

**SENATE  
STATE OF MINNESOTA  
NINETY-THIRD SESSION**

**S.F. No. 2485**

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DATE	D-PG	OFFICIAL STATUS
03/02/2023	1284	Introduction and first reading Referred to Health and Human Services
03/22/2023	2195a	Comm report: To pass as amended and re-refer to Commerce and Consumer Protection
03/27/2023	2384	Comm report: To pass and re-referred to Health and Human Services See SF2744

1.1 A bill for an act

1.2 relating to health; requiring commercial health plan coverage of certain treatment

1.3 at psychiatric residential treatment facilities; adding psychiatric treatment facility

1.4 to essential community provider designation; amending Minnesota Statutes 2022,

1.5 sections 62A.152, subdivision 3; 62K.10, subdivision 4; 62Q.19, subdivision 1;

1.6 62Q.47.

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

1.8 Section 1. Minnesota Statutes 2022, section 62A.152, subdivision 3, is amended to read:

1.9 Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber

1.10 contracts that provide benefits for mental or nervous disorder treatments in a hospital must

1.11 provide direct reimbursement for those services at a hospital or psychiatric residential

1.12 treatment facility if performed by a mental health professional qualified according to section

1.13 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of

1.14 mental health professional licensure.

1.15 This subdivision is intended to provide payment of benefits for mental or nervous disorder

1.16 treatments performed by a licensed mental health professional in a hospital or psychiatric

1.17 residential treatment facility and is not intended to change or add benefits for those services

1.18 provided in policies or contracts to which this subdivision applies.

1.19 Sec. 2. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

1.20 Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient

1.21 number and type of providers, including providers that specialize in mental health and

1.22 substance use disorder services, to ensure that covered services are available to all enrollees

2.1 without unreasonable delay. In determining network adequacy, the commissioner of health  
2.2 shall consider availability of services, including the following:

2.3 (1) primary care physician services are available and accessible 24 hours per day, seven  
2.4 days per week, within the network area;

2.5 (2) a sufficient number of primary care physicians have hospital admitting privileges at  
2.6 one or more participating hospitals within the network area so that necessary admissions  
2.7 are made on a timely basis consistent with generally accepted practice parameters;

2.8 (3) specialty physician service is available through the network or contract arrangement;

2.9 (4) mental health and substance use disorder treatment providers, including but not  
2.10 limited to psychiatric residential treatment facilities, are available and accessible through  
2.11 the network or contract arrangement;

2.12 (5) to the extent that primary care services are provided through primary care providers  
2.13 other than physicians, and to the extent permitted under applicable scope of practice in state  
2.14 law for a given provider, these services shall be available and accessible; and

2.15 (6) the network has available, either directly or through arrangements, appropriate and  
2.16 sufficient personnel, physical resources, and equipment to meet the projected needs of  
2.17 enrollees for covered health care services.

2.18 Sec. 3. Minnesota Statutes 2022, section 62Q.19, subdivision 1, is amended to read:

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

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

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

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

2.27 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section  
2.28 501(c)(3);

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

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

3.1 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a  
3.2 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal  
3.3 government, an Indian health service unit, or a community health board as defined in chapter  
3.4 145A;

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

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

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

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

3.18 (iii) consists of 40 or fewer licensed beds;

3.19 (6) a birth center licensed under section 144.615; ~~or~~

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

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

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

3.25 (8) a psychiatric residential treatment facility as defined in section 256B.0625, subdivision  
3.26 45a, paragraph (b), that is certified and licensed by the commissioner of health.

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

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

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

4.6 Sec. 4. Minnesota Statutes 2022, section 62Q.47, is amended to read:

4.7 **62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY**  
4.8 **SERVICES.**

4.9 (a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism,  
4.10 mental health, or chemical dependency services, must comply with the requirements of this  
4.11 section.

4.12 (b) Cost-sharing requirements and benefit or service limitations for outpatient mental  
4.13 health and outpatient chemical dependency and alcoholism services, except for persons  
4.14 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to  
4.15 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more  
4.16 restrictive than those requirements and limitations for outpatient medical services.

4.17 (c) Cost-sharing requirements and benefit or service limitations for inpatient hospital  
4.18 mental health services, psychiatric residential treatment facility services, and inpatient  
4.19 hospital and residential chemical dependency and alcoholism services, except for persons  
4.20 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to  
4.21 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more  
4.22 restrictive than those requirements and limitations for inpatient hospital medical services.

4.23 (d) A health plan company must not impose an NQTL with respect to mental health and  
4.24 substance use disorders in any classification of benefits unless, under the terms of the health  
4.25 plan as written and in operation, any processes, strategies, evidentiary standards, or other  
4.26 factors used in applying the NQTL to mental health and substance use disorders in the  
4.27 classification are comparable to, and are applied no more stringently than, the processes,  
4.28 strategies, evidentiary standards, or other factors used in applying the NQTL with respect  
4.29 to medical and surgical benefits in the same classification.

4.30 (e) All health plans must meet the requirements of the federal Mental Health Parity Act  
4.31 of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and  
4.32 Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal  
4.33 guidance or regulations issued under, those acts.

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

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

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

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

5.19 (2) identify any enforcement actions taken by either commissioner during the preceding  
5.20 12-month period regarding compliance with parity for mental health and substance use  
5.21 disorders benefits under state and federal law, summarizing the results of any market conduct  
5.22 examinations. The summary must include: (i) the number of formal enforcement actions  
5.23 taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the  
5.24 subject matter of each enforcement action, including quantitative and nonquantitative  
5.25 treatment limitations;

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

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

5.32 The report must be written in nontechnical, readily understandable language and must be  
5.33 made available to the public by, among other means as the commissioners find appropriate,

- 6.1 posting the report on department websites. Individually identifiable information must be
- 6.2 excluded from the report, consistent with state and federal privacy protections.