State of Minnesota

# HOUSE OF REPRESENTATIVES

**NINETY-THIRD SESSION**

**H. F. No. 1677**

02/13/2023 Authored by Kraft, Stephenson, Kotyza-Witthuhn, Tabke, Kozlowski and others
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy
03/02/2023 Adoption of Report: Amended and re-referred to the Committee on Health Finance and Policy

A bill for an act

relating to insurance; providing for network adequacy; requiring a report; amending Minnesota Statutes 2022, sections 62K.10, subdivision 4; 62Q.096; 62Q.47.

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

Section 1. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** (a) Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

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

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

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

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

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

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

(b) The commissioner must determine network sufficiency in a manner that is consistent with the requirements of this section and may establish sufficiency by referencing any reasonable criteria, which may include but is not limited to:

(1) provider-covered person ratios by specialty;

(2) primary care professional-covered person ratios;

(3) geographic accessibility of providers;

(4) geographic variation and population dispersion;

(5) waiting times for an appointment with participating providers;

(6) hours of operation;

(7) the ability of the network to meet the needs of covered persons, which may include: (i) low-income persons; (ii) children and adults with serious, chronic, or complex health conditions, physical disabilities, or mental illness; or (iii) persons with limited English proficiency and persons from underserved communities;

(8) other health care service delivery system options, including telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and

(9) the volume of technological and specialty care services available to serve the needs of covered persons that need technologically advanced or specialty care services.

**EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2022, section 62Q.096, is amended to read:

**62Q.096 CREDENTIALING OF PROVIDERS.**

(a) If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

(b) In order to ensure timely access by patients to mental health services, between July 1, 2023, and June 30, 2025, a health plan company must credential and enter into a contract for mental health services with any provider of mental health services that:

(1) meets the health plan company's credential requirements. For purposes of credentialing under this paragraph, a health plan company may waive credentialing requirements that are not directly related to quality of care in order to ensure patient access to providers from underserved communities or to providers in rural areas;

(2) seeks to receive a credential from the health plan company;

(3) agrees to the health plan company's contract terms. The contract shall include payment rates that are usual and customary for the services provided;

(4) is accepting new patients; and

(5) is not already under a contract with the health plan company under a separate tax identification number or, if already under a contract with the health plan company, has provided notice to the health plan company of termination of the existing contract.

(c) A health plan company shall not refuse to credential these providers on the grounds that their provider network has:

(1) a sufficient number of providers of that type, including but not limited to the provider types identified in paragraph (a); or

(2) a sufficient number of providers of mental health services in the aggregate.

(d) A health plan company must credential a mental health provider that meets the health plan company's standards in order to ensure fast access to mental health treatment.

**EFFECTIVE DATE.** This section is effective July 1, 2023.

Sec. 3. Minnesota Statutes 2022, section 62Q.47, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

(i) The commissioner must require health plans with contracts under section 256B.69 to use the timely filing timelines and prior authorization processes consistent with medical assistance fee-for-service for mental health and substance use disorder services covered under medical assistance.

Sec. 4. **GEOGRAPHIC ACCESSIBILITY AND NETWORK ADEQUACY STUDY.**

(a) The commissioner of health, in consultation with the commissioner of commerce and stakeholders, must study and develop recommendations on additional methods, other than maximum distance and travel times for enrollees, to determine adequate geographic accessibility of health care providers and the adequacy of health care provider networks maintained by health plan companies. The commissioner may examine the effectiveness and feasibility of using the following methods to determine geographic accessibility and network adequacy:

(1) establishing ratios of providers to enrollees by provider specialty;

(2) establishing ratios of primary care providers to enrollees; and

(3) establishing maximum waiting times for appointments with participating providers.

(b) The commissioner must examine:

(1) geographic accessibility of providers under current law;

(2) geographic variation and population dispersion;

(3) how provider hours of operations limit access to care;

(4) the ability of existing networks to meet the needs of enrollees, which may include low-income persons; children and adults with serious, chronic, or complex health conditions, physical disabilities, or mental illness; or persons with limited English proficiency and persons from underserved communities;

(5) other health care service delivery options, including telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and

(6) the availability of services needed to meet the needs of enrollees requiring technologically advanced or specialty care services.

(c) The commissioner must submit to the legislature a report on the study and recommendations required by this section no later than January 15, 2024.