CHAPTER 62Q

HEALTH PLAN COMPANIES

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62Q.001 MS 2006 [Renumbered 15.001]

62Q.01 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 1a. **Affordable Care Act.** "Affordable Care Act" means the Affordable Care Act as defined in section 62A.011, subdivision 1a.

Subd. 1b. **Bona fide association.** "Bona fide association" means an association that meets all of the following criteria:

(1) serves a single profession that requires a significant amount of education, training, or experience, or a license or certificate from a state authority to practice that profession;

(2) has been actively in existence for five years;

(3) has a constitution and bylaws or other analogous governing documents;

(4) has been formed and maintained in good faith for purposes other than obtaining insurance;

(5) is not owned or controlled by a health plan company or affiliated with a health plan company;

(6) does not condition membership in the association on any health status-related factor;

(7) has at least 1,000 members if it is a national association, 500 members if it is a state association, or 200 members if it is a local association;

(8) all members and dependents of members are eligible for coverage regardless of any health status-related factor;

(9) does not make health plans offered through the association available other than in connection with a member of the association;

(10) is governed by a board of directors and sponsors an annual meeting of its members; and

(11) produces only market association memberships, accepts applications for membership, or signs up members in the professional association where the subject individuals are actively engaged in, or directly related to, the profession represented by the association.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health for purposes of regulating health maintenance organizations, and community integrated service networks, or the commissioner of commerce for purposes of regulating all other health plan companies. For all other purposes, "commissioner" means the commissioner of health.

Subd. 2a. MS 2012 [Renumbered subd 2b]

Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan company must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status. For coverage under plans offered by the Minnesota Comprehensive Health Association, dependent to the limiting age means dependent as defined in section 62A.302, subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

(1) eligibility requirements regarding the absence of other health plan coverage as permitted by the Affordable Care Act for grandfathered plan coverage; or

(2) an age greater than 26 in its policy, contract, or certificate of coverage.

Subd. 2b. **Enrollee.** "Enrollee" means a natural person covered by a health plan and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 2c. **Grandfathered plan.** "Grandfathered plan" means a health plan as defined in section 62A.011, subdivision 1b.

Subd. 2d. **Group health plan.** "Group health plan" means a group health plan as defined in section 62A.011, subdivision 1c.

Subd. 3. **Health plan.** "Health plan" means a health plan as defined in section 62A.011 or a policy, contract, or certificate issued by a community integrated service network.

Subd. 4. **Health plan company.** "Health plan company" means:

(1) a health carrier as defined under section 62A.011, subdivision 2; or

(2) a community integrated service network as defined under section 62N.02, subdivision 4a.

Subd. 4a. **High deductible health plans.** "High deductible health plans" means those health coverage plans issued by a health plan company as defined under the provisions of sections 220 and 223 of the Internal Revenue Code of 1986, and implementing regulations.

Subd. 4b. **Individual health plan.** "Individual health plan" means an individual health plan as defined in section 62A.011, subdivision 4.

Subd. 4c. **Life-threatening condition.** "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Subd. 5. **Managed care organization.** "Managed care organization" means: (1) a health maintenance organization operating under chapter 62D; (2) a community integrated service network as defined under section 62N.02, subdivision 4a; or (3) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

Subd. 6. **Medicare-related coverage.** "Medicare-related coverage" means a policy, contract, or certificate issued as a supplement to Medicare, regulated under sections 62A.3099 to 62A.44, including Medicare select coverage; policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations; or policies, contracts, or certificates governed by sections 1833 (known as "cost" or "HCPP" contracts), 1851 to 1859 (Medicare Advantage), 1860D (Medicare Part D), or 1876 (known as "TEFRA" or "risk" contracts) of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended; or Section 4001 of the Balanced Budget Act of 1997 (BBA)(Public Law 105-33), Sections 1851 to 1859 of the Social Security Act establishing Part C of the Medicare program, known as the "Medicare Advantage program."

Subd 6a. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include but are not limited to:

(1) medical management standards limiting or excluding benefits based on (i) medical necessity or medical appropriateness, or (ii) whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the health plan;

(9) in-network and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

Subd. 6b. **No Surprises Act.** "No Surprises Act" means Division BB of the Consolidated Appropriations Act, 2021, which amended Title XXVII of the Public Health Service Act, Public Law 116-260, and any amendments to and any federal guidance or regulations issued under this act.

Subd. 7. **Primary care provider.** "Primary care provider" means a health care professional who specializes in the practice of family medicine, general internal medicine, obstetrics and gynecology, or general pediatrics and is a licensed physician, a licensed and certified advanced practice registered nurse, or a licensed physician assistant.

History: *1994 c 625 art 2 s 14; 1995 c 234 art 2 s 2-6; art 3 s 5; 1997 c 225 art 2 s 37-39,62; 1998 c 254 art 1 s 15; 2001 c 215 s 26; 2004 c 268 s 7; 2005 c 17 art 1 s 14; art 3 s 2; 2013 c 84 art 1 s 60-67; 1Sp2019 c 9 art 8 s 12; 2023 c 70 art 2 s 23*

62Q.02 APPLICABILITY OF CHAPTER.

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

History: *1995 c 234 art 2 s 7*

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.

Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider, and health facility shall comply with the No Surprises Act, including any federal regulations adopted under the act, to

the extent that the act imposes requirements that apply in this state but are not required under the laws of this state. This subdivision does not require compliance with any provision of the No Surprises Act before the effective date provided for that provision in the No Surprises Act. The commissioner shall enforce this subdivision.

History: *1997 c 175 art 4 s 2; 2013 c 84 art 1 s 68; 2023 c 70 art 2 s 24*

HIGH DEDUCTIBLE HEALTH PLANS

62Q.025 HIGH DEDUCTIBLE HEALTH PLANS.

Subdivision 1. **Qualified plan.** A high deductible health plan shall be deemed a qualified plan under sections 62E.06 and 62E.12. The plan must meet all other requirements of state law except those that are inconsistent with a high deductible health plan as defined in sections 220 and 223 of the Internal Revenue Code and supporting regulations.

Subd. 2. **Authorization.** Notwithstanding any other law of this state, any health plan company defined in section 62Q.01, subdivision 4, is permitted to offer high deductible health plans.

History: *2004 c 268 s 8*

62Q.03 PROCESS FOR RISK ADJUSTMENT SYSTEM.

Subdivision 1. **Purpose.** The purpose of risk adjustment is to reduce the effects of risk selection on health insurance premiums by making monetary transfers from health plan companies that insure lower risk populations to health plan companies that insure higher risk populations. Risk adjustment is needed to: achieve a more equitable, efficient system of health care financing; remove current disincentives in the health care system to insure and provide adequate access for high risk and special needs populations; promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the risk status of those in a given insurance pool; and help maintain the viability of health plan companies, by protecting them from the financial effects of enrolling a disproportionate number of high risk individuals. It is the commitment of the state to develop and implement a risk adjustment system. The risk adjustment system shall:

(1) possess a reasonable level of accuracy and administrative feasibility, be adaptable to changes as methods improve, incorporate safeguards against fraud and manipulation, and shall neither reward inefficiency nor penalize for verifiable improvements in health status;

(2) require participation by all health plan companies providing coverage in the individual, small group, and Medicare supplement markets;

(3) address unequal distribution of risk between health plan companies, but shall not address the financing of public programs or subsidies for low-income people; and

(4) be developed and implemented by the Risk Adjustment Association with joint oversight by the commissioners of health and commerce.

Subd. 2. [Repealed, 1995 c 234 art 2 s 36]

Subd. 3. [Repealed, 1995 c 234 art 2 s 36]

Subd. 4. [Repealed, 1995 c 234 art 2 s 36]

Subd. 5. [Repealed, 1995 c 234 art 2 s 36]

Subd. 5a. **Public programs.** (a) A separate risk adjustment system must be developed for state-run public programs, including medical assistance and MinnesotaCare. The system must be developed in accordance with the general risk adjustment methodologies described in this section, must include factors in addition to age and sex adjustment, and may include additional demographic factors, different targeted conditions, and/or different payment amounts for conditions. The risk adjustment system for public programs must attempt to reflect the special needs related to poverty, cultural, or language barriers and other needs of the public program population.

(b) The commissioner of human services shall phase in risk adjustment according to the following schedule:

(1) for the first contract year, no more than ten percent of reimbursements shall be risk adjusted; and

(2) for the second contract year, no more than 30 percent of reimbursements shall be risk adjusted.

Subd. 5b. **Medicare supplement market.** A risk adjustment system may be developed for the Medicare supplement market. The Medicare supplement risk adjustment system may include a demographic component and may, but is not required to, include a condition-specific risk adjustment component.

Subd. 6. **Creation of Risk Adjustment Association.** The Minnesota Risk Adjustment Association is created on July 1, 1994, and may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association may operate under the approved plan of operation and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles of incorporation.

The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 14, 60A, and 62A. The association is not a public employer and is not subject to the provisions of chapters 179A and 353. The board of directors and health carriers who are members of the association are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors and members of the association. The Risk Adjustment Association is subject to the Open Meeting Law.

Subd. 7. **Purpose of association.** The association is established to develop and implement a private sector risk adjustment system.

Subject to state oversight set forth in subdivision 10, the association shall:

(1) develop and implement comprehensive risk adjustment systems for individual, small group, and Medicare supplement markets consistent with the provisions of this chapter;

(2) submit a plan for the development of the risk adjustment system which identifies appropriate implementation dates consistent with the rating and underwriting restrictions of each market, recommends whether transfers attributable to risk adjustment should be required between the individual and small group

markets, and makes other appropriate recommendations to the commissioners of health and commerce by November 5, 1995;

(3) develop a combination of a demographic risk adjustment system and payments for targeted conditions;

(4) test an ambulatory care groups (ACGs) and diagnostic cost groups (DCGs) system, and recommend whether such a methodology should be adopted;

(5) fund the development and testing of the risk adjustment system;

(6) recommend market conduct guidelines; and

(7) develop a plan for assessing members for the costs of administering the risk adjustment system.

Subd. 8. **Governance.** The association shall be governed according to the plan of operation as established in subdivision 8a.

Subd. 8a. **Plan of operation.** The board shall submit a proposed plan of operation by August 15, 1995, to the commissioners of health and commerce for review. The commissioners of health and commerce shall have the authority to approve or reject the plan of operation.

Amendments to the plan of operation may be made by the commissioners or by the directors of the association, subject to the approval of the commissioners.

Subd. 9. **Data collection and data privacy.** The association members shall not have access to unaggregated data on individuals or health plan companies. The association shall develop, as a part of the plan of operation, procedures for ensuring that data is collected by an appropriate entity. The commissioners of health and commerce shall have the authority to audit and examine data collected by the association for the purposes of the development and implementation of the risk adjustment system. Data on individuals obtained for the purposes of risk adjustment development, testing, and operation are designated as private data. Data not on individuals which is obtained for the purposes of development, testing, and operation of risk adjustment are designated as nonpublic data, except that the proposed and approved plan of operation, the risk adjustment methodologies examined, the plan for testing, the plan of the risk adjustment system, minutes of meetings, and other general operating information are classified as public data. Nothing in this section is intended to prohibit the preparation of summary data under section 13.05, subdivision 7. The association, state agencies, and any contractors having access to this data shall maintain it in accordance with this classification. The commissioners of health and human services have the authority to collect data from health plan companies as needed for the purpose of developing a risk adjustment mechanism for public programs.

Subd. 10. **State oversight of risk adjustment activities.** The association's activities shall be supervised by the commissioners of health and commerce. The commissioners shall provide specific oversight functions during the development and implementation phases of the risk adjustment system as follows:

(1) the commissioners shall approve or reject the association's plan for testing risk adjustment methods, the methods to be used, and any changes to those methods;

(2) the commissioners must have the right to attend and participate in all meetings of the association and its work groups or committees, except for meetings involving privileged communication between the association and its counsel as permitted under section 13D.05, subdivision 3, paragraph (b);

(3) the commissioners shall approve any consultants or administrators used by the association;

(4) the commissioners shall approve or reject the association's plan of operation; and

(5) the commissioners shall approve or reject the plan for the risk adjustment system described in subdivision 7, clause (2).

If the commissioners reject any of the plans identified in clauses (1), (4), and (5), the directors shall submit for review an appropriate revised plan within 30 days.

Subd. 11. [Repealed, 1995 c 234 art 2 s 36]

Subd. 12. **Participation by all health plan companies.** Upon its implementation, all health plan companies, as a condition of licensure, must participate in the risk adjustment system to be implemented under this section.

History: *1994 c 625 art 2 s 15; 1995 c 234 art 2 s 8-17; 1996 c 440 art 1 s 33; 1996 c 451 art 4 s 2; 1997 c 192 s 18; 1997 c 225 art 2 s 40; 1998 c 254 art 1 s 16; 1999 c 245 art 2 s 12; 2001 c 161 s 15; 2016 c 158 art 2 s 23*

62Q.07 [Repealed, 2001 c 170 s 11]

62Q.075 [Renumbered 62D.081]

62Q.09 [Expired]

62Q.095 [Repealed, 2005 c 77 s 8]

62Q.096 CREDENTIALING OF PROVIDERS.

(a) If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

(b) In order to ensure timely access by patients to mental health services, between July 1, 2023, and June 30, 2025, a health plan company must credential and enter into a contract for mental health services with any provider of mental health services that:

(1) meets the health plan company's credential requirements. For purposes of credentialing under this paragraph, a health plan company may waive credentialing requirements that are not directly related to quality of care in order to ensure patient access to providers from underserved communities or to providers in rural areas;

(2) seeks to receive a credential from the health plan company;

(3) agrees to the health plan company's contract terms. The contract shall include payment rates that are usual and customary for the services provided;

(4) is accepting new patients; and

(5) is not already under a contract with the health plan company under a separate tax identification number or, if already under a contract with the health plan company, has provided notice to the health plan company of termination of the existing contract.

(c) A health plan company shall not refuse to credential these providers on the grounds that their provider network has:

(1) a sufficient number of providers of that type, including but not limited to the provider types identified in paragraph (a); or

(2) a sufficient number of providers of mental health services in the aggregate.

History: *1998 c 407 art 8 s 4; 2021 c 30 art 17 s 3; 2023 c 57 art 2 s 40*

NOTE: The amendment to this section by Laws 2021, chapter 30, article 17, section 3, is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2021, chapter 30, article 17, section 114.

62Q.097 REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. **Time limit for credentialing determination.** A health plan company that receives an application for provider credentialing must:

(1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic or facility of the date by which the health plan company will make a determination on the health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

Subd. 3. **Prohibited application questions.** An application for provider credentialing must not:

(1) require the provider to disclose past health conditions;

(2) require the provider to disclose current health conditions, if the provider is being treated so that the condition does not affect the provider's ability to practice medicine; or

(3) require the disclosure of any health conditions that would not affect the provider's ability to practice medicine in a competent, safe, and ethical manner.

History: *2021 c 30 art 6 s 1; 2024 c 127 art 57 s 32*

62Q.10 [Repealed, 2012 c 187 art 1 s 75]

62Q.101 EVALUATION OF PROVIDER PERFORMANCE.

A health plan company, or a vendor of risk management services as defined under section 60A.23, subdivision 8, shall, in evaluating the performance of a health care provider:

(1) conduct the evaluation using a bona fide baseline based upon practice experience of the provider group; and

(2) disclose the baseline to the health care provider in writing and prior to the beginning of the time period used for the evaluation.

History: *2007 c 147 art 15 s 10*

62Q.105 [Repealed, 1999 c 239 s 43]

62Q.1055 CHEMICAL DEPENDENCY.

All health plan companies shall use the assessment criteria in section 245G.05 when assessing and treating enrollees for chemical dependency treatment.

History: *1995 c 234 art 2 s 22; 2016 c 158 art 1 s 214; 2023 c 50 art 2 s 2*

62Q.106 DISPUTE RESOLUTION BY COMMISSIONER.

(a) A complainant may at any time submit a complaint to the appropriate commissioner to investigate. After investigating a complaint, or reviewing a company's decision, the appropriate commissioner may order a remedy as authorized under chapter 45, 60A, or 62D.

(b) In investigating a complaint filed against a health maintenance organization regarding a vulnerable adult, upon request, the commissioner of health must interview at least one family member of the complainant or the subject of the complaint. If the complainant or the subject of the complaint does not want any family members to be interviewed, this information will be included in the investigative file.

History: *1995 c 234 art 2 s 23; 1997 c 225 art 2 s 41; 1999 c 239 s 32; 2013 c 43 s 2*

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.

History: *1998 c 407 art 2 s 21*

62Q.11 [Repealed, 1999 c 239 s 43]

62Q.12 DENIAL OF ACCESS.

No health plan company may deny access to a covered health care service unless the denial is made by, or under the direction of, or subject to the review of a health care professional licensed to provide the service in question.

History: *1994 c 625 art 2 s 20*

62Q.121 LICENSURE OF MEDICAL DIRECTORS.

(a) No health plan company may employ a person as a medical director unless the person is licensed as a physician in this state. This section does not apply to a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

(b) For purposes of this section, "medical director" means a physician employed by a health plan company who has direct decision-making authority, based upon medical training and knowledge, regarding the health plan company's medical protocols, medical policies, or coverage of treatment of a particular enrollee, regardless of the physician's title.

(c) This section applies only to medical directors who make recommendations or decisions that involve or affect enrollees who live in this state.

(d) Each health plan company that is subject to this section shall provide the commissioner with the names and licensure information of its medical directors and shall provide updates no later than 30 days after any changes.

History: *1Sp2001 c 9 art 16 s 6; 2002 c 379 art 1 s 113*

62Q.135 CONTRACTING FOR CHEMICAL DEPENDENCY SERVICES.

No health plan company shall contract with a chemical dependency treatment program, unless the program participates in the chemical dependency treatment accountability plan established by the commissioner of human services. The commissioner of human services shall make data on chemical dependency services and outcomes collected through this program available to health plan companies.

History: *1994 c 625 art 2 s 21*

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.

History: *1Sp2001 c 9 art 19 s 1; 2002 c 379 art 1 s 113*

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;

(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.

History: *1994 c 625 art 2 s 22; 2024 c 127 art 57 s 33*

62Q.145 MS 2022 [Repealed, 2023 c 70 art 4 s 113]

62Q.16 MIDMONTH TERMINATION PROHIBITED.

The termination of a person's coverage under any health plan as defined in section 62A.011, subdivision 3, with the exception of individual health plans, issued or renewed on or after January 1, 1995, must provide coverage until the end of the month in which coverage was terminated.

History: *1994 c 625 art 2 s 23*

62Q.165 UNIVERSAL COVERAGE.

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans by the year 2011. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, 2011, all Minnesota residents have access to affordable health care. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income

Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

Subd. 3. [Repealed, 1997 c 225 art 2 s 63]

History: *1994 c 625 art 6 s 1; 1995 c 234 art 4 s 1; 2007 c 147 art 15 s 11,12*

62Q.17 VOLUNTARY PURCHASING POOLS.

Subdivision 1. **Permission to form.** Notwithstanding section 62A.10, employers, groups, and individuals may voluntarily form purchasing pools, solely for the purpose of negotiating and purchasing health plan coverage from health plan companies for members of the pool.

Subd. 2. **Common factors.** All participants in a purchasing pool must live within a common geographic region, be employed in a similar occupation, or share some other common factor as approved by the commissioner of commerce. The membership criteria must not be designed to include disproportionately employers, groups, or individuals likely to have low costs of health coverage, or to exclude disproportionately employers, groups, or individuals likely to have high costs of health coverage.

Subd. 3. **Governing structure.** Each pool must have a governing structure controlled by its members. The governing structure of the pool is responsible for administration of the pool. The governing structure shall review and evaluate all bids for coverage from health plan companies, shall determine criteria for joining and leaving the pool, and may design incentives for healthy lifestyles and health promotion programs. The governing structure may design uniform entrance standards for all employers, except small employers as defined under section 62L.02. Small employers must be permitted to enter any pool if the small employer meets the pool's membership requirements. Pools must provide as much choice in health plans to members as is financially possible. The governing structure may charge all members a fee for administrative purposes.

Subd. 4. **Enrollment.** Pools must have an annual open enrollment period of not less than 15 days, during which all individuals or groups that qualify for membership may enter the pool without any preexisting condition limitations or exclusions or exclusionary riders, except those permitted under chapter 62L for groups or section 62A.65 for individuals. Pools must reach and maintain an enrolled population of at least 1,000 members within six months of formation. If a pool fails to reach or maintain the minimum enrollment, all coverage subsequently purchased through the purchasing pool must be regulated through existing applicable laws and forgo all advantages under this section.

Subd. 5. **Members.** The governing structure of the pool shall set a minimum time period for membership. Members must stay in the purchasing pool for the entire minimum period to avoid paying a penalty. Penalties for early withdrawal from the purchasing pool shall be established by the governing structure.

Subd. 6. **Employer-based purchasing pools.** Employer-based purchasing pools must, with respect to small employers as defined in section 62L.02, meet all the requirements of chapter 62L. The experience of the pool must be pooled and the rates blended across all groups.

Subd. 7. **Individual members.** Purchasing pools that contain individual members must meet all of the underwriting and rate restrictions found in the individual health plan market.

Subd. 8. **Reports.** Prior to the initial effective date of coverage, and annually on July 1 thereafter, each pool shall file a report with the information clearinghouse and the commissioner of commerce. The information clearinghouse must use the report to promote the purchasing pools. The annual report must contain the following information:

(1) the number of lives in the pool;

(2) the geographic area the pool intends to cover;

(3) the number of health plans offered;

(4) a description of the benefits under each plan;

(5) a description of the premium structure, including any co-payments or deductibles, of each plan offered;

(6) evidence of compliance with chapter 62L;

(7) a sample of marketing information, including a phone number where the pool may be contacted; and

(8) a list of all administrative fees charged.

Subd. 9. **Enforcement.** Purchasing pools must register prior to offering coverage, and annually on July 1 thereafter, with the commissioner of commerce on a form prescribed by the commissioner. The commissioner of commerce shall enforce this section and all other state laws with respect to purchasing pools, and has for that purpose all general rulemaking and enforcement powers otherwise available to the commissioner of commerce. The commissioner may charge an annual registration fee sufficient to meet the costs of the commissioner's duties under this section.

History: *1994 c 625 art 6 s 2; 1995 c 234 art 7 s 24-26; 2013 c 84 art 1 s 69*

62Q.18 PORTABILITY OF COVERAGE.

Subdivision 1. **Definition.** For purposes of this section:

(1) "continuous coverage" has the meaning given in section 62L.02, subdivision 9;

(2) "guaranteed issue" means:

(i) for individual health plans, that a health plan company shall not decline an application by an individual for any individual health plan offered by that health plan company, including coverage for a dependent of the individual to whom the health plan has been or would be issued; and

(ii) for group health plans, that a health plan company shall not decline an application by a group for any group health plan offered by that health plan company and shall not decline to cover under the group health plan any person eligible for coverage under the group's eligibility requirements, including persons who become eligible after initial issuance of the group health plan; and

(3) "large employer" means an entity that would be a small employer, as defined in section 62L.02, subdivision 26, except that the entity has more than 50 current employees, based upon the method provided in that subdivision for determining the number of current employees.

Subd. 2. [Repealed, 1995 c 234 art 4 s 4]

Subd. 3. [Repealed, 1995 c 234 art 4 s 4]

Subd. 4. [Repealed, 1995 c 234 art 4 s 4]

Subd. 5. [Repealed, 1995 c 234 art 4 s 4]

Subd. 6. [Repealed, 1995 c 234 art 4 s 4]

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

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

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

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

To the extent that this subdivision conflicts with chapter 62L, chapter 62L governs, regardless of whether the group sponsor is a small employer as defined in section 62L.02, except that for group health plans issued to groups that are not small employers, this subdivision's requirement that the individual have maintained continuous coverage applies. An individual who has maintained continuous coverage, but would be considered a late entrant under chapter 62L, may be treated as a late entrant in the same manner under this subdivision as permitted under chapter 62L.

Subd. 8. [Repealed, 1995 c 234 art 4 s 4]

Subd. 9. [Repealed, 1995 c 234 art 4 s 4]

Subd. 10. **Guaranteed issue.** No health plan company shall offer, sell, or issue any health plan that does not make coverage available on a guaranteed issue basis in accordance with the Affordable Care Act.

History: *1994 c 625 art 6 s 3; art 8 s 72; 1995 c 96 s 2; 1995 c 234 art 4 s 2; 1997 c 175 art 3 s 1,2; 1997 c 225 art 2 s 63; 2013 c 84 art 1 s 70; 2016 c 158 art 1 s 21*

62Q.181 WRITTEN CERTIFICATION OF COVERAGE.

A health plan company shall provide the written certifications of coverage required under United States Code, title 42, sections 300gg(e) and 300gg-43. This section applies only to coverage that is subject to regulation under state law and only to the extent that the certification of coverage is required under federal law. The commissioner shall enforce this section.

History: *1997 c 175 art 4 s 3*

62Q.184 STEP THERAPY OVERRIDE.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Clinical practice guideline" means a systematically developed statement to assist health care providers and enrollees in making decisions about appropriate health care services for specific clinical circumstances and conditions developed independently of a health plan company, pharmaceutical manufacturer, or any entity with a conflict of interest. A clinical practice guideline also includes a preferred drug list developed in accordance with section 256B.0625.

(c) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan company to determine the medical necessity and appropriateness of health care services.

(d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, but also includes a county-based purchasing plan participating in a public program under chapter 256B or 256L and an integrated health partnership under section 256B.0755.

(e) "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered drugs and drugs that are administered by a physician, advanced practice registered nurse, or physician assistant, are medically appropriate for a particular enrollee and are covered under a health plan.

(f) "Step therapy override" means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing health care provider because at least one of the conditions of subdivision 3, paragraph (a), exists.

Subd. 2. **Establishment of a step therapy protocol.** A health plan company shall consider available recognized evidence-based and peer-reviewed clinical practice guidelines when establishing a step therapy protocol. Upon written request of an enrollee, a health plan company shall provide any clinical review criteria applicable to a specific prescription drug covered by the health plan.

Subd. 3. **Step therapy override process; transparency.** (a) When coverage of a prescription drug for the treatment of a medical condition is restricted for use by a health plan company through the use of a step therapy protocol, enrollees and prescribing health care providers shall have access to a clear, readily accessible, and convenient process to request a step therapy override. The process shall be made easily accessible on the health plan company's website. A health plan company may use its existing medical exceptions process to satisfy this requirement. A health plan company shall grant an override to the step therapy protocol if at least one of the following conditions exist:

(1) the prescription drug required under the step therapy protocol is contraindicated pursuant to the pharmaceutical manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(i) cause an adverse reaction to the enrollee;

(ii) decrease the ability of the enrollee to achieve or maintain reasonable functional ability in performing daily activities; or

(iii) cause physical or mental harm to the enrollee;

(2) the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event. This clause does not prohibit a health plan company from requiring an enrollee to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information. This clause does not apply to the commissioner of human services or a managed care plan, county-based purchasing plan, or integrated health partnership administering a pharmacy benefit under chapter 256B or 256L;

(3) for the fee-for-service system administered by the commissioner of human services, or a managed care plan, county-based purchasing plan, or integrated health partnership administering a pharmacy benefit under chapter 256B or 256L, the enrollee has had a trial of the required prescription drug covered by their current or previous health plan, or a drug in the same pharmacological class with the same mechanism of action, and was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and the prescription drug was discontinued by the enrollee's health care provider due to lack of effectiveness, or an adverse event, or the prescriber submits an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested drug over the required prescription drug. This clause does not prohibit a managed care plan, county-based purchasing plan, or integrated health partnership from requiring an enrollee to try another drug in the same pharmacologic class with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or

(4) the enrollee is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current health plan or the immediately preceding health plan, the enrollee received coverage for the prescription drug and the enrollee's prescribing health care provider gives documentation to the health plan company that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the enrollee based on the known characteristics of the specific enrollee and the known characteristics of the required prescription drug.

(b) Upon granting a step therapy override, a health plan company shall authorize coverage for the prescription drug if the prescription drug is a covered prescription drug under the enrollee's health plan.

(c) The enrollee, or the prescribing health care provider if designated by the enrollee, may appeal the denial of a step therapy override by a health plan company using the complaint procedure under sections 62Q.68 to 62Q.73 or 256.045.

(d) In a denial of an override request and any subsequent appeal, a health plan company's decision must specifically state why the step therapy override request did not meet the condition under paragraph (a) cited by the prescribing health care provider in requesting the step therapy override and information regarding the procedure to request external review of the denial pursuant to section 62Q.73. A denial of a request for a step therapy override that is upheld on appeal is a final adverse determination for purposes of section 62Q.73 and is eligible for a request for external review by an enrollee pursuant to section 62Q.73.

(e) A health plan company shall respond to a step therapy override request or an appeal within five days of receipt of a complete request. In cases where exigent circumstances exist, a health plan company shall respond within 72 hours of receipt of a complete request. If a health plan company does not send a response to the enrollee or prescribing health care provider if designated by the enrollee within the time allotted, the override request or appeal is granted and binding on the health plan company.

(f) Step therapy override requests must be accessible to and submitted by health care providers, and accepted by group purchasers electronically through secure electronic transmission, as described under section 62J.497, subdivision 5.

(g) Nothing in this section prohibits a health plan company from:

(1) requesting relevant documentation from an enrollee's medical record in support of a step therapy override request; or

(2) requiring an enrollee to try a generic equivalent drug pursuant to section 151.21, or a biosimilar, as defined under United States Code, chapter 42, section 262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(h) This section shall not be construed to allow the use of a pharmaceutical sample for the primary purpose of meeting the requirements for a step therapy override.

History: *2018 c 162 s 1; 1Sp2019 c 9 art 7 s 3,4; 2020 c 115 art 4 s 8; 2022 c 58 s 11*

62Q.1841 PROHIBITION ON USE OF STEP THERAPY FOR METASTATIC CANCER.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning given in section 62Q.01, subdivision 3. Health plan includes health coverage provided by a county-based purchasing plan participating in a public program under chapter 256B or 256L or an integrated health partnership under section 256B.0755.

(c) "Stage four advanced metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the body.

(d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions must not limit or exclude coverage for a drug approved by the United States Food and Drug Administration that is on the health plan's prescription drug formulary by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

(1) a United States Food and Drug Administration-approved indication; and

(2) a clinical practice guideline published by the National Comprehensive Care Network.

History: *1Sp2019 c 9 art 8 s 13*

62Q.185 GUARANTEED RENEWABILITY; LARGE EMPLOYER GROUP.

(a) No health plan company, as defined in section 62Q.01, subdivision 4, shall refuse to renew a health benefit plan, as defined in section 62L.02, subdivision 15, but issued to a large employer, as defined in section 62Q.18, subdivision 1.

(b) This section does not require renewal if:

(1) the large employer has failed to pay premiums or contributions as required under the terms of the health benefit plan, or the health plan company has not received timely premium payments unless the late payments were received within a grace period provided under state law;

(2) the large employer has performed an act or practice that constitutes fraud or misrepresentation of material fact under the terms of the health benefit plan;

(3) the large employer has failed to comply with a material plan provision relating to employer contribution or group participation rules not prohibited by state law;

(4) the health plan company is ceasing to offer coverage in the large employer market in this state in compliance with United States Code, title 42, section 300gg-12(c), and applicable state law;

(5) in the case of a health maintenance organization, there is no longer any enrollee in the large employer's health benefit plan who lives, resides, or works in the approved service area; or

(6) in the case of a health benefit plan made available to large employers only through one or more bona fide associations, the membership of the large employer in the association ceases, but only if such coverage is terminated uniformly without regard to any health-related factor relating to any covered individual.

(c) This section does not prohibit a health plan company from modifying the premium rate or from modifying the coverage for purposes of renewal.

(d) This section does not require renewal of the coverage of individual enrollees under the health benefit plan if the individual enrollee has performed an act or practice that constitutes fraud or misrepresentation of material fact under the terms of the health benefit plan.

History: *1997 c 175 art 3 s 3; 1999 c 177 s 57*

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.

Subd. 4. **Compliance with other restrictions on rescissions.** Nothing in this section allows rescission if rescission would otherwise be prohibited under section 62A.04, subdivision 2, clause (2).

History: *2013 c 84 art 1 s 71; 2014 c 275 art 1 s 8*

62Q.188 FLEXIBLE BENEFITS PLANS.

Subdivision 1. **Definitions.** For the purposes of this section, the terms used in this section have the meanings defined in section 62Q.01, except that "health plan" includes individual coverage and group coverage for employer plans with up to 100 employees.

Subd. 2. **Flexible benefits plan.** Notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health plan company may offer, sell, issue, and renew a health plan that is a flexible benefits plan under this section if the following requirements are satisfied:

(1) the health plan must be offered in compliance with the laws of this state, except as otherwise permitted in this section;

(2) the health plan must be designed to enable covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;

(3) the health plan may modify or exclude any or all coverages of benefits that would otherwise be required by law, except for maternity benefits and other benefits required under federal law;

(4) each health plan and plan's premiums must be approved by the commissioner of health or commerce, whichever is appropriate under section 62Q.01, subdivision 2, but neither commissioner may disapprove a plan on the grounds of a modification or exclusion permitted under clause (3); and

(5) prior to the sale of the health plan, the purchaser must be given a written list of the coverages otherwise required by law that are modified or excluded in the health plan. The list must include a description of each coverage in the list and indicate whether the coverage is modified or excluded. If coverage is modified, the list must describe the modification. The list may, but is not required to, also list any or all coverages otherwise required by law that are included in the health plan and indicate that they are included. The health plan company must require that a copy of this written list be provided, prior to the effective date of the health plan, to each enrollee or employee who is eligible for health coverage under the plan.

Subd. 3. **Employer health plan.** An employer may provide a health plan permitted under this section to its employees, the employees' dependents, and other persons eligible for coverage under the employer's plan, notwithstanding chapter 363A or any other law to the contrary.

History: *2010 c 384 s 24*

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian Tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions;

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds;

(6) a birth center licensed under section 144.615;

(7) a hospital and affiliated specialty clinics that predominantly serve patients who are under 21 years of age and meet the following criteria:

(i) provide intensive specialty pediatric services that are routinely provided in fewer than five hospitals in the state; and

(ii) serve children from at least one-half of the counties in the state; or

(8) a psychiatric residential treatment facility, as defined in section 256B.0625, subdivision 45a, paragraph (b), that is certified by the commissioner of health and licensed by the commissioner of human services.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner.

(b) Each application submitted must be accompanied by an application fee of $60. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

Subd. 2a. **Definition of health plan company.** For purposes of this section, "health plan company" does not include a health plan company as defined in section 62Q.01 with fewer than 50,000 enrollees, all of whose enrollees are covered under medical assistance or MinnesotaCare.

Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider contract to all designated essential community providers located within the area served by the health plan company. A health plan company must include all essential community providers that have accepted a contract in each of the company's provider networks. A health plan company shall not restrict enrollee access to services designated to be provided by the essential community provider for the population that the essential community provider is certified to serve. A health plan company may also make other providers available for these services. A health plan company may require an essential community provider to meet all data requirements, utilization review, and quality assurance requirements on the same basis as other health plan providers.

Subd. 4. **Essential community provider responsibilities.** Essential community providers must agree to serve enrollees of all health plan companies operating in the area in which the essential community provider is located.

Subd. 4a. **Contract payment rates; private.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be at least the same rate per unit of service as is paid by the health plan company to the essential community provider under the provider contract between the two with the highest number of enrollees receiving health care services from the provider or, if there is no provider contract between the health plan company and the essential community provider, the rate must be at least the same rate per unit of service as is paid to other plan providers for the same or similar services. The provider contract used to set the rate under this subdivision must be in relation to an individual, small group, or large group health plan. This subdivision applies only to provider contracts in relation to individual, small employer, and large group health plans.

Subd. 5. **Contract payment rates; public.** An essential community provider and a health plan company may negotiate the payment rate for covered services provided by the essential community provider. This rate must be at least the same rate per unit of service as is paid to other health plan providers for the same or similar services. This subdivision applies only to provider contracts in relation to health plans offered through the State Employee Group Insurance Program, medical assistance, and MinnesotaCare.

Subd. 5a. **Cooperation.** Each health plan company and essential community provider shall cooperate to facilitate the use of the essential community provider by the high risk and special needs populations. This includes cooperation on the submission and processing of claims, sharing of all pertinent records and data, including performance indicators and specific outcomes data, and the use of all dispute resolution methods.

Subd. 5b. **Enforcement.** For any violation of this section or any rule applicable to an essential community provider, the commissioner may suspend, modify, or revoke an essential community provider designation. The commissioner may also use the enforcement authority specified in section 62D.17.

Subd. 6. **Termination or renewal of designation; commissioner review.** The designation as an essential community provider shall be valid for a five-year period from the date of designation. Every five years after the designation or renewal of the designation of essential community provider is granted to a provider, the commissioner shall review the need for and appropriateness of continuing the designation for that provider. The commissioner may require a provider whose designation is to be reviewed to submit an application to the commissioner for renewal of the designation and may require an application fee of $60 to be submitted with the application to cover the administrative costs of processing the application. Based on that review, the commissioner may renew a provider's essential community provider designation for an additional five-year period or terminate the designation. Once the designation terminates, the former essential community provider has no rights or privileges beyond those of any other health care provider.

Subd. 7. **Rulemaking.** By January 1, 1996, the commissioner shall adopt rules for establishing essential community providers and for governing their relationship with health plan companies. The commissioner shall also identify and address any conflict of interest issues regarding essential community provider designation for local governments. The rules shall require health plan companies to comply with all provisions of section 62Q.14 with respect to enrollee use of essential community providers.

History: *1994 c 625 art 4 s 6; 1995 c 234 art 2 s 26; 1996 c 451 art 2 s 1,2; 1997 c 225 art 2 s 42; 1999 c 239 s 33; 2000 c 340 s 1,2; 2001 c 170 s 3; 2003 c 100 s 1; 1Sp2003 c 14 art 7 s 22,23; 2004 c 279 art 9 s 1; 2006 c 212 art 3 s 4; 2007 c 50 s 1,2; 1Sp2010 c 1 art 20 s 4; 2013 c 108 art 12 s 10; 2016 c 158 art 2 s 24; 2023 c 57 art 2 s 41; 2024 c 127 art 57 s 34-36*

62Q.20 DIRECT PRIMARY CARE SERVICE AGREEMENT.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Direct fee" means a fee charged by a direct primary care practice as consideration for being available to provide and for providing primary care services to a direct patient as specified in the direct agreement.

(c) "Direct patient" means an individual who is party to a direct agreement and is entitled to receive primary care services under the direct agreement from the direct primary care practice.

(d) "Direct primary care practice" or "direct practice" means a primary care provider who furnishes primary care services through a direct agreement.

(e) "Direct primary care service agreement" or "direct agreement" means a written agreement entered into between a direct primary care practice and a direct patient, or the direct patient's legal representative, in which the primary care direct practice charges a direct fee as consideration for being available to provide and for providing direct primary care services to the direct patient.

(f) "Primary care provider" means a physician who is licensed under chapter 147 or an advanced practice registered nurse licensed under chapter 148, who is authorized to engage in independent practice, and who is qualified to provide primary care services. This term includes an individual primary care provider or a group of primary care providers.

(g) "Primary care services" means:

(1) routine health care services, including screening, assessment, diagnosis, and treatment for the purpose of the promotion of health, and the detection and management of disease or injury within the competency and training of the primary care provider;

(2) medical supplies and prescription drugs that are administered or dispensed in the primary care provider's office or clinic; and

(3) laboratory work, including routine blood screening and routine pathology screening performed by a laboratory that is either associated with the direct primary care practice or is not associated with the direct primary care practice but has entered into a contract with the practice to provide laboratory work without charging a fee to the patient for the laboratory work.

Subd. 2. **Direct primary care services agreement requirements.** (a) To be considered a direct primary care service agreement for purposes of this section, the direct agreement must:

(1) be in writing;

(2) be signed by the primary care provider or agent of the primary care practice and the direct patient or the patient's legal representative;

(3) allow either party to terminate the direct agreement upon written notice to the other party according to subdivision 3;

(4) describe the scope of the primary care services that are to be covered under the direct agreement;

(5) specify the fee to be paid on a monthly basis or as specified in the direct agreement; and

(6) specify the duration of the direct agreement.

(b) The direct agreement must clearly state that a direct primary care service agreement: is not considered health insurance; does not meet the requirements of federal law mandating individuals to purchase health insurance; and the fees charged in the agreement may not be reimbursed or applied toward a deductible under a health plan offered through a health plan company.

Subd. 3. **Acceptance and discontinuance of patients.** (a) A direct practice may not decline to accept a new patient or discontinue care to an existing patient solely on the basis of the patient's health status. A direct practice may decline to accept a patient if:

(1) the practice has reached its maximum capacity;

(2) the patient's medical condition is such that the practice is unable to provide the level and type of primary care services the patient requires; or

(3) the patient has previously terminated a direct agreement with the direct practice within the preceding year.

(b) A direct patient or the patient's legal representative may terminate a direct agreement for any reason by providing written notice to the direct practice. Termination of the direct agreement is effective the first day of the month following the month the termination notice is provided to the direct practice. A direct practice may subsequently decline to accept the direct patient as a patient if the patient has terminated a previous direct agreement with the direct practice within the preceding year.

(c) A direct practice may terminate a direct agreement for any reason by providing written notice to the direct patient or the direct patient's representative. A direct practice must provide notice of termination at least 30 days prior to the effective date of termination.

(d) A direct practice may discontinue care to a direct patient if the direct practice discontinues operation as a direct primary care practice. Notice must be provided to the direct patient or the patient's legal representative specifying the effective date of termination. Notice must be sufficient to provide the patient with the opportunity to obtain care from another provider.

Subd. 4. **Direct fees.** (a) The direct fee charged must represent the total amount due for all primary care services specified in the direct agreement provided to the direct patient within the specified time period. The direct fee must not vary from patient to patient based on the patient's health status or sex. The direct fee may be paid by the direct patient, by the patient's legal representative, or on the patient's behalf by a third party. The direct fee may be billed at the end of each monthly period or may be paid in advance for a period not to exceed 12 months.

(b) Upon receipt of a written notice of termination of the direct agreement from a direct patient or the patient's legal representative, the direct practice must promptly refund the unearned amount of the direct fees. If the direct practice discontinues care for any reason described under subdivision 3, the direct practice must promptly refund to the direct patient the unearned amount of the direct fees at a prorated amount of the direct fee earned for the current month based on the date the notice for termination was sent to the direct patient or the direct patient's legal representative.

(c) A direct practice shall not increase the monthly fee that has been negotiated with an existing direct patient more frequently than on an annual basis. A direct practice must provide advance notice of at least 60 days to existing patients of any change in the direct fee.

Subd. 5. **Conduct of business.** (a) A direct practice must maintain appropriate accounts regarding payments made and services received by a direct patient and upon request provide any data requested to the direct patient or the patient's legal representative.

(b) A direct practice must not submit a claim for payment to a health plan company for a primary care service provided to a direct patient that is covered by a direct agreement.

(c) No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising related to the business of a direct practice.

(d) No person shall make, issue, or circulate, or cause to be made, issued, or circulated, a misrepresentation of the terms of a direct agreement or the benefits or advantages promised, or use the name or title of a direct agreement misrepresenting the nature of the direct agreement.

Subd. 6. **Other care not prohibited.** A direct primary care practice is not prohibited from providing services to other patients under a separate contract with a health plan company.

Subd. 7. **Enforcement.** A violation of this section shall constitute unprofessional conduct and may be grounds for disciplinary action under chapters 147 and 148.

History: *2026 c 127 art 14 s 3; 2026 c 131 s 3*

NOTE: This section, as added by Laws 2026, chapter 127, article 14, section 3, is effective August 1, 2027. Laws 2026, chapter 131, section 3.

62Q.21 [Repealed, 1995 c 234 art 2 s 36]

62Q.22 HEALTH CARE SERVICES PREPAID OPTION.

Subdivision 1. **Scope.** A community health clinic that is designated as an essential community provider under section 62Q.19 and is associated with a hospital, a governmental unit, or the University of Minnesota may offer to individuals and families the option of purchasing basic health care services on a fixed prepaid basis without satisfying the requirements of chapter 60A, 62A, 62C, or 62D, or any other law or rule that applies to entities licensed under those chapters.

Subd. 2. **Registration.** A community health clinic that offers a prepaid option under this section must register on an annual basis with the commissioner of health.

Subd. 3. **Premiums.** The premiums for a prepaid option offered under this section must be based on a sliding fee schedule based on current poverty income guidelines.

Subd. 4. **Health care services.** (a) A prepaid option offered under this section must provide basic health care services including:

(1) services for the diagnosis and treatment of injuries, illnesses, or conditions;

(2) child health supervision services up to age 18, as defined under section 62A.047; and

(3) preventive health services, including:

(i) health education;

(ii) health supervision, evaluation, and follow-up;

(iii) immunization; and

(iv) early disease detection.

(b) Inpatient hospital services shall not be offered as a part of a community health clinic's prepaid option. A clinic may associate with a hospital to provide hospital services to an individual or family who is enrolled in the prepaid option so long as these services are not offered as part of the prepaid option.

(c) All health care services included by the community health clinic in a prepaid option must be services that are offered within the scope of practice of the clinic by the clinic's professional staff.

Subd. 5. **Guaranteed renewability.** A community health clinic shall not refuse to renew a prepaid option, except for nonpayment of premiums, fraud, or misrepresentation, or as permitted under subdivisions 8 and 9, paragraph (b).

Subd. 6. **Information to be provided.** (a) A community health clinic must provide an individual or family who purchases a prepaid option a clear and concise written statement that includes the following information:

(1) the health care services that the prepaid option covers;

(2) any exclusions or limitations on the health care services offered, including any preexisting condition limitations, cost-sharing arrangements, or prior authorization requirements;

(3) where the health care services may be obtained;

(4) a description of the clinic's method for resolving patient complaints, including a description of how a patient can file a complaint with the Department of Health; and

(5) a description of the conditions under which the prepaid option may be canceled or terminated.

(b) The commissioner of health must approve a copy of the written statement before the community health clinic may offer the prepaid option described in this section.

Subd. 7. **Complaint process.** (a) A community health clinic that offers a prepaid option under this section must establish a complaint resolution process. As an alternative to establishing its own process, a community health clinic may use the complaint process of another organization.

(b) A community health clinic must make reasonable efforts to resolve complaints and to inform complainants in writing of the clinic's decision within 60 days of receiving the complaint.

(c) A community health clinic that offers a prepaid option under this section must report all complaints that are not resolved within 60 days to the commissioner of health.

Subd. 8. **Public assistance program eligibility.** A community health clinic may require an individual or family enrolled in the clinic's prepaid option to apply for medical assistance or the MinnesotaCare program. The clinic must assist the individual or family in filing the application for the appropriate public program. If, upon the request of the clinic, an individual or family refuses to apply for these programs, the clinic may disenroll the individual or family from the prepaid option at any time.

Subd. 9. **Limitations on enrollment.** (a) A community health clinic may limit enrollment in its prepaid option. If enrollment is limited, a waiting list must be established.

(b) A community health clinic may deny enrollment in its prepaid option to an individual or family whose gross family income is greater than 275 percent of the federal poverty guidelines.

(c) No community health clinic may restrict or deny enrollment in its prepaid option because of an individual's or a family's financial limitations, except as permitted under this subdivision.

History: *1997 c 194 s 1; 2016 c 158 art 2 s 25*

62Q.23 GENERAL SERVICES.

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children to the limiting age as defined in section 62Q.01, subdivision 2a, disabled dependent children, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

History: *1994 c 625 art 4 s 8; 2005 c 56 s 1; 2013 c 84 art 1 s 72; 2017 c 99 s 1*

62Q.25 [Repealed, 1997 c 225 art 2 s 63]

62Q.251 [Repealed, 2006 c 255 s 77]

62Q.27 [Repealed, 1995 c 234 art 2 s 36]

62Q.29 [Repealed, 1997 c 225 art 2 s 63]

62Q.30 [Repealed, 1999 c 239 s 43]

62Q.32 LOCAL OMBUDSPERSON.

County board or community health service agencies may establish an office of ombudsperson to provide a system of consumer advocacy for persons receiving health care services through a health plan company. The ombudsperson's functions may include, but are not limited to:

(1) mediation or advocacy on behalf of a person accessing the complaint and appeal procedures to ensure that necessary medical services are provided by the health plan company; and

(2) investigation of the quality of services provided to a person and determine the extent to which quality assurance mechanisms are needed or any other system change may be needed.

History: *1994 c 625 art 7 s 2; 1995 c 234 art 8 s 18; 1Sp2011 c 9 art 6 s 14*

62Q.33 LOCAL GOVERNMENT PUBLIC HEALTH FUNCTIONS.

Subdivision 1. **Findings.** The legislature finds that the local government public health functions of community assessment, policy development, and assurance of service delivery are essential elements in consumer protection and in achieving the objectives of health care reform in Minnesota. The legislature further finds that the site-based and population-based services provided by state and local health departments are a critical strategy for the long-term containment of health care costs. The legislature further finds that without adequate resources, the local government public health system will lack the capacity to fulfill these functions in a manner consistent with the needs of a reformed health care delivery system.

Subd. 2. **Report on system development.** The commissioner of health, in consultation with the State Community Health Services Advisory Committee and the commissioner of human services, and representatives of local health departments, county government, a municipal government acting as a community health board, area Indian health services, health care providers, and citizens concerned about public health, shall coordinate the process for defining implementation and financing responsibilities of the local government core public health functions. The commissioner shall submit recommendations and an initial and final report on local government core public health functions according to the timeline established in subdivision 5.

Subd. 3. **Core public health functions.** (a) The report required by subdivision 2 must describe the local government core public health functions of: assessment of community health needs; goal-determination, public policy, and program development for addressing these needs; and assurance of service availability and accessibility to meet community health goals and needs. The report must further describe activities for implementation of these functions that are the continuing responsibility of the local government public health system, taking into account the ongoing reform of the health care delivery system.

(b) The activities to be defined in terms of the local government core public health functions include, but are not limited to:

(1) consumer protection and advocacy;

(2) targeted outreach and linkage to personal services;

(3) health status monitoring and disease surveillance;

(4) investigation and control of diseases and injuries;

(5) protection of the environment, work places, housing, food, and water;

(6) laboratory services to support disease control and environmental protection;

(7) health education and information;

(8) community mobilization for health-related issues;

(9) training and education of public health professionals;

(10) public health leadership and administration;

(11) emergency medical services;

(12) violence prevention; and

(13) other activities that have the potential to improve the health of the population or special needs populations and reduce the need for or cost of health care services.

Subd. 4. **Capacity building, accountability and funding.** The recommendations required by subdivision 2 shall include:

(1) a definition of minimum outcomes for implementing core public health functions, including a local ombudsperson under the assurance of services function;

(2) the identification of counties and applicable cities with public health programs that need additional assistance to meet the minimum outcomes;

(3) a budget for supporting all functions needed to achieve the minimum outcomes, including the local ombudsperson assurance of services function;

(4) an analysis of the costs and benefits expected from achieving the minimum outcomes;

(5) strategies for improving local government public health functions throughout the state to meet the minimum outcomes including: (i) funding distribution for local government public health functions necessary to meet the minimum outcomes; and (ii) strategies for the financing of personal health care services through the health plan companies and identifying appropriate mechanisms for the delivery of these services; and

(6) a recommended level of dedicated funding for local government public health functions in terms of a percentage of total health service expenditures by the state or in terms of a per capita basis, including methods of allocating the dedicated funds to local government. Funding recommendations must be broad-based and must consider all financial resources.

Subd. 5. **Timeline.** (a) MS 2000 [Obsolete]

(b) By January 15, 1997, and by January 15 of each odd-numbered year thereafter, the commissioner shall present to the legislature an updated report and recommendations.

History: *1994 c 625 art 7 s 3; 1995 c 234 art 8 s 19,20; 1997 c 225 art 2 s 43; 2015 c 21 art 1 s 109*

62Q.37 AUDITS CONDUCTED BY INDEPENDENT ORGANIZATION.

Subdivision 1. **Applicability.** This section applies only to (1) a nonprofit health service plan corporation operating under chapter 62C; (2) a health maintenance organization operating under chapter 62D; (3) a community integrated service network operating under chapter 62N; and (4) managed care organizations operating under chapter 256B or 256L.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Commissioner" means the commissioner of health for purposes of regulating health maintenance organizations and community integrated service networks, the commissioner of commerce for purposes of regulating nonprofit health service plan corporations, or the commissioner of human services for the purpose of contracting with managed care organizations serving persons enrolled in programs under chapter 256B or 256L.

(c) "Health plan company" means (1) a nonprofit health service plan corporation operating under chapter 62C; (2) a health maintenance organization operating under chapter 62D; (3) a community integrated service network operating under chapter 62N; or (4) a managed care organization operating under chapter 256B or 256L.

(d) "Nationally recognized independent organization" means (1) an organization that sets specific national standards governing health care quality assurance processes, utilization review, provider credentialing, marketing, and other topics covered by this chapter and other chapters and audits and provides accreditation to those health plan companies that meet those standards. The American Accreditation Health Care Commission (URAC), the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Accreditation Association for Ambulatory Health Care (AAAHC) are, at a minimum, defined as nationally recognized independent organizations; and (2) the Centers for Medicare and Medicaid Services for purposes of reviews or audits conducted of health plan companies under Part C of Title XVIII of the Social Security Act or under section 1876 of the Social Security Act.

(e) "Performance standard" means those standards relating to quality management and improvement, access and availability of service, utilization review, provider selection, provider credentialing, marketing, member rights and responsibilities, complaints, appeals, grievance systems, enrollee information and materials, enrollment and disenrollment, subcontractual relationships and delegation, confidentiality, continuity and coordination of care, assurance of adequate capacity and services, coverage and authorization of services, practice guidelines, health information systems, and financial solvency.

Subd. 3. **Audits.** (a) The commissioner may conduct routine audits and investigations as prescribed under the commissioner's respective state authorizing statutes. If a nationally recognized independent organization has conducted an audit of the health plan company using audit procedures that are comparable to or more stringent than the commissioner's audit procedures:

(1) the commissioner shall accept the independent audit, including standards and audit practices, and require no further audit if the results of the independent audit show that the performance standard being audited meets or exceeds state standards;

(2) the commissioner may accept the independent audit and limit further auditing if the results of the independent audit show that the performance standard being audited partially meets state standards;

(3) the health plan company must demonstrate to the commissioner that the nationally recognized independent organization that conducted the audit is qualified and that the results of the audit demonstrate that the particular performance standard partially or fully meets state standards; and

(4) if the commissioner has partially or fully accepted an independent audit of the performance standard, the commissioner may use the finding of a deficiency with regard to statutes or rules by an independent audit as the basis for a targeted audit or enforcement action.

(b) If a health plan company has formally delegated activities that are required under either state law or contract to another organization that has undergone an audit by a nationally recognized independent organization, that health plan company may use the nationally recognized accrediting body's determination on its own behalf under this section.

Subd. 4. **Disclosure of national standards and reports.** The health plan company shall:

(1) request that the nationally recognized independent organization provide to the commissioner a copy of the current nationally recognized independent organization's standards upon which the acceptable accreditation status has been granted; and

(2) provide the commissioner a copy of the most current final audit report issued by the nationally recognized independent organization.

Subd. 5. [Repealed, 2013 c 84 art 1 s 94]

Subd. 6. **Continued authority.** Nothing in this section precludes the commissioner from conducting audits and investigations or requesting data as granted under the commissioner's respective state authorizing statutes.

Subd. 7. **Human services.** The commissioner of human services shall implement this section in a manner that is consistent with applicable federal laws and regulations and that avoids the duplication of review activities performed by a nationally recognized independent organization.

Subd. 8. **Confidentiality.** Any documents provided to the commissioner related to the audit report that may be accepted under this section are private data on individuals pursuant to chapter 13 and may only be released as permitted under section 60A.03, subdivision 9.

History: *2004 c 288 art 6 s 8; 1Sp2005 c 4 art 8 s 4; 2009 c 174 art 2 s 1; 2015 c 71 art 8 s 7; 2016 c 158 art 2 s 26,27; 2022 c 98 art 14 s 2*

62Q.41 [Repealed, 1997 c 225 art 2 s 63]

62Q.43 GEOGRAPHIC ACCESS.

Subdivision 1. **Closed-panel health plan.** For purposes of this section, "closed-panel health plan" means a health plan as defined in section 62Q.01 that requires an enrollee to receive all or a majority of primary care services from a specific clinic or primary care provider designated by the enrollee that is within the health plan company's clinic or provider network.

Subd. 2. **Access requirement.** Every closed-panel health plan must allow enrollees under the age of 26 years to change their designated clinic or primary care provider at least once per month, as long as the clinic or provider is part of the health plan company's statewide clinic or provider network. A health plan company shall not charge enrollees who choose this option higher premiums or cost sharing than would otherwise apply to enrollees who do not choose this option. A health plan company may require enrollees to provide 15 days' written notice of intent to change their designated clinic or primary care provider.

History: *1995 c 234 art 2 s 27; 2013 c 84 art 1 s 73; 2020 c 115 art 4 s 9,10*

62Q.45 COVERAGE FOR OUT-OF-AREA PRIMARY CARE.

Subdivision 1. **Study.** The commissioner of health shall develop methods to allow enrollees of managed care organizations to obtain primary care health services outside of the service area of their managed care

organization, from health care providers who are employed by or under contract with another managed care organization. The commissioner shall make recommendations on: (1) whether this out-of-area primary care coverage should be available to students and/or other enrollees without additional premium charges or cost sharing; (2) methods to coordinate the services provided by different managed care organizations; (3) methods to manage the quality of care provided by different managed care organizations and monitor health care outcomes; (4) methods to reimburse managed care organizations for care provided to enrollees of other managed care organizations; and (5) other issues relevant to the design and administration of out-of-area primary care coverage. The commissioner shall present recommendations to the legislature by January 15, 1996.

Subd. 2. **Definition.** For purposes of this section, "managed care organization" means:

(1) a health maintenance organization operating under chapter 62D;

(2) a community integrated service network as defined under section 62N.02, subdivision 4a; or

(3) an insurance company licensed under chapter 60A, nonprofit health service plan corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

History: *1995 c 234 art 2 s 28; 1997 c 225 art 2 s 44*

62Q.451 UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Rare disease or condition" means any disease or condition:

(1) that affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;

(2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;

(3) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or

(4) for which an enrollee:

(i) has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;

(ii) has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and

(iii) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

Subd. 2. **Unrestricted access.** (a) No health plan company may restrict the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, including but not limited to additional restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees, or other methods.

(b) Any services provided by, referred for, or ordered by an out-of-network provider for an enrollee who, before receiving and being notified of a definitive diagnosis, satisfied the requirements in subdivision 1, paragraph (b), clause (4), are governed by paragraph (c), even if the subsequent definitive diagnosis does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3). Once the enrollee is definitively diagnosed with a disease or condition that does not meet the definition of rare disease or condition in subdivision 1, paragraph (b), clause (1), (2), or (3), and notification of the diagnosis has been provided to both the health plan and the enrollee, or a parent or guardian of a minor enrollee, any services provided by, referred for, or ordered by an out-of-network provider related to the diagnosis are governed by paragraph (c) for up to 60 days, providing time for care to be transferred to a qualified in-network provider and to schedule needed in-network appointments. After this 60-day period, subsequent services provided by, referred for, or ordered by an out-of-network provider related to the diagnosis are no longer governed by paragraph (c).

(c) Cost-sharing requirements and benefit or services limitations for the diagnosis and treatment of a rare disease or condition must not place a greater financial burden on the enrollee or be more restrictive than those requirements for in-network medical treatment.

(d) A health plan company must provide enrollees with written information on the content and application of this section and must train customer service representatives on the content and application of this section.

Subd. 3. **Coverage; prior authorization.** (a) Nothing in this section requires a health plan company to provide coverage for a medication, procedure or treatment, or laboratory or clinical testing, that is not covered under the enrollee's health plan.

(b) Coverage for a service must not be denied solely on the basis that it was provided by, referred for, or ordered by an out-of-network provider.

(c) Any prior authorization requirements for a service that is provided by, referred for, or ordered by an out-of-network provider must be the same as any prior authorization requirements for a service that is provided by, referred for, or ordered by an in-network provider.

(d) Subject to the requirements of this section and chapter 62W, a health plan may require use of a specialty pharmacy, as defined in section 62W.02, subdivision 20.

Subd. 4. **Payments to out-of-network providers for services provided in this state.** (a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept the established contractual payment for that service as payment in full.

(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks, then the provider shall accept:

(1) the provider's established rate for uninsured patients for that service as payment in full; or

(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in this state over the past 12 months as payment in full.

(c) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in this state within the past 12 months, then the health plan company shall pay the lesser of the following:

(1) the average rate in the commercial insurance market the health plan company paid for that service across all states over the past 12 months; or

(2) the provider's standard charge.

(d) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapters 256B or 256L.

Subd. 5. **Payments to out-of-network providers when services are provided outside of the state.** (a) If a health plan company has an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay the established contractual payment for that service.

(b) If a health plan company does not have an established contractual payment under a health plan in the commercial insurance market with an out-of-network provider for a service provided in another state related to the diagnosis, monitoring, and treatment of a rare disease or condition, across any of the health plan's networks in the state where the service is provided, then the health plan company shall pay:

(1) the provider's established rate for uninsured patients for that service; or

(2) if the provider does not have an established rate for uninsured patients for that service, then the average commercial insurance rate the health plan company has paid for that service in the state where the service is provided over the past 12 months.

(c) If the payment amount is determined under paragraph (b), clause (2), and the health plan company has not paid for that service in the state where the service is provided within the past 12 months, then the health plan company shall pay the lesser of the following:

(1) the average commercial insurance rate the health plan company has paid for that service across all states over the last 12 months; or

(2) the provider's standard charge.

(d) This subdivision does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

Subd. 6. **Exclusion.** This section does not apply to medications obtained from a retail pharmacy as defined in section 62W.02, subdivision 18.

History: *2023 c 70 art 2 s 25*

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. Preventive items and services includes:

(1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this clause, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after the recommendation has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if the recommendation is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(4) with respect to women, additional preventive care and screenings that are not listed with a rating of A or B by the United States Preventive Services Task Force but that are provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(5) all contraceptive methods established in guidelines published by the United States Food and Drug Administration;

(6) screenings for human immunodeficiency virus for:

(i) all individuals at least 15 years of age but less than 65 years of age; and

(ii) all other individuals with increased risk of human immunodeficiency virus infection according to guidance from the Centers for Disease Control;

(7) all preexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention of HIV Infection United States Preventive Services Task Force Recommendation Statement; and

(8) all postexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control.

(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) A health plan shall not require prior authorization or step therapy for preexposure prophylaxis or postexposure prophylaxis, except that: if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of HIV, this paragraph does not require a health plan to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(f) This section does not apply to grandfathered plans.

(g) 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 under subdivision 1, paragraph (a), or from denying coverage for preventive items and services that are not recommended as preventive items and services specified under subdivision 1, paragraph (a). A health plan company may impose cost-sharing requirements for a treatment not described under subdivision 1, paragraph (a), even if the treatment results from a preventive item or service described under subdivision 1, paragraph (a).

History: *2013 c 84 art 1 s 74; 2023 c 57 art 2 s 42,43; 2024 c 127 art 60 s 1*

62Q.465 MENTAL HEALTH PARITY AND SUBSTANCE ABUSE ACCOUNTABILITY OFFICE.

(a) The Mental Health Parity and Substance Abuse Accountability Office is established within the Department of Commerce to create and execute effective strategies for implementing the requirements under:

(1) section 62Q.47;

(2) the federal Mental Health Parity Act of 1996, Public Law 104-204;

(3) the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, division C, sections 511 and 512;

(4) the Affordable Care Act, as defined under section 62A.011, subdivision 1a; and

(5) amendments made to, and federal guidance or regulations issued or adopted under, the acts listed under clauses (2) to (4).

(b) The office may oversee compliance reviews, conduct and lead stakeholder engagement, review consumer and provider complaints, and serve as a resource for ensuring health plan compliance with mental health and substance abuse requirements.

History: *2023 c 57 art 2 s 44*

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 seeking chemical dependency services under section 245G.05, 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 services, psychiatric residential treatment facility services, and inpatient hospital and residential chemical dependency and alcoholism services, except for persons seeking chemical dependency services under section 245G.05, 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) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) 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.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) All health plan companies offering health plans that provide coverage for alcoholism, mental health, or chemical dependency benefits shall provide reimbursement for the benefits delivered through the psychiatric

Collaborative Care Model, which must include the following Current Procedural Terminology or Healthcare Common Procedure Coding System billing codes:

(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

This paragraph does not apply to managed care plans or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

(i) The commissioner of commerce shall update the list of codes in paragraph (h) if any alterations or additions to the billing codes for the psychiatric Collaborative Care Model are made.

(j) "Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method described at Federal Register, volume 81, page 80230, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to the following elements:

(1) care directed by the primary care team;

(2) structured care management;

(3) regular assessments of clinical status using validated tools; and

(4) modification of treatment as appropriate.

(k) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

(l) A health plan must reimburse all alcoholism, mental health, and chemical dependency services provided by clinical trainees pursuant to section 245I.04, subdivision 6, at a rate at least equal to 100 percent of the rate that would be paid to an independently licensed mental health professional performing the same services. This paragraph does not apply if the service provided by the clinical trainee is not:

(1) within the clinical trainee's scope of practice under section 245I.04, subdivision 7; or

(2) a covered service if performed by an independently licensed mental health professional at the same clinic.

History: *1995 c 234 art 2 s 29; 2008 c 344 s 16; 2013 c 84 art 1 s 75; 2016 c 158 art 1 s 22,214; 1Sp2019 c 9 art 8 s 14; 2023 c 50 art 2 s 3; 2023 c 57 art 2 s 45; 2026 c 124 art 3 s 7*

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.

(b) For purposes of this section, "health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (4), (6), and (7) through (10).

History: *1Sp2001 c 9 art 9 s 1; 2002 c 379 art 1 s 113; 2005 c 132 s 16; 2014 c 275 art 1 s 9*

62Q.472 SCREENING AND TESTING FOR OPIOIDS.

(a) A health plan company shall not place a lifetime or annual limit on screenings and urinalysis testing for opioids for an enrollee in an inpatient or outpatient substance use disorder treatment program when the screening or testing is ordered by a health care provider and performed by an accredited clinical laboratory. A health plan company is not prohibited from conducting a medical necessity review when screenings or urinalysis testing for an enrollee exceeds 24 tests in any 12-month period.

(b) This section does not apply to managed care plans or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

History: *1Sp2021 c 4 art 3 s 16*

62Q.473 BIOMARKER TESTING.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

(c) "Biomarker testing" means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome, and whole transcriptome sequencing.

(d) "Clinical utility" means a test provides information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

(e) "Consensus statement" means a statement that: (1) describes optimal clinical care outcomes, based on the best available evidence, for a specific clinical circumstance; and (2) is developed by an independent, multidisciplinary panel of experts that: (i) uses a rigorous and validated development process that includes a transparent methodology and reporting structure; and (ii) strictly adheres to the panel's conflict of interest policy.

(f) "Nationally recognized clinical practice guideline" means an evidence-based clinical practice guideline that: (1) establishes a standard of care informed by: (i) a systematic review of evidence; and (ii) an assessment of the risks and benefits of alternative care options; and (2) is developed by an independent organization or medical professional society that: (i) uses a transparent methodology and reporting structure; and (ii) adheres to a conflict of interest policy. Nationally recognized clinical practice guideline includes recommendations to optimize patient care.

Subd. 2. **Biomarker testing; coverage required.** (a) A health plan must provide coverage for biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. For purposes of this section, a test's clinical utility may be demonstrated by medical and scientific evidence, including but not limited to:

(1) nationally recognized clinical practice guidelines as defined in this section;

(2) consensus statements as defined in this section;

(3) labeled indications for a United States Food and Drug Administration (FDA) approved or FDA-cleared test, indicated tests for an FDA-approved drug, or adherence to warnings and precautions on FDA-approved drug labels; or

(4) Centers for Medicare and Medicaid Services national coverage determinations or Medicare Administrative Contractor local coverage determinations.

(b) Coverage under this section must be provided in a manner that limits disruption of care, including the need for multiple biopsies or biospecimen samples.

(c) Nothing in this section prohibits a health plan company from requiring a prior authorization or imposing other utilization controls when approving coverage for biomarker testing.

Subd. 3. **Reimbursement.** (a) The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2023, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's

coverage as of January 1, 2023, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 4. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

History: *2023 c 70 art 2 s 26; 2024 c 127 art 57 s 37,38*

62Q.48 COST-SHARING IN PRESCRIPTION INSULIN DRUGS.

Subdivision 1. **Scope of coverage.** This section applies to all health plans issued or renewed to a Minnesota resident.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Cost-sharing" means a deductible payment, co-payment, or coinsurance amount imposed on an enrollee for a covered prescription drug in accordance with the terms and conditions of the enrollee's health plan.

(c) "Legend drug" has the same meaning as in section 151.01, subdivision 17.

(d) "Prescription insulin drug" means a legend drug that contains insulin and is used to treat diabetes.

(e) "Net price" means the health plan company's cost for a prescription insulin drug, including any rebates or discounts received by or accrued directly or indirectly to the health plan company from a drug manufacturer or pharmacy benefit manager.

Subd. 3. **Cost-sharing limits.** (a) A health plan that imposes a cost-sharing requirement on the coverage of a prescription insulin drug shall limit the total amount of cost-sharing that an enrollee is required to pay at point of sale, including deductible payments and the cost-sharing amounts charged once the deductible is met at an amount that does not exceed the net price of the prescription insulin drug.

(b) Nothing in this section shall prevent a health plan company from imposing a cost-sharing requirement that is less than the amount specified in paragraph (a).

History: *1Sp2019 c 9 art 8 s 15*

62Q.481 COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.

Subdivision 1. **Cost-sharing limits.** (a) A health plan must limit the amount of any enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more than: (1) $25 per one-month supply for each prescription drug, regardless of the amount or type of medication required to fill the prescription; and (2) $50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible.

(b) If application of this section before an enrollee has met the enrollee's plan deductible results in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health

plan ineligibility under United States Code, title 42, section 18022(e), this section applies to the specific prescription drug or related medical supply only after the enrollee has met the enrollee's plan deductible.

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of epinephrine auto-injectors.

(c) "Cost-sharing" means co-payments and coinsurance.

(d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips, glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and other medical supply items necessary to effectively and appropriately treat a chronic disease or administer a prescription drug prescribed to treat a chronic disease.

History: *2023 c 57 art 2 s 46*

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.

History: *1996 c 446 art 1 s 50*

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).

History: *1996 c 446 art 1 s 51,72,73; 1998 c 339 s 12*

62Q.51 POINT-OF-SERVICE OPTION.

Subdivision 1. **Definition.** For purposes for this section, "point-of-service option" means a health plan under which the health plan company will reimburse an appropriately licensed or registered provider for providing covered services to an enrollee, without regard to whether the provider belongs to a particular network and without regard to whether the enrollee was referred to the provider by another provider.

Subd. 2. **Required point-of-service option.** Each health plan company operating in the small group or large group market shall offer at least one point-of-service option in each such market in which it operates.

Subd. 3. **Rate approval.** The premium rates and cost sharing requirements for each option must be submitted to the commissioner of health or the commissioner of commerce as required by law. A health plan that includes lower enrollee cost sharing for services provided by network providers than for services provided by out-of-network providers, or lower enrollee cost sharing for services provided with prior authorization or second opinion than for services provided without prior authorization or second opinion, qualifies as a point-of-service option.

Subd. 4. **Exemption.** This section does not apply to a health plan company with fewer than 50,000 enrollees in its commercial health plan products.

History: *1996 c 446 art 1 s 52; 1999 c 181 s 6*

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.

(c) The health plan company shall treat the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services, pursuant to paragraph (a), by a participating health care provider who specializes in obstetrics or gynecology as the authorization of a primary care provider.

(d) The health plan company may require the health care provider to agree to otherwise adhere to the health plan company's policies and procedures, including procedures for obtaining prior authorization and for providing services in accordance with a treatment plan, if any, approved by the health plan company.

(e) Health plan companies shall not require higher co-payments, coinsurance, deductibles, or other enrollee cost-sharing for direct access.

(f) This section applies only to services described in paragraph (a) that are covered by the enrollee's coverage, but coverage of a preventive health examination for female enrollees must not exclude coverage of a gynecologic examination.

(g) For purposes of this section, a health care provider who specializes in obstetrics or gynecology means any individual, including an individual other than a physician, who is authorized under state law to provide obstetrical or gynecological care.

(h) This section does not:

(1) waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of obstetrical or gynecological care; or

(2) preclude the health plan company from requiring that the participating health care provider providing obstetrical or gynecological care notify the primary care provider or the health plan company of treatment decisions.

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.

Subd. 3. **Enforcement.** The commissioner of health shall enforce this section.

History: *1997 c 26 s 1; 2013 c 84 art 1 s 76*

62Q.521 POSTNATAL CARE.

(a) For purposes of this section, "comprehensive postnatal visit" means a visit with a health care provider that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

(b) A health plan must provide coverage for the following:

(1) a comprehensive postnatal visit with a health care provider not more than three weeks from the date of delivery;

(2) any postnatal visits recommended by a health care provider between three and 11 weeks from the date of delivery; and

(3) a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery.

(c) The requirements of this section are separate from and cannot be met by a visit made pursuant to section 62A.0411.

History: *2022 c 44 s 3*

62Q.522 COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(c) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy, excluding vasectomies. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

(d) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(e) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration; and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meets an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide coverage for contraceptive methods and services.

(b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or coinsurance, for contraceptive methods or services.

(c) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptive methods or services.

(d) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. If more than one therapeutic equivalent version of a contraceptive method is approved, a health plan must include at least one therapeutic equivalent version in its formulary, but is not required to include all therapeutic equivalent versions.

(e) For each health plan, a health plan company must list the contraceptive methods and services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(f) If an enrollee's attending provider recommends a particular contraceptive method or service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive method or service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive method or service is medically necessary for the enrollee.

Subd. 3. MS 2023 Supp [Repealed, 2024 c 114 art 1 s 17; 2024 c 127 art 57 s 71]

Subd. 4. MS 2023 Supp [Repealed, 2024 c 114 art 1 s 17; 2024 c 127 art 57 s 71]

History: *2023 c 70 art 2 s 27; 2024 c 114 art 1 s 5*

62Q.523 COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.679, subdivisions 2 and 3, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration to prescribe the prescription contraceptives for up to 12 months.

History: *2023 c 70 art 2 s 28; 2024 c 114 art 1 s 6*

62Q.524 COVERAGE OF ABORTIONS AND ABORTION-RELATED SERVICES.

Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy with a purpose other than producing a live birth.

Subd. 2. **Required coverage.** (a) A health plan must provide coverage for abortions and abortion-related services, including preabortion services and follow-up services.

(b) A health plan must not impose on the coverage under this section any co-payment, coinsurance, deductible, or other enrollee cost-sharing that is greater than the cost-sharing that applies to similar services covered under the health plan.

(c) A health plan must not impose any limitation on the coverage under this section, including but not limited to any utilization review, prior authorization, referral requirements, restrictions, or delays, that is not generally applicable to other coverages under the plan.

Subd. 3. **Exclusion.** This section does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

Subd. 4. **Reimbursement.** (a) The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2024, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2024, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

History: *2024 c 127 art 57 s 39*

62Q.525 COVERAGE FOR OFF-LABEL DRUG USE.

Subdivision 1. **Scope of coverage.** This section applies to all health plans, including the coverages described in section 62A.011, subdivision 3, clauses (7) and (10), that are issued or renewed to a Minnesota resident.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Medical literature" means articles from major peer reviewed medical journals that have recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or be published in a journal specified by the United States Secretary of Health and Human Services pursuant to United States Code, title 42, section 1395x, paragraph (t), clause (2), item (B), as amended, as acceptable peer review medical literature. Each article must use generally acceptable scientific standards and must not use case reports to satisfy this criterion.

(c) "Off-label use of drugs" means when drugs are prescribed for treatments other than those stated in the labeling approved by the federal Food and Drug Administration.

(d) "Standard reference compendia" means any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

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.

Subd. 4. **Construction.** This section must not be construed to:

(1) alter existing law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration;

(2) require coverage for any drug when the federal Food and Drug Administration has determined its use to be contraindicated;

(3) require coverage for experimental drugs not otherwise approved for any indication by the federal Food and Drug Administration; or

(4) reduce or limit coverage for off-label use of drugs otherwise required by law or contract.

History: *1998 c 301 s 1; 2009 c 159 s 3*

62Q.526 COVERAGE FOR PARTICIPATION IN APPROVED CLINICAL TRIALS.

Subdivision 1. **Definitions.** (a) As used in this section, the following definitions apply:

(b) "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.

(c) "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.

(d)(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.

Subd. 3. **Network plan conditions.** A health plan company that designates a network or networks of contracted providers may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the plan's network if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

Subd. 4. **Application to clinical trials outside of the state.** This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.

Subd. 5. **Construction.** (a) This section shall not be construed to require a health plan company offering health plan coverage through a network or networks of contracted providers to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

(b) This section shall not be construed to limit a health plan company's coverage with respect to clinical trials.

(c) This section shall apply to all health plan companies offering a health plan to a Minnesota resident, unless otherwise amended by federal regulations under the Affordable Care Act.

History: *2013 c 84 art 1 s 77*

62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS; REQUIRED COVERAGE.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Mental illness" has the meaning given in sections 245.462, subdivision 20, paragraph (a), and 245.4871, subdivision 15.

(c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

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 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 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.

History: *1Sp2001 c 9 art 9 s 2; 2002 c 379 art 1 s 113; 2025 c 38 art 8 s 1-3*

62Q.528 DRUG COVERAGE IN EMERGENCY SITUATIONS.

A health plan that provides prescription drug coverage must provide coverage for a prescription drug dispensed by a pharmacist under section 151.211, subdivision 3, under the terms of coverage that would apply had the prescription drug been dispensed according to a prescription.

History: *1Sp2019 c 9 art 9 s 2*

62Q.529 COVERAGE FOR DRUGS PRESCRIBED AND DISPENSED BY PHARMACIES.

(a) A health plan that provides prescription coverage must provide coverage for self-administered hormonal contraceptives, nicotine replacement medications, and opiate antagonists for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14, 15, or 16, under the same terms of coverage that would apply had the prescription drug been prescribed by a licensed physician, physician assistant, or advanced practice registered nurse.

(b) A health plan is not required to cover the drug if dispensed by an out-of-network pharmacy, unless the health plan covers prescription drugs dispensed by out-of-network pharmacies.

History: *2020 c 115 art 2 s 2; 2022 c 58 s 170*

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).

History: *1997 c 49 s 1*

62Q.531 AMINO ACID-BASED FORMULA COVERAGE.

Subdivision 1. **Definition.** (a) For purposes of this section, the following term has the meaning given.

(b) "Formula" means an amino acid-based elemental formula.

Subd. 2. **Required coverage.** A health plan company must provide coverage for formula when formula is medically necessary.

Subd. 3. **Covered conditions.** Conditions for which formula is medically necessary include but are not limited to:

(1) cystic fibrosis;

(2) amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;

(3) IgE mediated allergies to food proteins;

(4) food protein-induced enterocolitis syndrome;

(5) eosinophilic esophagitis;

(6) eosinophilic gastroenteritis;

(7) eosinophilic colitis; and

(8) mast cell activation syndrome.

History: *2024 c 127 art 57 s 40*

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.

(b) A party or interested person, including a health plan company or its designee, may make a motion for modification of the court-ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation according to this section.

History: *1Sp2001 c 9 art 9 s 3; 2002 c 379 art 1 s 113*

62Q.54 REFERRALS FOR RESIDENTS OF HEALTH CARE FACILITIES.

If an enrollee is a resident of a health care facility licensed under chapter 144A or an assisted living facility licensed under chapter 144G, the enrollee's primary care provider must refer the enrollee to that facility's skilled nursing unit or that facility's appropriate care setting, provided that the health plan company and the provider can best meet the patient's needs in that setting, if the following conditions are met:

(1) the facility agrees to be reimbursed at that health plan company's contract rate negotiated with similar providers for the same services and supplies; and

(2) the facility meets all guidelines established by the health plan company related to quality of care, utilization, referral authorization, risk assumption, use of health plan company network, and other criteria applicable to providers under contract for the same services and supplies.

History: *1997 c 225 art 2 s 45; 2020 c 115 art 4 s 11; 7Sp2020 c 1 art 6 s 25*

62Q.545 COVERAGE OF HOME CARE NURSING.

(a) Home care nursing services, as provided under section 256B.0625, subdivision 7, with the exception of section 256B.0654, subdivision 4, shall be covered under a health plan for persons who are concurrently covered by both the health plan and enrolled in medical assistance under chapter 256B.

(b) For purposes of this section, a period of home care nursing services may be subject to the co-payment, coinsurance, deductible, or other enrollee cost-sharing requirements that apply under the health plan. Cost-sharing requirements for home care nursing services must not place a greater financial burden on the insured or enrollee than those requirements applied by the health plan to other similar services or benefits. Nothing in this section is intended to prevent a health plan company from requiring prior authorization by the health plan company for such services as required by section 256B.0625, subdivision 7, or use of contracted providers under the applicable provisions of the health plan.

History: *1Sp2010 c 1 art 19 s 1; 2014 c 291 art 9 s 5*

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 and shall count toward the

in-network deductible. All coverage and charges for emergency services must comply with the No Surprises Act.

History: *1997 c 237 s 11; 2013 c 84 art 1 s 78; 2015 c 71 art 2 s 3; 2023 c 70 art 2 s 29*

62Q.556 CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

Subdivision 1. **Nonparticipating provider balance billing prohibition.** (a) Except as provided in paragraph (b), balance billing is prohibited when an enrollee receives services from:

(1) a nonparticipating provider at a participating hospital or ambulatory surgical center, as described by the No Surprises Act, including any federal regulations adopted under that act;

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

(3) a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of the No Surprises Act.

(b) The services described in paragraph (a), clauses (1), (2), and (3), as defined in the No Surprises Act, and any federal regulations adopted under that act, are subject to balance billing if the enrollee provides informed consent prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of the No Surprises Act, including any federal regulations adopted under that act.

Subd. 2. **Cost-sharing requirements and independent dispute resolution.** (a) An enrollee's financial responsibility for the nonparticipating provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for nonparticipating provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the nonparticipating provider services with the nonparticipating provider. If the attempt to negotiate reimbursement for the nonparticipating provider services does not result in a resolution, either party may initiate the federal independent dispute resolution process pursuant to the No Surprises Act, including any federal regulations adopted under that act.

Subd. 3. **Annual data reporting.** (a) Beginning April 1, 2024, a health plan company must report annually to the commissioner of health:

(1) the total number of claims and total billed and paid amounts for nonparticipating provider services, by service and provider type, submitted to the health plan in the prior calendar year; and

(2) the total number of enrollee complaints received regarding the rights and protections established by the No Surprises Act in the prior calendar year.

(b) The commissioners of commerce and health shall develop the form and manner for health plan companies to comply with paragraph (a).

Subd. 4. **Enforcement.** (a) Any provider or facility, including a health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to the relevant provisions of the No Surprises Act is subject to the requirements of this section and section 62J.811.

(b) The commissioner of commerce or health shall enforce this section.

(c) If a health-related licensing board has cause to believe that a provider has violated this section, it may further investigate and enforce the provisions of this section pursuant to chapter 214.

History: *2017 c 2 art 2 s 13; 2017 c 13 art 2 s 6; 2023 c 70 art 2 s 30*

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:

(1) how the health plan company will inform affected enrollees about termination at least 30 days before the termination is effective, if the health plan company or health care network cooperative has received at least 120 days' prior notice;

(2) how the health plan company will inform the affected enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its enrollees from the terminating provider to the new provider to maintain continuity of care;

(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;

(4) who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination; and

(5) how continuity of care will be provided for enrollees identified as having special needs or at special risk, and whether the health plan company has assigned this responsibility to its contracted primary care providers.

(b) For purposes of this section, contract termination includes nonrenewal.

Subd. 1a. **Change in health care provider; termination not for cause.** (a) If the contract termination was not for cause and the contract was terminated by the health plan company, the health plan company must provide the terminated provider and all enrollees being treated by that provider with notification of the enrollees' rights to continuity of care with the terminated provider.

(b) The health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician, advanced practice registered nurse, or physician assistant certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization to receive services under this paragraph, the health plan company must grant the request unless the enrollee does not meet the criteria provided in this paragraph.

(c) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees who request continuity of care with their former provider, if the enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

Subd. 1b. **Change in health care provider; termination for cause.** If the contract termination was for cause, enrollees must be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible to the affected enrollees. The health plan company is not required to refer an enrollee back to the terminating provider if the termination was for cause.

Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Subd. 2a. **Limitations.** (a) Subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of the health plan company's reimbursement rate for in-network providers for the same or similar service or the enrollee's health care provider's regular fee for that service;

(2) adhere to the health plan company's preauthorization requirements; and

(3) provide the health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 2b. **Request for authorization.** The health plan company may require medical records and other supporting documentation to be submitted with the requests for authorization made under subdivision 1, 1a, 1b, or 2. If the authorization is denied, the health plan company must explain the criteria it used to make its decision on the request for authorization. If the authorization is granted, the health plan company must explain how continuity of care will be provided.

Subd. 3. **Disclosure.** Information regarding an enrollee's rights under this section must be included in member contracts or certificates of coverage and must be provided by a health plan company upon request of an enrollee or prospective enrollee.

History: *1997 c 237 s 12; 1Sp2001 c 9 art 16 s 7; 2002 c 379 art 1 s 113; 2017 c 59 s 1; 2023 c 70 art 2 s 31*

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, advanced practice registered nurse, or physician assistant 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.

Subd. 3. **Enforcement.** The commissioner shall enforce this section.

History: *2013 c 84 art 1 s 79; 2020 c 115 art 4 s 12; 2022 c 58 s 12*

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. 1a. **Mandatory standing referral.** (a) An enrollee who requests a standing referral to a specialist qualified to treat the specific condition described in clauses (1) to (5) must be given a standing referral for visits to such a specialist if benefits for such treatment are provided under the health plan and the enrollee has any of the following conditions:

(1) a chronic health condition;

(2) a life-threatening mental or physical illness;

(3) pregnancy beyond the first trimester of pregnancy;

(4) a degenerative disease or disability; or

(5) any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

(b) Nothing in this section limits the application of section 62Q.52 specifying direct access to obstetricians and gynecologists.

(c) Paragraph (a) does not apply to health plans issued under sections 43A.23 to 43A.31.

Subd. 2. **Coordination of services.** An enrollee with a standing referral to a specialist may request primary care services from that specialist. The specialist, in agreement with the enrollee and primary care provider or primary care group, may elect to provide primary care services to the enrollee, authorize tests

and services, and make secondary referrals according to procedures established by the health plan company. The health plan company may limit the primary care services, tests and services, and secondary referrals authorized under this subdivision to those that are related to the specific condition or conditions for which the standing referral was made.

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.

History: *1997 c 237 s 13; 1Sp2001 c 9 art 16 s 8; 2002 c 379 art 1 s 113*

62Q.585 GENDER-AFFIRMING CARE COVERAGE; MEDICALLY NECESSARY CARE.

Subdivision 1. **Requirement.** No health plan that covers physical or mental health services may be offered, sold, issued, or renewed in this state that:

(1) excludes coverage for medically necessary gender-affirming care; or

(2) requires gender-affirming treatments to satisfy a definition of "medically necessary care," "medical necessity," or any similar term that is more restrictive 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. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Gender-affirming care" means all medical, surgical, counseling, or referral services, including telehealth services, that an individual may receive to support and affirm the individual's gender identity or gender expression and that are legal under the laws of this state.

(c) "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).

History: *2024 c 114 art 1 s 7*

62Q.64 [Repealed, 2012 c 247 art 1 s 32]

62Q.645 EFFICIENCY REPORTS AND DISTRIBUTION OF INFORMATION.

(a) The commissioner may use reports submitted by health plan companies, service cooperatives, and the public employee insurance program created in section 43A.316 to compile entity specific administrative efficiency reports; may make these reports available on state agency websites, including minnesotahealthinfo.com; and may include information on:

(1) number of covered lives;

(2) covered services;

(3) geographic availability;

(4) whom to contact to obtain current premium rates;

(5) administrative costs, using the definition of administrative costs developed under section 62J.38;

(6) Internet links to information on the health plan, if available; and

(7) any other information about the health plan identified by the commissioner as being useful for employers, consumers, providers, and others in evaluating health plan options.

(b) This section does not apply to a health plan company unless its annual Minnesota premiums exceed $50,000,000 based on the most recent assessment base of the Minnesota Comprehensive Health Association. For purposes of this determination, the premiums of a health plan company include those of its affiliates.

History: *2006 c 255 s 34*

62Q.65 ACCESS TO PROVIDER DISCOUNTS.

Subdivision 1. **Requirement.** A high deductible health plan must, when used in connection with a medical savings account or health savings account, provide the enrollee access to any discounted provider fees for services covered by the high deductible health plan, regardless of whether the enrollee has satisfied the deductible for the high deductible health plan.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "high deductible health plan" has the meaning given under the Internal Revenue Code of 1986, section 220(c)(2), with respect to a medical savings account; and the meaning given under Internal Revenue Code of 1986, section 223(c)(2), with respect to a health savings account;

(2) "medical savings account" has the meaning given under the Internal Revenue Code of 1986, section 220(d)(1);

(3) "discounted provider fees" means fees contained in a provider agreement entered into by the issuer of the high deductible health plan, or an affiliate of the issuer, for use in connection with the high deductible health plan; and

(4) "health savings account" has the meaning given under the Internal Revenue Code of 1986, section 223(d).

History: *1997 c 225 art 2 s 46; 2005 c 132 s 17*

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.

History: *1998 c 334 s 1*

62Q.665 COVERAGE FOR ORTHOTIC AND PROSTHETIC DEVICES.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Accredited facility" means any entity that is accredited to provide comprehensive orthotic or prosthetic devices or services by a Centers for Medicare and Medicaid Services approved accrediting agency.

(c) "Orthosis" means:

(1) an external medical device that is:

(i) custom-fabricated or custom-fitted to a specific patient based on the patient's unique physical condition;

(ii) applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or postoperative condition; and

(iii) deemed medically necessary by a prescribing physician or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and

(2) any provision, repair, or replacement of a device that is furnished or performed by:

(i) an accredited facility in comprehensive orthotic services; or

(ii) a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.

(d) "Orthotics" means:

(1) the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing and providing the initial training necessary to accomplish the fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity;

(2) evaluation, treatment, and consultation related to an orthotic device;

(3) basic observation of gait and postural analysis;

(4) assessing and designing orthosis to maximize function and provide support and alignment necessary to prevent or correct a deformity or to improve the safety and efficiency of mobility and locomotion;

(5) continuing patient care to assess the effect of an orthotic device on the patient's tissues; and

(6) proper fit and function of the orthotic device by periodic evaluation.

(e) "Prosthesis" means:

(1) an external medical device that is:

(i) used to replace or restore a missing limb, appendage, or other external human body part; and

(ii) deemed medically necessary by a prescribing physician or licensed health care provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies, and services; and

(2) any provision, repair, or replacement of a device that is furnished or performed by:

(i) an accredited facility in comprehensive prosthetic services; or

(ii) a health care provider licensed in Minnesota and operating within the provider's scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies, or services.

(f) "Prosthetics" means:

(1) the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences;

(2) the generation of an image, form, or mold that replicates the patient's body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or anatomical appearance, or both;

(3) observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient;

(4) providing and continuing patient care in order to assess the prosthetic device's effect on the patient's tissues; and

(5) assuring proper fit and function of the prosthetic device by periodic evaluation.

Subd. 2. **Coverage.** (a) A health plan must provide coverage for orthotic and prosthetic devices, supplies, and services, including repair and replacement, at least equal to the coverage provided under federal law for health insurance for the aged and disabled under sections 1832, 1833, and 1834 of the Social Security Act, United States Code, title 42, sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

(b) A health plan must not subject orthotic and prosthetic benefits to separate financial requirements that apply only with respect to those benefits. A health plan may impose co-payment and coinsurance amounts on those benefits, except that any financial requirements that apply to such benefits must not be more restrictive than the financial requirements that apply to the health plan's medical and surgical benefits, including those for internal restorative devices.

(c) A health plan may limit the benefits for, or alter the financial requirements for, out-of-network coverage of prosthetic and orthotic devices, except that the restrictions and requirements that apply to those benefits must not be more restrictive than the financial requirements that apply to the out-of-network coverage for the health plan's medical and surgical benefits.

(d) A health plan must cover orthoses and prostheses when furnished under an order by a prescribing physician or licensed health care prescriber who has authority in Minnesota to prescribe orthoses and prostheses, and that coverage for orthotic and prosthetic devices, supplies, accessories, and services must

include those devices or device systems, supplies, accessories, and services that are customized to the covered individual's needs.

(e) A health plan must cover orthoses and prostheses determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including but not limited to running, biking, and swimming, and maximizing the enrollee's limb function.

(f) A health plan must cover orthoses and prostheses for showering or bathing.

Subd. 3. **Prior authorization.** A health plan may require prior authorization for orthotic and prosthetic devices, supplies, and services in the same manner and to the same extent as prior authorization is required for any other covered benefit.

Subd. 4. **Reimbursement.** (a) The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments and services covered by the health plan as of January 1, 2024, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2024, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

History: *2024 c 127 art 57 s 41*

62Q.6651 MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.

(a) When performing a utilization review for a request for coverage of prosthetic or orthotic benefits, a health plan company shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists.

(b) A health plan company shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or perceived disability.

(c) A health plan company shall not deny a prosthetic or orthotic benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

(d) A health plan offered, issued, or renewed in Minnesota that offers coverage for prosthetics and custom orthotic devices shall include language describing an enrollee's rights pursuant to paragraphs (b) and (c) in its evidence of coverage and any benefit denial letters.

(e) A health plan that provides coverage for prosthetic or orthotic services shall ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two distinct prosthetic and custom orthotic providers in the plan's provider network located in Minnesota. In the event that medically necessary covered orthotics and prosthetics are not available from an in-network provider, the health plan company shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

(f) If coverage for prosthetic or custom orthotic devices is provided, payment shall be made for the replacement of a prosthetic or custom orthotic device or for the replacement of any part of the devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) of a change in the physiological condition of the patient;

(2) of an irreparable change in the condition of the device or in a part of the device; or

(3) the condition of the device, or the part of the device, requires repairs and the cost of the repairs would be more than 60 percent of the cost of a replacement device or of the part being replaced.

(g) Confirmation from a prescribing health care provider may be required if the prosthetic or custom orthotic device or part being replaced is less than three years old.

History: *2024 c 127 art 57 s 42*

62Q.666 INTERMITTENT CATHETERS.

Subdivision 1. **Required coverage.** A health plan must provide coverage for intermittent urinary catheters and insertion supplies if intermittent catheterization is recommended by the enrollee's health care provider. At least 180 intermittent catheters per month with insertion supplies must be covered unless a lesser amount is prescribed by the enrollee's health care provider. A health plan providing coverage under the medical assistance program may be required to provide coverage for more than 180 intermittent catheters per month with insertion supplies.

Subd. 2. **Cost-sharing requirements.** A health plan is prohibited from imposing a deductible, co-payment, coinsurance, or other restriction on intermittent catheters and insertion supplies that the health plan does not apply to durable medical equipment in general.

History: *2024 c 127 art 57 s 43*

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:

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

(2) 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.

History: *1998 c 334 s 2*

62Q.675 HEARING AIDS.

A health plan must cover hearing aids for all individuals 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.

History: *1Sp2003 c 14 art 7 s 24; 2007 c 60 s 1; 2023 c 70 art 3 s 2*

62Q.676 MEDICATION THERAPY MANAGEMENT.

A pharmacy benefit manager that provides prescription drug services must make available medication therapy management services for enrollees taking four or more prescriptions to treat or prevent two or more chronic medical conditions. For purposes of this section, "medication therapy management" means the provision of the following pharmaceutical care services by, or under the supervision of, a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(2) communicating essential information to the patient's other primary care providers; and

(3) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications.

Nothing in this section shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

History: *2009 c 79 art 4 s 7*

62Q.677 LIFETIME AND ANNUAL LIMITS.

Subdivision 1. **Applicability and scope.** Except as provided in subdivision 2, this section applies to a health plan company providing coverage under an individual or group health plan. For purposes of this section, essential health benefits is defined under section 62Q.81.

Subd. 2. **Grandfathered plan limits.** (a) The prohibition on lifetime limits applies to grandfathered plans providing individual health plan coverage or group health plan coverage.

(b) The prohibition and limits on annual limits apply to grandfathered plans providing group health plan coverage, but do not apply to grandfathered plans providing individual health plan coverage.

Subd. 3. **Prohibition on lifetime and annual limits.** (a) Except as provided in subdivisions 4 and 5, a health plan company offering coverage under an individual or group health plan shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.

(b) Except as provided in subdivisions 4, 5, and 6, a health plan company shall not establish any annual limit on the dollar amount of essential health benefits for any individual.

Subd. 4. **Nonessential benefits; out-of-network providers.** (a) Subdivision 3 does not prevent a health plan company from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits as defined in section 62Q.81, subdivision 4, to the extent that the limits are otherwise permitted under applicable federal or state law.

(b) Subdivision 3 does not prevent a health plan company from placing an annual or lifetime limit for services provided by out-of-network providers.

Subd. 5. **Excluded benefits.** This section does not prohibit a health plan company from excluding all benefits for a given condition.

Subd. 6. **Annual limits prior to January 1, 2014.** For plan or policy years beginning before January 1, 2014, for any individual, a health plan company may establish an annual limit on the dollar amount of benefits that are essential health benefits provided the limit is no less than the following:

(1) for a plan or policy year beginning after September 22, 2010, but before September 23, 2011, $750,000;

(2) for a plan or policy year beginning after September 22, 2011, but before September 23, 2012, $1,250,000; and

(3) for a plan or policy year beginning after September 22, 2012, but before January 1, 2014, $2,000,000.

In determining whether an individual has received benefits that meet or exceed the allowable limits, a health plan company shall take into account only essential health benefits.

Subd. 7. **Waivers.** For plan or policy years beginning before January 1, 2014, a health plan is exempt from the annual limit requirements if the health plan is approved for a waiver from the requirements by the United States Department of Health and Human Services, but the exemption only applies for the specified period of time that the waiver from the United States Department of Health and Human Services is applicable.

Subd. 8. **Notices.** (a) At the time a health plan company receives a waiver from the United States Department of Health and Human Services, the health plan company shall notify prospective applicants and affected policyholders and the commissioner in each state where prospective applicants and any affected insured are known to reside.

(b) At the time the waiver expires or is otherwise no longer in effect, the health plan company shall notify affected policyholders and the commissioner in each state where any affected insured is known to reside.

Subd. 9. **Reinstatement.** A health plan company shall comply with all provisions of the Affordable Care Act with regard to reinstatement of coverage for individuals whose coverage or benefits under a health plan ended by reason of reaching a lifetime dollar limit on the dollar value of all benefits for the individual.

Subd. 10. **Compliance.** This section does not require compliance with any provision of the Affordable Care Act before the effective date provided for that provision in the Affordable Care Act. The commissioner shall enforce this section.

History: *2013 c 84 art 1 s 80*

62Q.678 DEPENDENT CHILD NOTICE.

Group health plans and health plan companies that offer group or individual health plans with dependent coverage must provide written notice to an enrollee with dependent child coverage that the dependent child's coverage ends when the child reaches the age of 26. Notice must be sent to the enrollee at the enrollee's last known address at least 60 days before the dependent child reaches the age of 26. The notice must include the date on which coverage ends and information on accessing the MNsure website as applicable.

History: *2020 c 73 s 2*

62Q.679 RELIGIOUS OBJECTIONS.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners, and has no publicly traded ownership interest. For purposes of this paragraph:

(1) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;

(2) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(3) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this clause, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(4) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Eligible organization" means an organization that opposes covering some or all health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself out to be religious; or

(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of the owners' sincerely held religious beliefs.

(d) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Subd. 2. **Exemption.** (a) An exempt organization is not required to provide coverage under section 62Q.522, 62Q.524, or 62Q.585 if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage pursuant to this paragraph must notify employees as part of the hiring process and must notify all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524, or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of such coverage which the organization refuses to cover.

Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the coverage requirements of section 62Q.522, 62Q.524, or 62Q.585, with respect to the health benefits identified in the notice under this paragraph, if the eligible organization provides notice to any health plan company with which the eligible organization contracts that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of the health benefits under section 62Q.522, 62Q.524, or 62Q.585.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to coverage for some or all of the health benefits under section 62Q.522, 62Q.524, or 62Q.585, including a list of the health benefits to which the eligible organization objects, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (a) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must, for all future enrollments in the health plan:

(1) expressly exclude coverage for those health benefits identified in the notice under paragraph (a) from the health plan; and

(2) provide separate payments for any health benefits required to be covered under section 62Q.522, 62Q.524, or 62Q.585 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522 on the enrollee. The health plan company must not directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522, 62Q.524, or 62Q.585 on the eligible organization or health plan.

(f) On January 1, 2025, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision.

History: *2024 c 114 art 1 s 8; 2024 c 127 art 57 s 44,69*

NOTE: This section, as added by Laws 2024, chapter 127, article 57, section 44, supersedes the section as added in Senate File 4097, article 1, section 8. Laws 2024, chapter 127, article 57, section 69.

NOTE: This section was also added by Laws 2024, chapter 114, article 1, section 8, to read as follows:

"62Q.679 RELIGIOUS OBJECTIONS.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer owners, and has no publicly traded ownership interest. For purposes of this paragraph:

(1) ownership interests owned by a corporation, partnership, limited liability company, estate, trust, or similar entity are considered owned by that entity's shareholders, partners, members, or beneficiaries in proportion to their interest held in the corporation, partnership, limited liability company, estate, trust, or similar entity;

(2) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(3) ownership interests owned by all individuals in a family are considered held by a single owner. For purposes of this clause, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(4) if an individual or entity holds an option, warrant, or similar right to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Eligible organization" means an organization that opposes covering some or all health benefits under section 62Q.522 or 62Q.585 on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself out to be religious; or

(2) organized and operates as a closely held for-profit entity, and the organization's owners or highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that the organization objects to covering some or all health benefits under section 62Q.522 or 62Q.585 on account of the owners' sincerely held religious beliefs.

(d) "Exempt organization" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

Subd. 2. **Exemption.** (a) An exempt organization is not required to provide coverage under section 62Q.522 or 62Q.585 if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage pursuant to this paragraph must notify employees as part of the hiring process and must notify all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the exempt organization provides partial coverage under section 62Q.522 or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of such coverage which the organization refuses to cover.

Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the coverage requirements of section 62Q.522 or 62Q.585, with respect to the health benefits identified in the notice under this paragraph, if the eligible organization provides notice to any health plan company with which the eligible organization contracts that it is an eligible

organization and that the eligible organization has a religious objection to coverage for all or a subset of the health benefits under section 62Q.522 or 62Q.585.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to coverage for some or all of the health benefits under section 62Q.522 or 62Q.585, including a list of the health benefits to which the eligible organization objects, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (a) to prospective employees as part of the hiring process and to all employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must, for all future enrollments in the health plan:

(1) expressly exclude coverage for those health benefits identified in the notice under paragraph (a) from the health plan; and

(2) provide separate payments for any health benefits required to be covered under section 62Q.522 or 62Q.585 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522 on the enrollee. The health plan company must not directly or indirectly impose any premium, fee, or other charge for the health benefits under section 62Q.522 or 62Q.585 on the eligible organization or health plan.

(f) On January 1, 2024, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision."

COMPLAINT RESOLUTION

62Q.68 DEFINITIONS.

Subdivision 1. **Application.** For purposes of sections 62Q.68 to 62Q.72, the terms defined in this section have the meanings given them. For purposes of sections 62Q.69 and 62Q.70, the term "health plan company" does not include 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 or a nonprofit health service plan corporation regulated under chapter 62C that only provides dental coverage or vision coverage. For purposes of sections 62Q.69 through 62Q.73, the term "health plan company" does not include the Comprehensive Health Association created under chapter 62E. Section 62Q.70 does not apply to individual coverage. However, a health plan company offering individual coverage may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow the process outlined in section 62Q.70.

Subd. 2. **Complaint.** "Complaint" means any grievance against a health plan company that is not the subject of litigation and that has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services;

retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any grievance requiring a medical determination in its resolution must have the medical determination aspect of the complaint processed under the appeal procedure described in section 62M.06.

Subd. 3. **Complainant.** "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee, who submits a complaint.

History: *1999 c 239 s 34; 2002 c 330 s 28; 2013 c 84 art 1 s 81*

62Q.69 COMPLAINT RESOLUTION.

Subdivision 1. **Establishment.** Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

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.

(b) For group health plans, if the decision is partially or wholly adverse to the complainant, the notification must inform the complainant of the right to appeal the decision to the health plan company's internal appeal process described in section 62Q.70 and the procedure for initiating an appeal.

(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.

History: *1999 c 239 s 35; 2008 c 221 s 1; 2013 c 84 art 1 s 82*

62Q.70 APPEAL OF THE COMPLAINT DECISION.

Subdivision 1. **Establishment.** (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.69. The appeal process must meet the requirements of this section. This section applies only to group health plans. However, a health plan company offering individual coverage may, pursuant to section 62Q.69, subdivision 3, paragraph (c), follow the process outlined in this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.69.

(c) The internal appeal process must permit the enrollee to review the information relied upon in the course of the appeal and the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

(d) The enrollee must be allowed to receive continued coverage pending the outcome of the appeals process.

Subd. 2. **Procedures for filing an appeal.** The health plan company must provide notice to enrollees of its internal appeals process in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act. If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. **Notification of appeal decisions.** (a) If a complainant appeals in writing, the health plan company must give the complainant written notice of the appeal decision and all key findings within 30 days of the health plan company's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, the health plan company must give the complainant written notice of the appeal decision

and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of the right to submit the appeal decision to the external review process described in section 62Q.73 and the procedure for initiating the external process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

History: *1999 c 239 s 36; 2013 c 84 art 1 s 83,84*

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 authorization 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 has applied for internal review under chapter 62M.

History: *1999 c 239 s 37; 2003 c 2 art 1 s 8; 2013 c 84 art 1 s 85; 2020 c 114 art 2 s 17*

62Q.72 RECORD KEEPING; REPORTING.

Subdivision 1. **Record keeping.** Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available

to the appropriate commissioner upon request. An insurance company licensed under chapter 60A may instead comply with section 72A.20, subdivision 30.

Subd. 2. **Reporting.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days, or 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

History: *1999 c 239 s 38*

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 adverse determination, as defined in section 62M.02, subdivision 1a, that has been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse determination;

(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;

(6) the enrollee has met the requirements of subdivision 6, paragraph (e); or

(7) a decision relating to a health plan's coverage of nonparticipating provider services as described in and subject to section 62Q.556, subdivision 1, paragraph (a).

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; effective January 1, 2026, the medical assistance fee-for-service program; the MinnesotaCare 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.

(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 must 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. 4. **Contract.** Pursuant to a request for proposal, the commissioners of health and commerce must contract with more than one organization or business entity to provide independent external reviews of all adverse determinations submitted for external review. The contract must ensure that the fees for services rendered in connection with the reviews are reasonable.

Subd. 5. **Criteria.** The request for proposal must require that the entity demonstrate:

(1) no conflicts of interest in that it is not owned, a subsidiary of, or affiliated with a health plan company, utilization review organization, or a trade organization of health care providers;

(2) an expertise in dispute resolution;

(3) an expertise in health-related law;

(4) an ability to conduct reviews using a variety of alternative dispute resolution procedures depending upon the nature of the dispute;

(5) an ability to maintain written records, for at least three years, regarding reviews conducted and provide data to the commissioners of health and commerce upon request on reviews conducted;

(6) an ability to ensure confidentiality of medical records and other enrollee information;

(7) accreditation by nationally recognized private accrediting organization; and

(8) the ability to provide an expedited external review process.

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 or section 62Q.556, subdivision 1, paragraph (a).

(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:

(1) medical records;

(2) the recommendation of the attending physician, advanced practice registered nurse, physician assistant, or health care professional;

(3) consulting reports from health care professionals;

(4) the terms of coverage;

(5) federal Food and Drug Administration approval; and

(6) 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.

History: *1999 c 239 s 39; 2000 c 474 s 2; 2001 c 215 s 27; 2013 c 84 art 1 s 86; 2013 c 107 art 1 s 9; 2016 c 158 art 2 s 28; 2020 c 114 art 2 s 18; 2020 c 115 art 4 s 13; 2022 c 58 s 13; 2023 c 70 art 2 s 32,33; 2024 c 121 art 4 s 4; 2024 c 127 art 57 s 45; 1Sp2025 c 4 art 3 s 11*

62Q.731 APPEAL FROM ADVERSE DETERMINATION.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Enrollee" means an eligible person as defined in section 62E.02, subdivision 13, and who meets the eligibility criteria established in section 62E.14.

(c) "Board" means the board of directors of the Comprehensive Health Association, as described in section 62E.10, subdivision 2.

Subd. 2. **Appeal to external review entity.** If an enrollee receives an adverse determination as a result of the Comprehensive Health Association's internal appeal process, by which an established enrollee appeal committee renders an adverse determination, the enrollee then has the option of:

(1) appealing the adverse determination to the external review entity under section 62Q.73, which shall constitute a final determination subject to the conditions specified in section 62Q.73; or

(2) appealing to the commissioner of commerce from an adverse determination as provided by the operating rules of the Comprehensive Health Association, in which case the commissioner has the option of making a determination regarding the appeal, or submitting the appeal to the external review entity retained under section 62Q.73.

History: *2002 c 330 s 29*

MINNESOTA HEALTH PLAN CONTRACTING ACT

62Q.732 CITATION.

Sections 62Q.732 to 62Q.75 may be cited as the "Minnesota Health Plan Contracting Act."

History: *2004 c 246 s 2*

62Q.733 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62Q.732 to 62Q.739, the following definitions apply.

Subd. 2. **Contract.** "Contract" means a written agreement between a health care provider and a health plan company to provide health care services.

Subd. 3. **Health care provider or provider.** "Health care provider" or "provider" means a physician, advanced practice registered nurse, physician assistant, chiropractor, dentist, podiatrist, or other provider as defined under section 62J.03, other than hospitals, ambulatory surgical centers, or freestanding emergency rooms.

Subd. 4. **Health plan company.** (a) "Health plan company" means:

(1) a health maintenance organization operating under chapter 62D;

(2) a community integrated service network operating under chapter 62N;

(3) a preferred provider organization as defined in section 145.61, subdivision 4c; or

(4) an insurance company licensed under chapter 60A, nonprofit health service corporation operating under chapter 62C, fraternal benefit society operating under chapter 64B, or any other entity that establishes, operates, or maintains a health benefit plan or network of health care providers where the providers have entered into a contract with the entity to provide health care services.

(b) This subdivision does not apply to a health plan company with respect to coverage described in section 62A.011, subdivision 3, clauses (1) to (5) and (7) to (12).

Subd. 5. **Fee schedule.** "Fee schedule" means the total expected financial compensation paid to a health care provider for providing a health care service as determined by the contract between the health plan company and the provider, inclusive of withhold amounts and any amount for which the patient or other third party may be obligated to pay under the contract.

History: *2004 c 246 s 3; 2020 c 115 art 4 s 14; 2022 c 58 s 14*

62Q.734 EXEMPTION.

Sections 62Q.735 to 62Q.739 and 62Q.74 do not apply to health plan companies whose annual Minnesota health premium revenues are less than three percent of the total annual Minnesota health premium revenues, as measured by the assessment base of the Minnesota Comprehensive Health Association. For purposes of this percentage calculation, a health plan company's premiums include the Minnesota health premium revenues of its affiliates.

History: *2004 c 246 s 4*

62Q.735 PROVIDER CONTRACTING PROCEDURES.

Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign a contract, a health plan company shall give to the provider a complete copy of the proposed contract, including:

(1) all attachments and exhibits;

(2) operating manuals;

(3) a general description of the health plan company's health service coding guidelines and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

(4) all guidelines and treatment parameters incorporated or referenced in the contract.

(b) The health plan company shall make available to the provider the fee schedule or a method or process that allows the provider to determine the fee schedule for each health care service to be provided under the contract.

(c) Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.

Subd. 2. **Proposed amendments.** (a) Any amendment or change in the terms of an existing contract between a health plan company and a provider must be disclosed to the provider at least 45 days prior to the effective date of the proposed change, with the exception of amendments required of the health plan company by law or governmental regulatory authority, when notice shall be given to the provider when the requirement is made known to the health plan company.

(b) Any amendment or change in the contract that alters the fee schedule or materially alters the written contractual policies and procedures governing the relationship between the provider and the health plan company must be disclosed to the provider not less than 45 days before the effective date of the proposed change and the provider must have the opportunity to terminate the contract before the amendment or change is deemed to be in effect.

(c) By mutual consent, evidenced in writing in amendments separate from the base contract and not contingent on participation, the parties may waive the disclosure requirements under paragraphs (a) and (b).

(d) Notwithstanding paragraphs (a) and (b), the effective date of contract termination shall comply with the terms of the contract when a provider terminates a contract.

Subd. 3. **Hospital contract amendment disclosure.** (a) Any amendment or change in the terms of an existing contract between a network organization and a hospital, ambulatory surgical center, or freestanding emergency room must be disclosed to that provider.

(b) Any amendment or change in the contract that alters the financial reimbursement or alters the written contractual policies and procedures governing the relationship between the hospital, ambulatory surgical center, or freestanding emergency room and the network organization must be disclosed to that provider before the amendment or change is deemed to be in effect.

(c) For purposes of this subdivision, "network organization" means a preferred provider organization, as defined in section 145.61, subdivision 4c; a managed care organization, as defined in section 62Q.01, subdivision 5; or other entity that uses or consists of a network of health care providers.

Subd. 4. **Contract amendment and renewal provisions.** (a) A health plan company shall not require a provider to provide notice of intention to terminate its contract before communicating with the provider regarding contract renewals. A health plan company shall not communicate with enrollees about the possible termination until final termination notice is received from the provider.

(b) A health plan company shall not preclude a nonnetwork provider from subsequent network participation solely as a result of the provider having terminated its participation in accordance with the terms of its contract.

Subd. 5. **Fee schedules.** A health plan company shall provide, upon request, any additional fees or fee schedules relevant to the particular provider's practice beyond those provided with the renewal documents for the next contract year to all participating providers, excluding claims paid under the pharmacy benefit. Health plan companies may fulfill the requirements of this section by making the full fee schedules available through a secure web portal for contracted providers.

Subd. 6. **Reimbursement tiering methodologies.** Where health plan company reimbursement is related to tiering of providers, the health plan company shall provide to any tiered providers upon request an explanation of the methodology used to calculate tier ranking, including information on cost and quality. This explanation need not allow any provider access to proprietary or trade secret information. When a tiered product is used by a health plan, the health plan company shall provide notification to the provider of the tier in which the provider is included prior to the effective date of the tiered product.

History: *2004 c 246 s 5; 2010 c 331 s 1-3; 2023 c 57 art 2 s 47,48*

62Q.736 PAYMENT RATES.

A contract between a health plan company and a provider shall comply with section 62A.64.

History: *2004 c 246 s 6*

62Q.737 SERVICE CODE CHANGES.

(a) For purposes of this section, "service code" means current procedural terminology (CPT), current dental terminology (CDT), ICD-CM, diagnosis-related groups (DRGs), or other coding system.

(b) The health plan company shall determine the manner in which it adjudicates claims. The provider may request a description of the general coding guidelines applicable to the health care services the provider is reasonably expected to render pursuant to the contract. The health plan company or its designee shall provide the coding guidelines not later than 30 days after the date the health plan receives the request. The health plan company shall provide notice of material changes to the coding guidelines not later than 45 days prior to the date the changes take effect and shall not make retroactive revision to the coding guidelines, but may issue new guidelines. A provider who receives information under this section may use or disclose the information only for the purpose of practice management, billing activities, or other business operations and may not disclose the information to third parties without the consent of the health plan company.

(c) The health plan company may correct an error in a submitted claim that prevents the claim from being processed, provided that the health plan company:

(1) notifies the provider of the change and reason for the change according to federal Health Insurance Portability and Accountability Act (HIPAA) transaction standards; and

(2) offers the provider the opportunity to appeal any changes.

(d) Nothing in this section shall be interpreted to require a health plan company to violate copyright or other law by disclosing proprietary licensed software. In addition to the above, the health plan company shall, upon request of a contracted provider, disclose the name, edition, and model version of the software that the health plan company uses to determine bundling and unbundling of claims.

(e) This section does not apply to government programs, including state public programs, Medicare, and Medicare-related coverage.

History: *2004 c 246 s 7*

62Q.739 UNILATERAL TERMS PROHIBITED.

(a) A contract between a health plan company and a health care provider shall not contain or require unilateral terms regarding indemnification or arbitration. Notwithstanding any prohibitions in this section, a contract between a health plan company and a health care provider may be unilaterally terminated by either party in accordance with the terms of the contract.

(b) A health plan company may not terminate or fail to renew a health care provider's contract without cause unless the company has given the provider a written notice of the termination or nonrenewal 120 days before the effective date.

History: *2004 c 246 s 8*

62Q.74 NETWORK SHADOW CONTRACTING.

Subdivision 1. **Definitions.** (a) For purposes of this section, "category of coverage" means one of the following types of health-related coverage:

(1) health;

(2) no-fault automobile medical benefits; or

(3) workers' compensation medical benefits.

(b) "Health care provider" or "provider" means a physician, advanced practice registered nurse, physician assistant, chiropractor, dentist, podiatrist, hospital, ambulatory surgical center, freestanding emergency room, or other provider, as defined in section 62J.03.

Subd. 2. **Provider consent required.** (a) No health plan company shall require a health care provider to participate in a network under a category of coverage that differs from the category or categories of coverage to which the existing contract between the health plan company and the provider applies, without the affirmative consent of the provider obtained under subdivision 3.

(b) No health plan company shall require, as a condition of participation in any health plan, product, or other arrangement, the provider to participate in a new or different health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology without the affirmative consent of the provider obtained under subdivision 3. This paragraph does not apply to participation in health plan products or other arrangements that provide health care services to government programs, including state public programs, Medicare, and Medicare-related coverage.

(c) Compliance with this section may not be waived in a contract or otherwise.

Subd. 3. **Consent procedure.** (a) The health plan company, if it wishes to apply an existing contract with a provider to a different category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology, shall first notify the provider in writing. The written notice must include at least the following:

(1) the health plan company's name, address, and telephone number, and the name of the specific network, if it differs from that of the health plan company;

(2) a description of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage;

(3) the names of all payers expected by the health plan company to use the network for the new category of coverage or health plan, product, or other arrangement within a category of coverage;

(4) the approximate number of current enrollees of the health plan company in that category of coverage or health plan, product, or other arrangement within a category of coverage within the provider's geographical area;

(5) a disclosure of all contract terms of the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, including the discount or reduced fees, care guidelines, utilization review criteria, prior notification process, prior authorization process, and dispute resolution process;

(6) a form for the provider's convenience in accepting or declining participation in the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage, provided that the provider need not use that form in responding; and

(7) a statement informing the provider of the provisions of paragraph (b).

(b) Unless the provider has affirmatively agreed to participate within 60 days after the postmark date of the notice, the provider is deemed to have not accepted the proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology.

Subd. 4. **Contract termination restricted.** A health plan company must not terminate an existing contract with a provider, or fail to honor the contract in good faith, based solely on the provider's decision not to accept a proposed new category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology. The most recent agreed-upon contractual obligations remain in force until the existing contract's renewal or termination date.

Subd. 5. **Remedy.** If a health plan company violates this section by reimbursing a provider as if the provider had agreed under this section to participate in the network under a category of coverage or health plan, product, or other arrangement within a category of coverage that results in a different underlying financial reimbursement methodology to which the provider has not agreed, the provider has a cause of action against the health plan company to recover two times the difference between the reasonable charges for claims affected by the violation and the amounts actually paid to the provider. The provider is also entitled to recover costs, disbursements, and reasonable attorney fees.

Subd. 6. **Benefit design changes.** For purposes of this section, "different underlying financial reimbursement methodology" does not include health plan benefit design changes, including, but not limited to, changes in co-payment or deductible amounts or other changes in member cost-sharing requirements.

History: *1999 c 94 s 1; 2000 c 322 s 1; 2001 c 170 s 4,5; 2004 c 246 s 9; 2020 c 115 art 4 s 15; 2022 c 58 s 15*

62Q.745 [Repealed, 2004 c 246 s 11]

62Q.746 ACCESS TO CERTAIN INFORMATION REGARDING PROVIDERS.

Upon request of the commissioner, a health plan company licensed under chapters 62C and 62D must provide the following information:

(1) a detailed description of the health plan company's methods and procedures, standards, qualifications, criteria, and credentialing requirements for designating the providers who are eligible to participate in the health plan company's provider network, including any limitations on the numbers of providers to be included in the network;

(2) the number of full-time equivalent physicians, by specialty, nonphysician providers, and allied health providers used to provide services; and

(3) summary data that is broken down by type of provider, reflecting actual utilization of network and non-network practitioners and allied professionals by enrollees of the health plan company.

History: *2001 c 170 s 7*

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.** (a) This section applies to clean claims submitted to a health plan company or third-party administrator for services provided by any:

(1) health care provider, as defined in section 62Q.74, but does not include a provider licensed under chapter 151;

(2) home health care provider, as defined in section 144A.43, subdivision 4; or

(3) health care facility.

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.

(b) The health plan company or third-party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with section 62J.581.

(c) If a health plan company or third-party administrator does not pay or deny a clean claim within the period provided in paragraph (a), the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the health plan company or third-party administrator makes the payment or denies the claim. In any payment, the health plan company or third-party administrator must itemize any interest payment being made separately from other payments being made for services provided. The health plan company or third-party administrator shall not require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before any interest payment is made. Interest payments must be made to the health care provider no less frequently than quarterly.

(d) The rate of interest paid by a health plan company or third-party administrator under this subdivision shall be 1.5 percent per month or any part of a month.

(e) A health plan company or third-party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices.

(f) The commissioner may assess a financial administrative penalty against a health plan company for violation of this subdivision when there is a pattern of abuse that demonstrates a lack of good faith effort and a systematic failure of the health plan company to comply with this subdivision.

Subd. 3. **Claims filing.** (a) Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later.

(b) A health care provider or facility that does not make an initial submission of charges within the six-month period in paragraph (a), the 12-month period in paragraph (c), or the additional six-month period in paragraph (d) shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer.

(c) The six-month submission requirement in paragraph (a) may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis.

(d) The six-month submission requirement in paragraph (a) must be extended an additional six months if a health plan company or third-party administrator makes any adjustment or recoupment of payment. The additional six months begins on the date the health plan company or third-party administrator adjusts or recoups the payment.

(e) Any request by a health care provider or facility under paragraph (c) or (d) must reference that the submission is pursuant to this subdivision.

(f) Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline.

(g) This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

Subd. 4. **Claims adjustment timeline.** (a) Once a clean claim, as defined in section 62Q.75, subdivision 1, has been paid, the contract must provide a 12-month deadline on all adjustments to and recoupments of the payment with the exception of payments related to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.

(b) Paragraph (a) shall not apply to pharmacy contracts entered into between or on behalf of health plan companies.

History: *2000 c 349 s 1; 2004 c 246 s 10; 2005 c 77 s 4; 2010 c 331 s 4,5; 2013 c 84 art 1 s 87; 2025 c 38 art 9 s 1*

62Q.751 COLLECTING DEDUCTIBLES AND COINSURANCE.

A health plan company shall not prohibit providers from collecting deductibles and coinsurance from patients at or prior to the time of service. Providers may not withhold a service to a health plan company enrollee based on a patient's failure to pay a deductible or coinsurance at or prior to the time of service. Overpayments by patients to providers must be returned to the patient by the provider by check or electronic payment within 30 days of the date in which the claim adjudication is received by the provider.

History: *2010 c 331 s 6*

DENTAL PLANS

62Q.76 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62Q.76 to 62Q.79, the terms defined in this section have the meanings given them.

Subd. 2. **Dental care services.** "Dental care services" means services performed by a licensed dentist or any person working under the dentist's supervision as permitted under chapter 150A, which an enrollee

might reasonably require to maintain good dental health, including preventive services, diagnostic services, emergency dental care, and restorative services.

Subd. 3. **Dental plan.** "Dental plan" means a policy, contract, or certificate offered by a dental organization for the coverage of dental care services. Dental plan means individual or group coverage.

Subd. 4. **Dentist.** "Dentist" means a person licensed to practice dentistry under chapter 150A.

Subd. 5. **Emergency dental care.** "Emergency dental care" means the provision of dental care services for a sudden, acute dental condition that would lead a prudent layperson to reasonably expect that the absence of immediate care would result in serious impairment to the dentition or would place the person's oral health in serious jeopardy.

Subd. 6. **Enrollee.** "Enrollee" means an individual covered by a dental organization and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

Subd. 7. **Dental organization.** "Dental organization" means a health insurer licensed under chapter 60A; a health service plan corporation licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; or a third-party administrator that:

(1) provides, either directly or through contracts with providers or other persons, dental care services;

(2) arranges for the provision of these services to enrollees on the basis of a fixed, prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee; or

(3) administers dental plans.

Subd. 8. **Dental provider contract.** "Dental provider contract" means a written agreement between a dentist or dental clinic and dental organization to provide dental care services.

Subd. 9. **Third party.** "Third party" means a person or entity that enters into a contract with a dental organization or with another third party to gain access to the dental care services or contractual discounts under a dental provider contract. Third party does not include an enrollee of a dental organization or an employer or other group for whom the dental organization provides administrative services.

History: *2000 c 410 s 1; 2011 c 64 s 1; 2023 c 57 art 2 s 49*

62Q.77 TERMS OF COVERAGE DISCLOSURE.

A dental organization shall make available to an enrollee, upon request, a clear and concise description of the following terms of coverage:

(1) the dental care services and other benefits to which the enrollee is entitled under the dental plan;

(2) any exclusions or limitation on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or co-payment features and any requirements for referrals to specialists;

(3) a description as to how services, including emergency dental care and out-of-area service, may be obtained;

(4) a general description of payment and co-payment amounts, if any, for dental care services, which the enrollee is obligated to pay; and

(5) a telephone number by which the enrollee may obtain additional information regarding coverage.

History: *2000 c 410 s 2*

62Q.78 DENTAL BENEFIT PLAN REQUIREMENTS.

Subdivision 1. **Utilization profiling.** (a) A dental organization that uses utilization profiling as a method of differentiating provider reimbursement or as a requirement for continued participation in the organization's provider network shall, upon request, make available to participating dentists the following information:

(1) a description of the methodology used in profiling so that dentists can clearly understand why and how they are affected; and

(2)(i) a list of the codes measured; (ii) a dentist's personal frequency data within each code so that the accuracy of the data can be verified; and (iii) an individual dentist's representation of scoring compared to classification points and how the dentist compares with peers in each category including the cutoff point of the score impacting qualification in order to inform the dentist about how the dentist may qualify or retain qualification for differentiated provider reimbursement or continued participation in the dental organization's provider network.

(b) A dental organization that uses utilization profiling as a method of differentiating provider reimbursement or as a requirement for continued participation in the organization's provider network shall, upon request, provide a clear and concise description of the methodology of the utilization profiling on dental benefits to group purchasers and enrollees.

(c) A dental organization shall not be considered to be engaging in the practice of dentistry pursuant to chapter 150A, to the extent it releases utilization profiling information as required by sections 62Q.76 to 62Q.79.

Subd. 2. **Reimbursement codes.** (a) Unless the federal government requires the use of other procedural codes, for all dental care services in which a procedural code is used by the dental organization to determine coverage or reimbursement, the organization must use the most recent American Dental Association current dental terminology code that is available, within a year of its release. Current dental terminology codes must be used as specifically defined, must be listed separately, and must not be altered or changed by either the dentist or the dental organization.

(b) Enrollee benefits must be determined on the basis of individual codes subject to provider and group contracts.

(c) This subdivision does not prohibit or restrict dental organizations from setting reimbursement and pricing with groups, purchasers, and participating providers or addressing issues of fraud or errors in claims submissions.

Subd. 3. **Treatment options.** No contractual provision between a dental organization and a dentist shall in any way prohibit or limit a dentist from discussing all clinical options for treatment with the patient.

Subd. 4. **Contract amendment.** An amendment or change in terms of an existing contract between a dental organization and a dentist must be disclosed to the dentist at least 90 days before the effective date of the proposed change.

Subd. 5. **Provider audits.** (a) A dental organization that conducts audits of dental providers shall:

(1) provide a written explanation to the dental provider of the reason for the audit and the process the dental organization intends to use to audit patient charts, as well as a written explanation of the processes available to the provider once the dental organization completes its review of the audited patient records; and

(2) allow the provider a reasonable period of time from the date that the provider receives the verified audit or investigation findings to review, meet, and negotiate a resolution to the audit or investigation.

(b) If a dental organization conducts a provider audit, the dental organization must use a licensed dentist whose license is in good standing to review patient charts.

Subd. 6. **Payment for covered services.** (a) No contract of any dental plan or dental organization that covers any dental services or dental provider agreement with a dentist may require, directly or indirectly, that a dentist provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the dental plan or dental organization unless the dental services are covered services.

(b) A dental plan or dental organization or other person providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

(c) "Covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, co-payments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Subd. 7. **Method of payments.** A dental provider contract must include a method of payment for dental care services in which no fees associated with the method of payment, including credit card fees and fees related to payment in the form of digital or virtual currency, are incurred by the dentist or dental clinic. Any fees that may be incurred from a payment must be disclosed to a dentist prior to entering into or renewing a dental provider contract. For purposes of this section, fees related to a provider's electronic claims processing vendor, financial institution, or other vendor used by a provider to facilitate the submission of claims are excluded.

Subd. 8. **Network leasing.** (a) A dental organization may grant a third party access to a dental provider contract or a provider's dental care services or contractual discounts provided pursuant to a dental provider contract if, at the time the dental provider contract is entered into or renewed, the dental organization allows a dentist to choose not to participate in third-party access to the dental provider contract, without any penalty to the dentist. The third-party access provision of the dental provider contract must be clearly identified. A dental organization must not grant a third party access to the dental provider contract of any dentist who does not participate in third-party access to the dental provider contract.

(b) Notwithstanding paragraph (a), if a dental organization exists solely for the purpose of recruiting dentists for dental provider contracts that establish a network to be leased to third parties, the dentist waives the right to choose whether to participate in third-party access.

(c) A dental organization may grant a third party access to a dental provider contract, or a dentist's dental care services or contractual discounts under a dental provider contract, if the following requirements are met:

(1) the dental organization lists all third parties that may have access to the dental provider contract on the dental organization's website, which must be updated at least once every 90 days;

(2) the dental provider contract states that the dental organization may enter into an agreement with a third party that would allow the third party to obtain the dental organization's rights and responsibilities as if the third party were the dental organization, and the dentist chose to participate in third-party access at the time the dental provider contract was entered into; and

(3) the third party accessing the dental provider contract agrees to comply with all applicable terms of the dental provider contract.

(d) A dentist is not bound by and is not required to perform dental care services under a dental provider contract granted to a third party in violation of this section.

(e) This subdivision does not apply when:

(1) the dental provider contract is for dental services provided under a public health plan program, including but not limited to medical assistance, MinnesotaCare, Medicare, or Medicare Advantage; or

(2) access to a dental provider contract is granted to a dental organization, an entity operating in accordance with the same brand licensee program as the dental organization or other entity, or to an entity that is an affiliate of the dental organization, provided the entity agrees to substantially similar terms and conditions as the originating dental provider contract between the dental organization and the dentist or dental clinic. A list of the dental organization's affiliates must be posted on the dental organization's website.

History: *2000 c 410 s 3; 2011 c 64 s 2-4; 2023 c 57 art 2 s 50,51*

62Q.79 LIMITATIONS.

(a) The provisions contained in section 62Q.77 shall not require a dental organization to disclose information which the dental organization is already obligated to disclose under applicable Minnesota law governing the operation of the dental organization.

(b) Any information a dental organization is required to disclose or communicate under section 62Q.77 to its subscribers, enrollees, participating providers, contracting groups, or dentists may be accomplished by electronic communication including, but not limited to, email, the Internet, websites, and employer electronic bulletin boards.

History: *2000 c 410 s 4*

62Q.80 COMMUNITY-BASED HEALTH CARE COVERAGE PROGRAM.

Subdivision 1. **Scope.** (a) Any community-based health care initiative may develop and operate community-based health care coverage programs that offer to eligible individuals and their dependents the option of purchasing through their employer health care coverage on a fixed prepaid basis without meeting the requirements of chapter 60A, 62A, 62C, 62D, 62M, 62N, 62Q, 62T, or 62U, or any other law or rule that applies to entities licensed under these chapters.

(b) Each initiative shall establish health outcomes to be achieved through the programs and performance measurements in order to determine whether these outcomes have been met. The outcomes must include, but are not limited to:

(1) a reduction in uncompensated care provided by providers participating in the community-based health network;

(2) an increase in the delivery of preventive health care services; and

(3) health improvement for enrollees with chronic health conditions through the management of these conditions.

In establishing performance measurements, the initiative shall use measures that are consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures.

(c) Any program established under this section shall not constitute a financial liability for the state, in that any financial risk involved in the operation or termination of the program shall be borne by the community-based initiative and the participating health care providers.

Subd. 1a. [Repealed by amendment, 2012 c 247 art 2 s 1]

Subd. 2. **Definitions.** (a) For purposes of this section, the following definitions apply:

(b) "Community-based" means located in or primarily relating to the community, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(c) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(d) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization as defined in section 256B.692.

(e) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(f) "Dependent" means an eligible employee's spouse or child who is under the age of 26 years.

Subd. 3. **Approval.** (a) Prior to the operation of a community-based health care coverage program, a community-based health initiative, defined in subdivision 2, paragraph (d), shall submit to the commissioner of health for approval the community-based health care coverage program developed by the initiative. The commissioner shall ensure that each program meets the requirements described in this section and is actuarially sound based on a review of appropriate records and methods utilized by the community-based health initiative in establishing premium rates for the community-based health care coverage programs.

(b) Prior to approval, the commissioner shall also ensure that:

(1) the benefits offered comply with subdivision 8 and that there are adequate numbers of health care providers participating in the community-based health network to deliver the benefits offered under the program;

(2) the activities of the program are limited to activities that are exempt under this section or otherwise from regulation by the commissioner of commerce;

(3) the complaint resolution process meets the requirements of subdivision 10; and

(4) the data privacy policies and procedures comply with state and federal law.

Subd. 4. **Establishment.** The initiative shall establish and operate upon approval by the commissioner of health community-based health care coverage programs. The operational structure established by the initiative shall include, but is not limited to:

(1) establishing a process for enrolling eligible individuals and their dependents;

(2) collecting and coordinating premiums from enrollees and employers of enrollees;

(3) providing payment to participating providers;

(4) establishing a benefit set according to subdivision 8 and establishing premium rates and cost-sharing requirements;

(5) creating incentives to encourage primary care and wellness services; and

(6) initiating disease management services, as appropriate.

Subd. 5. **Qualifying employees.** To be eligible for the community-based health care coverage program, an individual must:

(1) reside in or work within the designated community-based geographic area served by the program;

(2) be employed by a qualifying employer, be an employee's dependent, or be self-employed on a full-time basis;

(3) not be enrolled in or have currently available health coverage, except for catastrophic health care coverage; and

(4) not be eligible for or enrolled in medical assistance, and not be enrolled in MinnesotaCare or Medicare.

Subd. 6. **Qualifying employers.** (a) To qualify for participation in the community-based health care coverage program, an employer must:

(1) employ at least one but no more than 50 employees at the time of initial enrollment in the program;

(2) pay its employees a median wage that equals 350 percent of the federal poverty guidelines or less for an individual; and

(3) not have offered employer-subsidized health coverage to its employees for at least 12 months prior to the initial enrollment in the program. For purposes of this section, "employer-subsidized health coverage" means health care coverage for which the employer pays at least 50 percent of the cost of coverage for the employee.

(b) To participate in the program, a qualifying employer agrees to:

(1) offer health care coverage through the program to all eligible employees and their dependents regardless of health status;

(2) participate in the program for an initial term of at least one year;

(3) pay a percentage of the premium established by the initiative for the employee; and

(4) provide the initiative with any employee information deemed necessary by the initiative to determine eligibility and premium payments.

Subd. 7. **Participating providers.** Any health care provider participating in the community-based health network must accept as payment in full the payment rate established by the initiatives and may not charge to or collect from an enrollee any amount in access of this amount for any service covered under the program.

Subd. 8. **Coverage.** (a) The initiatives shall establish the health care benefits offered through the community-based health care coverage programs. The benefits established shall include, at a minimum:

(1) child health supervision services up to age 18, as defined under section 62A.047; and

(2) preventive services, including:

(i) health education and wellness services;

(ii) health supervision, evaluation, and follow-up;

(iii) immunizations; and

(iv) early disease detection.

(b) Coverage of health care services offered by the program may be limited to participating health care providers or health networks. All services covered under the programs must be services that are offered within the scope of practice of the participating health care providers.

(c) The initiatives may establish cost-sharing requirements. Any co-payment or deductible provisions established may not discriminate on the basis of age, sex, race, disability, economic status, or length of enrollment in the programs.

(d) If any of the initiatives amends or alters the benefits offered through the program from the initial offering, that initiative must notify the commissioner of health and all enrollees of the benefit change.

Subd. 9. **Enrollee information.** (a) The initiatives must provide an individual or family who enrolls in the program a clear and concise written statement that includes the following information:

(1) health care services that are covered under the program;

(2) any exclusions or limitations on the health care services covered, including any cost-sharing arrangements or prior authorization requirements;

(3) a list of where the health care services can be obtained and that all health care services must be provided by or through a participating health care provider or community-based health network;

(4) a description of the program's complaint resolution process, including how to submit a complaint; how to file a complaint with the commissioner of health; and how to obtain an external review of any adverse decisions as provided under subdivision 10;

(5) the conditions under which the program or coverage under the program may be canceled or terminated; and

(6) a precise statement specifying that this program is not an insurance product and, as such, is exempt from state regulation of insurance products.

(b) The commissioner of health must approve a copy of the written statement prior to the operation of the program.

Subd. 10. **Complaint resolution process.** (a) The initiatives must establish a complaint resolution process. The process must make reasonable efforts to resolve complaints and to inform complainants in writing of the initiative's decision within 60 days of receiving the complaint. Any decision that is adverse to the enrollee shall include a description of the right to an external review as provided in paragraph (c) and how to exercise this right.

(b) The initiatives must report any complaint that is not resolved within 60 days to the commissioner of health.

(c) The initiatives must include in the complaint resolution process the ability of an enrollee to pursue the external review process provided under section 62Q.73 with any decision rendered under this external review process binding on the initiatives.

Subd. 11. **Data privacy.** The initiatives shall establish data privacy policies and procedures for the program that comply with state and federal data privacy laws.

Subd. 12. **Limitations on enrollment.** (a) The initiatives may limit enrollment in the program. If enrollment is limited, a waiting list must be established.

(b) The initiatives shall not restrict or deny enrollment in the program except for nonpayment of premiums, fraud or misrepresentation, or as otherwise permitted under this section.

(c) The initiatives may require a certain percentage of participation from eligible employees of a qualifying employer before coverage can be offered through the program.

Subd. 13. **Report.** Each initiative shall submit an annual status report to the commissioner of health on January 15 of each year, with the first report due January 15, 2008. Each status report shall include:

(1) the financial status of the program, including the premium rates, cost per member per month, claims paid out, premiums received, and administrative expenses;

(2) a description of the health care benefits offered and the services utilized;

(3) the number of employers participating, the number of employees and dependents covered under the program, and the number of health care providers participating;

(4) a description of the health outcomes to be achieved by the program and a status report on the performance measurements to be used and collected; and

(5) any other information requested by the commissioner of health or commerce or the legislature.

Subd. 14. [Repealed by amendment, 2012 c 247 art 2 s 1]

History: *2006 c 255 s 35; 2007 c 147 art 9 s 10-13; art 10 s 1; 2010 c 310 art 2 s 1; 2012 c 247 art 2 s 1; 2013 c 84 art 1 s 88; 2016 c 158 art 2 s 29*

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, and preventive items and services, as defined under section 62Q.46, subdivision 1, paragraph (a).

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.

Subd. 6. **Prescription drug benefits.** (a) A health plan company that offers individual health plans must ensure that, in each geographic area the health plan company services, no fewer than one silver plan and one gold plan the health plan company offers apply a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(b) A health plan company that offers small group health plans must ensure that, in each geographic area the health plan company services, no fewer than one silver plan and one gold plan the health plan

company offers apply a predeductible, flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

(c) The highest allowable co-payment for the highest cost drug tier for health plans offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket maximum for an individual.

(d) The flat-dollar amount co-payment tier structure for prescription drugs under this subdivision must be graduated and proportionate.

(e) All individual and small group health plans offered pursuant to this subdivision must be:

(1) clearly and appropriately named to aid the purchaser in the selection process;

(2) marketed in the same manner as other health plans offered by the health plan company; and

(3) offered for purchase to any individual or small group.

(f) This subdivision does not apply to catastrophic plans, grandfathered plans, large group health plans, health savings accounts, qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(g) A health plan company or a pharmacy benefit manager, as defined in section 62W.02, subdivision 15, must not delay or divide payment to a pharmacy or pharmacy provider, as defined in section 62W.02, subdivision 14, because of the co-payment structure of a health plan offered pursuant to this subdivision.

(h) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

(i) Notwithstanding section 62A.65, subdivision 2, a health plan company may discontinue offering a health plan under this subdivision if, three years after the date the silver or gold health plan is initially offered, the silver or gold health plan has fewer than 75 enrollees enrolled in the plan. A health plan company discontinuing a plan under this paragraph must only discontinue the silver or gold health plan that has fewer than 75 enrollees and:

(1) provide notice of the plan's discontinuation in writing, in a form prescribed by the commissioner, to each individual enrolled in the plan at least 90 calendar days before the date the coverage is discontinued;

(2) offer on a guaranteed issue basis to each individual enrolled the option to purchase an individual health plan currently being offered by the health plan company for individuals in that geographic rating area. An enrollee who does not select an option must be automatically enrolled in the individual health plan closest in actuarial value to the enrollee's current plan; and

(3) act uniformly without regard to any health status-related factor of enrolled individuals or dependents of enrolled individuals who may become eligible for coverage.

(j) A health plan company must annually report to the commissioner, as specified by the commissioner, the total enrollment in silver and gold plans under this subdivision.

Subd. 7. **Standard plans.** (a) A health plan company that offers individual health plans must ensure that no less than one individual health plan at each level of coverage described in subdivision 1, paragraph (b), clause (3), that the health plan company offers in each geographic rating area the health plan company serves conforms to the standard plan parameters determined by the commissioner under paragraph (e).

(b) An individual health plan offered under this subdivision must be:

(1) clearly and appropriately labeled as standard plans to aid the purchaser in the selection process;

(2) marketed as standard plans and in the same manner as other individual health plans offered by the health plan company; and

(3) offered for purchase to any individual.

(c) This subdivision does not apply to catastrophic plans, grandfathered plans, small group health plans, large group health plans, health savings accounts, qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(d) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

(e) The commissioner of commerce, in consultation with the commissioner of health, must annually determine standard plan parameters, including but not limited to cost-sharing structure and covered benefits, that comprise a standard plan in Minnesota.

(f) Notwithstanding section 62A.65, subdivision 2, a health plan company may discontinue offering a health plan under this subdivision if, three years after the date the plan is initially offered, the plan has fewer than 75 enrollees. A health plan company discontinuing a health plan under this paragraph may discontinue a health plan that has fewer than 75 enrollees if it:

(1) provides notice of the plan's discontinuation in writing, in a form prescribed by the commissioner, to each enrollee of the plan at least 90 calendar days before the date the coverage is discontinued;

(2) offers on a guaranteed issue basis to each enrollee the option to purchase an individual health plan currently being offered by the health plan company for individuals in that geographic rating area. An enrollee who does not select an option shall be automatically enrolled in the individual health plan closest in actuarial value to the enrollee's current plan; and

(3) acts uniformly without regard to any health status-related factor of an enrollee or an enrollee's dependents who may become eligible for coverage.

History: *2013 c 84 art 1 s 89; 2022 c 44 s 4; 2023 c 57 art 2 s 52,53*

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.

History: *2013 c 84 art 1 s 90*

62Q.83 FORMULARY CHANGES.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Enrollee" has the meaning given in section 62Q.01, subdivision 2b.

(d) "Formulary" means a current list of covered prescription drug products that is subject to periodic review and update.

(e) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

(f) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision 15.

(g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Formulary changes.** (a) Except as provided in paragraphs (b) and (c), a health plan must not, with respect to an enrollee who was previously prescribed the drug during the plan year, remove a drug from the health plan's formulary or place a drug in a benefit category that increases the enrollee's cost for the duration of the enrollee's plan year.

(b) Paragraph (a) does not apply if a health plan changes the health plan's formulary:

(1) for a drug that has been deemed unsafe by the United States Food and Drug Administration (FDA);

(2) for a drug that has been withdrawn by the FDA or the drug manufacturer; or

(3) when an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes with respect to a drug's use for reasons related to previously unknown and imminent patient harm.

(c) Paragraph (a) does not apply if a health plan removes a brand name drug from the health plan's formulary or places a brand name drug in a benefit category that increases the enrollee's cost if the health plan:

(1) adds to the health plan's formulary a generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, a biologic drug rated as interchangeable according to the FDA Purple Book, or a biosimilar at the same or lower cost to the enrollee; and

(2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

History: *1Sp2025 c 3 art 4 s 1*