MN HOUSE RESEARCH

Bill Summary

H.F. 1002

Second Engrossment

Subject	Health Insurance and the Affordable Care Act
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Overview

This bill removes cross references to the Affordable Care Act (ACA) and clarifies and modifies provisions of the ACA that are codified in state statute.

Summary

Section	Description
1	**Required provisions.** Removes cross-reference to ACA and inserts reference to statutes section 62A.65, subdivision 2a.
2	**Prohibition on waiting periods that exceed 90 days.** Prohibits a health carrier offering a group health plan from having an individual who is eligible to enroll wait to enroll for more than 90 days. Makes exceptions for service hours per period, cumulative hours of service, orientation period, and rehiring.
3	**Applicability.** Removes an unnecessary cross-reference. Requires a health carrier to offer individual health plans on a guaranteed issue bases and at a premium rate that is not based on the health status of the individual.
4	**Grace period for nonpayment of premiums.** Requires a health carrier to provide a 3-month grace period for nonpayment of premiums on an individual health plan.
5	**Co-payments.** Removes cross-reference to ACA.
6	**Deductibles.** Removes cross-reference to ACA.

Section	Description
7	**Annual out-of-pocket maximums.** Removes cross-reference to ACA and inserts reference to section 62Q.677, subdivision 6a.
8	**Exceptions.** Removes cross-reference to ACA and inserts reference to section 62Q.46, subdivision 1.
9	**Dependent child to the limiting age.** Removes cross-reference to ACA.
10	**Preventive items and services.** **Subd. 1. Coverage for preventive items and services.** Removes cross-reference to the ACA and inserts reference to subdivision 1a. **Subd. 1a. Preventive items and services.** Requires the commissioner of commerce to provide health plans with information regarding which items and services must be categorized as preventive. **Subd. 3. Additional services not prohibited.** Removes cross-reference to the ACA and inserts reference to subdivision 1a.
11	**Out-of-pocket annual maximum.** Requires the commissioner of commerce to determine by October of each year what the maximum annual out-of-pocket limit is for individual and small group health plans.
12	**Essential health benefit package requirements.** **Subd. 1. Essential health benefits package.** Removes cross-reference to the ACA and inserts reference to appropriate subdivisions in this section. **Subd. 2. Cost-sharing; coverage for enrollees under the age of 21.** Removes cross-reference to the ACA and limits cost-sharing for individual and small group health plans to the limits set under the Internal Revenue Code and a premium adjustment percentage. **Subd. 3. Levels of coverage; alternative compliance for catastrophic plans.** Requires bronze, silver, gold, and platinum health plans offered by health carriers to be actuarially equivalent to a certain percentage of the full actuarial value of the benefits provided. Clarifies the circumstances under which catastrophic health plans can be sold and what those plans must include.

Section	Description
	Subd. 4. Essential health benefits; definition. (a) Removes cross-reference to the ACA. (b) Requires out-of-network providers of emergency services to not impose more restrictive prior authorization requirements or limitations than those required by in-network providers. Requires cost-sharing to be equivalent between in and out-of-network providers for these services. (c) Requires the scope of essential health benefits under paragraph (a) to be equal in scope to those provided under a typical employer plan. (d) Lists requirements for essential health benefits. **Subd. 5. Exception.** Removes cross-reference to the ACA.
13	**Commissioner of commerce; determination of preventive items and services.** Requires the commissioner of commerce to determine what items and services are preventive, which at a minimum must include those currently categorized as preventive under federal law.
14	**Effective date.** Sections 1 to 13 are effective January 1, 2022, for health plans offered, issued, or renewed on or after that date.