

1.1 moves to amend H.F. No. 2414, the delete everything amendment
1.2 (A19-0349) as follows:

1.3 Page 769, after line 29, insert:

1.4 "Sec. 36. Minnesota Statutes 2018, section 62Q.81, is amended to read:

1.5 **62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.**

1.6 Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering
1.7 individual and small group health plans must include the essential health benefits package
1.8 ~~required under section 1302(a) of the Affordable Care Act~~ and as described in this
1.9 subdivision.

1.10 (b) The essential health benefits package means coverage that:

1.11 (1) provides essential health benefits as ~~outlined in the Affordable Care Act~~ described
1.12 in subdivision 4;

1.13 (2) limits cost-sharing for such coverage ~~in accordance with the Affordable Care Act,~~
1.14 as described in subdivision 2; and

1.15 (3) ~~subject to subdivision 3,~~ provides bronze, silver, gold, or platinum level of coverage
1.16 ~~in accordance with the Affordable Care Act~~ as described in subdivision 3.

1.17 Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing
1.18 includes deductibles, coinsurance, co-payments, or similar charges, and qualified medical
1.19 expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986, as amended.
1.20 It does not include premiums, balance billing from non-network providers, or spending for
1.21 noncovered services.

1.22 (b) Cost-sharing per year for individual health plans is limited to the amount allowed
1.23 under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased

2.1 by an amount equal to the product of that amount and the premium adjustment percentage.
2.2 The premium adjustment percentage is the percentage which the average per capita premium
2.3 for health insurance coverage in the United States for the preceding calendar year exceeds
2.4 the average per capita premium for 2017. If the amount of the increase is not a multiple of
2.5 \$50, the increases shall be rounded to the next lowest multiple of \$50.

2.6 (c) Cost-sharing per year for small group health plans is limited to twice the amount
2.7 allowed under paragraph (b).

2.8 (d) If a health plan company offers health plans in any level of coverage specified under
2.9 section 1302(d) of the Affordable Care Act, as described in subdivision 1, paragraph (b),
2.10 clause (3) 3, the health plan company shall also offer coverage in that level to individuals
2.11 who have not attained 21 years of age as of the beginning of a policy year.

2.12 **Subd. 3. Levels of coverage; alternative compliance for catastrophic plans. (a) A**
2.13 health plan in the bronze level shall provide a level of coverage that is designed to provide
2.14 benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits
2.15 provided under the plan.

2.16 (b) A health plan in the silver level shall provide a level of coverage that is designed to
2.17 provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of
2.18 the benefits provided under the plan.

2.19 (c) A health plan in the gold level shall provide a level of coverage that is designed to
2.20 provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of
2.21 the benefits provided under the plan.

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

2.25 (e) A health plan company that does not provide an individual or small group health
2.26 plan in the bronze, silver, gold, or platinum level of coverage, as described in subdivision
2.27 1, paragraph (b), clause (3), shall be treated as meeting the requirements of this section
2.28 1302(d) of the Affordable Care Act with respect to any policy plan year if the health plan
2.29 company provides a catastrophic plan that meets the following requirements of section
2.30 1302(e) of the Affordable Care Act.:

2.31 (1) the only individuals to enroll in the health plan are those that:

2.32 (i) have not attained age 30 before the beginning of the plan year;

2.33 (ii) have an inability to access affordable coverage; or

3.1 (iii) are experiencing a hardship in reference to their capability to access coverage; and
3.2 (2) the health plan provides essential health benefits, except that it provides no benefits
3.3 for any plan year until the individual has incurred cost-sharing expenses in amount equal
3.4 to the limitation in effect under subdivision 2, and the plan provides coverage for at least
3.5 three primary care visits.

3.6 Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential
3.7 health benefits" ~~has the meaning given under section 1302(b) of the Affordable Care Act~~
3.8 ~~and includes~~ means:

3.9 (1) ambulatory patient services;

3.10 (2) emergency services;

3.11 (3) hospitalization;

3.12 (4) laboratory services;

3.13 (5) maternity and newborn care;

3.14 (6) mental health and substance use disorder services, including behavioral health
3.15 treatment;

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

3.17 (8) prescription drugs;

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

3.19 (10) rehabilitative and habilitative services and devices; and

3.20 (11) additional essential health benefits included in the ~~EHB-benchmark plan, as defined~~
3.21 ~~under the Affordable Care Act~~ health plan described in paragraph (c).

3.22 (b) Emergency services must be provided without imposing any prior authorization
3.23 requirement or limitation on coverage, where the provider of services does not have a
3.24 contractual relationship with the health plan for the providing of services, that is more
3.25 restrictive than the requirements or limitations that apply to emergency services received
3.26 from providers who have a contractual relationship with the health plan. If services are
3.27 provided out-of-network the cost-sharing is the same that would apply if services were
3.28 provided in-network.

3.29 (c) The scope of essential health benefits under paragraph (a) must be equal to the scope
3.30 of benefits provided under a typical employer plan.

3.31 (d) The essential health benefits must:

4.1 (1) reflect an appropriate balance among the categories so that benefits are not unduly
4.2 weighted toward any category;

4.3 (2) not make coverage decisions, determine reimbursement rates, establish incentive
4.4 programs, or design benefits in ways that discriminate against individuals because of their
4.5 age, disability, or expected length of life;

4.6 (3) take into account the health care needs of diverse segments of the population,
4.7 including women, children, persons with disabilities, and other groups; and

4.8 (4) ensure that health benefits established as essential not be subject to denial to
4.9 individuals against their wishes on the basis of the individuals' age or expected length of
4.10 life or of the individuals' present or predicted disability, degree of medical dependency, or
4.11 quality of life.

4.12 Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section~~
4.13 ~~1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric
4.14 dental benefits."

4.15 Renumber the sections in sequence

4.16 Amend the title accordingly