A bill for an act

relating to health insurance; regulating coverages; amending Minnesota Statutes 2016, sections 62A.04, subdivision 1; 62A.21, subdivision 2a; 62A.65, subdivisions 2, 5, by adding a subdivision; 62D.105, subdivisions 1, 2; 62E.04, subdivision 11; 62E.05, subdivision 1; 62E.06, by adding a subdivision; 62Q.18, subdivision 7; Laws 2017, chapter 2, article 2, section 13; proposing coding for new law in Minnesota Statutes, chapter 62V.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

Subdivision 1. **Reference.** Any reference to "standard provisions" which may appear in other sections and which refer to accident and sickness or accident and health insurance shall hereinafter be construed as referring to accident and sickness policy provisions. The following provisions herein do not apply to accident and sickness or accident and health insurance that are health plans as defined in subdivision 2, clauses (4), (5), (6), (7), (8), (9), (10), and (12); subdivision 3, clauses (1), (3), (4), (5), (6), and (7); subdivision 6; subdivision 10; and section 62A.011, subdivision 3.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's ~~former spouse and~~ dependent children ~~upon~~ as defined in section 62Q.01, subdivision 2a, and

former spouse, who were covered on the day before entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

(a) the date the insured's former spouse becomes covered under any other group health plan; or

(b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's ~~former spouse or~~ dependent ~~child~~ children and former spouse, who were covered on the day before entry of a valid decree of dissolution, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 62A.65, subdivision 2, is amended to read:

Subd. 2. **Guaranteed renewal.** (a) No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan, except for nonpayment of premiums, fraud, or intentional misrepresentation of a material fact.

(b) A health carrier may elect to discontinue health plan coverage of an individual in the individual market, only in one or more of the following situations:

(1) the health carrier is ceasing to offer individual health plan coverage in the individual market in accordance with sections 62A.65, subdivision 8, and 62E.11, subdivision 9, and federal law;

(2) for network plans, the individual no longer resides, lives, or works in the service area of the health carrier, or the area for which the health carrier is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals; or

(3) a decision by the health carrier to discontinue offering a particular type of individual health plan if the health carrier:

(i) provides notice in writing to each individual provided coverage of that type of health plan at least 90 days before the date the coverage will be discontinued;

(ii) provides notice to the department at least 30 business days before the issuer or health carrier gives notice to the individuals;

(iii) offers to each covered individual, on a guaranteed issue basis, the option to purchase any other individual health plan currently being offered by the health carrier or related health carrier for individuals in that market; and

(iv) acts uniformly without regard to any health status-related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

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

Sec. 4. Minnesota Statutes 2016, section 62A.65, is amended by adding a subdivision to read:

Subd. 2a. **Uniform modification of plan.** (a) A health carrier may modify the health plan for a product, as defined under Code of Federal Regulations, title 45, section 144.103, offered to an individual in the individual market, at the time of coverage renewal if the modification is effective uniformly for all individuals with that product.

(b) For purposes of paragraph (a), modifications made uniformly and solely pursuant to applicable federal or state requirements are considered a uniform modification of coverage if:

(1) the modification is made within a reasonable time period after the imposition or modification of the federal or state requirement; and

(2) the modification is directly related to the imposition or modification of the federal or state requirement.

(c) Other types of modifications made uniformly are considered a uniform modification of coverage if the health plan for the product in the individual market meets all of the following criteria:

(1) the product is offered by the same health carrier;

(2) the product is offered as the same product network type which includes, but is not limited to, a health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity;

(3) the product continues to cover at least a majority of the same service area;

(4) within the product, each health plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal level, as defined under section 62K.06, subdivision 4; and

(5) the product provides the same covered benefits, except for any changes in benefits that cumulatively impact the plan-adjusted index rate as defined under Code of Federal Regulations, title 45, section 156.80(d)(2), for any health plan within the product within an allowable variation of plus or minus two percentage points, not including changes pursuant to applicable federal or state requirements.

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

Sec. 5. Minnesota Statutes 2016, section 62A.65, subdivision 5, is amended to read:

Subd. 5. **Portability and conversion of coverage.** (a) For plan years beginning on or after January 1, 2014, no individual health plan may be offered, sold, issued, or renewed, to a Minnesota resident that contains a preexisting condition limitation, preexisting condition exclusion, or exclusionary rider. An individual age 19 or older may be subjected to an 18-month preexisting condition limitation during plan years beginning prior to January 1, 2014, unless the individual has maintained continuous coverage as defined in section 62L.02. The individual must not be subjected to an exclusionary rider. During plan years beginning prior to January 1, 2014, an individual who is age 19 or older and who has maintained continuous coverage may be subjected to a onetime preexisting condition limitation of up to 12 months, with credit for time covered under qualifying coverage as defined in section 62L.02, at the time that the individual first is covered under an individual health plan by any health carrier. Credit must be given for all qualifying coverage with respect to all preexisting conditions, regardless of whether the conditions were preexisting with respect to any previous qualifying coverage. The individual must not be subjected to an exclusionary rider. Thereafter, the individual who is age 19 or older must not be subject to any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider under an individual health plan by any health carrier, except an unexpired portion of a limitation under prior

coverage, so long as the individual maintains continuous coverage as defined in section 62L.02. The prohibition on preexisting condition limitations for children age 18 or under does not apply to individual health plans that are grandfathered plans. The prohibition on preexisting condition limitations for adults age 19 and over beginning for plan years on or after January 1, 2014, does not apply to individual health plans that are grandfathered plans.

(b) A health carrier must offer an individual health plan to any individual previously covered under a group health plan issued by that health carrier, regardless of the size of the group, so long as the individual maintained continuous coverage as defined in section 62L.02. If the individual has available any continuation coverage provided under sections 62A.146; 62A.148; 62A.17, subdivisions 1 and 2; 62A.20; 62A.21; 62C.142; 62D.101; or 62D.105, or continuation coverage provided under federal law, the health carrier need not offer coverage under this paragraph until the individual has exhausted the continuation coverage. The offer must not be subject to underwriting, except as permitted under this paragraph. A health plan issued under this paragraph must be a qualified plan as defined in section 62E.02 and must not contain any preexisting condition limitation, preexisting condition exclusion, or exclusionary rider, except for any unexpired limitation or exclusion under the previous coverage. The individual health plan must cover pregnancy on the same basis as any other covered illness under the individual health plan. The offer of coverage by the health carrier must inform the individual that the coverage, including what is covered and the health care providers from whom covered care may be obtained, may not be the same as the individual's coverage under the group health plan. The offer of coverage by the health carrier must also inform the individual that the individual, if a Minnesota resident, may be eligible to obtain coverage from (i) other private sources of health coverage, or (ii) the Minnesota Comprehensive Health Association, without a preexisting condition limitation, and must provide the telephone number used by that association for enrollment purposes. The initial premium rate for the individual health plan must comply with subdivision 3. The premium rate upon renewal must comply with subdivision 2. In no event shall the premium rate exceed 100 percent of the premium charged for comparable individual coverage by the Minnesota Comprehensive Health Association, and the premium rate must be less than that amount if necessary to otherwise comply with this section. Coverage issued under this paragraph must provide that it cannot be canceled or nonrenewed as a result of the health carrier's subsequent decision to leave the individual, small employer, or other group market. Section 72A.20, subdivision 28, applies to this paragraph. <u>For plan years beginning on or after January 1, 2017, a health carrier is no longer required to offer coverage under this paragraph.</u>

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 6. Minnesota Statutes 2016, section 62D.105, subdivision 1, is amended to read:

Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to covering the enrollee also provides coverage to the ~~spouse and~~ dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, of the enrollee and spouse who were covered on the day before entry of a valid decree of dissolution shall: (1) permit the spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, to elect to continue coverage when the enrollee becomes enrolled for benefits under title XVIII of the Social Security Act (Medicare); and (2) permit the dependent children to continue coverage when they cease to be dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, under the generally applicable requirement of the plan.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 7. Minnesota Statutes 2016, section 62D.105, subdivision 2, is amended to read:

Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the contract;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the date the spouse or dependent children become covered under another group health plan or Medicare.

If coverage is provided under a group policy, any required fees for the coverage shall be paid by the enrollee on a monthly basis to the group contract holder for remittance to the health maintenance organization. In no event shall the fee charged exceed 102 percent of the cost to the plan for such coverage for other similarly situated spouse and dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 8. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

Subd. 11. **~~Essential health benefits package~~ Affordable Care Act compliant plans.** For ~~individual or small group health plans that include the essential health benefits package and are~~ any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, ~~2014~~ 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 9. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall make a determination within 90 days as to whether the plan is qualified. All plans of health coverage, except Medicare supplement policies, shall be labeled as "qualified" or "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified plans shall indicate whether they are number one, two, or three coverage plans. For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 10. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to read:

Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health insurance subject to the requirements of the Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1, 2018, the requirements of this section do not apply.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 11. Minnesota Statutes 2016, section 62Q.18, subdivision 7, is amended to read:

Subd. 7. **Portability of coverage.** Effective July 1, 1994, no health plan company shall offer, sell, issue, or renew any group health plan that does not, with respect to individuals who maintain continuous coverage and who qualify under the group's eligibility requirements:

(1) make coverage available on a guaranteed issue basis;

(2) give full credit for previous continuous coverage against any applicable preexisting condition limitation or preexisting condition exclusion; and

(3) with respect to a group health plan offered, sold, issued, or renewed to a large employer, impose preexisting condition limitations or preexisting condition exclusions except to the extent that would be permitted under chapter 62L if the group sponsor were a small employer as defined in section 62L.02, subdivision 26.

To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L. For plan years beginning on or after January 1, 2017, a health carrier is no longer required to offer coverage under this subdivision.

EFFECTIVE DATE. This section is effective for policies offered, sold, issued, or renewed on or after January 1, 2018.

Sec. 12. **[62V.052] PRE-ENROLLMENT VERIFICATION OF ELIGIBILITY REQUIRED.**

Notwithstanding any other law or rule to the contrary, prior to enrolling an individual in a qualified health plan, MNsure must confirm that an individual has provided sufficient information to determine the individual's eligibility as of the date of application for enrollment. MNsure must require that an individual or the individual's representative provide documentation confirming eligibility within 30 days of application. For purposes of this section, an individual has not provided sufficient information to determine the individual's eligibility for enrollment in a qualified health plan through MNsure if:

(1) the individual or the individual's representative has only provided an attestation of eligibility without documentation confirming the accuracy of the attestation, except when reliance upon attestation is strictly required by law;

(2) the documentation provided by the individual or the individual's representative is not sufficient to confirm eligibility; or

(3) inconsistencies in available information or documentation provided by the individual or the individual's representative have not been resolved.

If MNsure confirms an individual has provided sufficient information to determine the individual's eligibility for enrollment in a qualified health plan through MNsure, MNsure must enroll the individual in a qualified health plan with a coverage effective date determined based upon the application date for enrollment. In the event the determined coverage effective date would result in the individual being required to pay two or more months of retroactive premiums to effectuate coverage, MNsure must permit an individual or the individual's dependent to elect a coverage effective date that is either based upon the application date for enrollment in a qualified health plan through MNsure or one month later than if based upon the application date for enrollment. MNsure may not otherwise permit an individual or the individual's dependent to elect a coverage effective date.

EFFECTIVE DATE. This section is effective for all applications for enrollment in a qualified health plan received by MNsure on or after July 1, 2017.

Sec. 13. Laws 2017, chapter 2, article 2, section 13, is amended to read:

Sec. 13. **62Q.556 UNAUTHORIZED PROVIDER SERVICES.**

Subdivision 1. **Unauthorized provider services.** (a) Except as provided in paragraph (c), unauthorized provider services occur when an enrollee receives services:

(1) from a nonparticipating provider at a participating hospital or ambulatory surgical center, when the services are rendered:

(i) due to the unavailability of a participating provider;

(ii) by a nonparticipating provider without the enrollee's knowledge; or

(iii) due to the need for unforeseen services arising at the time the services are being rendered; or

(2) from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility.

(b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.

(c) The services described in paragraph (a), clause (2), are not unauthorized provider services if the enrollee gives advance written consent to the provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan.

Subd. 2. **Prohibition.** (a) An enrollee's financial responsibility for the unauthorized provider services shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties.

(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the department of health's Web Site, and update the list as appropriate.

(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation, and similar fees received by the provider for the same services from other health plans in which the provider is nonparticipating, in reaching a decision.

Subd. 3. **Scope.** This section does not apply to services provided under chapter 256B or 256L.

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

Sec. 14. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~90 days following final enactment~~ January 1, 2019, and applies to provider services provided on or after that date.

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