Bill Summary Comparison of

Health and Human Services

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| House File 2414-2 | Senate File UEH2414-1 |
| Article 13: Health Coverage | Article 12: Miscellaneous |

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| Section | Article 13: Health Coverage |  | Article 12: Miscellaneous |
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|  | Loss ratio standards.  Adds subd. 1a to § 62A.021. (a) Requires individual health plans to provide benefits to enrollees that equal at least 80 percent of premiums earned.  (b) Requires small employer health plans to provide benefits to enrollees that equal at least 82 percent of premiums earned.  (c) Requires health plans issued to large groups to provide benefits to enrollees that equal at least 85 percent of the premiums earned.  (d) Requires short-term health plans to provide benefits to enrollees that equal at least 80 percent of premiums earned.  (e) Provides information on how to calculate loss ratios for health plans issued by an HMO.  (f) Requires health carriers to submit evidence of compliance with paragraphs (a) to (d) to the commissioner by June 1 of every year for the previous year.  (g) Requires the commissioner to review the reports required under paragraph (f) for reasonable, soundness, and compliance with this section. Requires the commissioner to resolve issues in the report with the health carrier, and if they cannot be resolved, to require the carrier to issue an appropriate rebate.  (h) Provides that a health plan that does not comply with the requirements in paragraphs (a) to (d) is unfair and deceptive and subject to penalties.  (i) Requires the commissioners of health and commerce to issue a public report on loss ratios every year. | House only |  |
|  | Rebate.  Adds subd. 2a to § 62A.021. (a) Requires a health carrier to issue a rebate to each enrollee if the carrier does not meet the loss ratio requirements in subdivision 1a.  (b) Provides that the rebate must be the aggregate amount of premiums earned multiplied by the difference between the health carrier’s actual loss ratio and the loss ratio required under subdivision 1a.  (c) Requires a health carrier to issue the rebate by August 1 of the year following the year the loss ratio was insufficient.  (d) Requires the rebate to be in a lump-sum payment or direct deduction to the current plan year’s premium, as appropriate. | House only |  |
|  | Prohibiting subtractions from loss ratio calculations.  Adds subd. 3a to § 62A.021. Prohibits a health carrier from including the following in its loss ratio calculations under section 62A.021, subdivision 1a: (1) reinsurance payments received under section 62E.23; and (2) payments from the commissioner of commerce to health carriers to cover the cost of mandating coverage of treatments for ectodermal dysplasias, PANDAS, and PANS. | House only |  |
|  | Required coverage.  Amends § 62A.25, subd. 2. Requires health plans to provide coverage of reconstructive breast surgery when breast tissue is absent due to ecotodermal dysplasia. Provides that the commissioner of commerce shall reimburse health carriers for coverage for ectodermal dysplasias under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.  Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date. | House only |  |
|  | Required coverage.  Amends § 62A.28, subd. 1. Requires health plans to provide coverage for prosthetic hair when hair loss is due to ectodermal dysplasias. Provides that the commissioner of commerce shall reimburse health carriers for coverage for ectodermal dysplasias under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.  Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date. | House only |  |
|  | Mammograms.  Adds subd. 4 to § 62A.30. (a) Clarifies that coverage for an annual preventative mammogram screening includes digital breast tomosynthesis if the enrollee is at risk for breast cancer. This screening is at the option of the enrollee and at no cost to the enrollee.  (b) Defines “digital breast tomosynthesis” and “at risk for breast cancer”.  (c) States that this subdivision does not apply to public health care programs under chapter 256B (medical assistance) or 256L (MinnesotaCare).  (d) Clarifies that nothing in this subdivision limits the coverage of digital breast tomosynthesis for health plans in effect prior to January 1, 2020.  (e) Clarifies that nothing in this subdivision prohibits a health plan from providing coverage for digital breast tomosynthesis to enrollees who are not at risk for breast cancer.  Effective date. This section is effective January 1, 2020, and applies to health plans on or after that date. | Identical | **Section 1 (62A.30, subdivision 4)** provides health care coverage for preventive mammogram screening that includes digital breast tomosynthesis (3D) for enrollees who are at risk for breast cancer.  At risk of breast cancer included having a family history; testing positive for BRCA1 or BRCA2; having dense breasts; or having a previous diagnosis of breast cancer. |
|  | Coverage for ectodermal dysplasias.  Adds § 62A.3096.  Subd. 1. Definitions. Defines ectodermal dysplasias.  Subd. 2. Coverage. Requires health plans to provide coverage for ectodermal dysplasias.  Subd. 3. Dental coverage. (a) Requires health plans to provide coverage for dental treatments, including bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance, when related to ectodermal dysplasias.  (b) States that if the dental treatment is covered by a dental insurance plan or other health plan, the coverage provided under this section is secondary.  Subd. 4. Reimbursement. Provides that the commissioner of commerce shall reimburse health carriers for coverage for ectodermal dysplasias under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.  Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date. | House only |  |
|  | Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) treatment; coverage.  Adds § 62A.3097.  Subd. 1. Definitions. Provides definitions for PANDAS and PANS.  Subd. 2. Scope of coverage. Applies this section to all health plans that provide coverage to Minnesota residents.  Subd. 3. Required coverage. Requires all health plans to provide coverage for PANDAS and PANS, including antibiotics, medication, behavioral therapies, plasma exchange, and immunoglobulin.  Subd. 4. Reimbursement. Provides that the commissioner of commerce shall reimburse health carriers for coverage for PANDAS and PANS under this section at the medical assistance rate, and limits reimbursement to coverage that would not have otherwise been provided by the carrier without the requirements of this section. Prohibits a provider from billing an enrollee any amount in excess of the medical assistance rate, but permits the provider to bill the enrollee for the applicable copayment, deductible, or coinsurance.  Effective date. This section is effective January 1, 2020, and applies to health plans issued on or after that date. | House only |  |
|  |  | Senate only | **Section 2 (62A.65, subdivision 2) Paragraph (a)** clarifies in statute that any individual health plan offered, sold, issued, or renewed in Minnesota must be guaranteed issued and guaranteed renewable.  **Paragraph (b)** permits a health carrier to close a product offering if it covers less than 50 individuals, provided the carrier offers each covered individual on a guaranteed-issue basis the option to purchase another health plan currently being offered by the health carrier. |
|  | Short-term coverage.  Amends § 62A.65, subd. 7. Modifies the definition of short-term coverage by (1) allowing short-term coverage to provide coverage for 90 days or less, rather than 185 days or less as in current law; and (2) limiting the period of coverage under short-term coverage to a total of 185 days, rather than 365 days as in current law, out of any 555-day period. | House only |  |
|  | Application of other laws.  Adds § 62C.045. Provides that the new chapter governing nonprofit health care entity conversion transactions, and extending the moratorium on conversion transactions, apply to nonprofit health service plan corporations operating under chapter 62C. | House only |  |
|  | Health maintenance organization.  Amends § 62D.02, subd. 4. Amends the definition of health maintenance organization for chapter 62D, to require them to operate as nonprofit corporations organized under chapter 317A. | House only |  |
|  | Certificate of authority required.  Amends § 62D.03, subd. 1. Provides that a corporation applying to the commissioner of health for an HMO license must be a nonprofit corporation. | House only |  |
|  | Application of other law.  Adds § 62D.046. Provides that the new chapter governing nonprofit health care entity conversion transactions applies to nonprofit HMOs operating under chapter 62D. | House only |  |
|  | Authority granted.  Amend § 62D.05, subd. 1. Provides that a corporation that obtains a certificate of authority to operate an HMO must be nonprofit. | House only |  |
|  | Governing body composition; enrollee advisory board.  Amends § 62D.05, subd. 1. Makes a conforming change to conform with a section requiring HMOs to be organized as nonprofit corporations. | House only |  |
|  | Net earnings.  Adds subd. 8a to § 62D.12. Requires a nonprofit health maintenance organization to use its net earnings to provide comprehensive health care. Prohibits an organization from paying net earnings as a dividend or rebate to a person for any reason other than providing comprehensive health care. An exception to this is that the organization can make certain payments to health care providers. Requires the commissioner of health to revoke an organization’s certificate of authority if it violates this subdivision. | House only |  |
|  |  | Senate only | **Section 3 (62D.12, subdivision 20) Paragraph (a)** specifies that for-profit HMOs may pay dividends or make distributions or transfers in accordance with section 60D.20, subdivision 2.  **Paragraph (b)** specifies that if a nonprofit HMO plans on transferring an amount that together with other transfers made within the preceding 12 months exceeds the greater of: 10% of the HMO’s net worth; or the HMO’s net income for the preceding 12-month period, it must meet the requirements of paragraph (c).  **Paragraph (c)** requires a nonprofit HMO to notify the commissioner of the transfer. Requires the commissioner to review the proposed transfer to determine whether the proposed transfer is reasonable in relation to the HMO’s outstanding liabilities and the quality of the HMO’s earnings. Specifies that no transfer shall be made until 30 days after the commissioner has received notice and the commissioner has not disapproved the transfer; or the commissioner has approved the transfer within the 30-day period.  **Paragraph (d)** defines affiliate.  Paragraph (e) specifies that the commissioner of health shall enforce this section. |
|  | Emergency care; primary care; mental health services; general hospital services.  Amends § 62D.124, subd. 1. Requires emergency care to be available to HMO enrollees 24 hours a day, 7 days a week and establishes appointment wait time requirements for primary care services and for mental health and substance use disorder treatment services. | House only |  |
|  | Other health services.  Amends § 62D.124, subd. 2. Establishes appointment wait times for HMO enrollees for nonurgent specialty care and for dental, optometry, laboratory, and x-ray services for regular appointments and urgent care. | House only |  |
|  | Waiver.  Amends § 62D.124, subd. 3. Allows an HMO to apply for a waiver of the network geographic accessibility requirements, by submitting to the commissioner an application and an application fee of $1,000 per county per year. Specifies application and approval requirements. Allows the commissioner to approve a waiver if the HMO proposes to address network inadequacy through the use of telemedicine, when there are no providers of a specific type or specialty in the county. States that a waiver expires after four years and cannot be renewed; plans must instead submit a new application. Specifies review requirements for new applications. Requires application fees to be deposited in the state government special revenue fund. | House only |  |
|  | Complaints alleging violation of network adequacy requirements; investigation.  Amends § 62D.124, by adding subd. 6. Allows enrollees to file complaints with the commissioner regarding noncompliance of the network geographic accessibility standards. Requires the commissioner to investigate complaints, and allows the commissioner to use the program established under section 62K.105, subdivision 2, to do so. | House only |  |
|  | Provider network notifications.  Amends § 62D.124, by adding subd. 7. Requires an HMO to provide on the organization’s website the provider network for each product, and update the website at least once per month. Also requires the HMO to provide on the website a list of current waivers of the network geographic accessibility standard. | House only |  |
|  | Administrative penalty.  Amends § 62D.17, subd. 1. Allows the commissioner to impose an administrative penalty of $100 per day for violations of the network geographic accessibility requirements, and take other enforcement action, but prohibits the commissioner from also imposing an administrative penalty under section 62K.105, subdivision 3. | House only |  |
|  | Unreasonable expenses.  Amends § 62D.19. Makes a conforming change to conform with a section requiring HMOs to be organized as nonprofit corporations. | House only |  |
|  | Rural demonstration project.  Amends § 62D.30, subd. 8. Modifies a cross-reference to a subdivision related to loss ratios, from a subdivision being repealed to a new subdivision. | House only |  |
|  | Health maintenance organization.  Amends § 62E.02, subd. 3. Makes a conforming change to conform with a section requiring HMOs to be organized as nonprofit corporations. | House only |  |
|  | Calculation of reinsurance payments.  Amends § 62E.23, subd. 4. Prohibits a health carrier from including claims costs for coverage of ectodermal dysplasias, PANDAS, or PANS that are eligible for reimbursement by the commissioner of commerce, when the health carrier calculates claims costs incurred for an individual enrollee for purposes of reinsurance payments. | House only |  |
|  |  | Senate only | **Section 4 (62K.07)** requires a health plan company to provide information to the commissioner of commerce when they file rate information on prescription drugs that are reimbursed by the health plan company under health plans issued in this state. |
|  | Provider network notifications.  Amends § 62K.075. Requires health carriers to provide on the carrier’s website the provider network for each product, and to update the website at least once a month. Also requires the carrier to provide on the website a list of current waivers of the network geographic accessibility standard. | House only |  |
|  | Emergency care; primary care; mental health services; general hospital services.  Amends § 62K.10, subd. 2. Requires emergency care to be available to enrollees of individual or small group health plans 24 hours a day, 7 days a week and provides that the appointment wait times that apply to HMO enrollees for primary care services, mental health services, and substance use disorder treatment services also apply to these enrollees. | House only |  |
|  | Other health services.  Amends § 62K.10, subd. 3. Provides that the appointment wait times that apply to HMO enrollees for nonurgent specialty care and for dental, optometry, laboratory, and x-ray services also apply to enrollees of individual or small group health plans. | House only |  |
|  | Network adequacy.  Amends § 62K.10, subd. 4. Directs the commissioner to ensure a provider network is sufficient to satisfy the appointment wait time requirements in this section, as part of the commissioner’s evaluation of network adequacy. | House only |  |
|  | Waiver.  Amends § 62K.10, subd. 5. Requires health carriers applying for a waiver of the network geographic accessibility standard to submit an application fee of $1,000 per county for which a waiver is sought, and provide specified information. Sets requirements for the commissioner related to reviewing and approving waiver applications. Allows the commissioner to approve a waiver if the HMO proposes to address network inadequacy through the use of telemedicine, when there are no providers of a specific type or specialty in the county. Also specifies requirements related to the submittal and review of new waiver applications. Requires application fees to be deposited in the state government special revenue fund. | House only |  |
|  | Network adequacy complaints and investigations.  Adds § 62K.105.  Subd. 1. Complaints. Requires the commissioner to establish a process for accepting complaints from enrollees regarding health carrier and preferred provider organization network adequacy. Requires the commissioner to investigate all complaints.  Subd. 2. Commissioner investigations of provider networks. Requires the commissioner to establish a “secret shopper” program to determine whether covered services are available to enrollees without unreasonable delay, and whether a network complies with maximum distance and travel time requirements. Requires the commissioner to develop a schedule to ensure periodic examinations of all health carriers and preferred provider organizations, and to use this program to investigate network adequacy complaints under subdivision 1.  Subd. 3. Administrative penalties. Requires the commissioner to impose on a health carrier or preferred provider organization an administrative penalty of at least $100 a day for violations of network adequacy requirements. Allows the commissioner to take other administrative actions, except that the commissioner shall not also impose an administrative penalty under section 62D.17, subdivision 1. Applies the factors and procedures in section 62D.17, subdivision 1, to the administrative penalties imposed under this subdivision. | House only |  |
|  | Nonquantitative treatment limitations or NQTLs.  Adds subd. 6b to § 62Q.01. Defines “nonquantitative treatment limitations” or “NQTLs” as processes, strategies, or evidentially standards that limit the scope or duration of benefits for treatment. NQTLs may include medical management standards, formulary design, network tiers, requirements for providers, manner of determining charges, step therapy protocols, exclusions, restrictions, reimbursement rates, and other health plan design features. | Identical | **Section 5 (62Q.01, subdivision 6b)** defines nonquantitative treatment limitations, or NQTL. |
|  | Prohibition on use of step therapy for metastatic cancer.  Adds § 62Q.1841.  Subd. 1. Definitions. Defines the following terms: health plan, stage four metastatic cancer, and step therapy protocol.  Subd. 2. Prohibition on use of step therapy protocols. Prohibits a health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions from limiting or excluding coverage for a drug approved by the Food and Drug Administration (FDA) that is on the plan’s formulary, by mandating that the enrollees follow a step therapy protocol, if the use of the approved drug is consistent with: (1) a FDA-approved indication; and (2) a clinical practice guideline published by the National Comprehensive Care Network.  States that the section is effective January 1, 2020, and applies to health plans offered, issued, or renewed on or after that date. | House only |  |
|  | Alcoholism, mental health, and chemical dependency services.  Amends § 62Q.47. (d) Prohibits a health plan from imposing NQTLs for mental health and substance use disorders that are not-comparable or more stringent than those applied to medical and surgical benefits in the same classification.  (f) Requires health plan companies to provide certain information to the commissioner of commerce to confirm that the mental health parity required by this section is being implemented by health plan companies.  (g) Provides that mental health therapy visits and medication maintenance visits are primary care for purposes of applying patient cost-sharing requirements under a health plan. Requires the commissioner of commerce in consultation with the commissioner of health to issue a report to the legislature every year including detailed information about the commissioner’s compliance procedures, enforcement actions, corrective actions, and public information initiatives regarding mental health parity. | In paragraph (d), technical differences; staff recommends Senate.  In paragraph (f), House requires consultation with advocates, providers, and health plan companies and Senate does not. House lists information that may be required from health plan companies that Senate does not include. Also, technical differences; staff recommends Senate.  **In paragraph (g), technical differences; staff recommends Senate.**  In House paragraph (g)/Senate paragraph (h), House paragraph (g), clause (3), item (iv), is House-only. Senate requires individually identifiable information to be excluded from reports; House does not. Also technical differences; staff recommends Senate. | **Section 6 (62Q.47) Paragraph (d)** specifies that a health plan company must not impost an NQTL with respect to mental health and substance abuse disorders unless comparable to those applied to medical and surgical benefits in the same classification.  **Paragraph (f)** authorized the commissioner to require information from health plan companies to confirm that mental health parity is being implemented by the health plan company.  **Paragraph (g)** specifies that mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying enrollee cost-sharing requirements.  **Paragraph (h)** requires the commissioner of commerce to submit an annual report to the legislature on compliance with and oversight of the federal regulations regarding mental health parity, this section, and section 62Q.53 |
|  |  | Senate only | **Section 7 (62Q.48)** limits the total amount of cost sharing that an enrollee is required to pay at point of sale for insulin at an amount that does not exceed the net price of the insulin. Defines net price as the health plan company’s cost of the drug, including any rebates or discounts received on or accrued to the health plan company from a manufacturer or pharmacy benefit manager. |
|  | Coverage of contraceptive methods and services.  Adds § 62Q.521.  Subd. 1. Definitions. Provides definitions for closely held for-profit entity, contraceptive method, contraceptive service, eligible organization, medical necessity, religious employer, and therapeutic equivalent version.  Subd. 2. Required coverage; cost sharing prohibited. (a) Requires health plans to cover contraceptive methods and services.  (b) Prohibits health plan companies for imposing cost-sharing on contraceptive methods and services.  (c) Requires high-deductible health plans with a health savings account to include cost-sharing for contraceptive methods and services at the minimum amount necessary for the enrollee to make tax exempt contributions and withdrawals from the health savings account.  (d) Prohibits a health plan company from imposing referral requirements, restrictions, or delays for contraceptive methods and services.  (e) Requires a health plan company to include at least one type of each FDA approved contraceptive method in its formulary. Clarifies that all therapeutic equivalent versions do not need to be included in the formulary.  (f) Requires health plan companies to list the contraceptive methods and services that are covered without cost-sharing in an easily accessible manner. Requires the list to be promptly updated to reflect changes.  (g) Requires a health plan company to defer to a health care provider, and provide coverage without cost-sharing, if the provider recommends a particular contraceptive method or service based on medical necessity for the enrollee.  Subd. 3. Religious employers; exempt. (a) Allows a religious employer to not cover contraceptive methods or services if the employer has religious objections. Requires a religious employer to notify employees as part of the hiring process and all employees as least 30 days before enrollment in the health plan or the effective date of the health plan, whichever is first.  (b) Provides that if the religious employer covers some contraceptive methods or services, the notice in paragraph (a) must include a list of what the employer refuses to cover.  Subd. 4. Accommodation for eligible organizations. (a) Allows an eligible organization to not cover contraceptive methods or services if the eligible organizations notifies the health plan company.  (b) Requires the notice from an eligible organization to include certain information.  (c) Requires an eligible organization to provide notice to prospective employees and all employees at least 30 days before enrollment in the health plan or the effective date of the health plan, whichever is first.  (d) Requires a health plan company that receives notice from an eligible organization to exclude coverage for some or all of the contraceptive methods and services and provide separate payment for any method or service required to be covered under subdivision 2.  (e) Prohibits a health plan company from imposing any cost sharing requirements or premium or other charge for contraceptive services or methods to the eligible organization, health plan, or enrollee.  (f) Requires a health plan company to provide the commissioner of commerce with the number of eligible organization accommodations granted under this subdivision each year.  Effective date. This section is effective January 2021, and applies to coverage on or after that date. | House only |  |
|  | Coverage for prescription contraceptives; supply requirements.  Adds § 62Q.522.  Subd. 1. Scope of coverage. Requires all health plans that provide prescription coverage to comply with this section, excluding religious organizations.  Subd. 2. Definition. Defines prescription contraceptive as any FDA approved drug or device that prevents pregnancy, but does not include emergency contraceptive drugs.  Subd. 3. Required coverage. (a) Requires health plans to cover a 12-month supply of prescription contraceptives.  (b) Allows the prescribing health care provider to determine the appropriate number of months to prescribe for, up to 12.  Effective date. This section is effective January 2021, and applies to coverage on or after that date. | House only |  |
|  | Essential health benefits package requirements.  Amends § 62Q.81. Amends a section requiring individual and small group health plans to include an essential health benefits package, by striking requirements that the essential health benefits package comply with requirements in the Affordable Care Act and instead requiring the essential health benefits package to comply with requirements in this section.  Subd. 1. **Essential health benefits package**. Strikes references to the Affordable Care Act in the definition of essential health benefits package, and instead requires an essential health benefits package to comply with this section.  Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21**. Lists what is included in cost-sharing, and limits cost-sharing for individual health plans and small group health plans.  Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans**. Specifies levels of coverage for bronze level, silver level, gold level, and platinum level health plans, and establishes requirements for individuals eligible to enroll in catastrophic plans and the health benefits that a catastrophic plan must offer.  Subd. 4. **Essential health benefits; definition**. Removes references to the ACA in the definition of essential health benefits, and limits essential health benefits to items listed in paragraph (a) rather than including items listed in paragraph (a). Requires emergency services to be provided without imposing prior authorization requirement or limitation on coverage that is more restrictive than emergency services provided from an in-network provider. Requires cost sharing for out-of-network and in-network emergency services to be the same. Requires the scope of essential health benefits to equal the scope of benefits provided under a typical employer plan. Also requires essential health benefits to reflect an appropriate balance among categories; prohibits coverage decisions or reimbursement rate determinations that discriminate based on age, disability, or life expectance; requires diverse segments of the population to be taken into account, and prohibits essential health benefits from being subject to denial based on any of the listed conditions.  Subd. 5. **Exception**. Replaces a reference to the ACA in a subdivision establishing an exception, and instead specifies that the exception applies to pediatric dental plans. | House only |  |
|  | Drugs.  Amends § 256B.0625, subd. 13. Requires medical assistance and MinnesotaCare to provide the prescription coverage under section 62Q.522.  Effective date. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2021. | House only |  |
|  | Prior authorization.  Amends § 256B.0625, subd. 13f. Requires any step therapy protocol requirements established by the Commissioner of Human Services to comply with section 62Q.1841. Provides a January 1, 2020, effective date. | House only |  |
|  | Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).  Adds subd. 66 to § 256B.0625. Requires MA to cover treatments for PANDAS or PANS according to protocols developed by the Health Services Policy Committee. | House only |  |
|  | Ectodermal dysplasias.  Adds subd. 67 to § 256B.0625. Lists services for the treatment of ectodermal dysplasias covered by MA. | House only |  |
|  | Access standards; appointment wait times.  Adds subd. 6e to § 256B.69. Requires managed care and county-based purchasing plans to comply with the access standards for emergency care and the appointment wait times that apply to HMO enrollees. | House only |  |
|  | Coordination with state-administered health programs.  Amends § 256L.121, subd. 3. Requires the commissioner of human services to coordinate compliance with appointment wait time standards under the MinnesotaCare program with the same standards that apply to MA. | House only |  |
|  | Nonprofit health care entity; notice and approval required.  Adds subd. 1a to § 317A.811. Adds language to a section requiring notice to the attorney general and a waiting period when a nonprofit corporation intends to dissolve, merge, consolidate, convert, or transfer all or substantially all of its assets. This new subdivision requires a nonprofit health care entity to also comply with sections 62D.046 and 62D.047 for certain transactions. | House only |  |
|  | Nonprofit health care entity conversions; definitions.  Adds § 317B.01. Defines terms for sections governing nonprofit health care entity conversion transactions: commissioner, conversion benefit entity, conversion transaction or transaction, corporation, director, family member, full and fair value, key employee, material amount, member, nonprofit health care entity, officer, public benefit assets, and related organization.  Subd. 3. Conversion benefit entity. Defines conversion benefit entity as an entity that receives the value of a nonprofit health care entity’s public benefit assets, in connection with a conversion transaction.  Subd. 4. Conversion transaction or transaction. Defines conversion transaction or transaction as a transaction in which a nonprofit health care entity merges, consolidates, converts, or transfers (singly or in a series of separate transfers) all or a material amount of the nonprofit health care entity’s assets to an entity that is not a tax-exempt nonprofit corporation operating under chapter 317A or 322C, or in which the nonprofit health care entity adds or substitutes officers, directors, or members in a way that transfers control or governance of the nonprofit health care entity to an entity that is not a tax-exempt nonprofit corporation operating under chapter 317A or 322C.  Subd. 5. Corporation. Defines corporation to mean a nonprofit corporation organized under chapter 317A or a nonprofit limited liability company organized under chapter 322C.  Subd. 9. Material amount. Defines material amount to mean the lesser of 10 percent of a nonprofit health care entity’s total admitted net assets as of the end of the preceding calendar year, or $10,000,000.  Subd. 12. Nonprofit health care entity. Defines nonprofit health care entity to mean a nonprofit health service plan corporation, a nonprofit health maintenance organization, a nonprofit corporation that can exercise control over a nonprofit health service plan corporation or a nonprofit HMO, or an entity controlled by a corporation operating a nonprofit health service plan corporation or a nonprofit HMO.  Subd. 14. Public benefit assets. Defines public benefit assets as the entirety of a nonprofit health care entity’s tangible or intangible assets, including its goodwill and anticipated future revenue. | House only |  |
|  | Nonprofit health care entity conversion transactions; review, notice, approval.  Adds § 317B.02. Prohibits certain conversion transactions, requires the attorney general to receive notice of a conversion transaction and to review the transaction, requires attorney general approval of conversion transactions, and requires a nonprofit health care entity to transfer the value of its public benefit assets to one or more conversion benefit entities as part of the transaction.  Subd. 1. Certain conversion transactions prohibited. Prohibits a nonprofit health care entity from entering into a conversion transaction if a person who was an officer, director, or key employee of the nonprofit health care entity or of a related organization, or a family member, has received or will receive or has held or will hold one of the listed types of compensation, financial benefit, or financial interest in connection with the conversion transaction.  Subd. 2. Attorney general notice required. Requires a nonprofit health care entity to notify the attorney general as required in section 317A.811 before entering into a conversion transaction. Lists additional information the nonprofit health care entity must provide to the attorney general with the notice. Also requires the nonprofit health care entity to provide the notice and information to the commissioner, along with any other information provided to the attorney general at the attorney general’s request.  Subd. 3. Review elements. Allows the attorney general to approve, conditionally approve, or disapprove a proposed conversion transaction. Requires the attorney general to consider all relevant factors in evaluating whether the proposed transaction is in the public interest, and lists factors to be considered. Also requires the attorney general to consider public comments received and to consult with the appropriate commissioner before making a decision.  Subd. 4. Conversion benefit entity requirements. Paragraph (a) requires a conversion benefit entity to be an existing or new domestic, tax-exempt nonprofit corporation operating under chapter 317A; have in place policies to prohibit conflicts of interest, including conflicts of interest related to grantmaking activities that may benefit the listed individuals or entities; operate to benefit the health of the people of the state; and have in place policies that prohibit certain individuals from serving in certain positions or benefiting from the conversion transaction.  Paragraph (b) prohibits a conversion benefit entity from making grants or payments or providing financial benefit to an entity that receives public benefit assets, or to a related organization.  Paragraph (c) prohibits any person who has been an officer, director, or key employee of an entity receiving public benefit assets from serving as an officer, director, or key employee of the conversion benefit entity.  Paragraph (d) requires the attorney general to review and approve the governance structure of the conversion benefit entity before it receives the value of public benefit assets.  Paragraph (e) requires the attorney general to establish a community advisory committee for a conversion benefit entity receiving the value of public benefit assets.  Subd. 5. Hearing; public comment; maintenance of records. Before issuing a decision, requires the attorney general to hold one or more hearings to solicit public comments regarding the conversion transaction. Establishes a notice requirement for public hearings. Also requires the attorney general to develop a summary of comments received, obtain answers to questions posed, and provide those materials to people who request them.  Subd. 6. Approval required; period for approval or disapproval; extension. Paragraph (a) prohibits a nonprofit health care entity from entering into a conversion transaction until (1) 150 days after providing notice to the attorney general, unless all or part of this waiting period is waived; and (2) the attorney general approves the transaction, or conditionally approves the transaction and the conditions are satisfied.  Paragraph (b) requires the attorney general to approve, conditionally approve, or disapprove the conversion transaction during the waiting period, requires the attorney general to provide notice of the decision to the nonprofit health care entity, and allows the attorney general to extend the waiting period.  Paragraph (c) suspends the waiting period while a request for additional information is pending.  Subd. 7. Transfer of value of assets required. If a proposed conversion transaction is approved or conditionally approved, requires the nonprofit health care entity to transfer the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction.  Subd. 8. Assessment of costs. Requires the nonprofit health care entity to reimburse the attorney general or a state agency for costs incurred by the attorney general or state agency in reviewing the proposed conversion transaction and exercising enforcement remedies. Specifies what is included in costs, requires submission of a statement of costs, and establishes requirements for the nonprofit health care entity to pay or dispute the costs. Deposits payments made by the nonprofit health care entity into the general fund, and appropriates this money to the attorney general or state agency for costs paid or incurred.  Subd. 9. Challenge to disapproval or conditional approval. Allows a nonprofit health care entity to bring an action in district court to challenge the attorney general’s disapproval or conditional approval, and to prevail, requires the nonprofit health care entity to establish that the decision was arbitrary and capricious and unnecessary to protect the public health.  Subd. 10. Penalties; remedies. Allows the attorney general to bring an action to unwind a conversion transaction that violates subdivision 1, establishes civil penalties, and allows the attorney general to enforce this section under section 8.31.  Subd. 11. Relation to other law. Provides that this section does not affect or limit a power, remedy, or responsibility of an HMO, service plan corporation, conversion benefit entity, the attorney general, the commissioner of commerce, or the commissioner of health under other law. Also states that this section does not allow a nonprofit health care entity to enter into a conversion transaction prohibited under other law. | House only |  |
|  | Moratorium on conversion transactions.  Amends Laws 2017 first special session chapter 6, article 5, section 11. Extends the existing moratorium on conversion transactions for nonprofit service plan corporations and nonprofit health maintenance organizations from June 30, 2019, to June 30, 2029. Provides that an entity subject to this section includes a parent, subsidiary, or affiliate of a nonprofit HMO or nonprofit service plan corporation. Also provides that the transactions governed by this section include a transfer of a material amount of the entity’s assets as part of a single transaction or a series of transactions within the past 24 months, and defines material amount as the lesser of 10 percent of the entity’s total admitted net assets as of the previous December 31, or $10,000,000. Makes this section effective the day following final enactment. | **Differences in paragraph (a):**   * **House makes a direct or indirect parent, subsidiary, or other affiliate of a service plan corporation or nonprofit HMO subject to the moratorium and Senate does not.** * **House specifies that a transfer in a single transaction or a series of transactions within a 24-month period is subject to the moratorium and Senate does not.** * **House only allows transfers of all or a material amount of assets to a nonprofit corporation and defines material amount. Senate only allows transfers of all or a substantial portion of assets to a nonprofit corporation or to a nonprofit hospital within the same health system as the HMO.**   **Paragraph (b): Identical**  **Paragraph (c): technical difference, staff recommends House.**  Paragraph (d): House makes section expire in 2029, Senate makes section expire in 2023. | Section 10, Laws 2017, First Special Session chapter 6, article 5, section 11 (Moratorium on Conversion Transactions) extends the moratorium on conversion transactions by a nonprofit health maintenance organization or a nonprofit services plan corporation to an entity other than a nonprofit corporation or a nonprofit hospital that is part of the same integrated health system for four more years until July 1, 2023. |
|  | Findings.  Establishes legislative findings regarding nonprofit health care entities and their assets, and states that it is necessary for the attorney general to approve a nonprofit health care entity’s transfer of assets to ensure the public interest is protected. | House only |  |
|  | Report; denials of coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).  Subd. 1. Definitions. Provides definitions for health carrier, health plan, PANDAS, and PANS.  Subd. 2. Report required. Requires health carriers that offer health plans to Minnesota residents to report to the commissioner of health the number of times they deny coverage for the treatment of PANDAS and PANS, and the specific treatment for which coverage was denied. Requires the commissioner of health to post a report with this information to the department’s website by November 1, 2019.  Effective date. This section is effective the day following final enactment. | House only |  |
|  | Coverage for ectodermal dysplasias and PANDAS or PANS.  Requires a health carrier to use a health plan’s coverage as of January 1, 2019, to determine whether the health carrier would not have provided coverage for ectodermal dysplasias, PANDAS, or PANS, and states that treatments and services covered by a health plan as of January 1, 2019, are not eligible for reimbursement by the commissioner of commerce. | House only |  |
|  | Revisor instruction.  Directs the revisor to codify the moratorium on conversion transactions section in chapter 62D (the chapter governing HMOs). | House only |  |
|  | Repealer.  Repeals Minnesota Statutes, section 62A.021, subdivisions 1 and 3 (loss ratio standards, loss ratio disclosure). | House only |  |