

1.1 moves to amend H.F. No. 779, the third engrossment, as follows:

1.2 Page 1, after the enactment clause, insert:

1.3 "ARTICLE 1

1.4 CONFORMING STATE LAW TO AFFORDABLE CARE ACT

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

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

1.17 (b) All self-insured hospital and medical service products must comply with coverage
1.18 mandates, data reporting, and consumer protection requirements applicable to the licensed
1.19 carrier administering the product, had the product been insured, including chapters 62J,
1.20 62M, and 62Q. Any self-insured products that limit coverage to a network of providers
1.21 or provide different levels of coverage between network and nonnetwork providers shall
1.22 comply with section 62D.123 and geographic access standards for health maintenance
1.23 organizations adopted by the commissioner of health in rule under chapter 62D.

1.24 (c) Notwithstanding paragraph (b), a self-insured hospital and medical product
1.25 offered under sections 43A.22 to 43A.30 is not required to extend dependent coverage
1.26 to an eligible employee's unmarried child under the age of 25 to the full extent required

2.1 under chapters 62A and 62L. Dependent child coverage must, at a minimum, extend to an
 2.2 eligible employee's unmarried dependent child who is under the age of 19 or an unmarried
 2.3 child under the age of 25 who is a full-time student. A person who is at least 19 years of
 2.4 age but who is under the age of 25 and who is not a full-time student must be permitted
 2.5 to be enrolled as a dependent of an eligible employee until age 25 if the person: to the
 2.6 limiting age as defined in section 62Q.01, subdivision 9, disabled children to the extent
 2.7 required in sections 62A.14 and 62A.141, and dependent grandchildren to the extent
 2.8 required in sections 62A.042 and 62A.302.

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

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

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

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

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

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

2.27 Sec. 2. Minnesota Statutes 2012, section 43A.317, subdivision 6, is amended to read:

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

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

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

3.2 (1) the spouse, dependent children to the limiting age as defined in section 62Q.01,
3.3 subdivision 9, disabled children to the extent required in sections 62A.14 and 62A.141,
3.4 and dependent grandchildren of a covered employee to the extent required in sections
3.5 62A.042 and 62A.302;

3.6 (2) a retiree who is eligible to receive a pension or annuity from the employer and a
3.7 covered retiree's spouse, dependent children to the limiting age as defined in section
3.8 62Q.01, subdivision 9, disabled children to the extent required in sections 62A.14 and
3.9 62A.141, and dependent grandchildren to the extent required in sections 62A.042 and
3.10 62A.302;

3.11 (3) the surviving spouse, dependent children to the limiting age as defined in section
3.12 62Q.01, subdivision 9, disabled children, and dependent grandchildren of a deceased
3.13 employee or retiree, if the spouse, children, or grandchildren were covered at the time of
3.14 the death;

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

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

3.19 An employer shall determine when it applies to the program the criteria individuals
3.20 in these categories must meet to be eligible for coverage. An employer may subsequently
3.21 change the criteria annually, or at other times with approval of the commissioner. The
3.22 criteria for dependent children to the limiting age as defined in section 62Q.01, subdivision
3.23 9, disabled children, and dependent grandchildren may be no more inclusive than the
3.24 criteria under section 43A.18, subdivision 2. This paragraph shall not be interpreted
3.25 as relieving the program from compliance with any federal and state continuation of
3.26 coverage requirements.

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

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

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

3.34 Sec. 3. Minnesota Statutes 2012, section 60A.08, subdivision 15, is amended to read:

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

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

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

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

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

4.12 (f) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review
4.13 under section 2794 of the Public Health Services Act and any amendments to, or
4.14 regulations, or guidance issued under the act that are filed with the commissioner on or
4.15 after September 1, 2011, the commissioner:

4.16 (1) may acknowledge receipt of the information;

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

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

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

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

4.24 Sec. 4. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision
4.25 to read:

4.26 Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the federal Patient
4.27 Protection and Affordable Care Act, Public Law 111-148, as amended, including the
4.28 federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and
4.29 any amendments to, and any federal guidance or regulations issued under, these acts.

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

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

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

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

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

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

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

5.11 (2) an employee welfare benefit plan as defined in the Employee Retirement Income
5.12 Security Act of 1974, United States Code, title 29, section 1002, if the plan provides
5.13 payment for medical care to employees, including both current and former employees, or
5.14 their dependents, directly or through insurance, reimbursement, or otherwise, including
5.15 employee welfare benefit plans specifically exempt from the provisions of the Employee
5.16 Retirement Income Security Act of 1974 under United States Code, title 29, section 1003.

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

5.18 Sec. 7. Minnesota Statutes 2012, section 62A.011, subdivision 3, is amended to read:

5.19 **Subd. 3. Health plan.** "Health plan" means a policy or certificate of accident and
5.20 sickness insurance as defined in section 62A.01 offered by an insurance company licensed
5.21 under chapter 60A; a subscriber contract or certificate offered by a nonprofit health
5.22 service plan corporation operating under chapter 62C; a health maintenance contract or
5.23 certificate offered by a health maintenance organization operating under chapter 62D; a
5.24 health benefit certificate offered by a fraternal benefit society operating under chapter
5.25 64B; or health coverage offered by a joint self-insurance employee health plan operating
5.26 under chapter 62H. Health plan means individual and group coverage, unless otherwise
5.27 specified. Health plan does not include coverage that is:

5.28 (1) limited to disability or income protection coverage;

5.29 (2) automobile medical payment coverage;

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

5.32 (4) designed solely to provide payments on a per diem, fixed indemnity, or
5.33 non-expense-incurred basis, including coverage only for a specified disease or illness or

6.1 hospital indemnity or other fixed indemnity insurance, if the benefits are provided under a
 6.2 separate policy, certificate, or contract for insurance; there is no coordination between the
 6.3 provision of benefits and any exclusion of benefits under any group health plan maintained
 6.4 by the same plan sponsor; and the benefits are paid with respect to an event without regard
 6.5 to whether benefits are provided with respect to such an event under any group health
 6.6 plan maintained by the same plan sponsor;

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

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

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

6.10 (8) accident-only coverage;

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

6.12 (10) issued as a supplement to Medicare, as defined in sections 62A.3099 to

6.13 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health
 6.14 maintenance organizations or those policies, contracts, or certificates governed by section
 6.15 1833 or 1876, section 1851, et. seq.; or section 1860D-1, et seq., of title XVIII of the

6.16 federal Social Security Act, ~~United States Code, title 42, section 1395, et seq.,~~ as amended;

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

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

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

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

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

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

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

7.1 **EFFECTIVE DATE.** This section is effective for coverage effective on or after
7.2 January 1, 2014.

7.3 Sec. 9. Minnesota Statutes 2012, section 62A.011, is amended by adding a subdivision
7.4 to read:

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

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

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

7.10 Subd. 6. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace"
7.11 means the Minnesota Insurance Marketplace as defined in section 62V.02.

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

7.14 Subd. 7. **Qualified health plan.** "Qualified health plan" means a health plan that
7.15 meets the definition in section 1301(a) of the Affordable Care Act and has been certified
7.16 by the Board of the Minnesota Insurance Marketplace in accordance with chapter 62V to
7.17 be offered through the Minnesota Insurance Marketplace.

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

7.20 Subd. 8. **Filing by health carriers for purposes of complying with the**
7.21 **certification requirements of the Minnesota Insurance Marketplace.** No qualified
7.22 health plan shall be offered through the Minnesota Insurance Marketplace until its form
7.23 and the premium rates pertaining to the form have been approved by the commissioner of
7.24 commerce or health, as appropriate, and the health plan has been determined to comply
7.25 with the certification requirements of the Minnesota Insurance Marketplace in accordance
7.26 with an agreement between the commissioners of commerce and health and the Minnesota
7.27 Insurance Marketplace.

7.28 **EFFECTIVE DATE.** This section is effective for coverage effective on or after
7.29 January 1, 2014.

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

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

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

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

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

8.11 (a) husband,

8.12 (b) wife,

8.13 (c) dependent children as described in sections 62A.302 and 62A.3021, or

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

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

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

8.24 (5) **Description of policy.** The policy, on the first page, indicates or refers to its
8.25 provisions for renewal or cancellation either in the brief description, if any, or by a separate
8.26 statement printed in type not smaller than the type used for captions or a separate provision
8.27 bearing a caption which accurately describes the renewability or cancelability of the policy.

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

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

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

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

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

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

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

9.22 Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such
9.23 policy delivered or issued for delivery to any person in this state shall contain the
9.24 provisions specified in this subdivision in the words in which the same appear in this
9.25 section. The insurer may, at its option, substitute for one or more of such provisions
9.26 corresponding provisions of different wording approved by the commissioner which are
9.27 in each instance not less favorable in any respect to the insured or the beneficiary. Such
9.28 provisions shall be preceded individually by the caption appearing in this subdivision or, at
9.29 the option of the insurer, by such appropriate individual or group captions or subcaptions
9.30 as the commissioner may approve.

9.31 (1) A provision as follows:

9.32 ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and
9.33 the attached papers, if any, constitutes the entire contract of insurance. No change in this
9.34 policy shall be valid until approved by an executive officer of the insurer and unless such

10.1 approval be endorsed hereon or attached hereto. No agent has authority to change this
10.2 policy or to waive any of its provisions.

10.3 (2) A provision as follows:

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

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

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

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

10.25 (3) (a) Except as required for qualified health plans sold through the Minnesota
10.26 Insurance Marketplace to individuals receiving advance payments of the premium tax
10.27 credit, a provision as follows:

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

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

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

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

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

11.7 (b) For qualified health plans sold through the Minnesota Insurance Marketplace
11.8 to individuals receiving advance payments of the premium tax credit, a grace period
11.9 provision must be included that complies with the Affordable Care Act and is no less
11.10 restrictive than the grace period required by the Affordable Care Act.

11.11 (4) A provision as follows:

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

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

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

11.26 The reinstated policy shall cover only loss resulting from such accidental injury as
11.27 may be sustained after the date of reinstatement and loss due to such sickness as may
11.28 begin more than ten days after such date. In all other respects the insured and insurer shall
11.29 have the same rights thereunder as they had under the policy immediately before the due
11.30 date of the defaulted premium, subject to any provisions endorsed hereon or attached
11.31 hereto in connection with the reinstatement. Any premium accepted in connection with
11.32 a reinstatement shall be applied to a period for which premium has not been previously
11.33 paid, but not to any period more than 60 days prior to the date of reinstatement. The last
11.34 sentence of the above provision may be omitted from any policy which the insured has
11.35 the right to continue in force subject to its terms by the timely payment of premiums

12.1 (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least
12.2 five years from its date of issue.

12.3 (5) A provision as follows:

12.4 NOTICE OF CLAIM: Written notice of claim must be given to the insurer within
12.5 20 days after the occurrence or commencement of any loss covered by the policy, or as
12.6 soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or
12.7 the beneficiary to the insurer at (insert the location of such office as the insurer may
12.8 designate for the purpose), or to any authorized agent of the insurer, with information
12.9 sufficient to identify the insured, shall be deemed notice to the insurer.

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

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

12.22 (6) A provision as follows:

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

12.29 (7) A provision as follows:

12.30 PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its
12.31 said office in case of claim for loss for which this policy provides any periodic payment
12.32 contingent upon continuing loss within 90 days after the termination of the period for
12.33 which the insurer is liable and in case of claim for any other loss within 90 days after the
12.34 date of such loss. Failure to furnish such proof within the time required shall not invalidate
12.35 nor reduce any claim if it was not reasonably possible to give proof within such time,

13.1 provided such proof is furnished as soon as reasonably possible and in no event, except in
13.2 the absence of legal capacity, later than one year from the time proof is otherwise required.

13.3 (8) A provision as follows:

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

13.11 (9) A provision as follows:

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

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

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

13.28 Subject to any written direction of the insured in the application or otherwise all
13.29 or a portion of any indemnities provided by this policy on account of hospital, nursing,
13.30 medical, or surgical services may, at the insurer's option and unless the insured requests
13.31 otherwise in writing not later than the time of filing proofs of such loss, be paid directly to
13.32 the hospital or person rendering such services; but it is not required that the service be
13.33 rendered by a particular hospital or person.

13.34 (10) A provision as follows:

13.35 PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense
13.36 shall have the right and opportunity to examine the person of the insured when and as

14.1 often as it may reasonably require during the pendency of a claim hereunder and to make
14.2 an autopsy in case of death where it is not forbidden by law.

14.3 (11) A provision as follows:

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

14.8 (12) A provision as follows:

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

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

14.16 Sec. 15. Minnesota Statutes 2012, section 62A.047, is amended to read:

14.17 **62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND**
14.18 **PRENATAL CARE SERVICES.**

14.19 A policy of individual or group health and accident insurance regulated under this
14.20 chapter, or individual or group subscriber contract regulated under chapter 62C, health
14.21 maintenance contract regulated under chapter 62D, or health benefit certificate regulated
14.22 under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota
14.23 resident, must provide coverage for child health supervision services and prenatal care
14.24 services. The policy, contract, or certificate must specifically exempt reasonable and
14.25 customary charges for child health supervision services and prenatal care services from a
14.26 deductible, co-payment, or other coinsurance or dollar limitation requirement. Nothing
14.27 in this section prohibits a health carrier that has a network of providers from imposing
14.28 a deductible, co-payment, or other coinsurance or dollar limitation requirement for
14.29 child health supervision services and prenatal care services that are delivered by an
14.30 out-of-network provider. This section does not prohibit the use of policy waiting periods
14.31 or ~~preexisting condition limitations~~ for these services. Minimum benefits may be limited
14.32 to one visit payable to one provider for all of the services provided at each visit cited in
14.33 this section subject to the schedule set forth in this section. Nothing in this section applies
14.34 to a policy designed primarily to provide coverage payable on a per diem, fixed indemnity,

15.1 or non-expense-incurred basis, or a policy that provides only accident coverage. A policy,
15.2 contract, or certificate described under this section may not apply preexisting condition
15.3 limitations to individuals under 19 years of age. This section does not apply to individual
15.4 coverage under a grandfathered plan.

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

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

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

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

15.19 **62A.049 LIMITATION ON PREAUTHORIZATIONS; EMERGENCIES.**

15.20 No policy of accident and sickness insurance or group subscriber contract regulated
15.21 under chapter 62C issued or renewed in this state may contain a provision that makes an
15.22 insured person ineligible to receive full benefits because of the insured's failure to obtain
15.23 preauthorization, if that failure occurs because of the need for emergency confinement
15.24 or emergency treatment. The insured or an authorized representative of the insured shall
15.25 notify the insurer as soon after the beginning of emergency confinement or emergency
15.26 treatment as reasonably possible. However, to the extent that the insurer suffers actual
15.27 prejudice caused by the failure to obtain preauthorization, the insured may be denied all or
15.28 part of the insured's benefits. ~~This provision does not apply to admissions for treatment of~~
15.29 ~~chemical dependency and nervous and mental disorders.~~

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

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

15.32 **62A.136 HEARING, DENTAL, AND VISION PLAN COVERAGE.**

16.1 The following provisions do not apply to health plans as defined in section 62A.011,
16.2 subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections
16.3 62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17,
16.4 subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; and
16.5 62A.3093; ~~and 62E.16.~~

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

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

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

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

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

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

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

16.25 Subd. 2. **Responsibility of employee.** Every covered employee electing to continue
16.26 coverage shall pay the former employer, on a monthly basis, the cost of the continued
16.27 coverage. The policy, contract, or plan must require the group policyholder or contract
16.28 holder to, upon request, provide the employee with written verification from the insurer
16.29 of the cost of this coverage promptly at the time of eligibility for this coverage and at
16.30 any time during the continuation period. If the policy, contract, or health care plan is
16.31 administered by a trust, every covered employee electing to continue coverage shall pay
16.32 the trust the cost of continued coverage according to the eligibility rules established by the
16.33 trust. In no event shall the amount of premium charged exceed 102 percent of the cost

17.1 to the plan for such period of coverage for similarly situated employees with respect to
17.2 whom neither termination nor layoff has occurred, without regard to whether such cost
17.3 is paid by the employer or employee. The employee shall be eligible to continue the
17.4 coverage until the employee becomes covered under another group health plan, or for a
17.5 period of 18 months after the termination of or lay off from employment, whichever is
17.6 shorter. For an individual age 19 or older, if the employee becomes covered under another
17.7 group policy, contract, or health plan and the new group policy, contract, or health plan
17.8 contains any preexisting condition limitations, the employee may, subject to the 18-month
17.9 maximum continuation limit, continue coverage with the former employer until the
17.10 preexisting condition limitations have been satisfied. The new policy, contract, or health
17.11 plan is primary except as to the preexisting condition. In the case of a newborn child who
17.12 is a dependent of the employee, the new policy, contract, or health plan is primary upon
17.13 the date of birth of the child, regardless of which policy, contract, or health plan coverage
17.14 is deemed primary for the mother of the child.

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

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

17.17 Subd. 6. **Conversion to individual policy.** ~~A group insurance policy that provides~~
17.18 ~~posttermination or layoff coverage as required by this section shall also include a~~
17.19 ~~provision allowing a covered employee, surviving spouse, or dependent at the expiration~~
17.20 ~~of the posttermination or layoff coverage provided by subdivision 2 to obtain from the~~
17.21 ~~insurer offering the group policy or group subscriber contract, at the employee's, spouse's,~~
17.22 ~~or dependent's option and expense, without further evidence of insurability and without~~
17.23 ~~interruption of coverage, an individual policy of insurance or an individual subscriber~~
17.24 ~~contract providing at least the minimum benefits of a qualified plan as prescribed by~~
17.25 ~~section 62E.06 and the option of a number three qualified plan, a number two qualified~~
17.26 ~~plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to~~
17.27 ~~3, provided application is made to the insurer within 30 days following notice of the~~
17.28 ~~expiration of the continued coverage and upon payment of the appropriate premium.~~
17.29 ~~The required conversion contract must treat pregnancy the same as any other covered~~
17.30 ~~illness under the conversion contract. A health maintenance contract issued by a health~~
17.31 ~~maintenance organization that provides posttermination or layoff coverage as required~~
17.32 ~~by this section shall also include a provision allowing a former employee, surviving~~
17.33 ~~spouse, or dependent at the expiration of the posttermination or layoff coverage provided~~
17.34 ~~in subdivision 2 to obtain from the health maintenance organization, at the former~~
17.35 ~~employee's, spouse's, or dependent's option and expense, without further evidence of~~

18.1 ~~insurability and without interruption of coverage, an individual health maintenance~~
18.2 ~~contract. Effective January 1, 1985, enrollees who have become nonresidents of the health~~
18.3 ~~maintenance organization's service area shall be given the option, to be arranged by the~~
18.4 ~~health maintenance organization, of a number three qualified plan, a number two qualified~~
18.5 ~~plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3.~~
18.6 ~~This option shall be made available at the enrollee's expense, without further evidence of~~
18.7 ~~insurability and without interruption of coverage.~~

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

18.11 ~~The~~ An individual policy or contract issued as a conversion policy prior to January
18.12 1, 2014, shall be renewable at the option of the individual as long as the individual is not
18.13 covered under another qualified plan as defined in section 62E.02, subdivision 4. Any
18.14 revisions in the table of rate for the individual policy shall apply to the covered person's
18.15 original age at entry and shall apply equally to all similar conversion policies issued
18.16 by the insurer.

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

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

18.19 Subd. 2b. **Conversion privilege.** ~~Every policy described in subdivision 1 shall~~
18.20 ~~contain a provision allowing a former spouse and dependent children of an insured,~~
18.21 ~~without providing evidence of insurability, to obtain from the insurer at the expiration of~~
18.22 ~~any continuation of coverage required under subdivision 2a or sections 62A.146 and~~
18.23 ~~62A.20, conversion coverage providing at least the minimum benefits of a qualified~~
18.24 ~~plan as prescribed by section 62E.06 and the option of a number three qualified plan, a~~
18.25 ~~number two qualified plan, a number one qualified plan as provided by section 62E.06,~~
18.26 ~~subdivisions 1 to 3, provided application is made to the insurer within 30 days following~~
18.27 ~~notice of the expiration of the continued coverage and upon payment of the appropriate~~
18.28 ~~premium. The~~ An individual policy or contract issued as a conversion policy prior to
18.29 January 1, 2014 shall be renewable at the option of the covered person as long as the
18.30 covered person is not covered under another qualified plan as defined in section 62E.02,
18.31 subdivision 4. Any revisions in the table of rate for the individual policy shall apply to the
18.32 covered person's original age at entry and shall apply equally to all similar conversion
18.33 policies issued by the insurer.

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

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

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

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

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

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

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

19.12 **62A.302 COVERAGE OF DEPENDENTS.**

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

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

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

19.17 ~~(3)~~ (2) a policy, contract, or certificate issued by a community integrated service
19.18 network licensed under chapter 62N.

19.19 Subd. 2. **Required coverage.** Every health plan included in subdivision 1 that
19.20 provides dependent coverage must define "dependent" no more restrictively than the
19.21 definition provided in section 62L.02, subdivision 11.

19.22 Subd. 3. **No additional restrictions permitted.** Any health plan included in
19.23 subdivision 1 that provides dependent coverage of children shall make that coverage
19.24 available to children until the child attains 26 years of age. A health carrier must not place
19.25 restrictions on this coverage and must comply with the following requirements:

19.26 (1) with respect to a child who has not attained 26 years of age, a health carrier shall
19.27 not define dependent for purposes of eligibility for dependent coverage of children other
19.28 than the terms of a relationship between a child and the enrollee or spouse of the enrollee;

19.29 (2) a health carrier must not deny or restrict coverage for a child who has not attained
19.30 26 years of age based on (i) the presence or absence of the child's financial dependency upon
19.31 the participant, primary subscriber, or any other person; (ii) residency with the participant
19.32 and in the individual market the primary subscriber, or with any other person; (iii) marital
19.33 status; (iv) student status; (v) employment; or (vi) any combination of those factors; and

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

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

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

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

20.23 Subd. 7. **Grandfathered plan coverage.** (a) For plan years beginning before
20.24 January 1, 2014, a group health plan that is a grandfathered plan and makes available
20.25 dependent coverage of children may exclude an adult child who has not attained 26
20.26 years of age from coverage only if the adult child is eligible to enroll in an eligible
20.27 employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal
20.28 Revenue Code, other than the group health plan of a parent.

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

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

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

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

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

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

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

21.11 **62A.615 PREEXISTING CONDITIONS DISCLOSED AT TIME OF**
 21.12 **APPLICATION.**

21.13 No insurer may cancel or rescind a health insurance policy for a preexisting condition
 21.14 of which the application or other information provided by the insured reasonably gave
 21.15 the insurer notice. No insurer may restrict coverage for a preexisting condition of which
 21.16 the application or other information provided by the insured reasonably gave the insurer
 21.17 notice unless the coverage is restricted at the time the policy is issued and the restriction is
 21.18 disclosed in writing to the insured at the time the policy is issued. In addition, no health plan
 21.19 may restrict coverage for a preexisting condition for an individual who is under 19 years
 21.20 of age. This section does not apply to individual health plans that are grandfathered plans.

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

21.22 Sec. 26. Minnesota Statutes 2012, section 62A.65, subdivision 3, is amended to read:

21.23 **Subd. 3. Premium rate restrictions.** No individual health plan may be offered,
 21.24 sold, issued, or renewed to a Minnesota resident unless the premium rate charged is
 21.25 determined in accordance with the following requirements:

21.26 ~~(a) Premium rates must be no more than 25 percent above and no more than 25~~
 21.27 ~~percent below the index rate charged to individuals for the same or similar coverage,~~
 21.28 ~~adjusted pro rata for rating periods of less than one year. The premium variations~~
 21.29 ~~permitted by this paragraph must be based only upon health status, claims experience,~~
 21.30 ~~and occupation. For purposes of this paragraph, health status includes refraining from~~
 21.31 ~~tobacco use or other actuarially valid lifestyle factors associated with good health,~~
 21.32 ~~provided that the lifestyle factor and its effect upon premium rates have been determined~~
 21.33 ~~by the commissioner to be actuarially valid and have been approved by the commissioner.~~

22.1 ~~Variations permitted under this paragraph must not be based upon age or applied~~
22.2 ~~differently at different ages. This paragraph does not prohibit use of a constant percentage~~
22.3 ~~adjustment for factors permitted to be used under this paragraph.~~

22.4 ~~(b) (a) Premium rates may vary based upon the ages of covered persons only as~~
22.5 ~~provided in this paragraph. In addition to the variation permitted under paragraph (a), each~~
22.6 ~~health carrier may use an additional premium variation based upon age of up to plus or~~
22.7 ~~minus 50 percent of the index rate in accordance with the provisions of the Affordable~~
22.8 ~~Care Act.~~

22.9 ~~(e) A health carrier may request approval by the commissioner to establish separate~~
22.10 ~~geographic regions determined by the health carrier and to establish separate index rates~~
22.11 ~~for each such region.~~

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

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

22.16 ~~(2) each geographic region must be composed of no fewer than seven counties that~~
22.17 ~~create a contiguous region; and~~

22.18 ~~(3) the health carrier provides actuarial justification acceptable to the commissioner~~
22.19 ~~for the proposed geographic variations in index rates premium rates for each area,~~
22.20 ~~establishing that the variations are based upon differences in the cost to the health carrier~~
22.21 ~~of providing coverage.~~

22.22 ~~(d) Health carriers may use rate cells and must file with the commissioner the rate~~
22.23 ~~cells they use. Rate cells must be based upon the number of adults or children covered~~
22.24 ~~under the policy and may reflect the availability of Medicare coverage. The rates for~~
22.25 ~~different rate cells must not in any way reflect generalized differences in expected costs~~
22.26 ~~between principal insureds and their spouses.~~

22.27 ~~(c) Premium rates may vary based upon tobacco use, in accordance with the~~
22.28 ~~provisions of the Affordable Care Act.~~

22.29 ~~(e) (d) In developing its index rates and premiums for a health plan, a health carrier~~
22.30 ~~shall take into account only the following factors:~~

22.31 ~~(1) actuarially valid differences in rating factors permitted under paragraphs (a)~~
22.32 ~~and (b) (c); and~~

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

23.1 (e) The premium charged with respect to any particular individual health plan shall
23.2 not be adjusted more frequently than annually or January 1 of the year following initial
23.3 enrollment, except that the premium rates may be changed to reflect:

23.4 (1) changes to the family composition of the policyholder;

23.5 (2) changes in geographic rating area of the policyholder, as provided in paragraph
23.6 (b);

23.7 (3) changes in age, as provided in paragraph (a);

23.8 (4) changes in tobacco use, as provided in paragraph (c);

23.9 (5) transfer to a new health plan requested by the policyholder; or

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

23.12 (f) All premium variations must be justified in initial rate filings and upon request of
23.13 the commissioner in rate revision filings. All rate variations are subject to approval by
23.14 the commissioner.

23.15 (g) The loss ratio must comply with the section 62A.021 requirements for individual
23.16 health plans.

23.17 (h) The rates must not be approved, unless the commissioner has determined that the
23.18 rates are reasonable. In determining reasonableness, the commissioner shall consider the
23.19 growth rates applied under section 62J.04, subdivision 1, paragraph (b), to the calendar
23.20 year or years that the proposed premium rate would be in effect; and actuarially valid
23.21 changes in risks associated with the enrollee populations, ~~and actuarially valid changes as~~
23.22 ~~a result of statutory changes in Laws 1992, chapter 549.~~

23.23 (i) ~~An insurer~~ A health carrier may, as part of a minimum lifetime loss ratio
23.24 guarantee filing under section 62A.02, subdivision 3a, include a rating practices guarantee
23.25 as provided in this paragraph. The rating practices guarantee must be in writing and
23.26 must guarantee that the policy form will be offered, sold, issued, and renewed only with
23.27 premium rates and premium rating practices that comply with subdivisions 2, 3, 4, and 5.
23.28 The rating practices guarantee must be accompanied by an actuarial memorandum that
23.29 demonstrates that the premium rates and premium rating system used in connection with
23.30 the policy form will satisfy the guarantee. The guarantee must guarantee refunds of any
23.31 excess premiums to policyholders charged premiums that exceed those permitted under
23.32 subdivision 2, 3, 4, or 5. ~~An insurer~~ A health carrier that complies with this paragraph in
23.33 connection with a policy form is exempt from the requirement of prior approval by the
23.34 commissioner under paragraphs ~~(e)~~ (b), (f), and (h).

23.35 (j) The commissioner may establish regulations to implement the provisions of
23.36 the subdivision.

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

24.2 Sec. 27. Minnesota Statutes 2012, section 62A.65, is amended by adding a subdivision
24.3 to read:

24.4 **Subd. 3a. Disclosure.** (a) In connection with the offering for sale of a health plan
24.5 in the individual market, a health carrier shall make a reasonable disclosure, as part of
24.6 its solicitation and sales materials, of all of the following:

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

24.9 (2) a listing of and descriptive information, including benefits and premiums, about
24.10 all individual health plans actively marketed by the health carrier and the availability of
24.11 the individual health plans for which the individual is qualified.

24.12 (b) Paragraph (a), clause (1), may be satisfied by referring individuals to the Health
24.13 and Human Services Web portal, as defined under the Affordable Care Act.

24.14 Sec. 28. Minnesota Statutes 2012, section 62A.65, is amended by adding a subdivision
24.15 to read:

24.16 **Subd. 3b. Single risk pool.** A health carrier shall consider all enrollees in all health
24.17 plans, other than short-term and grandfathered plan coverage, offered by the health carrier
24.18 in the individual market, including those enrollees who enroll in qualified health plans
24.19 offered through the Minnesota Insurance Marketplace, to be members of a single risk pool.

24.20 Sec. 29. Minnesota Statutes 2012, section 62A.65, subdivision 5, is amended to read:

24.21 **Subd. 5. Portability and conversion of coverage.** (a) For plan years beginning
24.22 on or after January 1, 2014, no individual health plan may be offered, sold, issued, or
24.23 with respect to children age 18 or under renewed, to a Minnesota resident that contains a
24.24 preexisting condition limitation, preexisting condition exclusion, or exclusionary rider;
24.25 unless the limitation or exclusion is permitted under this subdivision and under chapter
24.26 62L, provided that, except for children age 18 or under, underwriting restrictions may
24.27 be retained on individual contracts that are issued without evidence of insurability as a
24.28 replacement for prior individual coverage that was sold before May 17, 1993. The An
24.29 individual age 19 or older may be subjected to an 18-month preexisting condition limitation
24.30 during plan years beginning prior to January 1, 2014, unless the individual has maintained
24.31 continuous coverage as defined in section 62L.02. The individual must not be subjected to
24.32 an exclusionary rider. During plan years beginning prior to January 1, 2014, an individual
24.33 who is age 19 or older and who has maintained continuous coverage may be subjected to a

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

25.15 (b) A health carrier must offer an individual health plan to any individual previously
25.16 covered under a group health plan issued by that health carrier, regardless of the size of
25.17 the group, so long as the individual maintained continuous coverage as defined in section
25.18 62L.02. If the individual has available any continuation coverage provided under sections
25.19 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or
25.20 62D.105, or continuation coverage provided under federal law, the health carrier need not
25.21 offer coverage under this paragraph until the individual has exhausted the continuation
25.22 coverage. The offer must not be subject to underwriting, except as permitted under this
25.23 paragraph. A health plan issued under this paragraph must be a qualified plan as defined
25.24 in section 62E.02 and must not contain any preexisting condition limitation, preexisting
25.25 condition exclusion, or exclusionary rider, except for any unexpired limitation or
25.26 exclusion under the previous coverage. The individual health plan must cover pregnancy
25.27 on the same basis as any other covered illness under the individual health plan. The offer
25.28 of coverage by the health carrier must inform the individual that the coverage, including
25.29 what is covered and the health care providers from whom covered care may be obtained,
25.30 may not be the same as the individual's coverage under the group health plan. The offer
25.31 of coverage by the health carrier must also inform the individual that the individual, if
25.32 a Minnesota resident, may be eligible to obtain coverage from (i) other private sources
25.33 of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a
25.34 preexisting condition limitation, and must provide the telephone number used by that
25.35 association for enrollment purposes. The initial premium rate for the individual health
25.36 plan must comply with subdivision 3. The premium rate upon renewal must comply with

26.1 subdivision 2. In no event shall the premium rate exceed 100 percent of the premium
26.2 charged for comparable individual coverage by the Minnesota Comprehensive Health
26.3 Association, and the premium rate must be less than that amount if necessary to otherwise
26.4 comply with this section. ~~An individual health plan offered under this paragraph to a~~
26.5 ~~person satisfies the health carrier's obligation to offer conversion coverage under section~~
26.6 ~~62E.16, with respect to that person.~~ Coverage issued under this paragraph must provide
26.7 that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent
26.8 decision to leave the individual, small employer, or other group market. Section 72A.20,
26.9 subdivision 28, applies to this paragraph.

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

26.12 Sec. 30. Minnesota Statutes 2012, section 62A.65, subdivision 6, is amended to read:

26.13 Subd. 6. **Guaranteed issue not required.** (a) Nothing in this section requires a
26.14 health carrier to initially issue a health plan to a Minnesota resident who is age 19 or older
26.15 on the date the health plan becomes effective if the effective date is prior to January 1,
26.16 2014, except as otherwise expressly provided in subdivision 4 or 5.

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

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

26.20 Sec. 31. Minnesota Statutes 2012, section 62A.65, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

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

27.35 Sec. 32. Minnesota Statutes 2012, section 62C.14, subdivision 5, is amended to read:

28.1 Subd. 5. **Disabled dependents.** A subscriber's individual contract or any group
28.2 contract delivered or issued for delivery in this state and providing that coverage of
28.3 a dependent child of the subscriber or a dependent child of a covered group member
28.4 shall terminate upon attainment of a specified limiting age as defined in section 62Q.01,
28.5 subdivision 9, shall also provide in substance that attainment of that age shall not terminate
28.6 coverage while the child is (a) incapable of self-sustaining employment by reason of
28.7 developmental disability, mental illness or disorder, or physical disability, and (b) chiefly
28.8 dependent upon the subscriber or employee for support and maintenance, provided proof
28.9 of incapacity and dependency is furnished by the subscriber within 31 days of attainment
28.10 of the limiting age as defined in section 62Q.01, subdivision 9, and subsequently as
28.11 required by the corporation, but not more frequently than annually after a two-year period
28.12 following attainment of the age. Any notice regarding termination of coverage due to
28.13 attainment of the limiting age must include information about this provision.

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

28.15 Sec. 33. Minnesota Statutes 2012, section 62C.142, subdivision 2, is amended to read:

28.16 Subd. 2. **Conversion privilege.** ~~Every subscriber contract, other than a contract~~
28.17 ~~whose continuance is contingent upon continued employment or membership, which~~
28.18 ~~contains a provision for termination of coverage of the spouse upon dissolution of~~
28.19 ~~marriage shall contain a provision allowing a former spouse and dependent children of a~~
28.20 ~~subscriber, without providing evidence of insurability, to obtain from the corporation at~~
28.21 ~~the expiration of any continuation of coverage required under subdivision 2a or section~~
28.22 ~~62A.146, or upon termination of coverage by reason of an entry of a valid decree of~~
28.23 ~~dissolution which does not require the insured to provide continued coverage for the~~
28.24 ~~former spouse, an individual subscriber contract providing at least the minimum benefits~~
28.25 ~~of a qualified plan as prescribed by section 62E.06 and the option of a number three~~
28.26 ~~qualified plan, a number two qualified plan, a number one qualified plan as provided by~~
28.27 ~~section 62E.06, subdivisions 1 to 3, provided application is made to the corporation within~~
28.28 ~~30 days following notice of the expiration of the continued coverage and upon payment of~~
28.29 ~~the appropriate fee. A subscriber contract providing reduced benefits at a reduced fee may~~
28.30 ~~be accepted by the former spouse and dependent children in lieu of the optional coverage~~
28.31 ~~otherwise required by this subdivision. The An individual subscriber contract issued as~~
28.32 conversion coverage shall be renewable at the option of the former spouse as long as the
28.33 former spouse is not covered under another qualified plan as defined in section 62E.02,
28.34 subdivision 4. Any revisions in the table of rate for the individual subscriber contract shall

29.1 apply to the former spouse's original age at entry and shall apply equally to all similar
 29.2 contracts issued as conversion coverage by the corporation.

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

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

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

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

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

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

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

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

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

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

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

29.31 ENROLLEE INFORMATION

29.32 (1) COVERED SERVICES: Services provided by (name of health maintenance
 29.33 organization) will be covered only if services are provided by participating (name of
 29.34 health maintenance organization) providers or authorized by (name of health maintenance

30.1 organization). Your contract fully defines what services are covered and describes
30.2 procedures you must follow to obtain coverage.

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

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

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

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

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

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

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

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

31.5 ENROLLEE BILL OF RIGHTS

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

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

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

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

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

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

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

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

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

31.28 **62D.095 ENROLLEE COST SHARING.**

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

32.1 underwriting restrictions, co-payment and deductible provisions must not discriminate
32.2 on the basis of preexisting health status.

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

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

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

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

32.24 (b) ~~All other health maintenance contracts may impose deductibles not to exceed~~
32.25 ~~\$2,250 per person, per year and \$4,500 per family, per year.~~

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

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

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

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

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

33.9 Sec. 36. Minnesota Statutes 2012, section 62D.181, subdivision 7, is amended to read:

33.10 Subd. 7. **Replacement coverage; limitations.** The association is not obligated
 33.11 to offer replacement coverage under this chapter ~~or conversion coverage under section~~
 33.12 ~~62E.16~~ at the end of the periods specified in subdivision 6. Any continuation obligation
 33.13 arising under this chapter or chapter 62A will cease at the end of the periods specified in
 33.14 subdivision 6.

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

33.16 Sec. 37. Minnesota Statutes 2012, section 62E.02, is amended by adding a subdivision
 33.17 to read:

33.18 Subd. 2a. **Essential health benefits.** "Essential health benefits" has the meaning
 33.19 given under section 62Q.81, subdivision 4.

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

33.21 Sec. 38. Minnesota Statutes 2012, section 62E.04, subdivision 4, is amended to read:

33.22 Subd. 4. **Major medical coverage.** Each insurer and fraternal shall affirmatively
 33.23 offer coverage of major medical expenses to every applicant who applies to the insurer
 33.24 or fraternal for a new unqualified policy, which has a lifetime benefit limit of less than
 33.25 \$1,000,000, at the time of application and annually to every holder of such an unqualified
 33.26 policy of accident and health insurance renewed by the insurer or fraternal. The coverage
 33.27 shall provide that when a covered individual incurs out-of-pocket expenses of \$5,000
 33.28 or more within a calendar year for services covered in section 62E.06, subdivision 1,
 33.29 benefits shall be payable, subject to any co-payment authorized by the commissioner, ~~up~~
 33.30 ~~to a maximum lifetime limit of not less than \$1,000,000~~ and shall not contain a lifetime
 33.31 maximum on essential health benefits. The offer of coverage of major medical expenses

34.1 may consist of the offer of a rider on an existing unqualified policy or a new policy which
34.2 is a qualified plan.

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

34.4 Sec. 39. Minnesota Statutes 2012, section 62E.04, is amended by adding a subdivision
34.5 to read:

34.6 **Subd. 11. Essential health benefits package.** For individual or small group health
34.7 plans that include the essential health benefits package and are offered, sold, issued, or
34.8 renewed on or after January 1, 2014, the requirements of this section do not apply.

34.9 Sec. 40. Minnesota Statutes 2012, section 62E.06, subdivision 1, is amended to read:

34.10 Subdivision 1. **Number three plan.** A plan of health coverage shall be certified as a
34.11 number three qualified plan if it otherwise meets the requirements established by chapters
34.12 62A, 62C, and 62Q, and the other laws of this state, whether or not the policy is issued in
34.13 Minnesota, and meets or exceeds the following minimum standards:

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

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

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

34.26 (1) hospital services;

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

34.30 (3) drugs requiring a physician's prescription;

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

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

- 35.1 (6) use of radium or other radioactive materials;
- 35.2 (7) oxygen;
- 35.3 (8) anesthetics;
- 35.4 (9) prostheses other than dental but including scalp hair prostheses worn for hair
35.5 loss suffered as a result of alopecia areata;
- 35.6 (10) rental or purchase, as appropriate, of durable medical equipment other than
35.7 eyeglasses and hearing aids, unless coverage is required under section 62Q.675;
- 35.8 (11) diagnostic x-rays and laboratory tests;
- 35.9 (12) oral surgery for partially or completely unerupted impacted teeth, a tooth root
35.10 without the extraction of the entire tooth, or the gums and tissues of the mouth when not
35.11 performed in connection with the extraction or repair of teeth;
- 35.12 (13) services of a physical therapist;
- 35.13 (14) transportation provided by licensed ambulance service to the nearest facility
35.14 qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney
35.15 dialysis center for treatment; and
- 35.16 (15) services of an occupational therapist.
- 35.17 (c) Covered expenses for the services and articles specified in this subdivision do
35.18 not include the following:
- 35.19 (1) any charge for care for injury or disease either (i) arising out of an injury in the
35.20 course of employment and subject to a workers' compensation or similar law, (ii) for
35.21 which benefits are payable without regard to fault under coverage statutorily required
35.22 to be contained in any motor vehicle, or other liability insurance policy or equivalent
35.23 self-insurance, or (iii) for which benefits are payable under another policy of accident and
35.24 health insurance, Medicare, or any other governmental program except as otherwise
35.25 provided by section 62A.04, subdivision 3, clause (4);
- 35.26 (2) any charge for treatment for cosmetic purposes other than for reconstructive
35.27 surgery when such service is incidental to or follows surgery resulting from injury,
35.28 sickness, or other diseases of the involved part or when such service is performed on a
35.29 covered dependent child because of congenital disease or anomaly which has resulted in a
35.30 functional defect as determined by the attending physician;
- 35.31 (3) care which is primarily for custodial or domiciliary purposes which would not
35.32 qualify as eligible services under Medicare;
- 35.33 (4) any charge for confinement in a private room to the extent it is in excess of
35.34 the institution's charge for its most common semiprivate room, unless a private room is
35.35 prescribed as medically necessary by a physician, provided, however, that if the institution

36.1 does not have semiprivate rooms, its most common semiprivate room charge shall be
 36.2 considered to be 90 percent of its lowest private room charge;

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

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

36.8 (d) The minimum benefits for a qualified plan shall include, in addition to those
 36.9 benefits specified in clauses (a) and (e), benefits for well baby care, effective July 1,
 36.10 1980, subject to applicable deductibles, coinsurance provisions, and maximum lifetime
 36.11 benefit limitations.

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

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

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

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

36.22 Sec. 41. Minnesota Statutes 2012, section 62E.09, is amended to read:

36.23 **62E.09 DUTIES OF COMMISSIONER.**

36.24 The commissioner may:

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

36.26 (b) supervise the creation of the Minnesota Comprehensive Health Association
 36.27 within the limits described in section 62E.10;

36.28 (c) approve the selection of the writing carrier by the association, approve the
 36.29 association's contract with the writing carrier, and approve the state plan coverage;

36.30 (d) appoint advisory committees;

36.31 (e) conduct periodic audits to assure the general accuracy of the financial data
 36.32 submitted by the writing carrier and the association;

36.33 (f) contract with the federal government or any other unit of government to ensure
 36.34 coordination of the state plan with other governmental assistance programs;

37.1 (g) undertake directly or through contracts with other persons studies or
37.2 demonstration programs to develop awareness of the benefits of sections 62E.01 to ~~62E.16~~
37.3 62E.15, so that the residents of this state may best avail themselves of the health care
37.4 benefits provided by these sections;

37.5 (h) contract with insurers and others for administrative services; and

37.6 (i) adopt, amend, suspend and repeal rules as reasonably necessary to carry out and
37.7 make effective the provisions and purposes of sections 62E.01 to 62E.19.

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

37.9 Sec. 42. Minnesota Statutes 2012, section 62E.10, subdivision 7, is amended to read:

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

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

37.12 (b) Sue or be sued;

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

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

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

37.22 (1) individual qualified plans, excluding group conversions;

37.23 (2) group conversions;

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

37.25 (4) major medical coverage.

37.26 A separate election may be made for each category of coverage. If a member elects
37.27 to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage
37.28 of every life covered under every policy issued in that category. A member electing to
37.29 reinsure risks of a category of coverage shall enter into a contract with the association
37.30 establishing a reinsurance plan for the risks. This contract may include provision for
37.31 the pooling of members' risks reinsured through the association and it may provide for
37.32 assessment of each member reinsuring risks for losses and operating and administrative
37.33 expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This
37.34 reinsurance plan shall be approved by the commissioner before it is effective. Members
37.35 electing to administer the risks which are reinsured in the association shall comply with the

38.1 benefit determination guidelines and accounting procedures established by the association.
38.2 The fee charged by the association for the reinsurance of risks shall not be less than 110
38.3 percent of the total anticipated expenses incurred by the association for the reinsurance; and

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

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

38.12 Sec. 43. Minnesota Statutes 2012, section 62H.04, is amended to read:

38.13 **62H.04 COMPLIANCE WITH OTHER LAWS.**

38.14 (a) A joint self-insurance plan is subject to the requirements of chapters 62A, 62E,
38.15 62L, and 62Q, and sections 72A.17 to 72A.32 unless otherwise specifically exempt. A
38.16 joint self-insurance plan must pay assessments made by the Minnesota Comprehensive
38.17 Health Association, as required under section 62E.11.

38.18 (b) A joint self-insurance plan is exempt from providing the mandated health
38.19 benefits described in chapters 62A, 62E, 62L, and 62Q if it otherwise provides the benefits
38.20 required under the Employee Retirement Income Security Act of 1974, United States
38.21 Code, title 29, sections 1001, et seq., for all employers and not just for the employers with
38.22 50 or more employees who are covered by that federal law.

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

38.27 (d) A joint self-insurance plan is exempt from sections 62A.146, 62A.16, 62A.17,
38.28 62A.20, 62A.21, and 62A.65, subdivision 5, paragraph (b), ~~and 62E.16~~ if the joint
38.29 self-insurance plan complies with the continuation requirements under the Employee
38.30 Retirement Income Security Act of 1974, United States Code, title 29, sections 1001, et
38.31 seq., for all employers and not just for the employers with 20 or more employees who
38.32 are covered by that federal law.

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

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

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

39.6 Sec. 44. Minnesota Statutes 2012, section 62L.02, subdivision 11, is amended to read:

39.7 Subd. 11. **Dependent.** "Dependent" means an eligible employee's spouse,
 39.8 ~~unmarried child who is under the age of 25 years~~ dependent child to the limiting age as
 39.9 defined in section 62Q.01, subdivision 9, dependent child of any age who is disabled and
 39.10 who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person
 39.11 whom state or federal law requires to be treated as a dependent for purposes of health
 39.12 plans. For the purpose of this definition, a dependent child to the limiting age as defined in
 39.13 section 62Q.01, subdivision 9, includes a child for whom the employee or the employee's
 39.14 spouse has been appointed legal guardian and an adoptive child as provided in section
 39.15 62A.27. A child also means a grandchild as provided in section 62A.042 with continued
 39.16 eligibility of grandchildren as provided in section 62A.302, subdivision 4.

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

39.18 Sec. 45. Minnesota Statutes 2012, section 62L.02, subdivision 14a, is amended to read:

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

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

39.26 Sec. 46. Minnesota Statutes 2012, section 62L.02, is amended by adding a subdivision
 39.27 to read:

39.28 Subd. 17a. **Individual health plan.** "Individual health plan" has the meaning as
 39.29 defined under section 62A.011, subdivision 4.

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

40.1 Sec. 47. Minnesota Statutes 2012, section 62L.02, subdivision 26, is amended to read:

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

40.27 (b) Where an association, as defined in section 62L.045, comprised of employers
40.28 contracts with a health carrier to provide coverage to its members who are small employers,
40.29 the association and health benefit plans it provides to small employers, are subject to
40.30 section 62L.045, with respect to small employers in the association, even though the
40.31 association also provides coverage to its members that do not qualify as small employers.

40.32 (c) If an employer has employees covered under a trust specified in a collective
40.33 bargaining agreement under the federal Labor-Management Relations Act of 1947,
40.34 United States Code, title 29, section 141, et seq., as amended, or employees whose health
40.35 coverage is determined by a collective bargaining agreement and, as a result of the
40.36 collective bargaining agreement, is purchased separately from the health plan provided

41.1 to other employees, those employees are excluded in determining whether the employer
41.2 qualifies as a small employer. Those employees are considered to be a separate small
41.3 employer if they constitute a group that would qualify as a small employer in the absence
41.4 of the employees who are not subject to the collective bargaining agreement.

41.5 (d) Small group health plans offered through the Minnesota Insurance Marketplace
41.6 under chapter 62V to employees of a small employer are not considered individual health
41.7 plans, regardless of whether the health plan is purchased using a defined contribution
41.8 from the small employer.

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

41.10 Sec. 48. Minnesota Statutes 2012, section 62L.03, subdivision 1, is amended to read:

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

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

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

41.25 ~~Paragraph (a) does not apply to a health benefit plan designed for a small employer~~
41.26 ~~to comply with a collective bargaining agreement, provided that the health benefit plan~~
41.27 ~~otherwise complies with this chapter and is not offered to other small employers, except~~
41.28 ~~for other small employers that need it for the same reason. This paragraph applies only~~
41.29 ~~with respect to collective bargaining agreements entered into prior to August 21, 1996,~~
41.30 ~~and only with respect to plan years beginning before the later of July 1, 1997, or the date~~
41.31 ~~upon which the last of the collective bargaining agreements relating to the plan terminates~~
41.32 ~~determined without regard to any extension agreed to after August 21, 1996.~~

41.33 (d) Every health carrier participating in the small employer market shall make
41.34 available both of the plans described in section 62L.05 to small employers and shall fully

42.1 ~~comply with the underwriting and the rate restrictions specified in this chapter for all~~
42.2 ~~health benefit plans issued to small employers.~~

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

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

42.6 Sec. 49. Minnesota Statutes 2012, section 62L.03, subdivision 3, is amended to read:

42.7 Subd. 3. **Minimum participation and contribution.** (a) A small employer that has
42.8 at least 75 percent of its eligible employees who have not waived coverage participating in
42.9 a health benefit plan and that contributes at least 50 percent toward the cost of coverage of
42.10 each eligible employee must be guaranteed coverage on a guaranteed issue basis from
42.11 any health carrier participating in the small employer market. The participation level
42.12 of eligible employees must be determined at the initial offering of coverage and at the
42.13 renewal date of coverage. A health carrier must not increase the participation requirements
42.14 applicable to a small employer at any time after the small employer has been accepted for
42.15 coverage. For the purposes of this subdivision, waiver of coverage includes only waivers
42.16 due to: (1) coverage under another group health plan; (2) coverage under Medicare
42.17 Parts A and B; or (3) coverage under medical assistance under chapter 256B or general
42.18 assistance medical care under chapter 256D.

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

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

43.1 (d) If a small employer cannot meet either the participation or contribution
43.2 requirement, the small employer may purchase coverage only during an open enrollment
43.3 period each year between November 15 and December 15.

43.4 (e) This section does not apply to health plans offered through the Minnesota
43.5 Insurance Marketplace under chapter 62V.

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

43.7 Sec. 50. Minnesota Statutes 2012, section 62L.03, subdivision 4, is amended to read:

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

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

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

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

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

44.4 Sec. 51. Minnesota Statutes 2012, section 62L.03, subdivision 6, is amended to read:

44.5 Subd. 6. **MCHA enrollees.** Health carriers shall offer coverage to any eligible
44.6 employee or dependent enrolled in MCHA at the time of the health carrier's issuance or
44.7 renewal of a health benefit plan to a small employer. The health benefit plan must require
44.8 that the employer permit MCHA enrollees to enroll in the small employer's health benefit
44.9 plan as of the first date of renewal of a health benefit plan occurring on or after July
44.10 1, 1993, and as of each date of renewal after that, or, in the case of a new group, as of
44.11 the initial effective date of the health benefit plan and as of each date of renewal after
44.12 that. ~~Unless otherwise permitted by this chapter,~~ Health carriers must not impose any
44.13 underwriting restrictions, including any preexisting condition limitations or exclusions, on
44.14 any eligible employee or dependent previously enrolled in MCHA and transferred to a
44.15 health benefit plan ~~so long as continuous coverage is maintained, provided that the health~~
44.16 ~~carrier may impose any unexpired portion of a preexisting condition limitation under the~~
44.17 ~~person's MCHA coverage. An MCHA enrollee is not a late entrant, so long as the enrollee~~
44.18 ~~has maintained continuous coverage.~~

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

44.20 Sec. 52. Minnesota Statutes 2012, section 62L.045, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

45.32 Sec. 53. Minnesota Statutes 2012, section 62L.045, subdivision 4, is amended to read:

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

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

46.3 (c) ~~A health carrier is not required under this chapter to comply with guaranteed
46.4 issue and guaranteed renewal with respect to its relationship with the association itself.~~

46.5 An arrangement between the health carrier and the association, once entered into, must
46.6 comply with guaranteed issue and guaranteed renewal with respect to members of the
46.7 association that are small employers and persons covered through them.

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

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

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

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

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

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

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

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

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

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

46.34 Sec. 54. Minnesota Statutes 2012, section 62L.05, subdivision 10, is amended to read:

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

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

47.12 Sec. 55. Minnesota Statutes 2012, section 62L.06, is amended to read:

47.13 **62L.06 DISCLOSURE OF UNDERWRITING RATING PRACTICES.**

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

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

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

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

47.22 ~~(4)~~ (2) provisions relating to renewability of coverage;

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

47.24 ~~(6)~~ (3) the application of any provider network limitations and their effect on
 47.25 eligibility for benefits; and

47.26 ~~(7)~~ (4) the ability of small employers to insure eligible employees and dependents
 47.27 currently receiving coverage from the Comprehensive Health Association ~~through health~~
 47.28 ~~benefit plans.~~

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

47.30 Sec. 56. Minnesota Statutes 2012, section 62L.08, is amended to read:

47.31 **62L.08 RESTRICTIONS RELATING TO PREMIUM RATES.**

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

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

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

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

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

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

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

48.26 Subd. 3. **Age-based premium variations.** Beginning July 1, 1993, Each health
48.27 carrier may offer premium rates to small employers that vary based upon the ages of
48.28 the eligible employees and dependents of the small employer only as provided in this
48.29 subdivision. In addition to the variation permitted by subdivision 2, each health carrier
48.30 may use an additional premium variation based upon age of up to plus or minus 50 percent
48.31 of the index rate. Premium rates may vary based upon the ages of the eligible employees
48.32 and dependents of the small employer in accordance with the provisions of the Affordable
48.33 Care Act as defined in section 62A.011, subdivision 1a.

48.34 Subd. 4. **Geographic premium variations.** A health carrier may request approval
48.35 by the commissioner to establish separate geographic regions determined by the health
48.36 carrier and to establish separate index rates for each such region Premium rates may vary

49.1 based on geographic rating areas set by the commissioner. The commissioner shall grant
 49.2 approval if the following conditions are met:

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

49.4 ~~(2) each geographic region must be composed of no fewer than seven counties that
 49.5 create a contiguous region; and~~

49.6 ~~(3) the health carrier provides actuarial justification acceptable to the commissioner
 49.7 for the proposed geographic variations in index rates, establishing that the variations are
 49.8 based upon differences in the cost to the health carrier of providing coverage.~~

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

49.13 Subd. 6. **Rate cells permitted Tobacco rating.** ~~Health carriers may use rate cells
 49.14 and must file with the commissioner the rate cells they use. Rate cells must be based on
 49.15 the number of adults and children covered under the policy and may reflect the availability
 49.16 of Medicare coverage. The rates for different rate cells must not in any way reflect marital
 49.17 status or differences in expected costs between employees and spouses~~ Premium rates
 49.18 may vary based upon tobacco use in accordance with the provisions of the Affordable
 49.19 Care Act as defined in section 62A.011, subdivision 1a.

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

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

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

49.24 ~~(3)~~ (2) actuarially valid geographic variations if approved by the commissioner as
 49.25 provided in subdivision 4.

49.26 (b) All premium variations permitted under this section must be based upon
 49.27 actuarially valid differences in expected cost to the health carrier of providing coverage.

49.28 The variation must be justified in initial rate filings and upon request of the commissioner in
 49.29 rate revision filings. All premium variations are subject to approval by the commissioner.

49.30 Subd. 8. **Filing requirement.** A health carrier that offers, sells, issues, or renews a
 49.31 health benefit plan for small employers shall file with the commissioner the index rates and
 49.32 must demonstrate that all rates shall be within the rating restrictions defined in this chapter.
 49.33 Such demonstration must include ~~the allowable range of rates from the index rates and a
 49.34 description of how the health carrier intends to use demographic factors including case
 49.35 characteristics in calculating the premium rates. The rates shall not be approved, unless the
 49.36 commissioner has determined that the rates are reasonable. In determining reasonableness,~~

50.1 the commissioner shall consider the growth rates applied under section 62J.04, subdivision
50.2 1, paragraph (b), to the calendar year or years that the proposed premium rate would be in
50.3 effect, and actuarially valid changes in risk associated with the enrollee population, ~~and~~
50.4 ~~actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.~~

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

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

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

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

50.23 Sec. 57. Minnesota Statutes 2012, section 62L.12, subdivision 2, is amended to read:

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

50.27 (b) A health carrier may ~~sell, issue, or~~ renew individual conversion policies to
50.28 eligible employees otherwise eligible for conversion coverage as a result of the expiration
50.29 of any continuation of group coverage required under sections 62A.146, 62A.17, 62A.21,
50.30 62C.142, 62D.101, and 62D.105.

50.31 (c) A health carrier may ~~sell, issue, or~~ renew conversion policies ~~under section~~
50.32 ~~62E.16~~ to eligible employees.

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

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

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

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

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

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

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

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

51.27 ~~(k)~~ (l) A health carrier may offer, sell, issue, or renew an individual health plan to
51.28 one or more employees of a small employer if the individual health plan is marketed
51.29 directly to all employees of the small employer and the small employer does not contribute
51.30 directly or indirectly to the premiums or facilitate the administration of the individual
51.31 health plan. The requirement to market an individual health plan to all employees does not
51.32 require the health carrier to offer or issue an individual health plan to any employee. For
51.33 purposes of this paragraph, an employer is not contributing to the premiums or facilitating
51.34 the administration of the individual health plan if the employer does not contribute to the
51.35 premium and merely collects the premiums from an employee's wages or salary through
51.36 payroll deductions and submits payment for the premiums of one or more employees in a

52.1 lump sum to the health carrier. Except for coverage under section 62A.65, subdivision 5,
52.2 paragraph (b), ~~or 62E.16~~, at the request of an employee, the health carrier may bill the
52.3 employer for the premiums payable by the employee, provided that the employer is not
52.4 liable for payment except from payroll deductions for that purpose. If an employer is
52.5 submitting payments under this paragraph, the health carrier shall provide a cancellation
52.6 notice directly to the primary insured at least ten days prior to termination of coverage for
52.7 nonpayment of premium. Individual coverage under this paragraph may be offered only
52.8 if the small employer has not provided coverage under section 62L.03 to the employees
52.9 within the past 12 months.

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

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

52.15 Sec. 58. Minnesota Statutes 2012, section 62M.05, subdivision 3a, is amended to read:

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

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

52.32 (c) When an initial determination is made not to certify, notification must be
52.33 provided by telephone, by facsimile to a verified number, or by electronic mail to a secure
52.34 electronic mailbox within one working day after making the determination to the attending
52.35 health care professional and hospital as applicable. Written notification must also be sent

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

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

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

53.20 Sec. 59. Minnesota Statutes 2012, section 62M.06, subdivision 1, is amended to read:

53.21 Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must
53.22 have written procedures for appeals of determinations not to certify. The right to appeal
53.23 must be available to the enrollee and to the attending health care professional.

53.24 (b) The enrollee shall be allowed to review the information relied upon in the
53.25 course of the appeal, present evidence and testimony as part of the appeals process, and
53.26 receive continued coverage pending the outcome of the appeals process. This paragraph
53.27 does not apply to managed care plan or county based purchasing plan enrollees under
53.28 section 256B.69 or 256B.692 serving state public program enrollees under 256B.69 or to
53.29 grandfathered plans as defined under section 62A.011, subdivision 1c.

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

53.31 Sec. 60. Minnesota Statutes 2012, section 62Q.01, is amended by adding a subdivision
53.32 to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

55.1 Subd. 2b. **Grandfathered health plan.** "Grandfathered health plan" means a
55.2 grandfathered health plan as defined in section 62A.011, subdivision 1b.

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

55.5 Subd. 2c. **Group health plan.** "Group health plan" means a group health plan as
55.6 defined in section 62A.011, subdivision 1c.

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

55.9 Subd. 4b. **Individual health plan.** "Individual health plan" means an individual
55.10 health plan as defined in section 62A.011, subdivision 4.

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

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

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

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

55.19 Subd. 8. **Primary care provider.** "Primary care provider" means a health care
55.20 professional who specializes in the practice of family medicine, general internal medicine,
55.21 obstetrics and gynecology, or general pediatrics and is a licensed physician, a licensed and
55.22 certified advanced practice registered nurse, or a licensed physician assistant.

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

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

55.26 Subd. 9. **Dependent child to the limiting age.** "Dependent child to the limiting
55.27 age" or "dependent children to the limiting age" means those individuals who are eligible
55.28 and covered as a dependent child under the terms of a health plan who have not yet
55.29 attained 26 years of age. A health plan company must not deny or restrict eligibility
55.30 for a dependent child to the limiting age based on financial dependency, residency,

56.1 marital status, or student status. For coverage under plans offered by the Minnesota
 56.2 Comprehensive Health Association, dependent to the limiting age means dependent
 56.3 as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this
 56.4 subdivision, a health plan may include:

56.5 (1) eligibility requirements regarding the absence of other health plan coverage as
 56.6 permitted by the Affordable Care Act for grandfathered plan coverage; or

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

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

56.9 Sec. 68. Minnesota Statutes 2012, section 62Q.021, is amended to read:

56.10 **62Q.021 FEDERAL ACT; COMPLIANCE REQUIRED.**

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

56.18 Subd. 2. **Compliance with 2010 federal law.** Each health plan company shall
 56.19 comply with the Affordable Care Act to the extent that it imposes a requirement that
 56.20 applies in this state but is not required under the laws of this state. This section does not
 56.21 require compliance with any provision of the Affordable Care Act before the effective
 56.22 date provided for that provision in the Affordable Care Act. The commissioner shall
 56.23 enforce this subdivision.

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

56.25 Sec. 69. Minnesota Statutes 2012, section 62Q.17, subdivision 6, is amended to read:

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

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

57.2 Sec. 70. Minnesota Statutes 2012, section 62Q.18, is amended by adding a subdivision
57.3 to read:

57.4 Subd. 8. **Guaranteed issue.** No health plan company shall offer, sell, or issue
57.5 any health plan that does not make coverage available on a guaranteed issue basis in
57.6 accordance with the Affordable Care Act.

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

57.8 Sec. 71. **[62Q.186] PROHIBITION ON RESCISSIONS OF HEALTH PLANS.**

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

57.11 (b) "Rescission" does not include:

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

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

57.14 (ii) the cancellation or discontinuance of coverage is effective retroactively to the

57.15 extent it is attributable to a failure to timely pay required premiums or contributions

57.16 toward the cost of coverage; or

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

57.22 Subd. 2. **Prohibition on rescissions.** (a) A health plan company shall not rescind
57.23 coverage under a health plan with respect to an individual, including a group to which
57.24 the individual belongs or family coverage in which the individual is included, after the
57.25 individual is covered under the health plan, unless:

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

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

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

58.1 (b) This section does not apply to any benefits classified as excepted benefits under
58.2 United States Code, title 42, section 300gg-91(c), or regulations enacted thereunder
58.3 from time to time.

58.4 Subd. 3. **Notice required.** A health plan company shall provide at least 30 days
58.5 advance written notice to each individual who would be affected by the proposed rescission
58.6 of coverage before coverage under the health plan may be terminated retroactively.

58.7 Subd. 4. **Compliance with other restrictions on rescissions.** Nothing in this
58.8 section allows rescission if rescission would otherwise be prohibited under section
58.9 62A.04, subdivision 2, clause (2), or 62A.615.

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

58.11 Sec. 72. Minnesota Statutes 2012, section 62Q.23, is amended to read:

58.12 **62Q.23 GENERAL SERVICES.**

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

58.16 (b) Health plan companies shall comply with sections 62A.047, 62A.27, and any
58.17 other coverage required under chapter 62A of newborn infants, dependent children ~~who~~
58.18 ~~do not reside with a covered person~~ to the limiting age as defined in section 62Q.01,
58.19 subdivision 9, disabled children and dependents dependent children, and adopted children.
58.20 A health plan company providing dependent coverage shall comply with section 62A.302.

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

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

58.24 Sec. 73. Minnesota Statutes 2012, section 62Q.43, subdivision 2, is amended to read:

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

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

59.2 Sec. 74. **[62Q.46] PREVENTIVE ITEMS AND SERVICES.**

59.3 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items
59.4 and services" has the meaning specified in the Affordable Care Act.

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

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

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

59.21 (e) This section does not apply to grandfathered plan coverage.

59.22 (f) This section does not apply to plans offered by the Minnesota Comprehensive
59.23 Health Association.

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

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

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

60.1 Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a
60.2 health plan company from providing coverage for preventive items and services in addition
60.3 to those specified in the Affordable Care Act, or from denying coverage for preventive
60.4 items and services that are not recommended as preventive items and services under the
60.5 Affordable Care Act. A health plan company may impose cost-sharing requirements for a
60.6 treatment not described in the Affordable Care Act even if the treatment results from a
60.7 preventive item or service described in the Affordable Care Act.

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

60.9 Sec. 75. Minnesota Statutes 2012, section 62Q.47, is amended to read:

60.10 **62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL**
60.11 **DEPENDENCY SERVICES.**

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

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

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

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

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

60.31 Sec. 76. Minnesota Statutes 2012, section 62Q.52, is amended to read:

60.32 **62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC**
60.33 **SERVICES.**

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

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

61.8 (2) maternity care; and

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

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

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

61.20 (d) The health plan company may require the health care provider to agree to
61.21 otherwise adhere to the health plan company's policies and procedures, including
61.22 procedures for obtaining prior authorization and for providing services in accordance with
61.23 a treatment plan, if any, approved by the health plan company.

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

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

61.29 (g) For purposes of this section, a health care provider who specializes in obstetrics
61.30 or gynecology means any individual, including an individual other than a physician, who
61.31 is authorized under state law to provide obstetrical or gynecological care.

61.32 (h) This section does not:

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

62.1 (2) preclude the health plan company from requiring that the participating health
 62.2 care provider providing obstetrical or gynecological care notify the primary care provider
 62.3 or the health plan company of treatment decisions.

62.4 Subd. 2. **Notice.** A health plan company shall provide notice to enrollees of the
 62.5 provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act.

62.6 Subd. 3. **Enforcement.** The commissioner of health shall enforce this section.

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

62.8 Sec. 77. **[62Q.526] COVERAGE FOR PARTICIPATION IN APPROVED**
 62.9 **CLINICAL TRIALS.**

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

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

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

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

62.18 (3) approved or funded by:

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

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

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

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

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

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

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

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

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

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

63.13 (2) Routine patient costs does not include:

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

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

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

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

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

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

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

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

63.27 Subd. 3. **Network plan conditions.** A health plan company that designates a
63.28 network or networks of contracted providers may require a qualified individual who
63.29 wishes to participate in an approved clinical trial to participate in a trial that is offered
63.30 through a health care provider who is part of the plan's network if the provider is
63.31 participating in the trial and the provider accepts the individual as a participant in the trial.

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

63.35 Subd. 5. **Construction.** (a) This section shall not be construed to require a health
63.36 plan company offering health plan coverage through a network or networks of contracted

64.1 providers to provide benefits for routine patient costs if the services are provided outside
64.2 of the plan's network unless the out-of-network benefits are otherwise provided under
64.3 the coverage.

64.4 (b) This section shall not be construed to limit a health plan company's coverage
64.5 with respect to clinical trials.

64.6 (c) This section shall apply to all health plan companies offering a health plan to a
64.7 Minnesota resident, unless otherwise amended by federal regulations under the Affordable
64.8 Care Act.

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

64.10 Sec. 78. Minnesota Statutes 2012, section 62Q.55, is amended to read:

64.11 **62Q.55 EMERGENCY SERVICES.**

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

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

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

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

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

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

64.32 (b) The health plan company may require enrollees to notify the health plan
64.33 company of nonreferred emergency care as soon as possible, but not later than 48 hours,
64.34 after the emergency care is initially provided. However, emergency care which would

65.1 have been covered under the contract had notice been provided within the set time frame
65.2 must be covered.

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

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

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

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

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

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

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

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

65.31 **Sec. 79. [62Q.57] DESIGNATION OF PRIMARY CARE PROVIDER.**

65.32 Subdivision 1. **Choice of primary care provider.** (a) If a health plan company
65.33 offering a group health plan, or an individual health plan that is not a grandfathered plan,
65.34 requires or provides for the designation by an enrollee of a participating primary care
65.35 provider, the health plan company shall permit each enrollee to:

66.1 (1) designate any participating primary care provider who is available to accept the
66.2 enrollee; and

66.3 (2) for a child, designate any participating physician who specializes in pediatrics as
66.4 the child's primary care provider and is available to accept the child.

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

66.7 Subd. 2. **Notice.** A health plan company shall provide notice to enrollees of the
66.8 provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act.

66.9 Subd. 3. **Enforcement.** The commissioner shall enforce this section.

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

66.11 Sec. 80. **[62Q.677] LIFETIME AND ANNUAL LIMITS.**

66.12 Subdivision 1. **Applicability and scope.** Except as provided in subdivision 2,
66.13 this section applies to a health plan company providing coverage under an individual or
66.14 group health plan. For purposes of this section, essential health benefits means as defined
66.15 under section 62Q.81.

66.16 Subd. 2. **Grandfathered plan limits.** (a) The prohibition on lifetime limits applies
66.17 to grandfathered plans providing individual health plan coverage or group health plan
66.18 coverage.

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

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

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

66.29 Subd. 4. **Nonessential benefits; out-of-network providers.** (a) Subdivision 3 does
66.30 not prevent a health plan company from placing annual or lifetime dollar limits for any
66.31 individual on specific covered benefits that are not essential health benefits as defined in
66.32 section 62Q.81, subdivision 4, to the extent that the limits are otherwise permitted under
66.33 applicable federal or state law.

66.34 (b) Subdivision 3 does not prevent a health plan company from placing an annual or
66.35 lifetime limit for services provided by out-of-network providers.

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

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

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

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

67.11 (3) for a plan or policy year beginning after September 22, 2012, but before January
67.12 1, 2014, \$2,000,000.

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

67.16 Subd. 7. **Waivers.** For plan or policy years beginning before January 1, 2014, a
67.17 health plan is exempt from the annual limit requirements if the health plan is approved for
67.18 a waiver from the requirements by the United States Department of Health and Human
67.19 Services, but the exemption only applies for the specified period of time that the waiver
67.20 from the United States Department of Health and Human Services is applicable.

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

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

67.28 Subd. 9. **Reinstatement.** A health plan company shall comply with all provisions of
67.29 the Affordable Care Act with regard to reinstatement of coverage for individuals whose
67.30 coverage or benefits under a health plan ended by reason of reaching a lifetime dollar limit
67.31 on the dollar value of all benefits for the individual.

67.32 Subd. 10. **Compliance.** This section does not require compliance with any
67.33 provision of the Affordable Care Act before the effective date provided for that provision
67.34 in the Affordable Care Act. The commissioner shall enforce this section.

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

68.1 Sec. 81. Minnesota Statutes 2012, section 62Q.68, subdivision 1, is amended to read:

68.2 Subdivision 1. **Application.** For purposes of sections 62Q.68 to 62Q.72, the terms
68.3 defined in this section have the meanings given them. For purposes of sections 62Q.69
68.4 and 62Q.70, the term "health plan company" does not include an insurance company
68.5 licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness
68.6 insurance as defined in section 62A.01 or a nonprofit health service plan corporation
68.7 regulated under chapter 62C that only provides dental coverage or vision coverage. For
68.8 purposes of sections 62Q.69 through 62Q.73, the term "health plan company" does
68.9 not include the Comprehensive Health Association created under chapter 62E. Section
68.10 62Q.70 does not apply to individual coverage. However, a health plan company offering
68.11 individual coverage may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow
68.12 the process outlined in section 62Q.70.

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

68.14 Sec. 82. Minnesota Statutes 2012, section 62Q.69, subdivision 3, is amended to read:

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

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

68.27 (c) For individual health plans, if the decision is partially or wholly adverse to
68.28 the complainant, the notification must inform the complainant of the right to submit the
68.29 complaint decision to the external review process described in section 62Q.73 and the
68.30 procedure for initiating the external process. Notwithstanding the provisions in this
68.31 subdivision, a health plan company offering individual coverage may instead follow the
68.32 process for group health plans outlined in paragraph (b).

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

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

69.2 Sec. 83. Minnesota Statutes 2012, section 62Q.70, subdivision 1, is amended to read:

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

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

69.12 (c) The internal appeal process must permit the enrollee to review the information
 69.13 relied upon in the course of the appeal and the receipt of testimony, correspondence,
 69.14 explanations, or other information from the complainant, staff persons, administrators,
 69.15 providers, or other persons as deemed necessary by the person or persons investigating or
 69.16 presiding over the appeal.

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

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

69.20 Sec. 84. Minnesota Statutes 2012, section 62Q.70, subdivision 2, is amended to read:

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

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

69.29 Sec. 85. Minnesota Statutes 2012, section 62Q.71, is amended to read:

69.30 **62Q.71 NOTICE TO ENROLLEES.**

69.31 Each health plan company shall provide to enrollees a clear and concise description
 69.32 of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1,

70.1 and the procedure used for utilization review as defined under chapter 62M as part of
 70.2 the member handbook, subscriber contract, or certificate of coverage. If the health plan
 70.3 company does not issue a member handbook, the health plan company may provide
 70.4 the description in another written document. The description must specifically inform
 70.5 enrollees:

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

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

70.10 (3) how to request an appeal either through the procedures described in ~~sections~~
 70.11 ~~62Q.69 and~~ section 62Q.70 if applicable, or through the procedures described in chapter
 70.12 62M;

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

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

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

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

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

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

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

70.29 Sec. 86. Minnesota Statutes 2012, section 62Q.73, is amended to read:

70.30 **62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.**

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

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

71.1 (2) an individual health plan that is grandfathered plan coverage may instead apply
 71.2 the definition of adverse determination for group coverage in clause (3);

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

71.6 ~~(2)~~ (4) any initial determination not to certify that has been appealed in accordance
 71.7 with section 62M.06 and the appeal did not reverse the initial determination not to certify; or

71.8 ~~(3)~~ (5) a decision relating to a health care service made by a health plan company
 71.9 licensed under chapter 60A that denies the service on the basis that the service was not
 71.10 medically necessary; or

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

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

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

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

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

71.28 Subd. 3. **Right to external review.** (a) Any enrollee or anyone acting on behalf
 71.29 of an enrollee who has received an adverse determination may submit a written request
 71.30 for an external review of the adverse determination, if applicable under section 62Q.68,
 71.31 subdivision 1, or 62M.06, to the commissioner of health if the request involves a health
 71.32 plan company regulated by that commissioner or to the commissioner of commerce if the
 71.33 request involves a health plan company regulated by that commissioner. Notification of
 71.34 the enrollee's right to external review must accompany the denial issued by the insurer.
 71.35 The written request must be accompanied by a filing fee of \$25. The fee may be waived
 71.36 by the commissioner of health or commerce in cases of financial hardship and must be

72.1 refunded if the adverse determination is completely reversed. No enrollee may be subject
 72.2 to filing fees totaling more than \$75 during a plan year for group coverage or policy year
 72.3 for individual coverage.

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

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

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

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

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

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

72.23 (2) an expertise in dispute resolution;

72.24 (3) an expertise in health-related law;

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

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

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

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

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

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

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

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

73.14 (c) An external review shall be made as soon as practical but in no case later than 40
73.15 45 days after receiving the request for an external review and must promptly send written
73.16 notice of the decision and the reasons for it to the enrollee, the health plan company, and
73.17 the commissioner who is responsible for regulating the health plan company.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

74.22 (c) For an external review of any issue in an adverse determination by a health plan
74.23 company, other than a health plan company licensed under chapter 62D, that requires a
74.24 medical necessity determination, the external review must determine whether the adverse
74.25 determination was consistent with the definition of medically necessary care in section
74.26 62Q.53, subdivision 2.

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

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

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

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

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

75.10 Sec. 87. Minnesota Statutes 2012, section 62Q.75, subdivision 1, is amended to read:

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

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

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

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

75.24 Sec. 88. Minnesota Statutes 2012, section 62Q.80, subdivision 2, is amended to read:

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

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

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

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

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

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

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

76.12 Sec. 89. **[62Q.81] ESSENTIAL HEALTH BENEFIT PACKAGE**

76.13 **REQUIREMENTS.**

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

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

76.19 (1) provides essential health benefits as outlined in the Affordable Care Act;

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

76.22 (3) subject to subdivision 3, provides bronze, silver, gold, or platinum level of
 76.23 coverage in accordance with the Affordable Care Act.

76.24 **Subd. 2. Coverage for enrollees under the age of 21.** If a health plan company
 76.25 offers health plans in any level of coverage specified under section 1302(d) of the
 76.26 Affordable Care Act, as described in subdivision 1, paragraph (b), clause (3), the health
 76.27 plan company shall also offer coverage in that level to individuals who have not attained
 76.28 21 years of age as of the beginning of a policy year.

76.29 **Subd. 3. Alternative compliance for catastrophic plans.** A health plan company
 76.30 that does not provide an individual or small group health plan in the bronze, silver, gold,
 76.31 or platinum level of coverage, as described in subdivision 1, paragraph (b), clause (3),
 76.32 shall be treated as meeting the requirements of section 1302(d) of the Affordable Care Act
 76.33 with respect to any policy year if the health plan company provides a catastrophic plan
 76.34 that meets the requirements of section 1302(e) of the Affordable Care Act.

77.1 Subd. 4. Essential health benefits; definition. For purposes of this section,
77.2 "essential health benefits" has the meaning given under section 1302(b) of the Affordable
77.3 Care Act, and includes:

- 77.4 (1) ambulatory patient services;
77.5 (2) emergency services;
77.6 (3) hospitalization;
77.7 (4) laboratory services;
77.8 (5) maternity and newborn care;
77.9 (6) mental health and substance use disorder services, including behavioral health
77.10 treatment;
77.11 (7) pediatric services, including oral and vision care;
77.12 (8) prescription drugs;
77.13 (9) preventive and wellness services and chronic disease management;
77.14 (10) rehabilitative and habilitative services and devices; and
77.15 (11) additional essential health benefits included in the EHB-benchmark plan, as
77.16 defined under the Affordable Care Act.

77.17 Subd. 5. Exception. This section does not apply to a dental plan described in
77.18 section 1311(d)(2)(B)(ii) of the Affordable Care Act.

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

77.20 Sec. 90. [62Q.82] BENEFITS AND COVERAGE EXPLANATION.

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

- 77.23 (1) an applicant at the time of application;
77.24 (2) an enrollee prior to the time of enrollment or reenrollment, as applicable; and
77.25 (3) a policyholder at the time of issuance of the policy.

77.26 Subd. 2. Compliance. A health plan company described in subdivision 1 shall be
77.27 deemed to have complied with subdivision 1 if the summary of benefits and coverage is
77.28 provided in paper or electronic form as required under the Affordable Care Act.

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

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

78.2 Sec. 91. Minnesota Statutes 2012, section 72A.20, subdivision 35, is amended to read:

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

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

78.12 Sec. 92. Minnesota Statutes 2012, section 471.61, subdivision 1a, is amended to read:

78.13 Subd. 1a. **Dependents.** Notwithstanding the provisions of Minnesota Statutes 1969,
 78.14 section 471.61, as amended by Laws 1971, chapter 451, section 1, the word "dependents" as
 78.15 used therein shall mean spouse and ~~minor unmarried~~ children under the age of ~~18~~ 26 years
 78.16 ~~and dependent students under the age of 25 years actually dependent upon the employee.~~

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

78.18 Sec. 93. **REPEALER.**

78.19 (a) Minnesota Statutes 2012, section 62E.02, subdivision 7, is repealed effective the
 78.20 day following final enactment.

78.21 (b) Minnesota Statutes 2012, sections 62A.615; 62A.65, subdivision 6; 62E.16;
 78.22 62E.20; 62L.02, subdivisions 4, 18, 19, 23, and 24; 62L.05, subdivisions 1, 2, 3, 4, 4a,
 78.23 5, 6, 7, 11, 12, and 13; 62L.081; 62L.10, subdivision 5; and 62Q.37, subdivision 5, are
 78.24 repealed effective January 1, 2014.

78.25 **ARTICLE 2**

78.26 **MARKET RULES FOR AFFORDABLE CARE ACT"**

78.27 Amend the title accordingly