House Language H2128-4

**ARTICLE 6**

**HEALTH INSURANCE**

Section 1. Minnesota Statutes 2020, section 62A.04, subdivision 2, is amended to read:

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

(1) A provision as follows:

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

(2) A provision as follows:

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

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

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

Senate Language UEH2128-1

**ARTICLE 5**

**HEALTH COVERAGE AND TRANSPARENCY**

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

(3)(a) Except as required for qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a provision as follows:

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

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

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

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

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

(b) For ~~qualified~~ individual and small group health plans ~~sold through MNsure to individuals receiving advance payments of the premium tax credit~~, a grace period provision must be included that complies with ~~the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act~~ section 62A.65, subdivision 2a.

(4) A provision as follows:

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

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

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

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

(5) A provision as follows:

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

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

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

(6) A provision as follows:

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

(7) A provision as follows:

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

(8) A provision as follows:

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

(9) A provision as follows:

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

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

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

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

(10) A provision as follows:

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

(11) A provision as follows:

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

(12) A provision as follows:

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

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2020, section 62A.10, is amended by adding a subdivision to read:

Subd. 5. **Prohibition on waiting periods that exceed 90 days.** (a) For purposes of this subdivision, "waiting period" means the period that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of a group health plan.

(b) A health carrier offering a group health plan must not apply a waiting period that exceeds 90 days, with exceptions for the circumstances described in paragraphs (c) to (e). A health carrier does not violate this subdivision solely because an individual is permitted to take additional time to elect coverage beyond the end of the 90-day waiting period.

(c) If a group health plan conditions eligibility on an employee working full time or regularly having a specified number of service hours per period, and the plan is unable to determine whether a newly hired employee is full time or reasonably expected to regularly work the specific number of hours per period, the plan may take a reasonable period of time, not to exceed 12 months beginning on any date between the employee's start date and the first day of the first calendar month after the employee's start date, to determine whether the employee meets the plan's eligibility condition.

(d) If a group health plan conditions eligibility on an employee having completed a cumulative number of service hours, the cumulative hours-of-service requirement must not exceed 1,200 hours.

(e) An orientation period may be added to the 90-day waiting period if the orientation period is one month or less. The one-month period is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage.

(f) A group health plan may treat an employee whose employment has terminated and is later rehired as newly eligible upon rehire and require the rehired employee to meet the plan's eligibility criteria and waiting period again, if doing so is reasonable under the circumstances. Treating an employee as rehired is reasonable if the employee has a break in service of at least 13 weeks, or at least 26 weeks if the employer is an educational institution.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2020, section 62A.15, is amended by adding a subdivision to read:

Subd. 3c. **Mental health services.** All benefits provided by a policy or contract referred to in subdivision 1 relating to expenses incurred for mental health treatment or services provided by a mental health professional must also include treatment and services provided by a clinical trainee to the extent that the services and treatment are within the scope of practice of the clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C. This subdivision is intended to provide equal payment of benefits for mental health treatment and services provided by a mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee and is not intended to change or add to the benefits provided for in those policies or contracts.

**EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to policies and contracts offered, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2020, section 62A.15, subdivision 4, is amended to read:

Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the payment of claims to employees in this state, deny benefits payable for services covered by the policy or contract if the services are lawfully performed by a licensed chiropractor, licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, ~~or~~ a licensed acupuncture practitioner, or a mental health clinical trainee.

(b) When carriers referred to in subdivision 1 make claim determinations concerning the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any of these determinations that are made by health care professionals must be made by, or under the direction of, or subject to the review of licensed doctors of chiropractic.

(c) When a carrier referred to in subdivision 1 makes a denial of payment claim determination concerning the appropriateness, quality, or utilization of acupuncture services for individuals in this state performed by a licensed acupuncture practitioner, a denial of payment claim determination that is made by a health professional must be made by, under the direction of, or subject to the review of a licensed acupuncture practitioner.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 5. Minnesota Statutes 2020, section 62A.65, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** No health carrier, as defined in section 62A.011, shall offer, sell, issue, or renew any individual health plan, as defined in section 62A.011, to a Minnesota resident except in compliance with this section. ~~This section does not apply to the Comprehensive Health Association established in section 62E.10.~~ A health carrier must only offer, sell, issue, or renew individual health plans on a guaranteed issue basis and at a premium rate that does not vary based on the health status of the individual.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2020, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Grace period for nonpayment of premium.** (a) Notwithstanding any other law to the contrary, an individual health plan may be canceled for nonpayment of premiums, but must include a grace period as described in this subdivision.

(b) The grace period must be three consecutive months. During the grace period, the health carrier must:

(1) pay all claims for services that would have been covered if the premium had been paid, which are provided to the enrollee during the first month of the grace period, and may pend claims for services provided to an enrollee in the second and third months of the grace period; and

(2) notify health care providers of the possibility of denied claims when an enrollee is in the second and third month of the grace period.

(c) In order to stop a cancellation, an enrollee must pay all outstanding premiums before the end of the grace period.

(d) If a health plan is canceled under this subdivision, the final day of the enrollment is the last day of the first month of the three-month grace period.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

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Sec. 7. Minnesota Statutes 2020, section 62D.095, subdivision 2, is amended to read:

Subd. 2. **Co-payments.** A health maintenance contract may impose a co-payment and coinsurance consistent with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ state and federal law.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 8. Minnesota Statutes 2020, section 62D.095, subdivision 3, is amended to read:

Subd. 3. **Deductibles.** A health maintenance contract may impose a deductible consistent with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ state and federal law.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 9. Minnesota Statutes 2020, section 62D.095, subdivision 4, is amended to read:

Subd. 4. **Annual out-of-pocket maximums.** A health maintenance contract may impose an annual out-of-pocket maximum consistent with the provisions of ~~the Affordable Care Act as defined under section 62A.011, subdivision 1a~~ section 62Q.677, subdivision 6a.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 10. Minnesota Statutes 2020, section 62D.095, subdivision 5, is amended to read:

Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive ~~health care~~ items and services ~~consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a,~~ as defined in section 62Q.46, subdivision 1.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

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Section 1. Minnesota Statutes 2020, section 62J.81, subdivision 1, is amended to read:

Subdivision 1. **Required disclosure by provider.** (a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate

of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered consumer will be required to pay.

(b) In addition to the information required to be disclosed under paragraph (a), a provider must also provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees.

(c) For a consumer with health plan coverage, the information required under this subdivision must be provided to ~~a~~ the consumer within ~~ten~~ five business days from the day that a complete request was received by the health care provider. ~~For purposes of this section, "complete request" includes all the patient and service information the health care provider requires to provide a good faith estimate, including a completed good faith estimate form if required by the health care provider.~~ For a consumer with no applicable public or private coverage, the information required by this subdivision must be provided to the consumer within three business days from the day that a complete request was received by the health care provider.

(d) Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this subdivision.

(f) For purposes of this subdivision, "complete request" includes all of the patient and service information that the health care provider requires to provide a good faith estimate, including a completed good faith estimate form, if required by the health care provider.

**EFFECTIVE DATE.** This section is effective January 1, 2023.

Sec. 2. Minnesota Statutes 2020, section 62J.81, subdivision 1a, is amended to read:

Subd. 1a. **Required disclosure by health plan company.** (a) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

(b) The information required under this subdivision must be provided by the health plan company to an enrollee within ~~ten~~ five business days from the day a complete request was received by the health plan company.

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Sec. 11. Minnesota Statutes 2020, section 62Q.01, subdivision 2a, is amended to read:

Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan company must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status. For coverage under plans offered by the Minnesota Comprehensive Health Association, dependent to the limiting age means dependent as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

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

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

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 12. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. **Time limit for credentialing determination.** A health plan company that receives an application for provider credentialing must:

(1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic

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(c) For purposes of this ~~section~~ subdivision, "complete request" includes all the patient and service information the health plan company requires to provide a good faith estimate, including a completed good faith estimate form if required by the health plan company.

**EFFECTIVE DATE.** This section is effective January 1, 2023.

Sec. 3. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. **Time limit for credentialing determination.** A health plan company that receives an application for provider credentialing must:

(1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic

or facility of the date by which the health plan company will make a determination on the health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

**EFFECTIVE DATE; APPLICATION.** This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 62Q.46, is amended to read:

**62Q.46 PREVENTIVE ITEMS AND SERVICES.**

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" ~~has the meaning specified in the Affordable Care Act~~ means the items and services categorized as preventive under subdivision 1a.

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

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

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

(e) This section does not apply to grandfathered plans.

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

or facility of the date by which the health plan company will make a determination on the health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

**EFFECTIVE DATE.** This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2022.

Subd. 1a. **Preventive items and services.** The commissioner of commerce must provide health plan companies with information regarding which items and services must be categorized as preventive.

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

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

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

Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health plan company from providing coverage for preventive items and services in addition to those specified in ~~the Affordable Care Act~~ subdivision 1a, or from denying coverage for preventive items and services that are not recommended as preventive items and services under ~~the Affordable Care Act~~ subdivision 1a. A health plan company may impose cost-sharing requirements for a treatment not described in ~~the Affordable Care Act~~ subdivision 1a even if the treatment results from a preventive item or service described in ~~the Affordable Care Act~~ subdivision 1a.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 14. **[62Q.472] SCREENING AND TESTING FOR OPIOIDS.**

(a) A health plan company shall not place a lifetime or annual limit on screenings and urinalysis testing for opioids for an enrollee in an inpatient or outpatient substance use disorder treatment program when ordered by a health care provider and performed by an accredited clinical laboratory. A health plan company is not prohibited from conducting a medical necessity review when screenings or urinalysis testing for an enrollee exceeds 24 tests in any 12-month period.

(b) This section does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to public health care program enrollees under chapter 256B or 256L.

**EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 15. Minnesota Statutes 2020, section 62Q.677, is amended by adding a subdivision to read:

Subd. 6a. **Out-of-pocket annual maximum.** By October of each year, the commissioner of commerce must determine the maximum annual out-of-pocket limits applicable to individual health plans and small group health plans.

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 16. Minnesota Statutes 2020, section 62Q.81, is amended to read:

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

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

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

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

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

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

Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing includes (1) deductibles, coinsurance, co-payments, or similar charges, and (2) qualified medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986, as amended. Cost-sharing does not include premiums, balance billing from non-network providers, or spending for noncovered services.

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

Sec. 4. **[62Q.524] DISCLOSURE OF APPLICATION OF FUNDS FROM A PATIENT ASSISTANCE PROGRAM TO A DEDUCTIBLE.**

A health plan company must include in the summary of benefits and coverage a statement indicating whether funds from a patient assistance program, as defined in section 62J.84, subdivision 2, paragraph (h), are applied by the health plan company to an enrollee's deductible.

**EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

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

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

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

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

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

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

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

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

(1) enrollment in the health plan is limited only to individuals that:

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

(ii) are unable to access affordable coverage; or

(iii) are experiencing a hardship in reference to the individual's capability to access coverage; and

(2) the health plan provides:

(i) essential health benefits, except that the plan does not provide benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the limitation in effect under subdivision 2; and

(ii) coverage for at least three primary care visits.

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

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

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

(8) prescription drugs;

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

(10) rehabilitative and habilitative services and devices; and

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

(b) If a service provider does not have a contractual relationship with the health plan to provide services, emergency services must be provided without imposing any prior authorization requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from providers who have a contractual relationship with the health plan. If services are provided out-of-network, the cost-sharing must be equivalent to services provided in-network.

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

(d) Essential health benefits must:

(1) reflect an appropriate balance among the categories to ensure benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in a manner that discriminates against individuals on the basis of age, disability, or expected length of life;

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

(4) ensure that health benefits established as essential are not subject to denial against the individual's wishes on the basis of the individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

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

**EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.

Sec. 17. Minnesota Statutes 2020, section 256B.0625, subdivision 10, is amended to read:

Subd. 10. **Laboratory ~~and~~, x-ray, and opioid screening services.** (a) Medical assistance covers laboratory and x-ray services.

(b) Medical assistance covers screening and urinalysis tests for opioids without lifetime or annual limits.

**EFFECTIVE DATE.** This section is effective January 1, 2022.

Sec. 18. **COMMISSIONER OF COMMERCE; DETERMINATION OF PREVENTIVE ITEMS AND SERVICES.**

The commissioner of commerce must determine the items and services that are preventive under Minnesota Statutes, section 62Q.46, subdivision 1a. Items and services that are preventive must include:

(1) evidence-based items or services that have in effect a rating of A or B pursuant to the recommendations of the United States Preventive Services Task Force in effect January 1, 2021, and with respect to the individual involved;

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

recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

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

(4) with respect to women, additional preventive care and screenings not described in clause (1), as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.