plan covers only active employees and, if applicable, dependents and those covered under continuation coverage provisions, the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative record-keeping.

Subd. 2. **Prohibition on rescissions.** (a) A health carrier, as defined in section 62A.011, shall not rescind coverage under a health plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the health plan, unless:

(1) the individual or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; and

(2) the individual makes an intentional misrepresentation or omission of material fact, as prohibited by the terms of the health plan.

For purposes of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.

(b) This section does not apply to any benefits classified as excepted benefits under United States Code, title 42, section 300gg-91(c), or regulations enacted thereunder from time to time.

Subd. 3. **Notice required.** A health carrier shall provide at least 30 days advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the plan may be terminated retroactively.

Subd. 4. **Compliance with other restrictions on rescissions.** Nothing in this section allows rescission if rescission would otherwise be prohibited under section 62A.04, subdivision 2, clause (2), or 62A.615.

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

Sec. 97. Minnesota Statutes 2012, section 471.61, subdivision 1a, is amended to read:

Subd. 1a. **Dependents.** Notwithstanding the provisions of Minnesota Statutes 1969, section 471.61, as amended by Laws 1971, chapter 451, section 1, the word "dependents" as used therein shall mean spouse and ~~minor unmarried~~ children under the age of ~~18~~ 26 years ~~and dependent students under the age of 25 years actually dependent upon the employee~~.

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

Sec. 98. **REPEALER.**

(a) Minnesota Statutes 2012, sections 62E.02, subdivision 7; 62L.081; and 62L.10, are repealed effective the day following final enactment.

(b) Minnesota Statutes 2012, sections 62A.65, subdivision 6; 62E.16; 62E.20; 62L.02, subdivisions 4, 18, 19, and 23; 62L.05, subdivisions 1, 2, 3, 4, 4a, 5, 6, 7, 11, 12, and 13; and 62Q.37, subdivision 5, are repealed.

62A.65 INDIVIDUAL MARKET REGULATION.

Subd. 6. **Guaranteed issue not required.** Nothing in this section requires a health carrier to initially issue a health plan to a Minnesota resident, except as otherwise expressly provided in subdivision 4 or 5.

62E.02 DEFINITIONS.

Subd. 7. **Dependent.** "Dependent" means a spouse or unmarried child under the age of 25, or a dependent child of any age who is disabled.

62E.16 POLICY CONVERSION RIGHTS.

Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state, shall include, in addition to the provisions required by section 62A.17, the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions after the individual insured has exhausted any continuation coverage provided under section 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, if any continuation coverage is available to the individual, and then leaves the group regardless of the reason for leaving the group or if an employer member of a group ceases to remit payment so as to terminate coverage for its employees, or upon cancellation or termination of the coverage for the group except where uninterrupted and continuous group coverage is otherwise provided to the group. If the health maintenance organization has canceled coverage for the group because of a loss of providers in a service area, the health maintenance organization shall arrange for other health maintenance or indemnity conversion options that shall be offered to enrollees without the addition of underwriting restrictions. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. The person may exercise this right to conversion within 30 days of exhausting any continuation coverage provided under section 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; or 62A.21, or continuation coverage provided under federal law, and then leaving the group or within 30 days following receipt of due notice of cancellation or termination of coverage of the group or of the employer member of the group and upon payment of premiums from the date of termination or cancellation. Due notice of cancellation or termination of coverage for a group or of the employer member of the group shall be provided to each employee having coverage in the group by the insurer, self-insurer or health maintenance organization canceling or terminating the coverage except where reasonable evidence indicates that uninterrupted and continuous group coverage is otherwise provided to the group. Every employer having a policy of group accident and health insurance, group subscriber or contract of coverage by a health maintenance organization shall, upon request, provide the insurer or health maintenance organization a list of the names and addresses of covered employees. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue coverage under the same or a different contract without the addition of underwriting restrictions until the individual would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived. An individual conversion contract issued by a health maintenance organization shall not be deemed to be an individual enrollment contract for the purposes of section 62D.10. An individual health plan offered under section 62A.65, subdivision 5, paragraph (b), to a person satisfies the health carrier's obligation to offer conversion coverage under this section with respect to that person.

62E.20 RELATIONSHIP TO TEMPORARY FEDERAL HIGH-RISK POOL.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Association" means the Minnesota Comprehensive Health Association.

(c) "Federal law" means Title I, subtitle B, section 1101, of the federal Patient Protection and Affordable Care Act, Public Law 111-148, including any federal regulations adopted under it.

(d) "Federal qualified high-risk pool" means an arrangement established by the federal secretary of health and human services that meets the requirements of the federal law.

Subd. 2. **Timing of this section.** This section applies beginning the date the temporary federal qualified high-risk health pool created under the federal law begins to provide coverage in this state.

Subd. 3. **Maintenance of effort.** The assessments made by the comprehensive health association on its member insurers must comply with the maintenance of effort requirement contained in paragraph (b), clause (3), of the federal law, to the extent that the requirement applies to assessments made by the association.

Subd. 4. **Coordination with state health care programs.** The commissioner of commerce and the Minnesota Comprehensive Health Association shall ensure that applicants for coverage through the federal qualified high-risk pool, or through the Minnesota Comprehensive Health Association, are referred to the medical assistance or MinnesotaCare programs if they are determined to be potentially eligible for coverage through those programs. The commissioner of human services shall ensure that applicants for coverage under medical assistance or MinnesotaCare who are determined not to be eligible for those programs are provided information about coverage through the federal qualified high-risk pool and the Minnesota Comprehensive Health Association.

Subd. 5. **Federal funding.** Minnesota shall coordinate its efforts with the United States Department of Health and Human Services (HHS) to obtain the federal funds to implement in Minnesota the federal qualified high-risk pool.

62L.02 DEFINITIONS.

Subd. 4. **Base premium rate.** "Base premium rate" means as to a rating period, the lowest premium rate charged or which could have been charged under the rating system by the health carrier to small employers for health benefit plans with the same or similar coverage.

Subd. 18. **Index rate.** "Index rate" means as to a rating period for small employers the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Subd. 19. **Late entrant.** "Late entrant" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period applicable to the employee or dependent under the terms of the health benefit plan, provided that the initial enrollment period must be a period of at least 30 days. However, an eligible employee or dependent must not be considered a late entrant if:

(1) the individual was covered under qualifying coverage at the time the individual was eligible to enroll in the health benefit plan, declined enrollment on that basis, and presents to the health carrier a certificate of termination of the qualifying coverage, due to loss of eligibility for that coverage, or proof of the termination of employer contributions toward that coverage, provided that the individual maintains continuous coverage and requests enrollment within 30 days of termination of qualifying coverage or termination of the employer's contribution toward that coverage. For purposes of this clause, loss of eligibility includes loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. For purposes of this clause, an individual is not a late entrant if the individual elects coverage under the health benefit plan rather than accepting continuation coverage for which the individual is eligible under state or federal law with respect to the individual's previous qualifying coverage;

(2) the individual has lost coverage under another group health plan due to the expiration of benefits available under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, as amended, and any state continuation laws applicable to the employer or health carrier, provided that the individual maintains continuous coverage and requests enrollment within 30 days of the loss of coverage;

(3) the individual is a new spouse of an eligible employee, provided that enrollment is requested within 30 days of becoming legally married;

(4) the individual is a new dependent child of an eligible employee, provided that enrollment is requested within 30 days of becoming a dependent;

(5) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(6) a court has ordered that coverage be provided for a former spouse or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order.

Subd. 23. **Preexisting condition.** "Preexisting condition" means, with respect to coverage, a condition present before the individual's enrollment date for the coverage, for which medical

advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the enrollment date.

62L.05 SMALL EMPLOYER PLAN BENEFITS.

Subdivision 1. **Two small employer plans.** Each health carrier in the small employer market must make available, on a guaranteed issue basis, to any small employer that satisfies the contribution and participation requirements of section 62L.03, subdivision 3, both of the small employer plans described in subdivisions 2 and 3. Under subdivisions 2 and 3, coinsurance and deductibles do not apply to child health supervision services and prenatal services, as defined by section 62A.047. The maximum out-of-pocket costs for covered services must be $3,000 per individual and $6,000 per family per year. The maximum lifetime benefit must be not less than $1,000,000.

Subd. 2. **Deductible-type small employer plan.** The benefits of the deductible-type small employer plan offered by a health carrier must be equal to 80 percent of the charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small employer plan, in excess of an annual deductible which must be $2,250 per individual and $4,500 per family.

Subd. 3. **Co-payment-type small employer plan.** The benefits of the co-payment-type small employer plan offered by a health carrier must be equal to 80 percent of the charges, as specified in subdivision 10, for health care services, supplies, or other articles covered under the small employer plan, in excess of the following co-payments:

(1) $15 per outpatient visit, including visits to an urgent care center but not including visits to a hospital outpatient department or emergency room, or similar facility;

(2) $15 per visit for the services of a home health agency or private duty registered nurse;

(3) $50 per outpatient visit to a hospital outpatient department or emergency room, or similar facility; and

(4) $300 per inpatient admission to a hospital.

Subd. 4. **Benefits.** The medical services and supplies listed in this subdivision are the benefits that must be covered by the small employer plans described in subdivisions 2 and 3. Benefits under this subdivision may be provided through the managed care procedures practiced by health carriers:

(1) inpatient and outpatient hospital services, excluding services provided for the diagnosis, care, or treatment of chemical dependency or a mental illness or condition, other than those conditions specified in clauses (10) and (11). The health care services required to be covered under this clause must also be covered if rendered in a nonhospital environment, on the same basis as coverage provided for those same treatments or services if rendered in a hospital, provided, however, that this sentence must not be interpreted as expanding the types or extent of services covered;

(2) physician, chiropractor, and nurse practitioner services for the diagnosis or treatment of illnesses, injuries, or conditions;

(3) diagnostic x-rays and laboratory tests;

(4) ground transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, or as otherwise required by the health carrier;

(5) services of a home health agency if the services qualify as reimbursable services under Medicare;

(6) services of a private duty registered nurse if medically necessary, as determined by the health carrier;

(7) the rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids, unless coverage is required under section 62Q.675;

(8) child health supervision services up to age 18, as defined in section 62A.047;

(9) maternity and prenatal care services, as defined in sections 62A.041 and 62A.047;

(10) inpatient hospital and outpatient services for the diagnosis and treatment of certain mental illnesses or conditions, as defined by the International Classification of Diseases-Clinical Modification (ICD-9-CM), seventh edition (1990) and as classified as ICD-9 codes 295 to 299; and

(11) 50 percent of eligible charges for prescription drugs, up to a separate annual maximum out-of-pocket expense of $1,000 per individual for prescription drugs, and 100 percent of eligible charges thereafter.

Subd. 4a. **Alternative benefit plan.** In addition to the small employer benefit plans described in subdivisions 1 to 4, a health carrier may offer to a small employer a benefit plan that differs from those plans in the following respects:

(1) the plan may include different co-payments and deductibles; and

(2) the plan may offer coverage on a per diem, fixed indemnity, or nonexpense incurred basis.

Subd. 5. **Plan variations.** (a) No health carrier shall offer to a small employer a health benefit plan that differs from the small employer plans described in subdivisions 1 to 4a, unless the health benefit plan complies with all provisions of chapters 62A, 62C, 62D, 62E, 62H, 62N, 62Q, and 64B that otherwise apply to the health carrier, except as expressly permitted by paragraph (b).

(b) As an exception to paragraph (a), a health benefit plan is deemed to be a small employer plan and to be in compliance with paragraph (a) if it differs from one of the two small employer plans described in subdivisions 1 to 4 only by providing benefits in addition to those described in subdivision 4, provided that the health benefit plan has an actuarial value that exceeds the actuarial value of the benefits described in subdivision 4 by no more than two percent. "Benefits in addition" means additional units of a benefit listed in subdivision 4 or one or more benefits not listed in subdivision 4.

Subd. 6. **Choice products exception.** Nothing in subdivision 1 prohibits a health carrier from offering a small employer plan which provides for different benefit coverages based on whether the benefit is provided through a primary network of providers or through a secondary network of providers so long as the benefits provided in the primary network equal the benefit requirements of the small employer plan as described in this section. For purposes of products issued under this subdivision, out-of-pocket costs in the secondary network may exceed the out-of-pocket limits described in subdivision 1. A secondary network must not be used to provide "benefits in addition" as defined in subdivision 5, except in compliance with that subdivision.

Subd. 7. **Benefit exclusions.** No medical, hospital, or other health care benefits, services, supplies, or articles not expressly specified in subdivision 4 are required to be included in a small employer plan. Nothing in subdivision 4 restricts the right of a health carrier to restrict coverage to those services, supplies, or articles which are medically necessary. Health carriers may exclude a benefit, service, supply, or article not expressly specified in subdivision 4 from a small employer plan.

Subd. 11. **Plan design.** Notwithstanding any other law, regulation, or administrative interpretation to the contrary, health carriers may offer small employer plans through any provider arrangement, including, but not limited to, the use of open, closed, or limited provider networks. A health carrier may only use product and network designs currently allowed under existing statutory requirements. The provider networks offered by any health carrier may be specifically designed for the small employer market and may be modified at the carrier's election so long as all otherwise applicable regulatory requirements are met. Health carriers may use professionally recognized provider standards of practice when they are available, and may use utilization management practices otherwise permitted by law, including, but not limited to, second surgical opinions, prior authorization, concurrent and retrospective review, referral authorizations, case management, and discharge planning. A health carrier may contract with groups of providers with respect to health care services or benefits, and may negotiate with providers regarding the level or method of reimbursement provided for services rendered under a small employer plan.

Subd. 12. **Demonstration projects.** Nothing in this chapter prohibits a health maintenance organization from offering a demonstration project authorized under section 62D.30. The commissioner of health may approve a demonstration project which offers benefits that do not meet the requirements of a small employer plan if the commissioner finds that the requirements of section 62D.30 are otherwise met.

Subd. 13. **Notice of plan availability.** Each health carrier in the small employer market must provide information to small employers regarding the availability of the plans described in subdivisions 2 and 3, and in section 62Q.188. At a minimum, each health carrier must provide information describing the plans and their availability:

(1) displayed with other small employer product information on the health carrier's public Web site; and

(2) delivered to each small employer currently insured by the health carrier at the time of the small employer's renewal, at the same time and in the same manner as the small employer's renewal information.

62L.081 PHASE-IN.

Subdivision 1. **Compliance.** No health carrier, as defined in section 62L.02, shall renew any health benefit plan, as defined in section 62L.02, except in compliance with this section.

Subd. 2. **Premium adjustments.** (a) Any increase or decrease in premiums by a health carrier that is caused by section 62L.08, and that is greater than 30 percent, is subject to this subdivision. A health carrier shall determine renewal premiums only as follows:

(1) one-half of that premium increase or decrease may be charged upon the first renewal of the coverage on or after July 1, 1993; and

(2) the remaining one-half of that premium increase or decrease may be charged upon the renewal of the coverage one year after the date of the renewal under clause (1).

(b) For purposes of this subdivision, the premium increase or decrease is the total premium increase or decrease caused by section 62L.08 and not just the portion that exceeds 30 percent. This subdivision does not apply to any portion of a premium increase or decrease that is not caused by section 62L.08.

62L.10 SUPERVISION BY COMMISSIONER.

Subdivision 1. **Reports.** A health carrier doing business in the small employer market shall file by April 1 of each year an annual actuarial opinion with the commissioner certifying that the health carrier complied with the underwriting and rating requirements of this chapter during the preceding year and that the rating methods used by the health carrier were actuarially sound. A health carrier shall retain a copy of the opinion at its principal place of business.

Subd. 2. **Records.** A health carrier doing business in the small employer market shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

Subd. 3. **Submissions to commissioner.** Subsequent to the annual filing, the commissioner may request information and documentation from a health carrier describing its rating practices and renewal underwriting practices, including information and documentation that demonstrates that a health carrier's rating methods and practices are in accordance with sound actuarial principles and the requirements of this chapter. Except in cases of violations of this chapter or of another chapter, information received by the commissioner as provided under this subdivision is nonpublic.

Subd. 4. **Review of premium rates.** The commissioner shall regulate premium rates charged or proposed to be charged by all health carriers in the small employer market under section 62A.02. 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.

Subd. 5. **Transitional practices.** The commissioner shall disapprove index rates, premium variations, or other practices of a health carrier if they violate the spirit of this chapter and are the result of practices engaged in by the health carrier between April 23, 1992, and July 1, 1993, where the practices engaged in were carried out for the purpose of evading the spirit of this chapter. Each health carrier shall report to the commissioner, within 30 days and on a form prescribed by the commissioner, each cancellation, nonrenewal, or other termination of coverage of a small employer between April 23, 1992, and June 30, 1993. The health carrier shall provide any related information requested by the commissioner within the time specified in the request. Any health carrier that engages in a practice of terminating or inducing termination of coverage of small employers in order to evade the effects of Laws 1992, chapter 549, is guilty of an unfair method of competition and an unfair or deceptive act or practice in the business of insurance and is subject to the remedies provided in sections 72A.17 to 72A.32.

62Q.37 AUDITS CONDUCTED BY INDEPENDENT ORGANIZATION.

Subd. 5. **Accreditation not required.** Nothing in this section requires a health plan company to seek an acceptable accreditation status from a nationally recognized independent organization.