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## **Checklist Guide: Minnesota Student Health Insurance**

The following information has been compiled as a Checklist Guide for Minnesota Department of Commerce (DOC) policy analysts to use in reviewing Student Health Insurance product filings submitted to the Department for approval in Minnesota. The Checklist Guide is designed as an internal DOC resource to outline certain state or federal laws that could apply to provisions typically found in student health certificates or policy forms. It may be periodically updated to reflect statutory changes. Additional state or federal law requirements may exist to the extent they apply to provisions not typically found in policy forms or certificates. Compliance with these additional requirements, if applicable to the product filing, would still be required even though they are not listed in this Checklist Guide.

NOTE: While the Department is making this Checklist Guide publicly available, companies or health plans should refer to all relevant Minnesota Statutes and Rules and applicable Federal laws in developing the product filings that they submit to the DOC for approval. To the extent the provisions in this Checklist Guide conflict with state or Federal law, companies making filings should comply with the language of the state or Federal law.

References to the Affordable Care Act (ACA) in this guidance document are intended to include the Federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendment to, or regulations or guidance issued under these acts.

This document focuses on the requirements for student health insurance product filings for plans with an effective date beginning or after April 15, 2016.

## Helpful Information

**Student health insurance** Under §147.145, student health insurance coverage is a type of individual health insurance coverage that, subject to certain limited exceptions, must comply with the PHS Act requirements that apply to individual health insurance coverage.

**The Public Health Service Act, Section 2791(b)(4)**, defines individual coverage as coverage other than group coverage. Since Student Health Plans are not employment based, they are not group, and therefore individual.

**Blanket accident and sickness insurance** is hereby declared to be that form of accident and sickness insurance covering special groups (62A.11 BLANKET ACCIDENT AND SICKNESS INSURANCE). Per Minnesota law, the definition of a "**Health plan**" does not include coverage that is: (7) blanket accident and sickness insurance as defined in section 62A.11; (62A.011 DEFINITIONS.)

"**Health carrier**" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H. (62A.011 DEFINITIONS.)

## Minnesota Specific Requirements

### 60A.06 Kinds of insurance permitted

#### Subd. 3. Limitation on combination policies.

(a) Unless specifically authorized by subdivision 1, clause (4), it is unlawful to combine in one policy coverage permitted by subdivision 1, clauses (4) and (5)(a). This subdivision does not prohibit the simultaneous sale of these products, but the sale must involve two separate and distinct policies.

(b) This subdivision does not apply to group policies.

(c) This subdivision does not apply to policies permitted by subdivision 1, clause (4), that contain benefits providing acceleration of life, endowment, or annuity benefits in advance of the time they would otherwise be payable, or to long-term care policies as defined in section 62A.46, subdivision 2, or chapter 62S.

**60A.08 Contracts of insurance.**

**Subd. 5. Signatures required.**

All insurance policies shall be signed by the secretary or an assistant secretary, and by the president or vice-president, or in their absence, by two directors of the insurer. The signatures may be facsimile signatures.

**62A.011 Definitions.**

**Subd. 1a. Affordable Care Act.**

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, and any federal guidance or regulations issued under, these acts.

**Subd. 1b. Grandfathered plan.**

"Grandfathered plan" means a health plan in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with the Affordable Care Act. Unless otherwise specified, grandfathered plans include both individual and group health plans.

**Subd. 1c. Group health plan.**

"Group health plan" means a policy or certificate issued to an employer or an employee organization that is both:

(1) a health plan as defined in subdivision 3; and

(2) an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, United States Code, title 29, section 1002, if the plan provides payment for medical care to employees, including both current and former employees, or their dependents, directly or through insurance, reimbursement, or otherwise, including employee welfare benefit plans specifically exempt from the provisions of the Employee Retirement Income Security Act of 1974 under United States Code, title 29, section 1003.

**Subd. 2. Health carrier.**

"Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section [62A.01](#); a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

**Subd. 3. Health plan.**

"Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

- (1) limited to disability or income protection coverage;
- (2) automobile medical payment coverage;
- (3) liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance;
- (4) designed solely to provide payments on a per diem, fixed indemnity, or non-expense-incurred basis, including coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance, if the benefits are provided under a separate policy, certificate, or contract for insurance; there is no coordination between the provision of benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor;
- (5) credit accident and health insurance as defined in section 62B.02;
- (6) designed solely to provide hearing, dental, or vision care;
- (7) blanket accident and sickness insurance as defined in section 62A.11;
- (8) accident-only coverage;
- (9) a long-term care policy as defined in section 62A.46 or 62S.01;
- (10) issued as a supplement to Medicare, as defined in sections 62A.3099 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1876, section 1851, et seq.; or section 1860D-1, et seq., of title XVIII of the federal Social Security Act, et seq., as amended;
- (11) workers' compensation insurance;
- (12) issued solely as a companion to a health maintenance contract as described in section 62D.12, subdivision 1a, so long as the health maintenance contract meets the definition of a health plan;
- (13) coverage for on-site medical clinics; or
- (14) coverage supplemental to the coverage provided under United States Code, title 10, chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

**Subd. 4. Individual health plan.**

"Individual health plan" means a health plan as defined in subdivision 3 that is offered to individuals in the individual market as defined in subdivision 5, but does not mean short-term coverage as defined in section 62A.65, subdivision 7. For purposes of this chapter, a health carrier shall not be deemed to be offering individual health plan coverage solely because the carrier maintains a conversion policy in connection with a group health plan.

**Subd. 5. Individual market.**

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

**Subd. 6. MNsure.**

"MNsure" means MNsure as defined in section 62V.02.

**Subd. 7. Qualified health plan.**

"Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act and has been certified by the board of MNsure in accordance with chapter 62V to be offered through MNsure.

**62A.02 Policy forms.**

**Subdivision 1. Filing.**

For purposes of this section, "health plan" means a health plan as defined in section 62A.011 or a policy of accident and sickness insurance as defined in section 62A.01. No health plan shall be issued or delivered to any person in this state, nor shall any application, rider, or endorsement be used in connection with the health plan, until a copy of its form and of the classification of risks and the premium rates pertaining to the form have been filed with the commissioner. The filing for nongroup health plan forms shall include a statement of actuarial reasons and data to support the rate. For health benefit plans as defined in section 62L.02, and for health plans to be issued to individuals, the health carrier shall file with the commissioner the information required in section 62L.08, subdivision 8. For group health plans for which approval is sought for sales only outside of the small employer market as defined in section 62L.02, this section applies only to policies or contracts of accident and sickness insurance. All forms intended for issuance in the individual or small employer market must be accompanied by a statement as to the expected loss ratio for the form. Premium rates and forms relating to specific insureds or proposed insureds, whether individuals or groups, need not be filed, unless requested by the commissioner.

**Subd. 2. Approval.**

(a) The health plan form shall not be issued, nor shall any application, rider, endorsement, or rate

be used in connection with it, until the expiration of 60 days after it has been filed unless the commissioner approves it before that time.

(b) Notwithstanding paragraph (a), a rate filed with respect to a policy of accident and sickness insurance as defined in section 62A.01 by an insurer licensed under chapter 60A, may be used on or after the date of filing with the commissioner. Rates that are not approved or disapproved within the 60-day time period are deemed approved. This paragraph does not apply to Medicare-related coverage as defined in section 62A.3099, subdivision 17.

(c) For coverage to begin on or after January 1, 2016, and each January 1 thereafter, health plans in the individual and small group markets that are not grandfathered plans to be offered outside MNsure and qualified health plans to be offered inside MNsure must receive rate approval from the commissioner no later than 30 days prior to the beginning of the annual open enrollment period for MNsure. Premium rates for all carriers in the applicable market for the next calendar year must be made available to the public by the commissioner only after all rates for the applicable market are final and approved. Final and approved rates must be publicly released at a uniform time for all individual and small group health plans that are not grandfathered plans to be offered outside MNsure and qualified health plans to be offered inside MNsure, and no later than 30 days prior to the beginning of the annual open enrollment period for MNsure.

**Subd. 3. Standards for disapproval.**

(a) The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

- (1) if the benefits provided are not reasonable in relation to the premium charged;
- (2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;
- (3) if the proposed premium rate is excessive or not adequate; or
- (4) the actuarial reasons and data submitted do not justify the rate.

**62A.03 General provisions of policy.**

**Subdivision 1. Conditions.**

No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:

- (1) **Premium.** The entire money and other considerations therefor are expressed therein.
- (2) **Time effective.** The time at which the insurance takes effect and terminates is expressed therein.
- (3) **One person.** It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:

- (a) husband,
- (b) wife,
- (c) dependent children as described in sections 62A.302 and 62A.3021, or
- (d) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lowercase unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) **Description of policy.** The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) **Exceptions in policy.** The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) **Form number.** Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) **No incorporation by reference.** It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

(9) **Medical benefits.** If the policy contains a provision for medical expense benefits, the term "medical benefits" or similar terms as used therein includes treatments by all licensed practitioners of the healing arts unless, subject to the qualifications contained in clause (10), the policy specifically states the practitioners whose services are covered.

(10) **Osteopath, optometrist, chiropractor, or registered nurse services.** With respect to any policy of individual accident and sickness insurance issued or entered into subsequent to August 1, 1974, notwithstanding the provisions of the policy, if it contains a provision providing for reimbursement for any service which is in the lawful scope of practice of a duly licensed osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision 3a, the person entitled to benefits or person performing services under the policy is entitled to reimbursement on an equal basis for the service, whether the service is performed by a physician, osteopath, optometrist, chiropractor, or registered nurse meeting the requirements of section 62A.15, subdivision

3a, licensed under the laws of this state.

#### 62A.04 Standard provisions.

##### Subd. 2. Required provisions.

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

(1) A provision as follows:

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

(2) A provision as follows:

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

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

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

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

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



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

A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

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

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

(b) For qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a grace period provision must be included that complies with the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act.

(4) A provision as follows:

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

- (1) the insured has in the interim left the state or the insurer's service area; or
- (2) the insured has applied for reinstatement on two or more prior occasions.

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

(5) A provision as follows:

**NOTICE OF CLAIM:** Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

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

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

(6) A provision as follows:

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

(7) A provision as follows:

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

(8) A provision as follows:

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

(9) A provision as follows:

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

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

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

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

(10) A provision as follows:

**PHYSICAL EXAMINATIONS AND AUTOPSY:** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows:

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

(12) A provision as follows:

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

### **Subd. 3. Optional provisions.**

Except as provided in subdivision 4, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in

the words in which the same appear in this section. The insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

#### 62A.041 Maternity benefits.

##### Subdivision 1. **Discrimination prohibited against unmarried women.**

Each group policy of accident and health insurance and each group health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy and each group contract shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy and each individual contract shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

##### Subd. 3. **Abortion.**

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

#### 62A.0411 Maternity care.

Every health plan as defined in section [62Q.01, subdivision 3](#), that provides maternity benefits must, consistent with other coinsurance, co-payment, deductible, and related contract terms, provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section.

The health plan must also provide coverage for postdelivery care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section.

Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child.

**62A.042 Family coverage; coverage of newborn infants.**

**Subdivision 1. Individual family policies.**

(a) No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered members of the family any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

(b) The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

**62A.043 Dental and podiatric coverage.**

**Subdivision 1. Policies and contracts covered.**

The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

**Subd. 2.Services covered.**

Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

**Subd. 3.Disorders covered.**

Except for policies which only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D, shall be issued, renewed, continued, delivered, issued for delivery, or executed in this state after August 1, 1987, unless the policy, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

**62A.044 Payments to governmental institutions.**

No group or individual policy of accident and sickness insurance issued or renewed after May 22, 1973, pursuant to this chapter, no group or individual service plan or subscriber contract issued or renewed after May 22, 1973, pursuant to chapter 62C, and no group or individual health maintenance contract issued or renewed after August 1, 1984, pursuant to chapter 62D, shall contain any provision excluding, denying, or prohibiting payments for covered and authorized services rendered or paid by a hospital or medical institution owned or operated by the federal, state, or local government, including correctional facilities, or practitioners therein in any instance wherein charges for such services are imposed against the policyholder, subscriber, or enrollee. The unit of government operating the institution may maintain an action for recovery of such charges.

**62A.045 Payments on behalf of enrollees in government health programs.**

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256; 256B; or 256D or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

**62A.047 Children's health supervision services and prenatal care services.**

A policy of individual or group health and accident insurance regulated under this chapter, or individual

or group subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or health benefit certificate regulated under chapter 64B, issued, renewed, or continued to provide coverage to a Minnesota resident, must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement. This section does not prohibit the use of policy waiting periods for these services. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section subject to the schedule set forth in this section. Nothing in this section applies to a commercial health insurance policy issued as a companion to a health maintenance organization contract, a policy designed primarily to provide coverage payable on a per diem, fixed indemnity, or nonexpense incurred basis, or a policy that provides only accident coverage. A policy, contract, or certificate described under this section may not apply to preexisting condition limitations to individuals under 19 years of age. This section does not apply to individual coverage under a grandfathered plan.

"Child health supervision services" means pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Reimbursement must be made for at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, once a year from 24 months to 72 months.

"Prenatal care services" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

#### 62A.048 Dependent coverage.

(a) A health plan that covers a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the participant to be covered on the same basis as if they reside with the participant. Every health plan must provide coverage in accordance with section [518A.41](#) to dependents covered by a qualified court or administrative order meeting the requirements of section [518A.41](#), and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the health carrier's service area.

#### 62A.049 Limitation on preauthorizations; emergencies.

No policy of accident and sickness insurance or group subscriber contract regulated under chapter 62C issued or renewed in this state may contain a provision that makes an insured person ineligible to receive full benefits because of the insured's failure to obtain preauthorization, if that failure occurs because of the need for emergency confinement or emergency treatment. The insured or an authorized

representative of the insured shall notify the insurer as soon after the beginning of emergency confinement or emergency treatment as reasonably possible. However, to the extent that the insurer suffers actual prejudice caused by the failure to obtain preauthorization, the insured may be denied all or part of the insured's benefits.

#### 62A.081 Payments to facilities operated by state or local government.

Every group or individual policy of accident and sickness insurance issued or renewed after July 1, 1973 regulated by this chapter, and every group or individual service plan or subscriber contract issued or renewed after July 1, 1973 regulated by chapter 62C, providing care or payment for care in this state, shall provide payments for services rendered by a hospital or medical facility owned or operated by, or on behalf of, the state or any unit of local government, or practitioners therein, on the same basis as are made for like care in other facilities. The unit of government concerned may maintain an action for recovery of such payments.

#### 62A.095 Subrogation clauses regulated.

##### Subdivision 1. **Applicability.**

(a) A health plan may not be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.

(b) Health plans providing benefits under health care programs administered by the commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; 256D.03, subdivision 8; or 256L.03, subdivision 6.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10).

##### Subd. 2. **Subrogation clause; limits.**

No health plan described in subdivision 1 shall contain a subrogation, reimbursement, or similar clause that provides subrogation, reimbursement, or similar rights to the health carrier issuing the health plan, unless:

(1) the clause provides that it applies only after the covered person has received a full recovery from another source; and

(2) the clause provides that the health carrier's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the health carrier is separately represented by an attorney.

If the health carrier is separately represented by an attorney, the health carrier and the covered person, by their attorneys, may enter into an agreement regarding allocation of the covered person's costs, disbursements, and reasonable attorney fees and other expenses. If the health carrier and



covered person cannot reach agreement on allocation, the health carrier and covered person shall submit the matter to binding arbitration.

Nothing in this section shall limit a health carrier's right to recovery from another source which may otherwise exist at law.

For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a covered person.

**Subd. 3. Retroactive amendments regulated.**

No addition of, or amendment of, a subrogation, reimbursement, or similar clause in a health plan shall be applied to the disadvantage of a covered person with respect to benefits provided by the health carrier in connection with an injury, illness, condition, or other covered situation that originated prior to the addition of or amendment to the clause.

**62A.096 Notice to insurer of subrogation claim required.**

A person covered by a health carrier who makes a claim against a collateral source for damages that include repayment for medical and medically related expenses incurred for the covered person's benefit shall provide timely notice, in writing, to the health carrier of the pending or potential claim. Notwithstanding any other law to the contrary, the statute of limitations applicable to the rights with respect to reimbursement or subrogation by the health carrier against the covered person does not commence to run until the notice has been given.

**62A.105 Coverages; transfers to substantially similar products.**

**Subd. 2. Requirement.**

If an issuer of policies or plans referred to in subdivision 1 ceases to offer a particular policy or subscriber contract to the general public or otherwise stops adding new insureds to the group of covered persons, the issuer shall allow any covered person to transfer to another substantially similar policy or contract currently being sold by the issuer. The issuer shall permit the transfer without any preexisting condition limitation, waiting period, or other restriction of any type other than those which applied to the insured under the prior policy or contract. This section does not apply to persons who were covered under an individual policy or contract prior to July 1, 1994.

**62A.14 Disabled children.**

**Subdivision 1. Individual family policies.**

An individual hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or an individual health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to

terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or health maintenance organization by the policyholder or enrollee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age must include all the information in this section.

**62A.146 Continuation of benefits to survivors.**

No policy, contract, or plan of accident and health protection issued by an insurer, nonprofit health service plan corporation, or health maintenance organization, providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis which in addition to coverage of the insured, subscriber, or enrollee, also provides coverage to dependents, shall, except upon the written consent of the survivor or survivors of the deceased insured, subscriber, or enrollee, terminate, suspend, or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy, contract, or plan to the survivor or survivors until the earlier of the following dates:

- (a) the date the surviving spouse becomes covered under another group health plan; or
- (b) the date coverage would have terminated under the policy, contract, or plan had the insured, subscriber, or enrollee lived.

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the insured, subscriber, or enrollee 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 or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy, contract, or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.

**62A.151 Health insurance benefits for emotionally disabled children.**

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under

this chapter, or nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D which provides coverage of or reimbursement for inpatient hospital and medical expenses shall be delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the commissioner of commerce, after July 1, 1975 unless the policy or plan includes and provides health service benefits to any subscriber or other person covered thereunder, on the same basis as other benefits, for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human services. For purposes of this section "emotionally disabled child" shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities. The restrictions and requirements of this section shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and family members as a nongroup policy. The mandatory coverage under this section shall be on the same basis as inpatient hospital medical coverage provided under the policy or plan.

#### **62A.153 Outpatient medical and surgical services.**

No policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C that provides coverage for services in a hospital shall be issued, renewed, continued, delivered, issued for delivery or executed in this state, or approved for issuance or renewal in this state by the commissioner of commerce unless the policy, plan or contract specifically provides coverage for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a hospital.

#### **62A.154 Benefits for des related conditions.**

##### **Subd. 2.Required coverage.**

No policy shall be issued or renewed in this state after August 1, 1981 if it provides an exclusion, reduction, or other limitation as to coverage, deductible, coinsurance or co-payment applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol, unless the covered person has been diagnosed as having diethylstilbestrol-related cancer prior to the date on which coverage for that person begins. In the absence of credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium. If there is credible evidence of a higher morbidity rate due to exposure to diethylstilbestrol, no insurer shall surcharge or in any other manner increase the premium without the prior approval of the commissioner.

#### **62A.155 Coverage for services provided to ventilator-dependent persons.**

##### **Subd. 2.Required coverage.**

If a policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1988, provides coverage for services provided by a home care nurse or personal care assistant to a

ventilator-dependent person in the person's home, it must provide coverage for up to 120 hours of services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

**62A.18 Prohibition against disability offsets.**

No individual or group policy of accident and health insurance issued, amended, renewed, or delivered in this state on or after January 1, 1976 shall contain any provision offsetting, or in any other manner reducing, any benefit under the policy by the amount of, or in proportion to, any increase in disability benefits received or receivable under the federal Social Security Act, the Railroad Retirement Act, any Veteran's Disability Compensation and Survivor Benefits Act, Workers' Compensation, or any similar federal or state law, as amended subsequent to the date of commencement of such benefit.

**62A.19 Prohibition against nondiagnostic x-rays.**

No individual or group policy of dental insurance offered for sale to a Minnesota resident by an insurer regulated under this chapter, individual or group service plan or subscriber contract regulated under chapter 62C, health maintenance contract regulated under chapter 62D, or fraternal contract benefit regulated under chapter 64B, shall subject any policyholder, subscriber, or enrollee to undue exposure to radiation by requiring a health care provider to take or obtain x-rays that are not directly related to patient care.

Any health care provider receiving such a request may refuse to provide x-rays not necessary to the diagnosis and treatment of the patient. An insurer, nonprofit health service plan corporation, health maintenance organization, fraternal benefit society, or dental plan may not deny or withhold benefits based solely upon the refusal to provide x-rays. Nothing in this section prohibits requests for x-rays or other diagnostic aids routinely taken in conjunction with the diagnosis and treatment of injury or disease, or routinely required by the insurer for preapproval or predetermination of treatment. An insurer may not retroactively request new x-rays not taken in conjunction with the diagnosis or treatment of injury or disease.

**62A.20 Continuation coverage of current spouse and children.**

**Subdivision 1. Requirement.**

Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense-incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain:

- (1) a provision which allows the spouse and dependent children to elect to continue coverage when

the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and

(2) a provision which allows the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Upon request by the insured or the insured's spouse or dependent child, a health carrier must provide the instructions necessary to enable the spouse or child to elect continuation of coverage.

**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 policy;
- (2) 36 months after continuation by the spouse or dependent was elected; or
- (3) the spouse or dependent children become covered under another group health plan.

If 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. 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 spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

**62A.21 Continuation and conversion privileges for insured former spouses and children.**

**Subdivision 1. Break in marital relationship, termination of coverage prohibited.**

No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship.

**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 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, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

**62A.22 Refusal to provide coverage because of option under workers' compensation.**

No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.041, subdivision 1a.

**62A.25 Reconstructive surgery.**

**Subd. 2. Required coverage.**

(a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery following mastectomies. In these cases, coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.

(c) Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

**62A.26 Coverage for phenylketonuria treatment.**

**Subd. 2. Required coverage.**

Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1985, must provide coverage for special dietary treatment for phenylketonuria when recommended by a physician.

**62A.265 Coverage for Lyme disease.**

**Subdivision 1. Required coverage.**

Every health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must cover treatment for diagnosed Lyme disease.

**Subd. 2. Special restrictions prohibited.**

No health plan included in subdivision 1 may impose a special deductible, co-payment, waiting period, or other special restriction on treatment for Lyme disease that the health plan does not apply to nonpreventive treatment in general.

**62A.27 Coverage of adopted children.**

(a) A health plan that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, participant, or enrollee on the same basis as other dependents. Consequently, the plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning children placed for adoption with the participant.

(b) The coverage required by this section is effective from the date of placement for adoption. For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation for total or partial support.

(c) For the purpose of this section, health plan includes:

(1) coverage offered by community integrated service networks;

(2) coverage that is designed solely to provide dental or vision care; and

(3) any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

(d) No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier is entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold



payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

#### 62A.28 Coverage for scalp hair prostheses.

##### Subd. 2. Required coverage.

Every policy, plan, certificate, or contract referred to in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata.

The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

#### 62A.285 Prohibited underwriting; breast implants.

##### Subd. 2. Required coverage.

No policy, plan, certificate, or contract referred to in subdivision 1 shall be issued or renewed to provide coverage to a Minnesota resident if it provides an exclusion, reduction, or other limitation as to coverage, deductible, coinsurance, or co-payment applicable solely to conditions caused by breast implants.

##### Subd. 3. Refusal to issue or renew.

No issuer of a policy, plan, certificate, or contract referred to in subdivision 1 shall refuse to issue or renew at standard premium rates a policy, plan, certificate, or contract referred to in subdivision 1 solely because the prospective insured or enrollee has breast implants.

#### 62A.30 Coverage for diagnostic procedures for cancer.

##### Subd. 2. Required coverage.

Every policy, plan, certificate, or contract referred to in subdivision 1 that provides coverage to a Minnesota resident must provide coverage for routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer as defined in subdivision 3, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine.

##### Subd. 3. Ovarian cancer surveillance tests.

For purposes of subdivision 2:

(a) "At risk for ovarian cancer" means:

(1) having a family history:

(i) with one or more first- or second-degree relatives with ovarian cancer;



(ii) of clusters of women relatives with breast cancer; or

(iii) of nonpolyposis colorectal cancer; or

(2) testing positive for BRCA1 or BRCA2 mutations.

(b) "Surveillance tests for ovarian cancer" means annual screening using:

(1) CA-125 serum tumor marker testing;

(2) transvaginal ultrasound;

(3) pelvic examination; or

(4) other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

## 62A.302 Coverage of dependents.

### Subd. 2. Required coverage.

Every health plan included in subdivision 1 that provides dependent coverage must define "dependent" no more restrictively than the definition provided in section [62L.02, subdivision 11](#).

### Subd. 3. No additional restrictions permitted.

Any health plan included in subdivision 1 that provides dependent coverage of children shall make that coverage available to children until the child attains 26 years of age. A health carrier must not place restrictions on this coverage and must comply with the following requirements:

(1) with respect to a child who has not attained 26 years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the enrollee or spouse of the enrollee;

(2) a health carrier must not deny or restrict coverage for a child who has not attained 26 years of age based on (i) the presence or absence of the child's financial dependency upon the participant, primary subscriber, or any other person; (ii) residency with the participant and in the individual market the primary subscriber, or with any other person; (iii) marital status; (iv) student status; (v) employment; or (vi) any combination of those factors; and

(3) a health carrier must not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in subdivision 5.

### Subd. 4. Grandchildren.

Nothing in this section requires a health carrier to make coverage available for a grandchild, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild or unless the grandchild meets the requirements of section [62A.042](#). For grandchildren included under a grandparent's policy pursuant to section [62A.042](#), coverage for the grandchild may terminate if the grandchild does not continue to reside with the covered grandparent continuously from birth, if the

grandchild does not remain financially dependent upon the covered grandparent, or when the grandchild reaches age 25, except as provided in section [62A.14](#) or if coverage is continued under section [62A.20](#).

**Subd. 5. Terms of coverage of dependents.**

The terms of coverage in a health plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are 26 years of age or older.

**Subd. 6. Opportunity to enroll.**

A health carrier must comply with all provisions of the Affordable Care Act in regards to providing an opportunity to enroll in coverage to any child whose coverage ended, or was not eligible for coverage under a group health plan or individual health plan because, under the terms of the coverage, the availability of dependent coverage of a child ended before age 26.

**62A.304 Coverage for port-wine stain elimination.**

**Subd. 2. Required coverage.**

Every health plan included in subdivision 1 must cover elimination or maximum feasible treatment of port-wine stains for any covered person who is a Minnesota resident. No health carrier may reduce or eliminate coverage due to this requirement.

**62A.305 Fibrocystic condition; termination or reduction of coverage.**

No health plan shall be terminated, canceled, nonrenewed, or contain any increased premium rate, or exclusion, reduction, or limitation on benefits, nor shall coverage be denied, solely because the covered person has been diagnosed as having a fibrocystic breast condition.

**62A.307 Prescription drugs; equal treatment of prescribers.**

**Subd. 2. Requirement.**

Coverage described in subdivision 1 that covers prescription drugs must provide the same coverage for a prescription written by a health care provider authorized to prescribe the particular drug covered by the health coverage described in subdivision 1, regardless of the type of health care provider that wrote the prescription. This section is intended to prohibit denial of coverage based on the prescription having been written by an advanced practice nurse under section [148.235](#), a physician assistant under section [147A.18](#), or any other nonphysician health care provider authorized to prescribe the particular drug.

**62A.3075 Cancer chemotherapy treatment coverage.**

a) A health plan company that provides coverage under a health plan for cancer chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance amount for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells than

what the health plan requires for an intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health plan company.

(b) A health plan company must not achieve compliance with this section by imposing an increase in co-payment, deductible, or coinsurance amount for an intravenously administered or injected cancer chemotherapy agent covered under the health plan.

(c) Nothing in this section shall be interpreted to prohibit a health plan company from requiring prior authorization or imposing other appropriate utilization controls in approving coverage for any chemotherapy.

(d) A plan offered by the commissioner of management and budget under section 43A.23 is deemed to be at parity and in compliance with this section.

(e) A health plan company is in compliance with this section if it does not include orally administered anticancer medication in the fourth tier of its pharmacy benefit.

#### **62A.308 Hospitalization and anesthesia for dental procedures.**

##### **Subd. 2. Required coverages.**

(a) A health plan included in subdivision 1 must cover anesthesia and hospital charges for dental care provided to a covered person who: (1) is a child under age five; or (2) is severely disabled; or (3) has a medical condition and who requires hospitalization or general anesthesia for dental care treatment. A health carrier may require prior authorization of hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(b) A health plan included in subdivision 1 must also provide coverage for general anesthesia and treatment rendered by a dentist for a medical condition covered by the health plan, regardless of whether the services are provided in a hospital or a dental office.

#### **62A.3091 Nondiscriminate coverage of tests.**

##### **Subd. 2. Requirement.**

Coverage described in subdivision 1 that covers laboratory tests, diagnostic tests, and x-rays must provide the same coverage, without requiring additional signatures, for all such tests ordered by an advanced practice nurse operating pursuant to chapter 148. Nothing in this section shall be construed to interfere with any written agreement between a physician and an advanced practice nurse.

#### **62A.3092 Equal treatment of surgical first assisting services.**

##### **Subd. 2. Requirement.**

Coverage described in subdivision 1 that provides for payment for surgical first assisting benefits or services shall be construed as providing for payment for a registered nurse who performs first assistant

functions and services that are within the scope of practice of a registered nurse.

#### 62A.3093 Coverage for diabetes.

##### Subdivision 1. Required coverage.

A health plan, including a plan providing the coverage specified in section 62A.011, subdivision 3, clause (10), must provide coverage for: (1) all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include persons with gestational, type I or type II diabetes. Coverage required under this section is subject to the same deductible or coinsurance provisions applicable to the plan's hospital, medical expense, medical equipment, or prescription drug benefits. A health carrier may not reduce or eliminate coverage due to this requirement.

#### 62A.60 Retroactive denial of expenses.

In cases where the subscriber or insured is liable for costs beyond applicable co-payments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, and the preexisting condition limitation provision, the general exclusion provision and any other coinsurance, or other policy requirements have been met, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

#### 62A.61 Disclosure of methods used by health carriers to determine usual and customary fees.

In cases where the subscriber or insured is liable for costs beyond applicable co-payments or deductibles, no insurer may retroactively deny payment to a person who is covered when the services are provided for health care services that are otherwise covered, if the insurer or its representative failed to provide prior or concurrent review or authorization for the expenses when required to do so under the policy, plan, or certificate. If prior or concurrent review or authorization was provided by the insurer or its representative, and the preexisting condition limitation provision, the general exclusion provision and any other coinsurance, or other policy requirements have been met, the insurer may not deny payment for the authorized service or time period except in cases where fraud or substantive misrepresentation occurred.

**62A.65 Individual market regulation.**

**Subd. 3a. Disclosure.**

(a) In connection with the offering for sale of a health plan in the individual market, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) the provisions of the coverage concerning the health carrier's right to change premium rates and the factors that may affect changes in premium rates; and

(2) a listing of and descriptive information, including benefits and premiums, about all individual health plans actively marketed by the health carrier and the availability of the individual health plans for which the individual is qualified.

(b) Paragraph (a), clause (2), may be satisfied by referring individuals to the Health and Human Services Web portal, as defined under the Affordable Care Act.

**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.

**Subd. 6. Guaranteed issue required.**

(a) Nothing in this section requires a health carrier to initially issue a health plan to a Minnesota resident who is age 19 or older on the date the health plan becomes effective if the effective date is prior to January 1, 2014, except as otherwise expressly provided in subdivision 4 or 5.

(b) Guaranteed issue is required for all health plans, except grandfathered plans, beginning January 1, 2014.

**62A.672 Coverage of telemedicine services.**

**Subdivision 1. Coverage of telemedicine.**

(a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

**Subd. 2. Parity between telemedicine and in-person services.**

A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

**Subd. 3. Reimbursement for telemedicine services.**

(a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

**61B.28 Miscellaneous provisions.**

**Subd. 7. Notice concerning limitations and exclusions.**

(a) No person, including an insurer, agent, or affiliate of an insurer or agent, shall offer for sale in this state a covered life insurance, annuity, or health insurance policy or contract without delivering, either at the time of application for that policy or contract or at the time of delivery of the policy or contract, a notice in the form specified in subdivision 8, or in a form approved by the commissioner under paragraph (b), relating to coverage provided by the Minnesota Life and Health Insurance Guaranty Association. The notice may be part of the application. A copy of the notice must be given to the applicant or the policyholder. The person offering the policy or contract shall document the fact that the notice was given at the time of application or the fact that the notice was delivered at the time the policy or contract was delivered. This does not require that the receipt of the notice be acknowledged by the applicant.

**62E.05 Information on qualified plans.**

**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.



**62M.04 Standards for utilization review performance.**

**Subdivision 1. Responsibility for obtaining certification.**

A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining certification for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any provider or provider's designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain certification for health care services.

**62M.05 Procedures for review determination.**

**Subdivision 1. Written procedures.**

A utilization review organization must have written procedures to ensure that reviews are conducted in accordance with the requirements of this chapter.

**Subd. 2. Concurrent review.**

A utilization review organization may review ongoing inpatient stays based on the severity or complexity of the enrollee's condition or on necessary treatment or discharge planning activities. Such review must not be consistently conducted on a daily basis.

**Subd. 3. Notification of determinations.**

A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with this section.

**Subd. 3a. Standard review determination.**

(a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this



subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

**Subd. 3b. Expedited review determination.**

(a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

**62M.06 Appeals of determinations not to certify.**

**Subdivision 1. Procedures for appeal.**

(a) A utilization review organization must have written procedures for appeals of determinations not to certify. The right to appeal must be available to the enrollee and to the attending health care professional.

(b) The enrollee shall be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. This paragraph does not apply to managed care plans or county-based purchasing plans serving state public health care program enrollees under section 256B.69, 256B.692, or chapter 256L, or to grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this paragraph shall be construed to limit or restrict the appeal rights of state public health care program enrollees provided under section 256.045 and Code of Federal Regulations, title 42, section 438.420(d).

**Subd. 2. Expedited appeal.**

(a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

**Subd. 3. Standard appeal.**

The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending

health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

(c) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

(e) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

- (1) a complete summary of the review findings;
- (2) qualifications of the reviewers, including any license, certification, or specialty designation; and
- (3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

**Subd. 4. Notification to claims administrator.**

If the utilization review organization and the claims administrator are separate entities, the utilization review organization must notify, either electronically or in writing, the appropriate claims administrator for the health benefit plan of any determination not to certify that is reversed on appeal.

**62M.07 Prior authorization of services.**

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

- (1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;
- (2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare, general assistance medical care, or medical assistance.

**62Q.021 Federal act; compliance required.**

**Subdivision 1. Compliance with 1996 federal law.**

Each health plan company shall comply with the federal Health Insurance Portability and Accountability Act of 1996, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this subdivision.

**Subd. 2. Compliance with 2010 federal law.**

Each health plan company shall comply with the Affordable Care Act to the extent that it imposes a requirement that applies in this state but is not required under the laws of this state. 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 subdivision.

**62Q.107 Prohibited provision; judicial review.**

Beginning January 1, 1999, no health plan, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), may specify a standard of review upon which a court may review denial of a claim or of any other decision made by a health plan company with respect to an enrollee. This section prohibits limiting court review to a determination of whether the health plan company's

decision is arbitrary and capricious, an abuse of discretion, or any other standard less favorable to the enrollee than a preponderance of the evidence.

#### 62Q.137 Chemical dependency treatment; coverage.

a) Any health plan that provides coverage for chemical dependency treatment must cover chemical dependency treatment provided to an enrollee by the Department of Corrections while the enrollee is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense under section 169A.24 if: (1) a court of competent jurisdiction makes a preliminary determination based on a chemical use assessment conducted under section 169A.70 that treatment may be appropriate and includes this determination as part of the sentencing order; and (2) the Department of Corrections makes a determination based on a chemical assessment conducted while the individual is in the custody of the department that treatment is appropriate. Treatment provided by the Department of Corrections that meets the requirements of this section shall not be subject to a separate medical necessity determination under the health plan company's utilization review procedures.

(b) The health plan company must be given a copy of the court's preliminary determination and supporting documents and the assessment conducted by the Department of Corrections.

(c) Payment rates for treatment provided by the Department of Corrections shall not exceed the lowest rate for outpatient chemical dependency treatment paid by the health plan company to a participating provider of the health plan company.

(d) For purposes of this section, chemical dependency treatment means all covered services that are intended to treat chemical dependency and that are covered by the enrollee's health plan or by law.

#### 62Q.14 Restrictions on enrollee services.

No health plan company may restrict the choice of an enrollee as to where the enrollee receives services related to:

- (1) the voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;
- (2) the diagnosis of infertility;
- (3) the testing and treatment of a sexually transmitted disease; and
- (4) the testing for AIDS or other HIV-related conditions.

#### 62Q.186 Prohibition on rescissions of health plans.

##### Subdivision 1. Definitions.

- (a) "Rescission" means a cancellation or discontinuance of coverage under a health plan that has a

retroactive effect.

(b) "Rescission" does not include:

(1) a cancellation or discontinuance of coverage under a health plan if:

(i) the cancellation or discontinuance of coverage has only a prospective effect; or

(ii) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage; or

(2) when the health plan covers only active employees and, if applicable, dependents and those covered under continuation coverage provisions, the employee pays no premiums for coverage after termination of employment and the cancellation or discontinuance of coverage is effective retroactively back to the date of termination of employment due to a delay in administrative record keeping.

**Subd. 2. Prohibition on rescissions.**

(a) A health plan company shall not rescind coverage under a health plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the health plan, unless:

(1) the individual, or a person seeking coverage on behalf of the individual, performs an act, practice, or omission that constitutes fraud; or

(2) the individual makes an intentional misrepresentation or omission of material fact, as prohibited by the terms of the health plan.

For purposes of this section, a person seeking coverage on behalf of an individual does not include an insurance producer or employee or authorized representative of the health carrier.

(b) This section does not apply to any benefits classified as excepted benefits under United States Code, title 42, section 300gg-91(c), or regulations enacted thereunder from time to time.

**Subd. 3. Notice required.**

A health plan company shall provide at least 30 days' advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the health plan may be terminated retroactively.

**62Q.46 Preventive items and services.**

**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.

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

**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.

**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.

**62Q.47 Alcoholism, mental health, and chemical dependency services.**

(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.

(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.

(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.

(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 Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

#### **62Q.471 Exclusion for suicide attempts prohibited.**

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.

#### **62Q.49 Enrollee cost sharing; negotiated provider payments.**

##### **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:

(1) through contracts in which health care providers agree to accept discounted charges, negotiated charges, or other limits on health care provider charges;

(2) by employees of, or facilities or entities owned by, the issuer of the health plan; or

(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.

##### **Subd. 2. Disclosure required.**

(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.

(b) Any summary or other marketing material used in connection with marketing of a health plan that is subject to this section must prominently disclose and clearly explain the provisions required under paragraph (a), if the summary or other marketing material refers to co-payments, coinsurance, or maximum lifetime benefits.

(c) A health plan that is subject to paragraph (a) must not be used in this state if the commissioner



of commerce or health, as appropriate, has determined that it does not comply with this section.

#### 62Q.50 Prostate cancer screening.

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.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (7) and (10).

#### 62Q.52 Direct access to obstetric and gynecologic services.

##### Subdivision 1. Direct access.

(a) Health plan companies shall allow female enrollees direct access to providers who specialize in obstetrics and gynecology for the following services:

(1) evaluation and necessary treatment for obstetric conditions or emergencies;

(2) maternity care; and

(3) evaluation and necessary treatment for gynecologic conditions or emergencies, including annual preventive health examinations.

(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.

#### 62Q.525 Coverage for off-label drug use.

##### Subd. 3. Required coverage.

(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.

(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.

(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.

(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.

(e) The commissioner of commerce or health, as appropriate, may direct a person that issues coverage included in subdivision 1 to make payments required by this section.

### **62Q.526 Coverage for participation in approved clinical trials.**

#### **Subdivision 1. Definitions.**

As used in this section, the following definitions apply:

(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:

(1) conducted under an investigational new drug application reviewed by the United States Food and Drug Administration (FDA);

(2) exempt from obtaining an investigational new drug application; or

(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.

(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.

(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.

**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.

**62Q.527 Nonformulary antipsychotic drugs; required coverage.**

**Subd. 2. Required coverage for antipsychotic drugs.**

(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.

(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.

(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.

**Subd. 3. Continuing care.**

(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.

(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.

(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.

**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:

(1) the formulary drug causes an adverse reaction in the patient;

(2) the formulary drug is contraindicated for the patient; or

(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.

**62Q.53 Mental health coverage; medically necessary care.**

**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.

**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.

**Subd. 3. Health plan; definition.**

For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

**62Q.535 Coverage for court-ordered mental health services.**

**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.

**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.

**62Q.55 Emergency services.**

**Subdivision 1. Access to emergency services.**

(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.

(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.

(c) Notwithstanding paragraphs (a) and (b), a health plan company that is in compliance with the rules regarding accessibility of services adopted under section 62D.20 is in compliance with this section.

**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.

**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;

(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; and

(3) emergency services as defined in sections 245.462, subdivision 11, and 245.4871, subdivision 14.

**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).

**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.

**62Q.56 Continuity of care.**

**Subdivision 1. Change in health care provider; general notification.**

(a) If enrollees are required to access services through selected primary care providers for coverage, the health plan company shall prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. The written plan must explain:

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;

**62Q.57 Designation of primary care provider.**

**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.

**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.

**62Q.58 Access to specialty care**

**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.

**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.

**Subd. 4. Referral.**

(a) If a standing referral is authorized under subdivision 1 or is mandatory under subdivision 1a, the health plan company must provide a referral to an appropriate participating specialist who is reasonably available and accessible to provide the treatment or to a nonparticipating specialist if the health plan company does not have an appropriate participating specialist who is reasonably available and accessible to treat the enrollee's condition or disease.

(b) If an enrollee receives services from a nonparticipating specialist because a participating specialist is not available, services must be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received from a participating specialist.

**62Q.66 Durable medical equipment coverage**

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.

**62Q.67 Disclosure of covered durable medical equipment**

**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.

**Subd. 2. Information to be disclosed.**

A health plan company that covers durable medical equipment shall disclose the following information:

(a) general descriptions of the coverage for durable medical equipment, level of coverage available, and criteria and procedures for any required prior authorizations; and

(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.**

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.

#### **62Q.677 Lifetime and annual limits.**

##### **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.

#### **62Q.69 Complaint resolution.**

##### **Subd. 2. Procedures for filing a complaint.**

(a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted orally and the resolution of the complaint, as determined by the complainant, is partially or wholly adverse to the complainant, or the oral complaint is not resolved to the satisfaction of the complainant, by the health plan company within ten days of receiving the complaint, the health plan company must inform the complainant that the complaint may be submitted in writing. The health plan company must also offer to provide the complainant with any assistance needed to submit a written complaint, including an offer to complete the complaint form for a complaint that was previously submitted orally and promptly mail the completed form to the complainant for the complainant's signature. At the complainant's request, the health plan company must provide the assistance requested by the complainant. The complaint form must include the following information:

(1) the telephone number of the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time

limits; and

(4) the toll-free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(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.

**Subd. 3. Notification of complaint decisions.**

(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.

(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).

(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.

**62Q.71 Notice to enrollees.**

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.

### **62Q.73 External review of adverse determinations.**

#### **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.

**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 judge 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.

**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.

**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.

(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.

(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.

**Subd. 7. Standards of review.**

(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.

**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.

**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.

**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.



**62Q.75 Prompt payment required.**

**Subdivision 1. Definitions.**

(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.

**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.

**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 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.

**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.

**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.

**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:

- (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.

**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.

**62Q.82 Benefits and coverage explanation.**

**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.

**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.

**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.

**72A.139 Use of genetic tests.**

**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:

- (1) require or request an individual or a blood relative of the individual to take a genetic test;
- (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;
- (3) take into consideration the fact that a genetic test was taken or refused by an individual or blood relative of the individual; or
- (4) take into consideration the results of a genetic test taken by an individual or a blood relative of the individual.

**72A.20 Methods, acts, and practices which are defined as unfair or deceptive.**

**Subd. 22. Limitations on health care providers.**

(a) No insurer providing benefits under the Minnesota No-Fault Automobile Insurance Act or a plan authorized by sections 471.617 or 471.98 to 471.982 may limit the type of licensed health care provider who may provide treatment for covered conditions under a policy so long as the services provided are within the scope of licensure for the provider. The insurer may not exclude a specific method of treatment for a covered condition if that exclusion has the effect of excluding a specific type of licensed health care provider from treating a covered condition.

(b) This subdivision does not limit the right of an insurer to contract with individual members of any

type of licensed health care provider to the exclusion of other members of the group, nor shall it limit the right to the insurer to exclude coverage for a type of treatment if the insurer can show the treatment is not medically necessary or is not medically appropriate.

#### 72A.201 Regulation of claims practices.

##### 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.

#### 72A.52 Notice requirements.

##### Subdivision 1. Contents.

In addition to all other legal requirements a policy or contract of insurance described in section 72A.51 shall show the name and address of the insurer and the seller of the policy or contract and shall include a notice, clearly and conspicuously in boldface type of a minimum size of ten points, which shall include the following elements:

- (1) a minimum of ten days to cancel the policy beginning on the date the policy is received by the owner;
- (2) if the policy is a replacement policy, a minimum of 30 days beginning on the date the policy is received by the owner. Pursuant to section 61A.57, this requirement may also be provided in a separate written notice that is delivered with the policy or contract;
- (3) a requirement for the return of the policy to the company or an agent of the company;
- (4) a statement that the policy is considered void from the beginning;
- (5) for policies or contracts other than a variable annuity or a variable life policy, a statement that the insurer will refund all premiums paid, including any fees or charges, if the policy is returned; and
- (6) a statement describing when the cancellation becomes effective.

The insurer must return all payments made for this policy within ten days after it receives notice of cancellation and the returned policy. For variable annuity contracts issued pursuant to sections 61A.13 to 61A.21, this notice shall be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of the amount calculated in accordance with the provisions of section 72A.51, subdivision 3. For variable life insurance policies, this notice must be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of: (i) the premiums paid; or (ii) the variable account value plus any amount deducted from the portion of the premium applied to the account.

#### 72C.10 Filing requirements; duties of commissioner.

##### Subdivision 1. Readability compliance; filing and approval.

No insurer shall make, issue, amend, or renew any policy or contract after the dates specified in section 72C.11 for the applicable type of policy unless the contract is in compliance with the requirements of sections 72C.06 to 72C.09 and unless the contract is filed with the commissioner for approval. The contract shall be deemed approved 60 days after filing unless disapproved by the commissioner within the 60-day period. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. The commissioner shall not unreasonably withhold approval. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor. Any policy filed with the commissioner shall be accompanied by a Flesch scale readability analysis and test score and by the insurer's certification that the policy or contract is in its judgment readable based on the factors specified in sections 72C.06 to 72C.08.

**Subd. 2. Contract or policy disapproval.**

The commissioner shall disapprove any contract or policy covered by subdivision 1 if the commissioner finds that:

- (a) it is not accompanied by a certified Flesch scale analysis readability score of more than 40;
- (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;
- (c) it does not comply with the readability standards established by section 72C.06;
- (d) it does not comply with the legibility standards established by section 72C.07; or
- (e) it does not comply with the format requirements established by section 72C.08.

## Federal Requirements

- Pursuant to the HHS Notice of Benefits and Payment Parameters for 2017 issued on February 29, 2016 the cost-sharing maximums applicable for the 2017 Plan Year are: \$7,150 for self-only coverage \$14,300 for other than self-only coverage
- 45 CFR § 147.108 Prohibition of preexisting condition exclusions.
- 45 CFR § 147.145 Student health insurance coverage.
- 45 CFR § 147.120 Eligibility of children until at least age 26.
- 45 CFR § 147.128 Rules regarding rescissions.
- 45 CFR § 147.131 Exemption and accommodations in connection with coverage of preventive health services.
- 45 CFR § 147.130 Coverage of preventive health services.
- 45 CFR § 147.138 Patient protections.
- 45 CFR § 147.136 Internal claims and appeals and external review processes.
- 45 CFR § 156.122(c) Prescriptions Drugs Benefits.
- 45 CFR § 147.200 Summary of Benefits and Coverage and Uniform Glossary
- 45 CFR § 156.602 Other coverage that qualifies as minimum essential coverage.
- 45 CFR §§ 146.136 and 147.160 Requiring parity for mental health and substance use disorder benefits.
- 45 CFR § 147.150 Requiring coverage of essential health benefits.
- 45 CFR § 148.180 Genetic Information Non-discrimination Act requiring that issuers may not adjust premiums based on genetic information, request genetic testing, or collect genetic information in connection with enrollment.
- 45 CFR § 147.104 Guaranteed availability for students and dependents. Requiring issuers in the individual market to offer special enrollment periods for qualifying events. See also 45 CFR § 147.145.
- 45 CFR § 147.106 Guaranteed renewability required unless canceled for non-payment of premiums, fraud, discontinuation of plan, and student status. See also 45 CFR 147.145.
- 45 CFR § 156.130 Cost sharing requirements including that coverage of emergency department services must be provided without prior authorization or limits on coverage where the provider is out of network that is more restrictive than requirements or limits applied to emergency services in network.
- 45 CFR §§ 156.110 and 156.115 Explaining the standards of an essential health benefits benchmark plan and further giving the provisions of essential health benefits, substantially equal to the benchmark plan.
- Public Health Services Act § 2709(a) Issuers may not deny a qualified individual participation in an approved clinical trial with respect to the treatment of cancer or other life-threatening diseases or conditions, may not deny or limit the coverage of routine patient costs in connection with the trial, and may not discriminate on the basis of participation.
- 45 CFR § 115.410 Requires the exchange to have an annual open enrollment period.

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- 45 CFR § 155.420 Gives criteria for special enrollment periods.
- 45 CFR § 156.200 Health insurance issuers must have certification or recognition from the exchange to demonstrate status as a QHP and must adhere to nondiscrimination requirements, state requirements, and all other requirements given in this regulation.
- 45 CFR § 156.235 A QHP must have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access for health care consumers.
- 45 CFR § 156.230 Providing network adequacy standards to ensure a sufficient network of providers within a qualified health plan, and requiring that a QHP issuer must make its provider directory for a QHP available for potential enrollees.
- 45 CFR § 148.170 Standards relating to benefits for mothers and newborns.
- 45 CFR § 155.305 Eligibility standards for enrollment in QHP.
- 45 CFR §§ 160 and 164 HIPAA requirements regarding privacy of health information.
- 42 USC § 300gg-5 Requiring that a policy cannot discriminate against providers acting within the scope of licensure or certification.
- 45 CFR § 147.110 Prohibiting discrimination against participants, beneficiaries, and individuals based on a health factor.
- 42 USC § 18116 The civil rights provision of the Affordable Care Act prohibiting discrimination on the ground of race, color, national origin, sex, age, or disability.
- 42 USC § 300gg-52 Required coverage for reconstructive surgery following mastectomies.
- 42 USC § 300gg-28 Required coverage of dependent students on a medically necessary leave of absence.



## Helpful Resources

*Minnesota Statutes:*

<https://www.revisor.mn.gov/statutes/>

*Commerce Webpage: Student Health Plan General Filing Guidelines:*

<http://mn.gov/commerce/#/list/appld//filterType//filterValue//page//sort//order/>

*Summary of Benefits and Coverages:*

<http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html>

*2017 Minnesota Benchmark plan:*

<https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>