State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 886

02/06/2017 Authored by Gruenhagen, McDonald, Slocum, Zerwas, Franson and others
The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform

A bill for an act

relating to health insurers; requiring nondiscrimination policies in providing health care services; proposing coding for new law in Minnesota Statutes, chapter 62Q.

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

Section 1. **[62Q.461] PATIENT RIGHTS AND PROVIDER NONDISCRIMINATION.**

Subdivision 1. **Covered providers.** A health plan company as defined in section 62Q.01, subdivision 4, or regulated under section 60A.23 and Minnesota Rules, chapter 2767; managed care organizations offering group or individual health insurance; third-party administrators that manage benefits for self-insured plans; workers' compensation; Minnesota health care programs including MA, MNsure, and SEGIP; and automobile insurers must not discriminate against health care providers who are licensed or registered by a health-related licensing board or the commissioner of health, in providing covered services to plan enrollees as long as the provider is acting within the scope of the provider's license, registration, or certification. Health plan companies must maintain network adequacy by ensuring a sufficient number of health care providers to serve the number of enrollees. Co-payments, deductible structures, conversion factors, and covered essential health benefits under health plans, workers' compensation, and public health programs must apply equally to all covered providers and not differ based solely on category or professional title of the provider or by licensure, registration, or certification of the provider.

Subd. 2. **Prohibited practice.** (a) Health plan companies, self-insured plans, third-party administrators, workers' compensation, Minnesota health care programs, and automobile insurers shall not engage in the following practices in order to limit the implementation of nondiscrimination policies:

(1) lower reimbursement rates for certain categories of providers who are delivering the same services as other provider types, as defined by procedural codes;

(2) apply limits to the number of allowable visits to some categories of providers and not others;

(3) limit the amount of payment for a service provided by a licensed, registered, or certified provider acting within the provider's scope of practice;

(4) limit the number of providers in the health plan's network;

(5) eliminate or restrict covered services that are otherwise within the provider's scope of practice;

(6) restrict CPT codes by provider type;

(7) exclude coverage for diagnosis and treatment of a condition or illness by a provider licensed or registered by a health-related licensing board or the commissioner of health who is acting within the provider's scope of practice if the health plan covers diagnosis and treatment of the condition or illness by a licensed physician or osteopath;

(8) make access to providers difficult by implementing cumbersome approval processes; and

(9) implement exclusionary language that references "not medically necessary," "not clinically efficacious," or "experimental," solely to deny services.

(b) The provisions in paragraph (a) do not prohibit plans from offering variable reimbursement based on quality and performance measures so long as the standard measures used are applied uniformly across provider types.

(c) Prior to meeting any deductible threshold, if applicable, the expense of any service paid by the policy holder which is rendered by a provider who is licensed or registered by the state shall be applied to the deductible. When attributing the expense of services paid for by the policy holder to the deductible, there shall be no differentiation between in-network and out-of-network providers until the point at which the deductible is met.

Subd. 3. **Requirements if service deemed not medically necessary or experimental.** (a) A health plan company or a self-insured plan that limits coverage of experimental treatment, or treatment determined to be not medically necessary, shall define the limitation and disclose the limits in any agreement, policy, or certificate of coverage. The disclosure must include the following:

(1) who is authorized to make the determination on limiting coverage; and

(2) the criteria the plan uses to determine whether a treatment, procedure, drug, or device is experimental.

(b) A health plan company or a self-insured plan that includes all of the required information upon which to make a decision must, within five business days after receiving the request, issue a coverage decision. The coverage decision must provide the insured a denial letter that includes:

(1) a statement of the specific medical and scientific factors considered in making a decision; and

(2) a notice of the insured's right to appeal and an explanation of the appeal process.

Subd. 4. **Conformity with federal law.** Each insurance company, fraternal benefit society, hospital service corporation, medical services corporation, and health care center licensed to do business in the state shall comply with: (1) sections 1251, 1252, and 1304 of the Affordable Care Act, Public Law 111-148; (2) sections 2701 to 2709, United States Code, title 42, section 300gg et seq.; (3) sections 2711 to 2719A, inclusive, United States Code, title 42, section 300gg-11 et seq.; and (4) section 2794, United States Code, title 42, section 300gg-94.

Subd. 5. **Enforcement.** Noncompliance with this section shall result in suspension of a plan participating in any state public health program under chapter 256B and sections 43A.317, 471.6161, and 471.617 for up to two years.