Report of Past and Potential Future Use of Small Employer Alternative Health Plan Statutes

March 1, 2017

Introduction

Minnesota Laws 2017 chapter 2 directed the Minnesota Department of Commerce to submit a report to the Legislature regarding the past and future use of Minnesota Statutes section 62L.056 (2005) and Minnesota Statutes section 62Q.188 (2010) (see Appendix 1). These state statutes allowed health plan companies to offer alternative benefit plans to small employers (with 50 employees or less).

Senate File 1, 3rd engrossment, Section 17.[1]
INSURANCE MARKET OPTIONS
The commissioner of commerce shall report by March 1, 2017, to the standing committees of the legislature having jurisdiction over insurance and health on the past and future use of Minnesota Statutes 2005, section 62L.056, and Minnesota Statutes, section 62Q.188, including:
(1) rate and form filings received, approved, or withdrawn;
(2) barriers to current utilization, including federal and state laws; and
(3) recommendations for allowing or increasing the offering of health plans compliant with Minnesota Statutes, section 62Q.188.
EFFECTIVE DATE.
This section is effective the day following final enactment.

Definitions

This report uses numerous specific terms throughout:

Alternative Benefit Plan is a health plan that can exclude state mandates, other than maternity coverage. See Appendix 1 for reference to Minnesota Statutes section 62L.056 and section 62Q.188.

Essential health benefits (EHB) is a set of covered services and benefits that individual and small employer health insurance plans must cover under the Affordable Care Act (ACA) to ensure comprehensive major medical coverage. The EHB includes ten federally-mandated categories including preventive care, physician services, emergency care, inpatient and outpatient hospital care, prescription drugs, pregnancy and childbirth, rehabilitation and habilitation services (these include physical therapy, occupational therapy and speech therapy), and mental health and substance abuse services, as well as all state mandated benefits in effect on December 31, 2012.

Health plan company is a term used throughout this report to refer to any organization offering health plans organized either as an insurer, a health maintenance organization, or a health service plan corporation.

[1] https://www.revisor.mn.gov/pages/doctypes/bills/text.php?number=SF1&version=3&session=ls90&session_year=2017&session_number=0

Health maintenance organization is a company offering health plans operating under Minnesota Statutes section 62D. The regulatory authority of health maintenance organizations is the Minnesota Department of Health.

Health service plan corporation is a company offering health plans under Minnesota Statutes section 62C. The regulatory authority of health service corporations is the Minnesota Department of Commerce.

Insurer is a company offering health plans operating under Minnesota Statutes section 62A. The regulatory authority of insurers is the Minnesota Department of Commerce.

Small employer is an insured group actively engaged in business (including political subdivisions of the state) that employed 2-50 workers who worked at least 20 hours per week on business days during the preceding calendar year; and employs at least 2 current employees on the first day of the health plan year.

Health Plan Company Feedback Summary: Past Use

In order to learn about the health plan companies' use of alternative benefit plans in the small group market, Commerce sought direct input from health plan companies regarding their experiences with these products. Health plan companies provided important historical context on the use of these plans because:

- Prior to ACA implementation, rate and form filings did not specifically allow identification of the covered services sold by product. Prior to 2014, health plan companies filed overall policy forms with bracketed language, where the brackets indicated covered services that might or might not be included or excluded on any given plan or product.[2] Since 2014, small-employer health-insurance plan filings identify variations in non-essential health benefits.

- No data source exists that provides enrollment data by product. The only data available is presented in aggregate for the entire small group market sold by a health plan company. This aggregated data is submitted annually through the Supplemental Health Care Exhibit of a health insurer's annual financial report.[3]

[2] This has always been common practice in all states, and in all product form filings. Regulators monitor that the covered service is allowed to be bracketed and thus optional and provide oversight over the language used to describe the covered service.
[3] See page 1083 of 1833 (page 63 of the 2015 Supplemental Health Care Exhibit Report, Volume II) for a summary of Minnesota's small group financial items from the 2015 annual reports: http://www.naic.org/documents/prod_serv_statistical_hcs_zb.pdf

- Strategic information on why a health plan company chose (or did not choose) to make use of an optional statute is not available through the regulatory process.

Based on participation in the small employer group health insurance market in 2013, Commerce requested information from the following health plan companies that had participated in the small employer group market both before and after the Affordable Care Act: Blue Cross, Federated, HealthPartners, Medica, and PreferredOne.[4]

- Of these health plan companies, two did not sell products using these statutes under Minnesota Statutes section 62Q.188 and section 62L.056.
    - One company cited a lack of market demand for such products, a desire to avoid customer confusion, and administrative burden as the factors driving their decision to not make use of the statutes to exclude state mandated benefits.
    - One company cited that the coverage of services was not onerous at the time.
- One other health plan company filed a flexible benefit product but found that no small employers were interested in purchasing it and so discontinued the product as an offering.
- One company launched a product in July 2009, which at its peak only attracted enrollment of about 700 small group members. The product was closed in July 2011, due mainly to its low enrollment but also to small employers' return to more comprehensive coverage after purchasing. The following benefits were excluded in the product line: chiropractic care, infant formula and dietary treatment for PKU, hair prosthesis, mental health and substance abuse disorder services, services for temporomandibular joint disorders (TMJ), infertility, and bariatric surgery.[5]
- One health plan company made greater use of the flexible benefit statutes—reaching peak enrollment at 81,399 small group members just prior to the Affordable Care Act's implementation in 2014. The following benefits were excluded in its product line: acupuncture, orthognathic (jaw) surgery, erectile dysfunction drugs, and bariatric surgery. These excluded services were normally offered by health maintenance organizations under the requirement to provide comprehensive health maintenance services, but were not generally considered state mandates.[6] The coverage set was comparable to that offered to small employers by insurers and health service corporations at the time.

[4] The Department did not request information from Time and John Alden (Assurant), as they left all health insurance markets nationwide in 2016.
[5] Note that most of these exclusions are not state mandates, but the exclusion of these services is noted because it is in comparison to popular services that were covered by major medical coverage alternatives offered by the health plan company.
[6] Note that none of these exclusions is a state mandate, but the exclusion of these services is noted because it is in reference to popular services that were covered by major medical coverage alternatives.

Barriers to Use of the Statute

Under current Federal law, creation of new alternative benefit plans appear unlikely. Since 2014, the Affordable Care Act (ACA) and subsequent federal regulations set a very specific set of choices for essential health benefits (EHB) and has preempted the use of Minnesota's alternative benefit plan statute.[7] For the EHB coverage set, states may only choose one plan from among ten plans found in the following four categories:

- the largest plan, based on enrollment, in any of the three largest small group products in the state
- any one of the three largest state employee health plans
- any one of the three largest federal employee health plan options
- the largest HMO plan offered in the state's commercial market.

Without clear, express authority for the state to make a proactive benchmark plan selection, Minnesota has used the default EHB benchmark plan since ACA implementation in 2014. All of the EHB benchmark options, however, provide comprehensive major medical coverage. Many of the choices above are redundant in terms of coverage inclusions and exclusions. The differences in the EHB choices affect less common coverages, such as acupuncture, bariatric surgery, nutritional counseling, and hearing services/devices.

At the time of this report it is unknown and uncertain as to future changes to the ACA, which might provide states with additional opportunities to determine their own essential health benefits sets, select their own benchmark plans, or use plan designs that deviate from an EHB benchmark plan's coverage requirements. If any of these changes are made at the Federal level, it is possible that health plan companies will begin to use Minnesota Statute section 62Q.188 in order to offer alternative benefit plans.

Prior to ACA implementation, however, the market for alternative benefit plans was not widely used. Most companies either did not offer these products, or did not generate significant interest in alternative benefit products. While one company made use of Minnesota Statute section 62Q.188 in a very popular way, its alternative benefit set was very similar to what other health plan companies used and did not actually exclude Minnesota's state mandates.

Health plan companies likely chose not to take advantage of alternative benefit plans under Minnesota Statute section 62Q.188 because of the actuarial/adverse selection risks that offering coverage set choices presents to them. Small employers are generally much more attuned to the health needs of their employees than large employers are, and this presents a financial risk to the health plan company. Employers who would choose to buy certain optional covered services would likely do so because they expect their employees

[7] See Minn. Stat. § 62Q.188.

will use those services. While having those who use the services be the same ones who pay for them may seem attractive, it presents a financial risk in that insurance principles rely upon pooling all health risks together. In order to manage such adverse selection risks, health plan companies would likely choose to exclude or include whole packages of covered services, rather than single covered services.

Also, it is important to note that health plan companies evaluate and often follow what their competition offers, because 1) they are concerned about attracting poorer health risks from their competition, 2) want to remain competitive on price, and 3) must manage their brand's reputation.

Finally, state benefit mandates that employers would forgo often do not add up to a material financial savings. For example, very few employers would be willing to forgo financially material coverages such as pharmacy, mental health, and substance abuse coverages. Many of the other state benefit mandates result in minor financial effects, even when assembled in a package.

These strategic issues present major barriers to the application of the statute, as witnessed by its lack of broad use even prior to the Affordable Care Act.

The Current State of Small Group Health Benefits in Minnesota

Since January 1, 2014, the ACA requires insurers in the small employer market to cover ten broad categories of medical services known as Essential Health Benefits (EHBs), meant to be equal in scope to benefits offered by a "typical employer plan." Because the ten categories are very broad, to determine the specific services in the EHB package, the U.S. Department of Health and Human Services (HHS) left it to each state to select from among a small list of existing health plans.

What are the 10 Essential Health Benefits (EHBs) that must be covered?

- ✓ Ambulatory patient services (outpatient services)
- ✓ Emergency services
- ✓ Hospitalization
- ✓ Maternity and newborn care
- ✓ Mental health and substance use disorder services, including behavioral health treatment
- ✓ Prescription drugs
- ✓ Rehabilitative and habilitative services and devices
- ✓ Laboratory services
- ✓ Preventive and wellness services and chronic disease management
- ✓ Pediatric services, including oral and vision care

The Minnesota EHB coverage set is based on HealthPartners Insurance Company's 2012 small group coverage package.[8] All health plan companies in Minnesota's small employer group market (whether sold through MNsure or not), are required to provide at least equivalent benefits available to those in this benchmark plan. Because of federal law specifically requiring it, the EHB package includes all small group state mandates that had

[8] Even after the one federal allowance to re-benchmark the plan provided to states since 2014, in effect, the Minnesota covered benefit set for EHB is still set based on a plan from that long ago.

existed in 2011.[9]

Due to provisions in the ACA, health plan company costs of new mandates enacted after December 31, 2011 must be defrayed by the state. This consequence has effectively prevented new mandates from passage at the legislature in the individual and small group marketplaces.[10]

Below is a list of the Minnesota statutes mandating coverage of benefits in the small employer group market:

62A.041 MATERNITY BENEFITS
62A.0411 MATERNITY CARE
62A.042 FAMILY COVERAGE; COVERAGE OF NEWBORN INFANTS
62A.043 DENTAL AND PODIATRIC COVERAGE
62A.047 CHILDREN'S HEALTH SUPERVISION SERVICES AND PRENATAL CARE SERVICES
62A.149 BENEFITS FOR ALCOHOLICS AND DRUG DEPENDENTS[11]
62A.151 HEALTH INSURANCE BENEFITS FOR EMOTIONALLY DISABLED CHILDREN
62A.153 OUTPATIENT MEDICAL AND SURGICAL SERVICES
62A.154 BENEFITS FOR DES RELATED CONDITIONS
62A.155 COVERAGE FOR SERVICES PROVIDED TO VENTILATOR-DEPENDENT PERSONS
62A.25 RECONSTRUCTIVE SURGERY
62A.26 COVERAGE FOR PHENYLKETONURIA TREATMENT
62A.265 COVERAGE FOR LYME DISEASE
62A.28 COVERAGE FOR SCALP HAIR PROSTHESES
62A.30 COVERAGE FOR DIAGNOSTIC PROCEDURES FOR CANCER
62A.304 COVERAGE FOR PORT-WINE STAIN ELIMINATION
62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE
62A.308 HOSPITALIZATION AND ANESTHESIA FOR DENTAL PROCEDURES
62A.3093 COVERAGE FOR DIABETES
62D.102 FAMILY THERAPY
62D.103 SECOND OPINION RELATED TO CHEMICAL DEPENDENCY AND MENTAL HEALTH
62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES[12]
62Q.471 EXCLUSION FOR SUICIDE ATTEMPTS PROHIBITED
62Q.50 PROSTATE CANCER SCREENING
62Q.52 DIRECT ACCESS TO OBSTETRIC AND GYNECOLOGIC SERVICES
62Q.525 COVERAGE FOR OFF-LABEL DRUG USE
62Q.527 NONFORMULARY ANTIPSYCHOTIC DRUGS; REQUIRED COVERAGE
62Q.53 MENTAL HEALTH COVERAGE; MEDICALLY NECESSARY CARE
62Q.535 COVERAGE FOR COURT-ORDERED MENTAL HEALTH SERVICES

[9] The only exception where federal law requires a state mandate to be excluded from EHB was in the case of abortion, adult vision, and adult dental.
[10] Large group mandates are not subject to this payment provision; in Minnesota, an autism coverage mandate has passed in the large group market. Note that large employer groups are not affected by EHB, other than the limitation that lifetime and annual limits cannot be placed on EHBs.
[11] Identical effect to federal mental health parity law and only affects cost sharing, so this statute is not truly a state mandate of coverage.
[12] Id.

62Q.545 COVERAGE OF HOME CARE NURSING
62Q.55 EMERGENCY SERVICES
62Q.556 UNAUTHORIZED PROVIDER SERVICES
62Q.56 CONTINUITY OF CARE
62Q.58 ACCESS TO SPECIALTY CARE
62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE
62Q.675 HEARING AIDS; PERSONS 18 OR YOUNGER

In addition, there is a federal mandate that all health plans must provide breast reconstruction surgery after mastectomy, assuming mastectomy was a covered benefit. Prior to the EHB requirements implemented with the Affordable Care Act, this was the only federal benefit coverage mandate in place prior to 2014.

Recommendations

The Commerce Department recommends the following:

- The Legislature should wait for expected Federal action before making changes to Minnesota's alternative benefit statute.
- Financial data from health plan companies could be gathered and analyzed to better understand the financial costs and benefits associated with plan designs that omit certain mandates.
- The Legislature could also examine disclosure requirements to policyholders so employees are properly but efficiently informed when an insurance product option is available to them that may omit certain benefits that are otherwise standard.
- The Legislature could also study the interaction between alternative benefit plans and the federal CURES Act, Section 18001, enacted on December 13, 2016, which created a new savings account product for small employers that allows small employers to fully or partially fund their employees' purchase of individual market products.

Additional Reference Sources

Information on essential health benefits under the Affordable Care Act, including other states' benchmark covered services set:
https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

Information on specific state mandates applicable throughout the U.S.:
http://www.ncsl.org/research/health/mandated-health-insurance-benefits-and-state-laws.aspx

The CURES Act, Section 18001, enacted on December 13, 2016, has created a new savings account product for small employers that allow small employers to fully or partially fund their employees' purchase of individual market products:
https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf

Minnesota Statutes Affecting Small Group Employer Plans
https://www.revisor.mn.gov/statutes/?id=62A
https://www.revisor.mn.gov/statutes/?id=62C
https://www.revisor.mn.gov/statutes/?id=62D
https://www.revisor.mn.gov/statutes/?id=62E
https://www.revisor.mn.gov/statutes/?id=62K
https://www.revisor.mn.gov/statutes/?id=62L
https://www.revisor.mn.gov/statutes/?id=62Q

Appendix 1: Minnesota Statutes Section 62L.056 and Section 62Q.188

Minnesota Statutes 2005, Section 62L.056 SMALL EMPLOYER FLEXIBLE BENEFITS PLANS.

(repealed 2010 and replaced by 62Q.188)
(a) Notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health carrier may offer, sell, issue, and renew a health benefit plan that is a flexible benefits plan under this section to a small employer if the following requirements are satisfied:
(1) the health benefit plan must be offered in compliance with this chapter, except as otherwise permitted in this section;
(2) the health benefit plan to be offered must be designed to enable employers and covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;
(3) the health benefit plan must be issued and administered in compliance with sections 62E.141; 62L.03, subdivision 6; and 62L.12, subdivisions 3 and 4, relating to prohibitions against enrolling in the Minnesota Comprehensive Health Association persons eligible for employer group coverage;
(4) the health benefit 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;
(5) each health benefit plan must be approved by the commissioner of commerce, but the commissioner may not disapprove a plan on the grounds of a modification or exclusion permitted under clause (4); and
(6) prior to sale of the health benefit plan, the small employer must be given a written list of the coverages otherwise required by law that are modified or excluded in the health benefit plan. The list must include a description of each coverage in the list and indicate whether the coverage is modified or excluded. If a coverage is modified, the list must describe the modification. The list may, but need not, also list any or all coverages otherwise required by law that are included in the health benefit plan and indicate that they are included. The insurer must require that a copy of this written list be provided, prior to the effective date of the health benefit plan, to each employee who is eligible for health coverage under the employer's plan.
(b) The definitions in section 62L.02 apply to this section as modified by this section.
(c) An employer may provide a health benefit 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.

Minnesota Statutes, Section 62Q.188 FLEXIBLE BENEFITS PLANS.

Subd. 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.

Appendix 2: CMS Statute Citations of Minnesota State Required Benefits

A Name of Required Benefit	B Market Applicability	C Year of Enactment	D Citation Number
Outpatient medical & surgical services	Individual, Group, HMO	Before 2012	62A.153 4685.0100 Subp. 5 4685.0700, Subp. 2 62D.02, Subd. 7 (Citations individually apply to specific markets)
Outpatient services	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(2) 4685.0100 Subp. 5 4685.0700, Subp. 2 62D.02, Subd. 7 (Citations individually apply to specific markets)
Private duty nurse	Individual, Group, HMO	Before 2012	62A.155 Subd. 2
Preventive health services	Individual, Group, HMO	Before 2012	62Q.46 62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Home health services	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(5)
Emergency services	Individual, Group, HMO	Before 2012	62A.049 62Q.81 Subd. 4 (a) 62M.07 (b); 62Q.55 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Ambulance services	All health plans	Before 2012	62E.06 Subd. 1(b)(14) 62J.48 4685.0100 subp. 5 62D.02, subd. 7 (Citations individually apply to specific markets)
Hospital services	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(1) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Inpatient hospital services	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(2) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Skilled nursing facility	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(4)
Maternity benefits	Individual, Group, HMO	Before 2012	62Q.81 Subd. 4(5) 62A.047 62A.041 62A.0411 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)

A Name of Required Benefit	B Market Applicability	C Year of Enactment	D Citation Number
Pre-natal care	Individual, Group, HMO	Before 2012	62Q.81 Subd. 4(5) 62A.047 62A.041 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Minimum maternity stay	Individual, Group, HMO	Before 2012	62A.0411
Ambulatory mental health services	Individual, Group, HMO	Before 2012	62A.152 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Inpatient mental health benefits	Individual, Group, HMO	Before 2012	62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Treatment for alcoholism and chemical dependency	Individual, Group, HMO	Before 2012	62A.149 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations apply to specific markets)
Treatment for alcoholism and chemical dependency	Individual, Group, HMO	Before 2012	62A.149 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Prescription drug coverage	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(3) 4685.0700, subp. 3 4685.0700, subp. 3A (Citations individually apply to specific markets)
Therapeutic services	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1 (b)(3) 4685.0700 Subd. 2E 4685.0100 Subd. 5D (Citations individually apply to specific markets)
Durable medical equipment	Individual, Group, HMO	Before 2012	62Q. 66 62E.06 Subd. 1(b)(10) 4685.0700, subp. 2 4685.0700, subp. 3B (Citations individually apply to specific markets)
Scalp-hair prostheses for alopecia	Individual, Group, HMO	Before 2012	62A.28
Durable medical equipment	Individual, Group, HMO	Before 2012	62Q. 66 62E.06 Subd. 1(b)(10) (Citations individually apply to specific markets)
Prostheses	Qualified Plans	Before 2012	62E.06 Subd. 1(b)(9)
Hearing aids	Individual, Group, HMO	Before 2012	62Q.675

A Name of Required Benefit	B Market Applicability	C Year of Enactment	D Citation Number
Professional services, outpatient services and hospital services	Qualified Plans, HMO	Before 2012	62E.06 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Well-child visits, immunizations	Individual, Group, HMO	Before 2012	62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Routine cancer screenings (mammograms, ovarian cancer screening for women at risk , pap smears)	Individual, Group, HMO	Before 2012	62A.30 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Prostate cancer screening	Individual, Group, HMO	Before 2012	62Q.50 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive health services	Individual, Group, HMO	Before 2012	62Q.46 62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Routine eye exams	HMO plans	Before 2012	4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7
Diagnostic testing	Qualified Plans, HMO	Before 2012	62E.06 Subd. 1(b)(11) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Radiation therapy	Qualified Plans	Before 2012	62E.06 Subd. 1(b)(6)
Temporomandibular joint disorder (TMJ)	Individual, Group, HMO	Before 2012	62A.043
Reconstructive surgery	Individual, Group, HMO	Before 2012	62A.25
Clinical trials	Individual, Group, HMO	Before 2012	62D.109, 62Q.526 (Citations individually apply to specific markets)
Coverage for diabetes	Individual, Group, HMO	Before 2012	62A.3093
PKU treatment	Individual, Group, HMO	Before 2012	62A.26
Coverage for off-label drugs to treat cancer in certain	Individual, Group, HMO	Before 2012	62Q.525
Anesthesia and hospital charges for	Individual, Group, HMO	Before 2012	62A.308
Coverage for chemical dependency in corrections facilities	Health plan that provides coverage for	Before 2012	62Q.137
Coverage for mental health	Individual, Group, HMO	Before 2012	62Q.53
Court-ordered mental health	Individual, Group, HMO	Before 2012	62Q.535
Nonformulary antipsychotic drugs	Individual, Group, HMO	Before 2012	62Q.527
Cleft lip/cleft palate	Individual, Group, HMO	Before 2012	62A.042
Lyme disease	Individual, Group, HMO	Before 2012	62A.265
Port-wine stain removal	Individual, Group, HMO	Before 2012	62A.304

A Name of Required Benefit	B Market Applicability	C Year of Enactment	D Citation Number
Health insurance benefits for emotionally disabled	All health plans	Before 2012	62A.151
Coverage of services to ventilator-	All health plans	Before 2012	62A.155
Anesthetics	Qualified Plans	Before 2012	62E.06 Subd. 1(b)(8)
Family therapy	HMO	Before 2012	62D.102
Oral surgery	Qualified Plans	Before 2012	62E.06 Subd. 1(b)(12)
Oxygen	Qualified Plans	Before 2012	62E.06 Subd. 1(b)(7)
Second opinions related to chemical dependency and	HMO	Before 2012	62D.103
Second surgical opinions	Qualified Plans	Before 2012	62E.06 Subd. 1(e)
Cancer Chemotherapy Treatment	All health Plans	Before 2012	62A.3075
Benefits for DES Related	All health Plans	Before 2012	62A.154
Conditions caused by Breast	All health Plans	Before 2012	62A.285 Subd. 2