State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3169

A bill for an act

relating to health insurance; clarifying certain health insurance provisions; amending Minnesota Statutes 2018, section 62Q.81.

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

Section 1. Minnesota Statutes 2018, 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 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 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(e) of the Affordable Care Act.~~:

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

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

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

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

(2) the health plan provides:

(i) essential health benefits, except that it 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 to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' 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 August 1, 2020, for health plans offered, issued, or renewed on or after that date.