

1.1 ..... moves to amend H.F. No. 1002 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. Minnesota Statutes 2018, section 62A.04, subdivision 2, is amended to read:

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

1.13 (1) A provision as follows:

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

1.19 (2) A provision as follows:

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

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

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

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

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

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

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

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

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

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

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

3.5 (4) A provision as follows:

3.6 REINSTATEMENT: If any renewal premium be not paid within the time granted the  
3.7 insured for payment, a subsequent acceptance of premium by the insurer or by any agent  
3.8 duly authorized by the insurer to accept such premium, without requiring in connection  
3.9 therewith an application for reinstatement, shall reinstate the policy. If the insurer or such  
3.10 agent requires an application for reinstatement and issues a conditional receipt for the  
3.11 premium tendered, the policy will be reinstated upon approval of such application by the  
3.12 insurer or, lacking such approval, upon the forty-fifth day following the date of such  
3.13 conditional receipt unless the insurer has previously notified the insured in writing of its  
3.14 disapproval of such application. For health plans described in section 62A.011, subdivision  
3.15 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the  
3.16 policy, if the insured applies for reinstatement no later than 60 days after the due date for  
3.17 the premium payment, unless:

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

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

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

3.31 (5) A provision as follows:

3.32 NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20  
3.33 days after the occurrence or commencement of any loss covered by the policy, or as soon  
3.34 thereafter as is reasonably possible. Notice given by or on behalf of the insured or the

4.1 beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate  
4.2 for the purpose), or to any authorized agent of the insurer, with information sufficient to  
4.3 identify the insured, shall be deemed notice to the insurer.

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

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

4.16 (6) A provision as follows:

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

4.23 (7) A provision as follows:

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

4.32 (8) A provision as follows:

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

5.8 (9) A provision as follows:

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

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

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

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

5.31 (10) A provision as follows:

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

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

6.3 (11) A provision as follows:

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

6.8 (12) A provision as follows:

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

6.15 Sec. 2. Minnesota Statutes 2018, section 62A.10, is amended by adding a subdivision to  
6.16 read:

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

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

6.25 (c) If a group health plan conditions eligibility on an employee working full time or  
6.26 regularly having a specified number of service hours per period, and it cannot be determined  
6.27 that a newly hired employee is full time or reasonably expected to regularly work the specific  
6.28 number of hours per period, the plan may take a reasonable period of time, not to exceed  
6.29 12 months beginning on any date between the employee's start date and the first day of the  
6.30 first calendar month after the employee's start date, to determine whether the employee  
6.31 meets the plan's eligibility condition.

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

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

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

7.14 Sec. 3. Minnesota Statutes 2020, section 62A.65, subdivision 1, is amended to read:

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

7.21 Sec. 4. Minnesota Statutes 2018, section 62A.65, is amended by adding a subdivision to  
7.22 read:

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

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

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

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

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

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

8.7 Sec. 5. Minnesota Statutes 2018, section 62D.095, subdivision 2, is amended to read:

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

8.11 Sec. 6. Minnesota Statutes 2018, section 62D.095, subdivision 3, is amended to read:

8.12 Subd. 3. **Deductibles.** A health maintenance contract may impose a deductible consistent  
8.13 with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision~~  
8.14 ~~1a~~ state and federal law.

8.15 Sec. 7. Minnesota Statutes 2018, section 62D.095, subdivision 4, is amended to read:

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

8.19 Sec. 8. Minnesota Statutes 2018, section 62D.095, subdivision 5, is amended to read:

8.20 Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive  
8.21 ~~health care items and services consistent with the provisions of the Affordable Care Act as~~  
8.22 ~~defined under section 62A.011, subdivision 1a,~~ as defined in section 62Q.46, subdivision  
8.23 1.

8.24 Sec. 9. Minnesota Statutes 2018, section 62Q.01, subdivision 2a, is amended to read:

8.25 Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age"  
8.26 or "dependent children to the limiting age" means those individuals who are eligible and  
8.27 covered as a dependent child under the terms of a health plan who have not yet attained 26  
8.28 years of age. A health plan company must not deny or restrict eligibility for a dependent  
8.29 child to the limiting age based on financial dependency, residency, marital status, or student  
8.30 status. For coverage under plans offered by the Minnesota Comprehensive Health



9.1 Association, dependent to the limiting age means dependent as defined in section 62A.302,  
9.2 subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

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

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

9.6 Sec. 10. Minnesota Statutes 2018, section 62Q.46, is amended to read:

9.7 **62Q.46 PREVENTIVE ITEMS AND SERVICES.**

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

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

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

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

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

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

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

9.31 Subd. 2. **Coverage for office visits in conjunction with preventive items and**  
9.32 **services.** (a) A health plan company may impose cost-sharing requirements with respect to

10.1 an office visit if a preventive item or service is billed separately or is tracked separately as  
10.2 individual encounter data from the office visit.

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

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

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

10.19 Sec. 11. Minnesota Statutes 2018, section 62Q.677, is amended by adding a subdivision  
10.20 to read:

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

10.24 Sec. 12. Minnesota Statutes 2018, section 62Q.81, is amended to read:

10.25 **62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.**

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

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

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

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

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

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

11.10 (b) Cost-sharing per year for individual health plans is limited to the amount allowed  
11.11 under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased  
11.12 by an amount equal to the product of that amount and the premium adjustment percentage.  
11.13 The premium adjustment percentage is the percentage that the average per capita premium  
11.14 for health insurance coverage in the United States for the preceding calendar year exceeds  
11.15 the average per capita premium for 2017. If the amount of the increase is not a multiple of  
11.16 \$50, the increases must be rounded to the next lowest multiple of \$50.

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

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

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

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

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

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

12.4 (e) A health plan company that does not provide an individual or small group health  
 12.5 plan in the bronze, silver, gold, or platinum level of coverage, as described in subdivision  
 12.6 1, paragraph (b), clause (3), shall be treated as meeting the requirements of this section  
 12.7 1302(d) of the Affordable Care Act with respect to any policy plan year if the health plan  
 12.8 company provides a catastrophic plan that meets the following requirements of section  
 12.9 1302(e) of the Affordable Care Act.:

12.10 (1) the only individuals to enroll in the health plan:

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

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

12.13 (iii) are experiencing a hardship in reference to their capability to access coverage; and

12.14 (2) the health plan provides:

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

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

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

12.22 (1) ambulatory patient services;

12.23 (2) emergency services;

12.24 (3) hospitalization;

12.25 (4) laboratory services;

12.26 (5) maternity and newborn care;

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

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

12.30 (8) prescription drugs;

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

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

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

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

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

13.13 (d) Essential health benefits must:

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

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

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

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

13.25 Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section~~  
13.26 ~~1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric  
13.27 dental benefits.

13.28 **Sec. 13. [363A.115] UNFAIR DISCRIMINATORY PRACTICES RELATED TO**  
13.29 **HEALTH CARE.**

13.30 (a) It is an unfair discriminatory practice for an individual to be excluded from  
13.31 participation in, be denied the benefits of, or be subjected to discrimination on the basis of  
13.32 race, color, creed, religion, disability, national origin, marital status, sexual orientation, or

14.1 sex by any health program or health insurance provider if any part of the health care program  
14.2 receives federal financial assistance or is administered by a state or federal agency, or by  
14.3 any health insurance provider that provides insurance through a state or federal marketplace.

14.4 (b) An entity covered under this section is required to: (1) make all programs and activities  
14.5 provided through electronic and information technology accessible; (2) ensure the physical  
14.6 accessibility of newly constructed or altered facilities; and (3) provide appropriate auxiliary  
14.7 aids and services to individuals with disabilities. Entities covered under this section must  
14.8 take reasonable steps to provide meaningful access to each individual with limited English  
14.9 proficiency and provide information about language assistance services.

14.10 **Sec. 14. COMMISSIONER OF COMMERCE; DETERMINATION OF**  
14.11 **PREVENTIVE ITEMS AND SERVICES.**

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

14.15 (1) evidence-based items or services that have in effect a rating of A or B pursuant to  
14.16 the recommendations of the United States Preventive Services Task Force in effect January  
14.17 1, 2021, and with respect to the individual involved;

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

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

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

14.32 **EFFECTIVE DATE.** Sections 1 to 13 are effective January 1, 2022, for health plans  
14.33 offered, issued, or renewed on or after that date."

15.1 Amend the title accordingly