406	**Subd. 4. Compliance with other restrictions on rescissions.** Nothing in this section allows rescission if rescission would otherwise be prohibited under section 62A.04, subdivision 2, clause (2), or 62A.615. Note: The rescission provisions under federal law apply to individual plans for plan years beginning on or after September 23, 2010 and to group plans for plan years beginning on or after January 1, 2014. There is an exception for enrollees under 19 years old on individual plans, which is subject to the 9/23/10 start date (so this should already be in effect).	X	X	X	X	X	X	X
407	**62Q.46 PREVENTIVE ITEMS AND SERVICES**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
408	**Subdivision 1. Coverage for preventive items and services.** (a) "Preventive items and services" has the meaning specified in the Affordable Care Act. **(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.**		X	X	X	X	X	X
409	**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.		X	X	X	X	X	X
410	**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, or from denying coverage for preventive items and services that are not recommended as preventive items and services under the Affordable Care Act. A health plan company may impose cost-sharing requirements for a treatment not described in the Affordable Care Act even if the treatment results from a preventive item or service described in the Affordable Care Act.		X	X	X	X	X	X
411	**62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange

412	**(a)** All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.	X	X	X	X	X	X	X
413	**(b)** Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.	X	X	X	X	X	X	X
414	**(c)** Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.	X	X	X	X	X	X	X
415	**(d)** All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health 1Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.	X	X	X	X	X	X	X
416	**62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
417	**(a)** No health plan may exclude or reduce coverage for health care for an enrollee who is otherwise covered under the health plan on the basis that the need for the health care arose out of a suicide or suicide attempt by the enrollee.	X	X	X	X	X	X	X
418	**62Q.49 ENROLLEE COST SHARING; NEGOTIATED PROVIDER PAYMENTS.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
419	**Subdivision 1.Applicability**.This section applies to all health plans, as defined in section 62Q.01, subdivision 3, that provide coverage for health care to be provided entirely or partially:	X	X	X	X	X	X	X
420	**(1)** through contracts in which health care providers agree to accept discounted charges, negotiated charges, or other limits on health care provider charges;	X	X	X	X	X	X	X
421	**(2)** by employees of, or facilities or entities owned by, the issuer of the health plan; or	X	X	X	X	X	X	X
422	**(3)** through contracts with health care providers that provide for payment to the providers on a fully or partially capitated basis or on any other non-fee-for-service basis.	X	X	X	X	X	X	X
423	**Subd. 2.Disclosure required**	X	X	X	X	X	X	X
424	**(a)** All health plans included in subdivision 1 must clearly specify how the cost of health care used to calculate any co-payments, coinsurance, or lifetime benefits will be affected by the arrangements described in subdivision 1.	X	X	X	X	X	X	X

	◊ 62Q.50 PROSTATE CANCER SCREENING.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
425	◊ A health plan must cover prostate cancer screening for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening must consist at a minimum of a prostate-specific antigen blood test and a digital rectal examination. This coverage is subject to any deductible, coinsurance, co-payment, or other limitation on coverage applicable to other coverages under the plan.	X	X	X	X	X	X	X
426								
	◊ 62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC SERVICES.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
427								
428	◊ **(a)** Health plan companies shall allow female enrollees direct access to providers who specialize in obstetrics and gynecology for the following services:	X	X	X	X	X	X	X
429	**(1)** evaluation and necessary treatment for obstetric conditions or emergencies;	X	X	X	X	X	X	X
430	**(2)** maternity care; and	X	X	X	X	X	X	X
431	**(3)** evaluation and necessary treatment for gynecologic conditions or emergencies.	X	X	X	X	X	X	X
432	◊ **(b)** For purposes of this section, "direct access" means that a female enrollee may obtain the obstetric and gynecologic services specified in paragraph (a) from providers who specialize in obstetrics and gynecology in the enrollee's network without a referral from, or prior approval through a primary care provider, another physician, the health plan company, or its representatives.	X	X	X	X	X	X	X
433	◊ **(c)** The health plan company shall treat the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services, pursuant to paragraph (a), by a participating health care provider who specializes in obstetrics or gynecology as the authorization of a primary care provider.	X	X	X	X	X	X	X
434	◊ **(d)** The health plan company may require the health care provider to agree to otherwise adhere to the health plan company's policies and procedures, including procedures for obtaining prior authorization and for providing services in accordance with a treatment plan, if any, approved by the health plan company.	X	X	X	X	X	X	X
435	◊ **(e)** Health plan companies shall not require higher co-payments, coinsurance, deductibles, or other enrollee cost-sharing for direct access.	X	X	X	X	X	X	X
436	◊ **(f)** This section applies only to services described in paragraph (a) that are covered by the enrollee's coverage, but coverage of a preventive health examination for female enrollees must not exclude coverage of a gynecologic examination.	X	X	X	X	X	X	X
437	**(g)** For purposes of this section, a health care provider who specializes in obstetrics or gynecology means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.	X	X	X	X	X	X	X
438	**(h)** This section does not: **(1)** waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of obstetrical or gynecological care; or **(2)** preclude the health plan company from requiring that the participating health care provider providing obstetrical or gynecological care notify the primary care provider or the health plan company of treatment decisions.	X	X	X	X	X	X	X

	◊ 62Q.525 COVERAGE FOR OFF-LABEL DRUG USE.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
439								
440	◊ **Subd. 3.Required coverage.**	X	X	X	X	X	X	X
441	**(a)** Every type of coverage included in subdivision 1 that provides coverage for drugs may not exclude coverage of a drug for the treatment of cancer on the ground that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature, as defined in subdivision 2.	X	X	X	X	X	X	X
442	**(b)** Coverage of a drug required by this subdivision includes coverage of medically necessary services directly related to and required for appropriate administration of the drug.	X	X	X	X	X	X	X
443	**(c)** Coverage required by this subdivision does not include coverage of a drug not listed on the formulary of the coverage included in subdivision 1.	X	X	X	X	X	X	X
444	**(d)** Coverage of a drug required under this subdivision must not be subject to any co-payment, coinsurance, deductible, or other enrollee cost-sharing greater than the coverage included in subdivision 1 applies to other drugs.	X	X	X	X	X	X	X

	62Q.526 COVERAGE FOR PARTICIPATION IN APPROVED CLINICAL TRIALS.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
445								
446	**Subdivision 1. Definitions.** As used in this section, the following definitions apply:		X	X	X	X	X	X
447	**(a)** "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and must be:		X	X	X	X	X	X
448	**(1)** conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA);		X	X	X	X	X	X
449	**(2)** exempt from obtaining an investigational new drug application; or		X	X	X	X	X	X
450	**(3)** approved or funded by: (i) the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperating group or center of any of the entities described in this item; (ii) a cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs; (iii) a qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants; or (iv) the United States Departments of Veterans Affairs, Defense, or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to: (A) be comparable to the system of peer review of studies and investigations used by the NIH; and (B) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.		X	X	X	X	X	X

451	**(b)** "Qualified individual" means an individual with health plan coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because: **(1)** the referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or **(2)** the individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol.		X	X	X	X	X	X
452	**(c)(1)** "Routine patient costs" includes all items and services covered by the health benefit plan of individual market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial. **(2)** Routine patient costs does not include: (i) an investigational item, device, or service that is part of the trial; (ii) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient; (iii) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or (iv) an item or service customarily provided and paid for by the sponsor of a trial.		X	X	X	X	X	X
453	**Subd.** 2. **Prohibited acts.** A health plan company that offers a health plan to a Minnesota resident may not: **(1)** deny participation by a qualified individual in an approved clinical trial; **(2)** deny, limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or **(3)** discriminate against an individual on the basis of an individual's participation in an approved clinical trial.		X	X	X	X	X	X
454	**Subd. 3. Network plan conditions.** A health plan company that designates a network or networks of contracted providers may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the plan's network if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.		X	X	X	X	X	X
455	**Subd. 4. Application to clinical trials outside of the state.** This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.		X	X	X	X	X	X
456	**Subd. 5. Construction. (a)** This section shall not be construed to require a health plan company offering health plan coverage through a network or networks of contracted providers to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage. **(b)** This section shall not be construed to limit a health plan company's coverage with respect to clinical trials. **(c)** This section shall apply to all health plan companies offering a health plan to a Minnesota resident, unless otherwise amended by federal regulations under the Affordable Care Act.		X	X	X	X	X	X
457	◊ **62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS; REQUIRED COVERAGE.**	**Grandfathered**	**Non-Grandfathered**	**Small Group**	**Large Group**	**Individual**	**Applies to the Exchange**	**Applies outside the Exchange**
458	◊ **Subd. 2.Required coverage for antipsychotic drugs.**	X	X	X	X	X	X	X
459	◊ **(a)** A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug: **(1)** indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and **(2)** certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.	X	X	X	X	X	X	X
460	◊ **(b)** The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.	X	X	X	X	X	X	X

461	◊ **(c)** For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a), may: **(1)** impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or **(2)** require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.	X	X	X	X	X	X	X
462	◊ **Subd. 3.Continuing care.**	X	X	X	X	X	X	X
463	**(a)** Enrollees receiving a prescribed drug to treat a diagnosed mental illness or emotional disturbance may continue to receive the prescribed drug for up to one year without the imposition of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit: **(1)** the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan; **(2)** the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and **(3)** the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition. .	X	X	X	X	X	X	X
464	**(b)** The continuing care benefit shall be extended annually when the health care provider prescribing the drug: **(1)** indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and **(2)** certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.	X	X	X	X	X	X	X
465	**(c)** The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.	X	X	X	X	X	X	X
466	◊ **Subd. 4.Exception to formulary.** A health plan company must promptly grant an exception to the health plan's drug formulary for an enrollee when the health care provider prescribing the drug indicates to the health plan company that:	X	X	X	X	X	X	X
467	**(1)** the formulary drug causes an adverse reaction in the patient;	X	X	X	X	X	X	X
468	**(2)** the formulary drug is contraindicated for the patient; or	X	X	X	X	X	X	X
469	**(3)** the health care provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.	X	X	X	X	X	X	X
470	◊ **62Q.53 MENTAL HEALTH COVERAGE; MEDICALLY NECESSARY CARE.**	**Grandfathered**	**Non-Grandfathered**	**Small Group**	**Large Group**	**Individual**	**Applies to the Exchange**	**Applies outside the Exchange**
471	◊ **Subdivision 1.Requirement.**No health plan that covers mental health services may be offered, sold, issued, or renewed in this state that requires mental health services to satisfy a definition of "medically necessary care," "medical necessity," or similar term that is more restrictive with respect to mental health than the definition provided in subdivision 2.	X	X	X	X	X	X	X
472	◊ **Subd. 2.Minimum definition.**"Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must: (1) help restore or maintain the enrollee's health; or (2) prevent deterioration of the enrollee's condition.	X	X	X	X	X	X	X

	◊ 62Q.535 COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
473								
474	◊ **Subdivision 1.Mental health services**. For purposes of this section, mental health services means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.	X	X	X	X	X	X	X
475	◊ **Subd. 2.Coverage required.**(a) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.	X	X	X	X	X	X	X

	◊ 62Q.55 EMERGENCY SERVICES.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
476								
477	◊ **Subd. 1. Access to emergency services.**		X	X	X	X	X	X
478	**(a)** Enrollees have the right to available and accessible emergency services, 24 hours a day and seven days a week. The health plan company shall inform its enrollees how to obtain emergency care for treatment of emergency medical conditions. Emergency services shall be covered whether provided by participating or nonparticipating providers and whether provided within or outside the health plan company's service area. In reviewing a denial for coverage of emergency services, the health plan company shall take the following factors into consideration: **(1)** a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment; **(2)** the time of day and day of the week the care was provided; **(3)** the presenting symptoms, including, but not limited to, severe pain, to ensure that the decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis; **(4)** the enrollee's efforts to follow the health plan company's established procedures for obtaining emergency care; and **(5)** any circumstances that precluded use of the health plan company's established procedures for obtaining emergency care.		X	X	X	X	X	X
479	**(b)** The health plan company may require enrollees to notify the health plan company of nonreferred emergency care as soon as possible, but not later than 48 hours, after the emergency care is initially provided. However, emergency care which would have been covered under the contract had notice been provided within the set time frame must be covered.		X	X	X	X	X	X
480	◊ **Subd. 2. Emergency medical condition.** For purposes of this section, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii), of section 1867(e)(1)(A) of the Social Security Act.		X	X	X	X	X	X

481	◊ **Subd. 3. Emergency services.** As used in this section, "emergency services" means, with respect to an emergency medical condition: (1) a medical screening examination, as required under section 1867 of the Social Security Act, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.		X	X	X	X	X	X
482	◊ **Subd. 4. Stabilize.** For purposes of this section, "stabilize," with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the Social Security Act, United States Code, title 42, section 1395dd(e)(3).		X	X	X	X	X	X
483	◊ **Subd. 5. Coverage restrictions or limitations.** If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network.		X	X	X	X	X	X
484	**62Q.56 CONTINUITY OF CARE.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
485	**(3)** the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers;	X	X	X	X	X	X	X
486	**62Q.57 DESIGNATION OF PRIMARY CARE PROVIDER.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
487	**Subdivision 1. Choice of primary care provider.** (a) If a health plan company offering a group health plan **, or an individual health plan that is not a grandfathered plan**, requires or provides for the designation by an enrollee of a participating primary care provider, the health plan company shall permit each enrollee to: (1) designate any participating primary care provider available to accept the enrollee; and (2) for a child, designate any participating physician who specializes in pediatrics as the child's primary care provider and is available to accept the child. (b) This section does not waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of pediatric care.	Look at bolded text	X	X	X	Look at bolded text	X	X
488	**Subd. 2. Notice.** A health plan company shall provide notice to enrollees of the provisions of subdivision 1 in accordance with the requirements of the Affordable Care Act.		X	X	X	X	X	X

	62Q.58 ACCESS TO SPECIALTY CARE	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
489								
490	**Subdivision 1.Standing referral**. A health plan company shall establish a procedure by which an enrollee may apply for and, if appropriate, receive a standing referral to a health care provider who is a specialist if a referral to a specialist is required for coverage. This procedure for a standing referral must specify the necessary managed care review and approval an enrollee must obtain before such a standing referral is permitted.	X	X	X	X	X	X	X
491	**Subd. 3.Disclosure**.Information regarding referral procedures must be included in member contracts or certificates of coverage and must be provided to an enrollee or prospective enrollee by a health plan company upon request.	X	X	X	X	X	X	X

	◊ 62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
492								
493	◊ No health plan company that covers durable medical equipment may utilize medical coverage criteria for durable medical equipment that limits coverage solely to equipment used in the home.	X	X	X	X	X	X	X

	◊ 62Q.67 DISCLOSURE OF COVERED DURABLE MEDICAL EQUIPMENT.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
494								
495	◊ **Subdivision 1.Disclosure.**A health plan company that covers durable medical equipment shall provide enrollees, and upon request prospective enrollees, written disclosure that includes the information set forth in subdivision 2. The health plan company may include the information in the member contract, certificate of coverage, schedule of payments, member handbook, or other written enrollee communication.	X	X	X	X	X	X	X
496	◊ **Subd. 2**.**Information to be disclosed.** A health plan company that covers durable medical equipment shall disclose the following information:							
497	**(a)** general descriptions of the coverage for durable medical equipment, level of coverage available, and criteria and procedures for any required prior authorizations; and							
498	**(b)** the address and telephone number of a health plan representative whom an enrollee may contact to obtain specific information verbally, or upon request in writing, about prior authorization including criteria used in making coverage decisions and information on limitations or exclusions for durable medical equipment.							

	◊ 62Q.675 HEARING AIDS; PERSONS 18 OR YOUNGER.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
499								
500	◊ A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.	X	X	X	X	X	X	X
501	**62Q.677 LIFETIME AND ANNUAL LIMITS.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
502	**Subdivision 1. Applicability and scope**. Except as provided in subdivision 2, this section applies to a health plan company providing coverage under an individual or group health plan. For purposes of this section, essential health benefits is defined under section 62Q.81.	X	X	X	X	X	X	X
503	**Subd. 2. Grandfathered plan limits.** (a) The prohibition on lifetime limits applies to grandfathered plans providing individual health plan coverage or group health plan coverage. **(b) The prohibition and limits on annual limits apply to grandfathered plans providing group health plan coverage, but do not apply to grandfathered plans providing individual health plan coverage.**	Look at bolded text	X	X	X	Look at bolded text	X	X
504	**Subd. 3. Prohibition on lifetime and annual limits.** (a) Except as provided in subdivisions 4 and 5, a health plan company offering coverage under an individual or group health plan shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual. (b) Except as provided in subdivisions 4, 5, and 6, a health plan company shall not establish any annual limit on the dollar amount of essential health benefits for any individual.	Look at Minn. Stat. 62Q.677, Subd. 2	X	X	X	Look at Minn. Stat. 62Q.677, Subd. 2	X	X
505	**Subd. 4. Nonessential benefits; out-of-network providers.** (a) Subdivision 3 does not prevent a health plan company from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits as defined in section 62Q.81, subdivision 4, to the extent that the limits are otherwise permitted under applicable federal or state law. 67.16(b) Subdivision 3 does not prevent a health plan company from placing an annual or 67.17lifetime limit for services provided by out-of-network providers.		X	X	X		X	X
506	**Subd. 5. Excluded benefits.** This section does not prohibit a health plan company from excluding all benefits for a given condition.		X	X	X		X	X
507	**Subd. 6. Annual limits prior to January 1, 2014.** For plan or policy years beginning before January 1, 2014, for any individual, a health plan company may establish an annual limit on the dollar amount of benefits that are essential health benefits provided the limit is no less than the following: (1) for a plan or policy year beginning after September 22, 2010, but before September 23, 2011, $750,000; (2) for a plan or policy year beginning after September 22, 2011, but before September 23, 2012, $1,250,000; and (3) for a plan or policy year beginning after September 22, 2012, but before January 1, 2014, $2,000,000. In determining whether an individual has received benefits that meet or exceed the allowable limits, a health plan company shall take into account only essential health benefits.		X	X	X		X	X

	Look at Minn. Stat. 62Q.677, Subd. 2				Look at Minn. Stat. 62Q.677, Subd. 2		
Subd. 7. Waivers. For plan or policy years beginning before January 1, 2014, a health plan is exempt from the annual limit requirements if the health plan is approved for a waiver from the requirements by the United States Department of Health and Human Services, but the exemption only applies for the specified period of time that the waiver from the United States Department of Health and Human Services is applicable.		X	X	X		X	X
Subd. 8. Notices. (a) At the time a health plan company receives a waiver from the United States Department of Health and Human Services, the health plan company shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside. (b) At the time the waiver expires or is otherwise no longer in effect, the health plan company shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.		X	X	X		X	X
Subd. 9. Reinstatement. A health plan company shall comply with all provisions of the Affordable Care Act with regard to reinstatement of coverage for individuals whose coverage or benefits under a health plan ended by reason of reaching a lifetime dollar limit on the dollar value of all benefits for the individual.		X	X	X		X	X
Subd. 10. Compliance. This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act. The commissioner shall enforce this section. EFFECTIVE DATE. This section is effective the day following final enactment.		X	X	X		X	X
◊ 62Q.69 COMPLAINT RESOLUTION.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
◊ Subd. 2.Procedures for filing a complaint.	X	X	X	X	X	X	X
(a) A complainant may submit a complaint to a health plan company either by telephone or in writing.	X	X	X	X	X	X	X
(c) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.	X	X	X	X	X	X	X
◊ Subd. 3. Notification of complaint decisions.	X	X	X	X	X	X	X
(a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint. If the health plan company cannot make a decision within 30 days due to circumstances outside the control of the health plan company, the health plan company may take up to 14 additional days to notify the complainant of its decision. If the health plan company takes any additional days beyond the initial 30-day period to make its decision, it must inform the complainant, in advance, of the extension and the reasons for the extension.	X	X	X	X	X	X	X
(b) For group health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.	X	X	X	X	X	X	X
(c) For individual health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to submit the complaint decision to the external review process described in section 62Q.73 and the procedure for initiating the external review process. Notwithstanding the provisions in this subdivision, a health plan company offering individual coverage may instead follow the process for group health plans outlined in paragraph (b).	X	X	X	X	X	X	X
(d) The notification must also inform the complainant of the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner.	X	X	X	X	X	X	X

	◊ 62Q.70 APPEAL OF THE COMPLAINT DECISION.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
521								
522	◊ **Subd. 3. Notification of appeal decisions.**	X	X	X	X	X	X	X
523	**(a)** If a complainant appeals in writing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal.	X	X	X	X	X	X	X
524	**(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.**	X	X	X	X	X	X	X
525	**(c)** Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.	X	X	X	X	X	X	X

	◊ 62Q.71 NOTICE TO ENROLLEES.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
526								
527	◊ Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees: **(1)** how to submit a complaint to the health plan company; **(2)** if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services; **(3)** how to request an appeal either through the procedures described in section 62Q.70, if applicable, or through the procedures described in chapter 62M; **(4)** of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process; **(5)** of the toll-free telephone number of the appropriate commissioner; and **(6)** of the right, for individual and group coverage, to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised, including that under most circumstances an enrollee must exhaust the internal complaint or appeal process prior to external review. However, an enrollee may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances: **(i)** the health plan company waives the exhaustion requirement; **(ii)** the health plan company is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or **(iii)** the enrollee has applied for an expedited external review at the same time the enrollee qualifies for and has applied for an expedited internal review under chapter 62M.	X	X	X	X	X	X	X

528	62Q.73 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
529	**Subdivision 1. Definition.** For purposes of this section, "adverse determination" means: **(1)** for individual health plans, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant; **(2) an individual health plan that is grandfathered plan coverage may instead apply the definition of adverse determination for group coverage in clause (3);** **(3)** for group health plans, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant; **(4)** any initial determination not to certify that has been appealed in accordance with section 62M.06 and the appeal did not reverse the initial determination not to certify; **(5)** a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary; or **(6)** the enrollee has met the requirements of subdivision 6, paragraph (e). An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.	Look at bolded text	X	X	X	Look at bolded text	X	X
530	**Subd. 2. Exception. (a)** This section does not apply to governmental programs except as permitted under paragraph (b). For purposes of this subdivision, "governmental programs" means the prepaid medical assistance program, the MinnesotaCare program, the prepaid general assistance medical care program, the demonstration project for people with disabilities, and the federal Medicare program. **(b)** In the course of a recipient's appeal of a medical determination to the commissioner of human services under section 256.045, the recipient may request an expert medical opinion be arranged by the external review entity under contract to provide independent external reviews under this section. If such a request is made, the cost of the review shall be paid by the commissioner of human services. Any medical opinion obtained under this paragraph shall only be used by a state human services referee as evidence in the recipient's appeal to the commissioner of human services under section 256.045. **(c)** Nothing in this subdivision shall be construed to limit or restrict the appeal rights provided in section 256.045 for governmental program recipients.	X	X	X	X	X	X	X
531	**Subd. 3. Right to external review.** (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1 , or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. The written request must be accompanied by a filing fee of $25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. No enrollee may be subject to filing fees totaling more than $75 during a plan year for group coverage or policy year for individual coverage. **(b)** Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review. **(c)** If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company. **(d)** The enrollee must request external review within six months from the date of the adverse determination.	X	X	X	X	X	X	X

532	**Subd. 6. Process. (a)** Upon receiving a request for an external review, the commissioner shall assign an external review entity on a random basis. The assigned external review entity must provide immediate notice of the review to the enrollee and to the health plan company. Within ten business days of receiving notice of the review, the health plan company and the enrollee must provide the assigned external review entity with any information that they wish to be considered. Each party shall be provided an opportunity to present its version of the facts and arguments. The assigned external review entity must furnish to the health plan company any additional information submitted by the enrollee within one business day of receipt. An enrollee may be assisted or represented by a person of the enrollee's choice. **(b)** As part of the external review process, any aspect of an external review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed. **(c)** An external review shall be made as soon as practical but in no case later than 45 days after receiving the request for an external review and must promptly send written notice of the decision and the reasons for it to the enrollee, the health plan company, and the commissioner who is responsible for regulating the health plan company.	X	X	X	X	X	X	X
533	**(d)** The external review entity and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with: **(1)** the health plan company that is the subject of the external review; **(2)** the enrollee, or any parties related to the enrollee, whose treatment is the subject of the external review; **(3)** any officer, director, or management employee of the health plan company; **(4)** a plan administrator, plan fiduciaries, or plan employees; **(5)** the health care provider, the health care provider's group, or practice association recommending treatment that is the subject of the external review; **(6)** the facility at which the recommended treatment would be provided; or **(7)** the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.							
534	**(e)(1)** An expedited external review must be provided if the enrollee requests it after receiving: **(i)** an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function and the enrollee has simultaneously requested an expedited internal appeal; **(ii)** an adverse determination that concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services but has not been discharged from a facility; or **(iii)** an adverse determination that involves a medical condition for which the standard external review time would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function. **(2)** The external review entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited review and notify the enrollee and the health plan company of the determination. **(3)** If the external review entity's notification is not in writing, the external review entity must provide written confirmation of the determination within 48 hours of the notification.	X	X	X	X	X	X	X
535	**Subd. 7. Standards of review.**	X	X	X	X	X	X	X
536	**(a)** For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan. **(b)** For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b. **(c)** For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2 . **(d)** For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including medical records, the attending physician or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.	X	X	X	X	X	X	X
537	**Subd. 8. Effects of external review.** A decision rendered under this section shall be nonbinding on the enrollee and binding on the health plan company. The health plan company may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.	X	X	X	X	X	X	X

	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
Subd. 9. Immunity from civil liability. A person who participates in an external review by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless misconduct.	X	X	X	X	X	X	X
Subd. 10. Data reporting. The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section, including the number of reviews heard and decided and the final outcomes. Any data released to the public must not individually identify the enrollee initiating the request for external review.	X	X	X	X	X	X	X
62Q.75 PROMPT PAYMENT REQUIRED	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
Subdivision 1. Definitions.	X	X	X	X	X	X	X
(a) For purposes of this section, the following terms have the meanings given to them. **(b)** "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, including, but not limited to, coordination of benefits information, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim under this section. A special circumstance includes, but is not limited to, a claim held pending payment of an overdue premium for the time period during which the expense was incurred as allowed by the Affordable Care Act. Nothing in this section alters an enrollee's obligation to disclose information as required by law. **(c)** "Third-party administrator" means a third-party administrator or other entity subject to section 60A.23, subdivision 8, and Minnesota Rules, chapter 2767.	X	X	X	X	X	X	X
Subd. 2.Claims payments. All health plan companies and third-party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third-party administrator received the claim.	X	X	X	X	X	X	X
◊ 62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS. **(Note:** *Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.)*	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
◊ Subdivision 1. Essential health benefits package.		X	X		X	X	X
(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.		X	X		X	X	X
(b) The essential health benefits package means coverage that: **(1)** provides essential health benefits as outlined in the Affordable Care Act; **(2)** limits cost-sharing for such 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.		X	X		X	X	X

549	◊ **Subd. 2. Coverage for enrollees under the age of 21.** 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), 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.		X	X		X	X	X
550	◊ **Subd. 3. Alternative compliance for catastrophic plans.** 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 section 1302(d) of the Affordable Care Act with respect to any policy year if the health plan company provides a catastrophic plan that meets the requirements of section 1302(e) of the Affordable Care Act.		X	X		X	X	X
551	◊ **Subd. 4. Essential health benefits; definition.** For purposes of this section, "essential health benefits" has the meaning given under section 1302(b) of the Affordable Care Act and includes:		X	X		X	X	X
552	**(1)** ambulatory patient services;		X	X		X	X	X
553	**(2)** emergency services;		X	X		X	X	X
554	**(3)** hospitalization;		X	X		X	X	X
555	**(4)** laboratory services;		X	X		X	X	X
556	**(5)** maternity and newborn care;		X	X		X	X	X
557	**(6)** mental health and substance abuse disorder services, including behavioral health treatment;		X	X		X	X	X
558	**(7)** pediatric services, including oral and vision care;		X	X		X	X	X
559	**(8)** prescription drugs;		X	X		X	X	X
560	**(9)** preventative and wellness services and chronic disease management;		X	X		X	X	X
561	**(10)** rehabilitative and habilitative services and devices; and		X	X		X	X	X
562	**(11)** additional essential health benefits included in the EHB-benchmark plan, as defined under the Affordable Care Act.		X	X		X	X	X
563	◊ **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.		X	X		X	X	X
564	(note: Minnesota's Benchmark Plan for Essential Health Benefits can be found on the National Association of Insurance Commissioners website at: http://www.naic.org/index_health_reform_section.htm)							

565	**62Q.82 BENEFITS AND COVERAGE EXPLANATION.**	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
566	**Subdivision 1. Summary.** Health plan companies offering health plans shall provide a summary of benefits and coverage explanation as required by the Affordable Care Act to: **(1)** an applicant at the time of application; **(2)** an enrollee prior to the time of enrollment or reenrollment, as applicable; and **(3)** a policyholder at the time of issuance of the policy.	X	X	X	X	X	X	X
567	**Subd. 2. Compliance.** A health plan company described in subdivision 1 shall be deemed to have complied with subdivision 1 if the summary of benefits and coverage explanation is provided in paper or electronic form as required under the Affordable Care Act.	X	X	X	X	X	X	X
568	**Subd. 3. Notice of modification.** Except in connection with a policy renewal or reissuance, if a health plan company makes any material modifications in any of the terms of the coverage, as defined for purposes of section 102 of the federal Employee Retirement Income Security Act of 1974, as amended, that is not reflected in the most recently provided summary of benefits and coverage explanation, the health plan company shall provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective.	X	X	X	X	X	X	X

	72A.139 USE OF GENETIC TESTS.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
569								
570	**Subd. 3.Prohibited acts; health plan companies**. A health plan company, in determining eligibility for coverage, establishing premiums, limiting coverage, renewing coverage, or any other underwriting decision, shall not, in connection with the offer, sale, or renewal of a health plan:	X	X	X	X	X	X	X
571	**(1)** require or request an individual or a blood relative of the individual to take a genetic test;.	X	X	X	X	X	X	X
572	**(2)** make any inquiry to determine whether an individual or a blood relative of the individual has taken or refused a genetic test, or what the results of any such test were;	X	X	X	X	X	X	X
573	**(3)** take into consideration the fact that a genetic test was taken or refused by an individual or blood relative of the individual; or	X	X	X	X	X	X	X
574	**(4)** take into consideration the results of a genetic test taken by an individual or a blood relative of the individual.	X	X	X	X	X	X	X
	72A.201 REGULATION OF CLAIMS PRACTICES.	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
575								
576	**Subd. 4a.Standards for preauthorization approval.** If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be processed in accordance with section 62M.07.	X	X	X	X	X	X	X
	72C.10 Readability	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
577								
578	**Minn. Stat. § 72C.10, subd. 2** The commissioner shall disapprove any contract or policy if the commissioner finds that:	X	X			X	X	X
579	**(a)** it is not accompanied by a certified Flesch scale analysis readability score of more than 40;	X	X			X	X	X
580	**(b)** it is not accompanied by the insurer's certification that the policy or contract is in its judgment readable under the standards of sections 72C.01 to 72C.13;	X	X			X	X	X

	Grandfathered	Non-Grandfathered	Small Group	Large Group	Individual	Applies to the Exchange	Applies outside the Exchange
(c) it does not comply with the readability standards established by section 72C.06;	X	X			X	X	X
(d) it does not comply with the legibility standards established by section 72C.07; or	X	X			X	X	X
(e) it does not comply with the format requirements established by section 72C.08.	X	X			X	X	X
◊ Patient Protection and Affordable Care Act (PPACA) - September 23, 2010	**Grandfathered**	**Non-Grandfathered**	**Small Group**	**Large Group**	**Individual**	**Applies to the Exchange**	**Applies outside the Exchange**
◊ **(2)** Coverage cannot be rescinded except for fraud or intentional misrepresentation of a material fact. ***(Section 2712 of PHSA/Section 1001 of the PPACA)***		X	X	X	X	X	X
Patient Protection and Affordable Care Act (PPACA) - August 1, 2012	**Grandfathered**	**Non-Grandfathered**	**Small Group**	**Large Group**	**Individual**	**Applies to the Exchange**	**Applies outside the Exchange**
◊ **(1) Women's preventive services.** Since the list of covered preventive services is lengthy and may change over time, a partial list may be included with a statement that complete, up-to-date list can be obtained at a location on the health plan's website and a Customer Service number included that can be used for obtaining additional information.		X	X		X	X	X
◊ **(2) Contraceptive coverage.** Language must be included stating that all FDA approved contraceptive methods prescribed by a physician are covered. The PPACA requirement is not limited to oral contraceptives. Also, if a physician determines that the available contraceptives in a particular plan are not "safe and effective" for an individual patient, a "safe and effective" alternative must be made available to that patient with no cost-sharing.		X	X		X	X	X

Levels of Coverage per PPACA
BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.
SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.
GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.
PLATINUM LEVEL.— A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

Helpful Resources and Links
Federal Employees Dental and Vision Insurance Program (FEDVIP):
http://archive.opm.gov/insure/health/planinfo/2012/brochures/MetLife.pdf
Federal Blue Vision:
http://archive.opm.gov/insure/health/planinfo/2012/brochures/FEPBlueVi.pdf
HealthCare.gov (Affordable Care Act, Section by Section)
http://www.healthcare.gov/law/full/
CMS.gov (Regulations, timelines and guidance on health market reforms):
http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html
Patient Protection and Affordable Care Act (PPACA):
https://www.healthcare.gov/where-can-i-read-the-affordable-care-act/
Minnesota's Benchmark Plan (HealthPartners)
http://www.naic.org/index_health_reform_section.htm
The Final Rule: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value and Accreditation:
http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf
The Federal Guide for reviewing EHB benchmark materials:
http://cciio.cms.gov/resources/data/ehb.html#review benchmarks