Bill Summary Comparison of Health and Human Services

House File 2128-4
Article 6: Health Insurance

Senate File UEH2128-1
Article 5: Health Coverage and Transparency

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Section	Article 6: Health Insurance		Article 5: Health Coverage and Transparency
1	**Required provisions.** Amends § 62A.04, subd. 2. Amends a subdivision specifying required provisions for health insurance policies, to delete a reference to qualified health plans and instead refer to individual and small group health plans, and to replace a reference to the ACA with a reference to section 62A.65, subd. 2a that governs a grace period for nonpayment of premiums. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R1: House only**	
2	**Prohibition on waiting periods that exceed 90 days.** Adds subd. 5 to § 62A.10. Prohibits a health carrier offering a group health plan from having an individual who is eligible to enroll in the plan wait to enroll for longer than 90 days. Makes an exception for employees for whom the employer takes time to determine the employee's eligibility, prohibits a cumulative hours of service requirement from exceeding 1,200 hours, allows an orientation period of one month or less to be added to the 90 days, and allows an employer to require a rehired employee to meet the employer's eligibility criteria and waiting period if doing so is reasonable. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R5: House only**	
3	**Mental health services.** Adds subd. 3c to § 62A.15. Requires a group policy or subscriber contract that covers mental health treatment or services provided by a mental health professional to also cover treatment and services provided by a clinical trainee practicing in compliance	**Page R6: House only**	

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	with the medical assistance requirements for covering services provided by a clinical trainee. This section is effective January 1, 2022 and applicable to policies and contracts offered, issued, or renewed on or after that date.		
4	**Denial of benefits.** Amends § 62A.15, subd. 4. Prohibits an insurance company or nonprofit health service plan corporation from denying benefits for services covered by a policy or contract of the services are performed by a mental health clinical trainee. This section is effective January 1, 2022.	**Page R6: House only**	
5	**Applicability.** Amends § 62A.65, subd. 1. Removes a cross-reference to the Comprehensive Health Association. Requires a health carrier to offer individual health plans on a guaranteed issue basis and at a premium rate that does not vary based on the health status of the individual. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R7: House only**	
6	**Grace period for nonpayment of premium.** Adds subd. 2a to § 62A.65. Allows an individual health plan to be canceled for nonpayment of premiums but requires a health carrier to provide a 3-month grace period. Allows an enrollee to stop a cancellation by paying all outstanding premiums before the end of the grace period. Provides that if a health plan is canceled	**Page R7: House only**	

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	under this subdivision, the final day of enrollment is the last day of the first month of the grace period. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.		
7	**Co-payments.** Amends § 62D.095, subd. 2. Removes a reference to the ACA and instead requires any co-payments and coinsurance imposed in a health maintenance contract to be consistent with state and federal law. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R8: House only**	
8	**Deductibles.** Amends § 62D.095, subd. 3. Removes a reference to the ACA and instead requires any deductibles imposed in a health maintenance contract to be consistent with state and federal law. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R8: House only**	
9	**Annual out-of-pocket maximums.** Amends § 62D.095, subd. 4. Removes a reference to the ACA and instead requires any annual out-of-pocket maximums imposed in a health maintenance contract to be consistent with section 62Q.677, subd. 6a. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R8: House only**	

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10	**Exceptions.** Amends § 62D.095, subd. 5. Removes language prohibiting imposition of co-payments and deductibles on preventive health care services consistent with the ACA, and instead prohibits imposition of co-payments and deductibles on preventive items and services as defined in other state law. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R8: House only**	
		Page R8: Senate only	**Sections 1-2 (62J.81, subd. 1, 1a)** modify the time in which a provider or health plan company must provide to a consumer a good faith estimate of the amount the provider has agreed to accept for payment by the consumer's the health plan company or the average allowable reimbursement the provider accepts as payment from third party payers for services specified by the consumer.
11	**Dependent child to the limiting age.** Amends § 62Q.01, subd. 2a. Removes a reference to the ACA in a subdivision prohibiting a health plan company from denying health plan eligibility for a dependent child under age 26. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R10: House only**	
12	**Requirements for timely provider credentialing.** Adds § 62Q.097. Establishes requirements governing the process of health care provider credentialing by health plan companies. **Subd. 1. Definitions.** Defines terms for this section: clean application for provider credentialing or clean application; and provider credentialing.	**Page R10: Same except for one technical difference on House 315.8/Senate 146.10; staff recommend the Senate language on the technical difference.**	**Section 3 [62Q.097]** requires a health plan company (HPC) when it receives a clean application for provider credentialing, to upon request, affirm that the application was received and the date by which the HPC will make a determination on the application. The HPC must also within three business days inform the provider of the application's deficiencies if it is determined that the application is not a clean application. The

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	Subd. 2. Time limit for credentialing determination. Requires a health plan company that receives an application for provider credentialing to do the following. If the application is a clean application and if the provider so requests, the health plan company must notify the provider that the application is clean and specify when the health plan company will make a determination on the application. If the application is not a clean application, the health plan company must notify the provider of the application's deficiencies within 3 business days after a determination that the application is not clean. A health plan company must make a determination on a clean application within 45 days after receipt and, upon notice to the provider, clinic, or facility, may take 30 additional days to investigate quality or safety concerns. This section applies to applications for provider credentialing submitted on or after January 1, 2022.		HPC is also required to make a determination on a clean application within 45 days after receipt of the application unless there are substantive quality or safety concerns identified that require further investigation.
13	**Preventive items and services.** Amends § 62Q.46. **Subd. 1. Coverage for preventive items and services.** Amends a definition for preventive items and services by removing a reference to the definition of that term in the ACA and instead adding a reference to subdivision 1a. **Subd. 1a. Preventive items and services.** Requires the commissioner of commerce to provide health plan companies with information on which items and services must be categorized as preventive. **Subd. 3. Additional services not prohibited.** Removes references to the ACA and instead refers to preventive items and services categorized as preventive under subdivision 1a.	**Page R11: House only**	

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	This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.		
14	**Screening and testing for opioids.** Adds § 62Q.472. Prohibits a health plan company from placing lifetime or annual limits on screenings and urinalysis testing for opioids for enrollees in SUD treatment programs, when ordered by a health care provider and performed by an accredited clinical laboratory. Allows a health plan company to perform medical necessity review for more than 24 screenings or urinalysis tests per 12 months. Specifies that this section does not apply to managed care plans and county-based purchasing plans covering MA or MinnesotaCare enrollees. This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.	**Page R12: House only**	
		Page R13: Senate only	**Section 4 [62Q.524]** requires a HPC to include in the summary of benefits and coverage a statement indicating whether funds from a patient assistance program will be applied by the HPC to an enrollee's deductible requirement.
15	**Out-of-pocket annual maximum.** Adds subd. 6a to § 62Q.677. By October of each year, requires the commissioner of commerce to determine the maximum annual out-of-pocket limits that apply to individual and small group health plans. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.	**Page R13: House only**	

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16	**Essential health benefit package requirements.** Amends § 62Q.81. **Subd. 1. Essential health benefits package.** Removes cross-references to the ACA and inserts appropriate references to subdivisions in this section governing essential health benefits and metal levels for health plans. **Subd. 2. Cost-sharing; coverage for enrollees under the age of 21.** Paragraph (a) specifies what is and is not included in cost-sharing. Paragraph (b) limits cost-sharing per year for individual health plans to the amount allowed under the Internal Revenue Code plus a premium adjustment percentage. Paragraph (c) limits cost-sharing per year for small group health plans to twice the amount allowed for individual health plans. In paragraph (d) a reference to the ACA is stricken and a cross-reference is modified. **Subd. 3. Levels of coverage; alternative compliance for catastrophic plans.** Requires bronze, silver, gold, and platinum level health plans offered by health carriers to be actuarially equivalent to a certain percentage of the actuarial value of the benefits provided. Specifies circumstances under which catastrophic health plans may be sold and what those plans must include. Removes references to the ACA. **Subd. 4. Essential health benefits; definition.** Paragraph (a) removes a reference to the ACA to define essential health benefits and instead defines that term as the services listed in that paragraph plus additional benefits included in a typical employer plan.	**Page R13: House only**	

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	Paragraph (b) provides out-of-network providers of emergency services cannot impose more restrictive prior authorization requirements or coverage limitations than those required by in-network providers. Requires cost-sharing to be equivalent between in-network and out-of-network providers for these services. Paragraph (c) requires the scope of essential health benefits to be equal to the scope of benefits provided under a typical employer plan. Paragraph (d) lists requirements for essential health benefits. **Subd. 5. Exception.** Removes a reference to the ACA and instead provides that this section does not apply to dental plans that are limited in scope and provide pediatric dental benefits. This section is effective January 1, 2022, for health plans offered, sold, issued, or renewed on or after that date.		
17	**Laboratory, x-ray, and opioid screening services.** Amends § 256B.0625, subd. 10. Specifies that medical assistance covers screenings and urinalysis tests for opioids without lifetime or annual limits. This section is effective January 1, 2022.	**Page R16: House only**	
18	**Commissioner of commerce; determination of preventive items and services.** Directs the commissioner of commerce to determine the items and services that are preventive, and lists what must be included as preventive items and services.	**Page R16: House only**	