Senator ..... moves to amend S.F. No. 3716 as follows:

Delete everything after the enacting clause and insert:

"Section 1. **[62Q.505] COVERAGE OF CERVICAL CANCER SCREENING TESTS.**

Subdivision 1. **Required coverage.** All health plans must cover:

(1) cervical cancer screening tests, including all cervical cancer screening tests recommended in the American Cancer Society Guideline for Cervical Cancer Screening at the time the medical service is performed; and

(2) additional diagnostic services after a cervical cancer screening test, if a health care provider determines the additional services are medically necessary based on the test's result. Additional diagnostic services under this clause include follow-up examinations used to evaluate an abnormality seen or suspected from a cervical cancer screening, regardless of whether different samples from the prior cervical cancer screening are used or the follow-up examination is performed on a different date than the cervical cancer screening. Follow-up examinations include, but are not limited to, human papillomavirus examinations with typing, cytology, dual stain, or colposcopy with biopsy.

Subd. 2. **Cost-sharing requirements.** A health plan must not impose any cost-sharing requirement on the coverage under this section including but not limited to the following requirements:

(1) deductible;

(2) co-payment; or

(3) coinsurance.

Subd. 3. **Review and referral limitations.** A health plan must not impose any review or referral limitation on the coverage under this section including but not limited to the following limitations:

(1) utilization review, as defined in section 62M.02;

(2) referral requirement; or

(3) delay period.

Subd. 4. **Quantity limitations.** A health plan must not impose any quantity limitation on the coverage under this section, including limitations on test frequency.

Subd. 5. **Application.** If the application of subdivision 2 before an enrollee has met the enrollee's health plan's deductible would result 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), then subdivision 2 applies to coverage under this section only after the enrollee has met the enrollee's health plan's deductible.

Subd. 6. **Reimbursement.** (a) The commissioner of commerce must reimburse health plan companies for coverage under this section, as required by Code of Federal Regulations, title 45, section 155.170. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments, services, supplies, and equipment covered by the health plan as of January 1, 2026, are ineligible for payments 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, 2026, 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. 7. **Appropriation.** Beginning in fiscal year 2028, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is annually appropriated from the general fund to the commissioner of commerce. The amount appropriated under this subdivision must include the administrative costs incurred by the commissioner to make the defrayal payments.

**EFFECTIVE DATE.** This section is effective January 1, 2027, and applies to all health plans offered, issued, or sold on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 14, is amended to read:

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "Preventive services" include services related to pregnancy, including:

(1) services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

(2) prenatal HIV risk assessment, education, counseling, and testing; and

(3) alcohol abuse assessment, education, and counseling on the effects of alcohol usage while pregnant. Preventive services available to a woman at risk of poor pregnancy outcome

may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

(c) "Screening services" include, but are not limited to, blood lead tests.

(d) The commissioner shall encourage, at the time of the child and teen checkup or at an episodic care visit, the primary care health care provider to perform primary caries preventive services. Primary caries preventive services include, at a minimum:

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age one to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services. The provider must obtain parental or legal guardian consent before a fluoride varnish is applied to a minor child's teeth.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of one. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

(e) "Diagnostic services" include but are not limited to the following:

(1) cervical cancer screening tests, including all cervical cancer screening tests recommended in the American Cancer Society Guideline for Cervical Cancer Screening at the time the medical service is performed; and

(2) additional diagnostic services after a cervical cancer screening test, if a health care provider determines the additional services are medically necessary based on the test's result. Additional diagnostic services under this clause include follow-up examinations used to evaluate an abnormality seen or suspected from a cervical cancer screening, regardless of whether different samples from the prior cervical cancer screening are used or the follow-up examination is performed on a different date than the cervical cancer screening. Follow-up

examinations include, but are not limited to, human papillomavirus examinations with typing, cytology, dual stain, or colposcopy with biopsy.

**EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 14a. **Cervical cancer screening tests.** For the coverage of cervical cancer screening tests and additional diagnostic services after a test, pursuant to subdivision 14, medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.505, except that medical assistance is not required to comply with any provision of section 62Q.505 if compliance with the provision would:

(1) prevent the state from receiving federal financial participation for the coverage under this subdivision; or

(2) result in a lower level of coverage or reduced access to coverage for medical assistance enrollees.

**EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained."

Delete the title and insert:

"A bill for an act

relating to health insurance; requiring health plans to cover cervical cancer screening tests and subsequent diagnostic services; requiring the commissioner of commerce to defray the cost of coverage of cervical cancer screening tests and subsequent diagnostic services; modifying language relating to coverage of cervical cancer screening tests and subsequent diagnostic services in the medical assistance program; appropriating money; amending Minnesota Statutes 2024, section 256B.0625, subdivision 14, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62Q."