# Request for Information

Mandated Health Benefit Proposal Evaluations

10/27/2025

## Contact Information

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*Upon request, this material will be made available in an alternative format such as large print, Braille, or audio recording.*

# Contents



# Background on Evaluation Requests under Minn. Stat. § 62J.26

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in coordination with the Minnesota Department of Health and Minnesota Management and Budget, evaluates mandated health benefit proposals for potential fiscal, economic, and public health impacts. Per statute, a mandated health benefit proposal is a proposal that would require health plan companies to (1) provide coverage or (2) increase the amount of coverage for treatment of certain conditions, diseases, or other health care needs.[a] A mandated health benefit proposal also includes bills that (3) require coverage for care performed by a specific type of provider or (4) impose limitations on a contract between a provider and a health plan company.

Evaluations of mandated health benefit proposals must consider the following:

- the potential **scientific or medical benefit** of the proposal relative to any applicable alternatives;
- the **public health and fiscal impact** of the proposal on both the health care system in general, and in Minnesota;

[a] In this case, "health care needs" may refer to general health care needs, or it may refer to specific health care services, items, or equipment.

- description of the **extent to which the service/item in the proposal is used** by a significant portion of the population;
- the **extent to which insurance already covers the services/items** in the proposal, including a description of how the mandated health benefit proposal would apply to all categories of health insurance;
- an analysis of **how much the proposal would increase or decrease the cost** of the applicable service/item;
- the overall **extent to which the proposal would increase or decrease enrollee premiums**; and
- the potential **amount required by the state to defray costs** associated with the proposal (for Affordable Care Act (ACA) benefit mandates).

Commerce is directed by Minn. Stat. § 62J.26 to publish preliminary information on mandated health benefit proposals to ensure that proposals that receive a final evaluation report include input from those who may be impacted by the mandate, such as individuals, health care plans, and providers. Accordingly, Commerce seeks public comment on the below mandated health benefit proposals that may receive an evaluation report.

After reviewing public feedback received in response to this request for information (RFI), Commerce will produce an evaluation report for mandates selected by the legislature and that are feasible for evaluation based on topic and data availability (Appendix A).

Table 1 (below) displays the mandated health benefit proposal's bill number and title. The hyperlinks will direct the commenter to the mandated health benefit proposal's description. The text for all proposals is provided in Appendices C through J.

**Table 1. Mandated Health Benefit Proposals**

| Bill | Title |
|---|---|
| **HFXXXX** | Coverage for Coordinated Specialty Care |
| **HF2193** | Coverage for Imaging Services for Brain Aneurysms |
| **HFXXXX** | Cost-Sharing Limitations for Epilepsy Medications and Supplies |
| **HF0743** | Prohibition of Step Therapy Protocols for Diabetes Treatment |
| **SFXXXX** | Coverage for Doula Services |
| **SF0205** | Prohibition of Prior Authorization for Antineoplastic Cancer Treatment |
| **SF1101** | Coverage for Augmentative and Alternative Communication Systems |
| **SF1946** | Coverage for Prescription Opioid Alternatives |

## Solicitation of Public Comment

Obtaining feedback from the public is an important part of the evaluation process to understand the potential impact of each proposal. Commerce will accept and review public comments pertaining to any of the mandated health benefit proposals. Commerce may summarize comments received or may display some comments verbatim in each evaluation report to the legislature. Due to this, commenters should note whether information provided in their comments is confidential, private, nonpublic, and/or protected nonpublic.

In developing public comments, Commerce encourages commenters to consider:

- As it is written now, does this mandated health benefit proposal achieve its presumed purpose?
- Does the mandated health benefit proposal include all services or items that should be covered? If not, what else should be considered?
- If the mandated health benefit proposal were signed into law, how would it impact individuals' access to health care? In your response, please consider access under current coverage requirements, whether additional steps are required to access care (e.g., prior authorization), and if the change in coverage associated with the proposal would impact certain populations more than others.
- Are there any currently established health care policies related to this mandated health benefit proposal that Commerce should consider during their evaluation?
- Based on the Data Availability and Sources (Appendix A) outlined in the RFI, are there resources or considerations Commerce should assess during their evaluation of the mandated health benefit proposal (e.g., journal articles, databases, etc.)?
- If the mandated health benefit proposal were signed into law, would you expect there to be a difference in the cost of services or items covered for patients? for payers/issuers?
- If the mandated health benefit proposal were signed into law, are there any other potential outcomes that should be considered (e.g., health outcomes)?

**Directions for Submitting Comments**

To submit a public comment for a mandated health benefit proposal, please fill out the form at this link.[b] If you have already prepared a document with public comments for multiple proposals, you can upload it with your submission or email it to Tricia Hearth at patricia.hearth@state.mn.us. To ensure Commerce has sufficient time to review suggested data sources and incorporate new information into the final reports, interested parties should submit comments by **December 11, 2025**. Commerce may follow up with RFI respondents to request additional information about their submissions as needed.

[b] https://redcap.link/rfi2025

## HFXXXX – Coverage for Coordinated Specialty Care

**Author(s):**
Rep. Bierman

**Legislative Session:**
94th Legislature (2025-2026)

**Date Introduced:**
N/A

**Bill Version:**
N/A

**Existing Statute:**
Minnesota Statutes 2024, section 62Q.47

**New Statute:**
None

**Proposed Mandate Summary**

This proposed mandate would require health carriers providing health insurance for "alcoholism, mental health, or chemical dependency benefits" to also provide coverage for services delivered through the Coordinated Specialty Care (CSC) treatment model for early episode psychosis treatment and assertive community treatment services. This proposed mandate would exclude education and employment support components of the CSC model.

This proposed mandate would require coverage for CSC to be coded and paid for as a bundle of services, as opposed to individual services.

This proposed mandate would include the following requirements for CSC delivery:

- Providers can only deliver CSC if they have been recognized by the Department of Human Services' Division of Behavioral Health (DHSDBH).
- The credentialing of the psychiatrist or the licensed clinical leader of an early episode psychosis treatment team qualifies all members of the team to be credentialed with the insurer.

**Key Terms**:

For the purposes of this mandate, "coordinated specialty care" or "CSC" is an evidence-based model for treating psychosis resulting from a serious mental illness. This model was developed by the National Institute of Mental Health and evaluated in the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative.

**Associated/ Relevant Conditions:**

Psychosis refers to a collection of symptoms where perception, sense of reality, and thoughts may be disrupted.[1] Symptoms and clinical manifestations can differ between individuals and episodes of psychosis, but can include hallucinations, delusions, depression, behavioral changes, and anxiety. While psychosis is considered a symptom of a serious mental illness, it can occur without an identifiable diagnosis. Associated serious mental illnesses include but are not limited to:[2]

- Schizophrenia;
- Mood disorders (e.g., bipolar and major depressive disorder);
- Anxiety disorders; and
- Post-traumatic stress disorder.

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| | **Associated Services/ Treatments:**<br><br>CSC is a multi-component, evidence-based early intervention for individuals who are experiencing early episode psychosis. CSC is recovery-oriented, team-based approach for treating early episode psychosis.[3] CSC programs can include:[3]<br><br>• Medication management;<br>• Psychotherapy;<br>• Family education and support; and<br>• Case management.<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, and the State Employee Group Insurance Program (SEGIP). This would not apply to self-insured employer plans or grandfathered plans. While this proposed mandate, as written, doesn't apply to Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare), licensed HMOs are required to meet 62Q requirements of coverage if the service is not already covered under Medical Assistance. |

## HF2193 – Coverage for Imaging Services for Brain Aneurysms

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| **Author(s):**<br>• Rep. Clardy<br>• Rep. Engen<br><br>**Legislative Session:**<br>94th Legislature (2025-2026)<br><br>**Date Introduced:**<br>03/12/2025<br><br>**Bill Version:**<br>As Introduced<br><br>**Existing Statute:**<br>Minnesota Statutes 2024, section 256B.0625, subdivision 10<br><br>**New Statute:** | **Proposed Mandate Summary**<br>This proposed mandate would require health carriers to provide coverage for imaging services used to identify and monitor the status of unruptured brain aneurysms. Additionally, for women 40 years of age or over, a health carrier would be required to cover these services as a preventive screening with no cost-sharing (e.g., co-payment, deductible, or coinsurance).<br><br>This proposed mandate would require the Commissioner of Health to conduct a statewide public awareness campaign on the risks of brain aneurysms for women aged 40 and over and inform individuals of the new coverage provided under this mandate.<br><br>**Associated/ Relevant Conditions:**<br><br>An unruptured brain aneurysm is a weak, bulging area of a blood vessel in the brain that has not burst.[4] If an aneurysm proceeds to the stage of rupture, this can lead to health consequences such as stroke, brain damage, and/or death. Risk factors associated with developing a brain aneurysm may include, but are not limited to:[5]<br><br>• Family history of brain aneurysm; |

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| 62Q.512 | • Smoking;<br>• Chronic conditions (e.g., high blood pressure, diabetes, high cholesterol);<br>• Gender; and<br>• Age.<br><br>**Associated Services/ Treatments:**<br><br>This proposed mandate would require coverage for imaging services used to identify and manage unruptured brain aneurysms, which includes:[6]<br><br>• Magnetic resonance imaging (MRI);<br>• MR Angiogram (MRA);<br>• Computerized tomography (CT);<br>• CT Angiogram; and<br>• Angiograms.<br><br>This proposed mandate also requires coverage for imaging used for preventive purposes to screen for brain aneurysm for women at or over the age of 40. The standard modalities used to screen for brain aneurysms are MRA, followed by CT.<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, the State Employee Group Insurance Program (SEGIP), and Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to self-insured employer plans or grandfathered plans. |

| **HFXXXX – Cost-Sharing Limitations for Epilepsy Medications and Supplies** | |
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| **Author(s):**<br>Rep. Greene<br><br>**Legislative Session:**<br>94th Legislature (2025-2026)<br><br>**Date Introduced:**<br>N/A<br><br>**Bill Version:**<br>N/A<br><br>**Existing Statute:** | **Proposed Mandate Summary**<br><br>This proposed mandate would limit health carriers' amount of enrollee cost-sharing for prescription drugs prescribed to treat epilepsy to no more than: (1) $25 per one-month supply for each prescription drug, regardless of the amount or type of medication required to fill the prescription; and (2) $50 per month in total for all related medical supplies. The cost-sharing limit for related medical supplies does not increase with the number of chronic diseases for which an enrollee is treated. Coverage under this section shall not be subject to any deductible.<br><br>For health plans that require an enrollee to meet a plan deductible in order to maintain health savings account eligibility under United States Code, title 26, |

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| Minnesota Statues 2024, section 62Q.481, subdivision 2<br><br>**New Statute:**<br>None | section 223 or catastrophic health plan eligibility under United States Code, title 42, section 18022(e), this proposed mandate would apply only after the deductible has been met.<br><br>**Associated/ Relevant Conditions:**<br><br>Epilepsy is a chronic brain disorder where groups of nerve cells, or neurons, in the brain may misfire, causing seizures.[7] There are many types of seizures, with some individuals experiencing convulsions and loss of consciousness (e.g., tonic-clonic seizures) while others cause a person to appear as if they are staring into space for extended periods of time (e.g., absence seizures). Epilepsy can vary in severity and frequency of seizures, but having a seizure does not mean an individual has epilepsy. There are several types of epilepsy, including but not limited to:[7]<br><br>• Absence epilepsy;<br>• Frontal lobe epilepsy;<br>• Temporal lobe epilepsy; and<br>• Neocortical epilepsy.<br><br>The cause of epilepsy is not always known, but it can occur with a range of other conditions that disrupt normal brain activity, known as co-occurring conditions. These may include, but are not limited to:[7]<br><br>• Brain tumors;<br>• Head trauma;<br>• Stroke;<br>• Cerebral palsy and other developmental disorders; and<br>• Infections (e.g., meningitis).<br><br>**Associated Services/ Treatments:**<br><br>Antiseizure prescription medications used to treat epilepsy are generally categorized into two groups: broad-spectrum and narrow-spectrum. Broad-spectrum medications (e.g., levetiracetam, lamotrigine, zonisamide, topiramate) treat various seizure types, while narrow-spectrum medications (e.g., ethosuximide, pregabalin, gabapentin, carbamazepine) target focal or partial seizures.[8]<br><br>This proposed mandate would require coverage for all medical supplies used to treat epilepsy, such as federal Food and Drug Administration-approved seizure detection devices.[9]<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, and the State Employee Group Insurance Program (SEGIP). This would not apply to self-insured employer plans, grandfathered plans, Medicare supplemental policies, and |

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| | Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare). |

## HF0743 – Prohibition of Step Therapy Protocols for Diabetes Treatment

**Author(s):**
Rep. Howard

**Legislative Session:**
94th Legislature (2025-2026)

**Date Introduced:**
02/13/2025

**Bill Version:**
As Introduced

**Existing Statute:**
Minnesota Statues 2024, section 256B.0625, subdivision 13f

**New Statute:**
62Q.1842

**Proposed Mandate Summary**

This proposed mandate would prohibit health carriers that cover diabetes treatment from using step therapy protocols to limit or exclude coverage for prescription insulin drugs. If enacted, any step therapy protocol requirements established by the Commissioner would need to comply with this prohibition.

**Key Terms**:

For the purposes of this mandate:

- "Diabetes" means the three types of diabetes defined by the Centers for Disease Control and Prevention (CDC), including type I diabetes, type II diabetes, and gestational diabetes.
- "Prescription insulin drug" means a prescription drug that contains insulin and is used to treat diabetes.
- "Step therapy protocol" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered drugs and drugs that are administered by a physician, advanced practice registered nurse, or physician assistant, are medically appropriate for a particular enrollee and are covered under a health plan.

**Associated/ Relevant Conditions:**

Diabetes is a chronic health condition that occurs when an individual's body does not make enough insulin or does not use the insulin it creates efficiently. The CDC has identified three types of diabetes:[10]

- Type I diabetes;
- Type II diabetes; and
- Gestational diabetes (diabetes that occurs during pregnancy).

If an individual with diabetes does not receive appropriate treatment, serious health conditions (e.g., heart disease, vision loss, kidney disease, and death) can occur.[10] As of 2020, 8.8% of Minnesotans had been diagnosed with either type I or type II diabetes.[11]

**Associated Services/ Treatments:**

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| | Treatment for diabetes can vary depending on the type.[12] Type I diabetes is treated with insulin as individuals with this type do not produce insulin or produce limited levels of insulin naturally. Type II and gestational diabetes can typically be managed through eating a healthy diet, maintaining a healthy weight, and getting regular physical activity. However, some individuals may also require insulin to maintain healthy blood sugar levels.<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, the State Employee Group Insurance Program (SEGIP), and Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to self-insured employer plans, grandfathered plans, and Medicare supplemental policies. |

| **SFXXXX – Coverage for Doula Services** | |
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| **Author(s):**<br>Sen. Oumou Verbeten<br><br>**Legislative Session:**<br>94th Legislature (2025-2026)<br><br>**Date Introduced:**<br>N/A<br><br>**Bill Version:**<br>N/A<br><br>**Existing Statute:**<br>Minnesota Statues 2024, 256B.0625, subdivision 28b<br><br>**New Statute:**<br>62Q.5205 | **Proposed Mandate Summary**<br><br>This proposed mandate would require health carriers to cover doula services without cost sharing (e.g., deductible, co-payment, coinsurance), without referral limitations (e.g., utilization review, referral requirement, delay period), and without quantity limits.<br><br>For health plans that require an enrollee to meet a plan deductible in order to maintain health savings account eligibility under United States Code, title 26, section 223 or catastrophic health plan eligibility under United States Code, title 42, section 18022(e), this proposed mandate would apply only after the deductible has been met.<br><br>Medical Assistance would also be required to cover doula services under the same conditions unless complying with this mandate would prevent the state from receiving federal funding or result in a lower level of coverage or reduced access to coverage for enrollees.<br><br>**Key Terms**:<br><br>For the purposes of this mandate:<br><br>• “Certified doula" means the mother’s choice of an individual who has received a certification to perform doula services from an approved organization. |

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| | • "Childbirth education and support services" means emotional and physical support provided during pregnancy, labor, birth, and the postpartum period.<br>• "Doula services" means childbirth education and support services provided by a certified doula.<br><br>**Associated/ Relevant Conditions:**<br><br>Doula services are provided for a variety of associated and relevant conditions that impact pregnancy, childbirth, and the postpartum period.[13,14] These include high-risk pregnancies, such as those involving gestational diabetes, preeclampsia, or advanced maternal age, where additional emotional and informational support can be vital.[15] Other relevant conditions include Vaginal Birth After Cesarean (VBAC), unmedicated or natural births, home births, and births within culturally specific practices.[15] Additionally, doulas offer assistance in reproductive health, family planning, and support in the event of a miscarriage or stillbirth.[16] Access to doula services can be beneficial for individuals in certain geographical locations where there is limited access to healthcare facilities and has shown improved maternal and child health outcomes.[17]<br><br>**Associated Services/ Treatments:**<br><br>Doula services include physical, emotional, and informational support during pregnancy, labor and delivery, and the postpartum period.[18]<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, the State Employee Group Insurance Program (SEGIP), and Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to Medicare supplemental policies, self-insured employer plans, or grandfathered plans. |

| **SF0205 – Prohibition of Prior Authorization for Antineoplastic Cancer Treatment** | |
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| **Author(s):**<br>• Sen. Port<br>• Sen. Mann<br>• Sen. Maye Quade<br>• Sen. Boldon<br><br>**Legislative Session:**<br>94th Legislature (2025-2026)<br><br>**Date Introduced:** | **Proposed Mandate Summary**<br><br>This proposed mandate would prohibit prior authorization for antineoplastic cancer treatment that is consistent with nationally or internationally accepted standards of care. This would also remove the prior authorization requirement for medications used for antineoplastic cancer treatment.<br><br>**Associated/ Relevant Conditions:**<br><br>Antineoplastic cancer treatments can be used to treat many types of cancers, such as Hodgkin's disease, leukemia, Burkitt's lymphoma, localized diffuse large |

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| 01/16/2025<br><br>**Bill Version:**<br>1st Engrossment<br><br>**Existing Statute:**<br>Minnesota Statutes 2024, section 62M.07, subdivision 2<br><br>**New Statute:**<br>None | cell lymphoma, Wilms' tumor, small cell lung cancer, and testicular cancer.[22,23] The type of antineoplastic treatment a patient receives depends on the location of the cancer, the stage of the cancer, and the patient's overall health.[24]<br><br>**Associated Services/ Treatments:**<br><br>Antineoplastic cancer treatments, or chemotherapy drugs, are drugs and therapies designed to target and remove cancer cells by damaging the DNA and triggering the natural process of cell death.[25] They also affect rapidly dividing normal cells, which can suppress bone marrow, suppress growth, impair healing, and cause hair loss. These drugs can be used to treat different types of cancers in different ways, including in combination with other treatments such as surgery, radiation therapy, immunotherapy, and hormone therapy.[23]<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, the State Employee Group Insurance Program (SEGIP), and Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to self-insured employer plans or grandfathered plans. |

## SF1101 – Coverage for Augmentative and Alternative Communication Systems

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| **Author(s):**<br>• Sen. Wiklund<br>• Sen Boldon<br>• Sen. Abeler<br><br>**Legislative Session:**<br>94th Legislature (2025-2026)<br><br>**Date Introduced:**<br>02/06/2025<br><br>**Bill Version:**<br>As Introduced<br><br>**Existing Statute:**<br>Minnesota Statues 2024, sections 256B.0625, subdivisions 31, 31a; 256B.4914, subdivision 12<br><br>**New Statute:** | **Proposed Mandate Summary**<br><br>This proposed mandate would require health carriers to provide coverage for augmentative and alternative communication systems, including repair and replacement, as determined medically necessary and appropriate. This proposed mandate also requires coverage for habilitation services as medically necessary.<br><br>Health carriers would be prohibited from imposing separate financial requirements or quantity limits on augmentative and alternative communication systems or associated habilitation services. While prior authorization may be required for these systems and services, it must be applied in a consistent manner comparable to other covered benefits requiring prior authorization. If performing utilization reviews, health carriers must use the most current version of evidence-based guidelines relevant to the system or service and conduct reviews in a non-discriminatory fashion.<br><br>**Key Terms**:<br><br>For the purposes of this mandate: |

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| 62Q.671 | • "Augmentative and alternative communication system" means any electronic or nonelectronic device and related software and components, including mounting systems, that assist a person with severe expressive communication limitations to supplement existing speech or replace speech that is not functional.<br>• "Habilitation services" means speech therapy provided for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal speech to assess, select, and develop augmentative and alternative communication systems and to provide training in their use.<br><br>**Associated/ Relevant Conditions:**<br><br>Augmentative and alternative communication systems and habilitation services are associated with speech-language impairments due to conditions such as:[26]<br><br>• Cerebral palsy;<br>• Developmental disability;<br>• Genetic disorders; and<br>• Amyotrophic lateral sclerosis (ALS).<br><br>**Associated Services/ Treatments:**<br><br>Augmentative and alternative communication systems and habilitation services include, but are not limited to:[27]<br><br>• Use of an electronic tablet with an application that allows a person to communicate;<br>• Use of a computer as a speech-generating device; and<br>• Speech language therapy.<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, the State Employee Group Insurance Program (SEGIP), and Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to Medicare supplemental policies, self-insured employer plans, or grandfathered plans. |

| **SF1946 – Coverage for Prescription Opioid Alternatives** | |
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| **Author(s):**<br>• Sen. Kupec<br>• Sen. Abeler | **Proposed Mandate Summary**<br><br>This proposed mandate would require health carriers to provide coverage for alternatives to prescription opioids to treat and manage pain, such as nonopioid |

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| **Legislative Session:**<br>94th Legislature (2025-2026)<br><br>**Date Introduced:**<br>02/27/2025<br><br>**Bill Version:**<br>As Introduced<br><br>**Existing Statute:**<br>None<br><br>**New Statute:**<br>62Q.474 | drugs and nonpharmacologic, nonoperative modalities. This coverage would include at least two alternative prescription drugs as approved by the federal Food and Drug Administration to treat and manage pain that are not Schedule I, II, or III controlled substances and at least three alternative nonpharmacologic, nonoperative modalities to treat and manage pain.<br><br>This proposed mandate would prohibit plans from providing preferential coverage for, and access to, opioids and would also prohibit utilization controls (e.g., prior authorization or step therapy).<br><br>The proposal would also require health plans to provide annual education material to in-network providers and enrollees on these requirements.<br><br>**Associated/ Relevant Conditions:**<br><br>Opioid alternatives can be used to treat and manage acute and chronic pain from conditions such as lower back pain, headache, and fibromyalgia.[28]<br><br>**Associated Services/ Treatments:**<br><br>Opioid alternative prescription drugs that are not Schedule I, II, or III controlled substances include, but are not limited to:[29]<br><br>• Acetaminophen;<br>• Nonsteroidal anti-inflammatory drugs (NSAIDs);<br>• Neuropathic pain medications (e.g., gabapentin); and<br>• Muscle relaxants.<br><br>Alternative nonpharmacologic, nonoperative modalities for pain management include, but are limited to:[28]<br><br>• Rehabilitative therapies (e.g., physical therapy, occupational therapy, and chiropractic care);<br>• Therapeutic massage;<br>• Psychotherapy;<br>• Acupuncture; and<br>• Transcutaneous electrical nerve stimulation.<br><br>**Applicable Plans:**<br><br>This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, the State Employee Group Insurance Program (SEGIP). This would not apply to Medicare supplemental policies, Minnesota public health insurance programs (e.g., Medical Assistance and MinnesotaCare), self-insured employer plans, or grandfathered plans. |

# Appendix A – Data Availability and Sources

### Literature Review Data Sources:

- Peer-reviewed scientific literature database - PubMed
- Evidence-based clinical practice updates - UpToDate
- Google Scholar
- Open Evidence
- Grey literature including articles, opinion statements/pieces, news briefings, reports, working papers (i.e. those in National Bureau of Economic Research)

All included literature must meet the following inclusion criteria: (1) Published within the last 10 years, (2) Independent publication and primary data source (3) Based on data from the United States (4) relevant to the proposal (5) and moderate to high quality of research, as guided by the Joanna Briggs Institute Clinical Appraisal Tools.

### Actuarial Analysis Sources:

- Minnesota state population projections are from Long-Term Population Projections for Minnesota, published by the Minnesota State Demographic Center
- Minnesota non-public health insurance coverage levels are from Minnesota Public Health Data Access.
- Trends and projection factors are derived from National Health Expenditure data compiled by the Centers for Medicare & Medicaid Services
- Minnesota Department of Health tabulations of data from the Minnesota All Payer Claims Database (MN APCD) for 2021-2024

# Appendix B - Common Terms and Definitions

- Evidence-Based Practices – approaches to treatment that consider research to inform choices for effective courses of treatment.[30]
- Health Plan– a plan that provides medical or other health care benefits, provided by an employer or union or can be purchased in the private market, and is provided on an individual or group basis.[31] Health plans do not include coverage designed only to provide hearing, dental, or vision care.[32] Specific health plans that will be impacted by the proposed mandate, if enacted, are identified in the individual proposed mandate section.[31] Health plans do not include coverage designed only to provide hearing, dental, or vision care.[32] Specific health plans that will be impacted by the proposed mandate, if enacted, are identified in the individual proposed mandate section.
- Health Plan Company – a insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance, a nonprofit health service plan corporation, a health maintenance organization, a fraternal benefit society, a joint self-insurance employee health plan, or community integrated service networks.[33]
- Medically Necessary Care – health care services appropriate to the enrollee's diagnosis or condition, and diagnostic testing and preventive services in terms of type, frequency, level, setting, and duration. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition,

procedure, or treatment at issue. This care must help restore or maintain the enrollee's health or prevent deterioration of the enrollee's condition.[34]

- Scope of Practice – the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience. Scope of practice is established by the practice act of the specific practitioner's board, and the rules adopted pursuant to that act.[35] Scope of practice is established by the practice act of the specific practitioner's board, and the rules adopted pursuant to that act. [35]

# Appendix C – Coverage for Coordinated Specialty Care

**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 seeking chemical dependency services under section 245G.05, 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 services, psychiatric residential treatment facility services, and inpatient hospital and residential chemical dependency and alcoholism services, except for persons seeking chemical dependency services under section 245G.05, 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) All health plan companies offering health plans that provide coverage for alcoholism, mental health, or chemical dependency benefits shall provide reimbursement for the benefits delivered through the psychiatric Collaborative Care Model, which must include the following Current Procedural Terminology or Healthcare Common Procedure Coding System billing codes:

(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

This paragraph does not apply to managed care plans or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

(i) The commissioner of commerce shall update the list of codes in paragraph (h) if any alterations or additions to the billing codes for the psychiatric Collaborative Care Model are made.

(j) "Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method described at Federal Register, volume 81, page 80230, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to the following elements:

(1) care directed by the primary care team;

(2) structured care management;

(3) regular assessments of clinical status using validated tools; and

(4) modification of treatment as appropriate.

(k) All health plan companies offering health plans that provide coverage for alcoholism, mental health, or chemical dependency benefits shall provide reimbursement for the benefits delivered through the coordinated specialty care model for early episode psychosis treatment and assertive community treatment services as defined in section 256B.0622.

(l) Coordinated specialty care means the evidence-based model conducted by the National Institute of Mental Health in the Recovery After an Initial Schizophrenia Episode (RAISE) for psychosis resulting from a serious mental illness, but excluding the components of the treatment model related to education and employment support. Only providers recognized by the Department of Human Services' Division of Behavioral Health to deliver coordinated specialty care for early episode psychosis treatment shall be permitted to provide such

treatment in accordance with this section and such providers must adhere to the fidelity of the treatment model. Insurers shall use a bundled treatment approach to determine a coding solution that allows for these bundled treatment models to be coded and paid for as a bundle of services, similar to intensive outpatient treatment where multiple services are covered under one billing code or a bundled set of billing codes. For purposes of credentialing the mental health professionals and other medical professionals that are part of a coordinated specialty care for early episode psychosis treatment team, the credentialing of the psychiatrist or the licensed clinical leader of the treatment team shall qualify all members of the treatment team to be credentialed with the insurer.

~~(k)~~ (m) 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.

## Appendix D – Coverage for Imaging Services for Brain Aneurysms

Section 1. [62Q.512] COVERAGEFOR BRAIN ANEURYSMIMAGING SERVICES.

(a) Every health plan company shall provide coverage for the use of imaging services, including but not limited to magnetic resonance imaging, computerized tomography, or angiograms, to identify and check on the status of unruptured brain aneurysms.

(b) The imaging services described in paragraph (a) must be provided with no cost sharing at least annually to women 40 years of age or older and be classified as a preventive service.

**EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 10, is amended to read:

Subd. 10. **Laboratory, ~~x ray~~ imaging, and opioid testing services.**

(a) Medical assistance covers laboratory ~~and~~, x-ray, and other imaging services.

(b) Medical assistance covers screening and urinalysis tests for opioids without lifetime or annual limits.

(c) Medical assistance covers laboratory tests ordered and performed by a licensed pharmacist, according to the requirements of section 151.01, subdivision 27, clause (3), at no less than the rate for which the same services are covered when provided by any other licensed practitioner.

(d) Medical assistance coverage for brain aneurysm imaging must meet the requirements that would otherwise apply to health plan companies under section 62Q.512.

**EFFECTIVE DATE.** This section is effective January 1, 2026.

Sec. 3. **PUBLIC AWARENESS CAMPAIGN.**

Beginning January 1, 2026, and for two years thereafter, the commissioner of health shall operate a statewide public awareness campaign related to the risks of brain aneurysms for women 40 years of age or older and the coverage that may be available to them under Minnesota Statutes, section 62Q.512.

## Appendix E – Cost-Sharing Limitations for Epilepsy Medications and Supplies

Section 1. Minnesota Statutes 2024, section 62Q.481, subdivision 2, is amended to read:

Subd. 2. **Definitions.**

(a) For purposes of this section, the following definitions apply.

(b) "Chronic disease" means diabetes, asthma, epilepsy, and allergies requiring the use of epinephrine auto-injectors.

(c) "Cost-sharing" means co-payments and coinsurance.

(d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips, glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and other medical supply items necessary to effectively and appropriately treat a chronic disease or administer a prescription drug prescribed to treat a chronic disease.

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

## Appendix F – Prohibition of Step Therapy Protocols for Diabetes Treatment

Section 1. **[62Q.1842] STEP THERAPY PROTOCOL FOR INSULIN; PROHIBITION.**

Subdivision 1. **Definitions.**

(a) For purposes of this section, the following terms have the meanings given.

(b) "Diabetes" means the three types of diabetes defined by the Centers for Disease Control and Prevention, including type I diabetes, type II diabetes, and gestational diabetes.

(c) "Prescription insulin drug" has the meaning given in section 62Q.48, subdivision 2.

(d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

Subd. 2. **Prohibition on use of step therapy protocol.** A health plan that provides coverage for the treatment of diabetes must not limit or exclude coverage by mandating step therapy protocol requirements for prescription insulin drugs.

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

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.**

(a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs,

information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization must not be required for liquid methadone if only one version of liquid methadone is available. If more than one version of liquid methadone is available, the commissioner shall ensure that at least one version of liquid methadone is available without prior authorization.

(e) Prior authorization may be required for an oral liquid form of a drug, except as described in paragraph (d). A prior authorization request under this paragraph must be automatically approved within 24 hours if the drug is being prescribed for a Food and Drug Administration-approved condition for a patient who utilizes an enteral tube for feedings or medication administration, even if the patient has current or prior claims for pills for that condition. If more than one version of the oral liquid form of a drug is available, the commissioner may select the version that is able to be approved for a Food and Drug Administration-approved condition for a patient who utilizes an enteral tube for feedings or medication administration. This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. The commissioner shall design and implement a streamlined prior authorization form for patients who utilize an enteral tube for feedings or medication administration and are prescribed an oral liquid form of a drug. The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization,

for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(g) Prior authorization under this subdivision shall comply with section 62Q.184.

(h) Any step therapy protocol requirements established by the commissioner must comply with ~~section~~ sections 62Q.1841 and 62Q.1842.

(i) Notwithstanding any law to the contrary, prior authorization or step therapy shall not be required or utilized for any class of drugs that is approved by the United States Food and Drug Administration for the treatment or prevention of HIV and AIDS.

**EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval, whichever is later.

## Appendix G – Coverage for Doula Services

Section 1. **[62Q.5205] COVERAGE OF DOULA SERVICES.**

Subdivision 1. **Definitions.**

(a) For purposes of this section, the following terms have the meanings given.

(b) "Certified doula" means a certified doula, as defined in section 148.995, of the mother's choice.

(c) "Childbirth education and support services" means emotional and physical support provided during pregnancy, labor, birth, and the postpartum period.

(d) "Doula services" means childbirth education and support services provided by a certified doula.

Subd. 2. **Required coverage.** All health plans must cover doula services.

Subd. 3. **Cost-sharing requirements.** A health plan must not impose on the coverage under this section any cost-sharing requirement, including but not limited to the following requirements:

(1) deductible;

(2) co-payment; or

(3) coinsurance.

Subd. 4. **Review and referral limitations.** A health plan must not impose on the coverage under this section any review or referral limitation, including but not limited to the following limitations:

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

(2) referral requirement; or

(3) delay period.

Subd. 5. **Quantity limitations.** A health plan must not impose on the coverage under this section any quantity limitation.

Subd. 6. **Application.** If the application of subdivision 3 before an enrollee has met their health plan's deductible would result in: (1) health savings account ineligibility under United States Code, title 26, section 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section 18022(e), then subdivision 3 applies to coverage under this section only after the enrollee has met the enrollee's health plan's deductible.

Subd. 7. **Reimbursement.**

(a) The commissioner of commerce must reimburse health plan companies for coverage under this section, as required by Code of Federal Regulations, title 45, section 155.170. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Treatments, services, supplies, and equipment covered by the health plan as of January 1, 2026, are ineligible for payments under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2026, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 8. **Appropriation.** Beginning in fiscal year 2028, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is annually appropriated from the general fund to the commissioner of commerce. The amount appropriated under this subdivision must include the administrative costs incurred by the commissioner to make the defrayal payments.

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

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 28b, is amended to read:

Subd. 28b. **Doula services.**

(a) Medical assistance covers doula services provided by a certified doula as defined in section 148.995, subdivision 2, of the mother's choice.

(b) Medical assistance must meet the requirements that would otherwise apply to a health plan under section 62Q.5205, except that medical assistance is not required to comply with any provision of section 62Q.5205, if compliance with the provision would:

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

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

(c) For purposes of this section, "doula services" means childbirth education and support services, including emotional and physical support provided during pregnancy, labor, birth, and postpartum. The commissioner shall enroll doula agencies and individual treating doulas to provide direct reimbursement.

**EFFECTIVE DATE**. This section is effective January 1, 2027.

## Appendix H – Prohibition of Prior Authorization for Antineoplastic Cancer Treatment

Section 1. Minnesota Statutes 2024, section 62M.07, subdivision 2, is amended to read:

Subd. 2. **Prior authorization of certain services prohibited.** No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of:

(1) emergency confinement or an emergency service. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon as reasonably possible after the beginning of the emergency confinement or emergency service;

(2) outpatient mental health treatment or outpatient substance use disorder treatment, except for treatment which is a medication. Prior authorizations required for medications used for outpatient mental health treatment or outpatient substance use disorder treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(3) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network or nationally and internationally accepted standards of care, ~~except for~~ including but not limited to treatment ~~which~~ that is a medication~~. Prior authorizations required for medications used for antineoplastic cancer treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals~~;

(4) services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130;

(5) pediatric hospice services provided by a hospice provider licensed under sections144A.75 to 144A.755; and

(6) treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care subspecialists.

Clauses (2) to (6) are effective January 1, 2026, and apply to health benefit plans offered, sold, issued, or renewed on or after that date.

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

## Appendix I – Coverage for Augmentative and Alternative Communication Systems

Section 1. **[62Q.671] COVERAGE FOR AUGMENTATIVE AND ALTERNATIVE COMMUNICATION SYSTEMS.**

Subdivision 1. **Definitions.**

(a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Augmentative and alternative communication system" means any electronic or nonelectronic device and related software and components, including mounting systems, that assist a person with severe expressive communication limitations to supplement existing speech or replace speech that is not functional.

(c) "Habilitation services" means speech therapy rendered for congenital, developmental, or medical conditions that have significantly limited the successful initiation of normal speech to assess, select, and develop augmentative and alternative communication systems and to provide training in their use.

Subd. 2. **Coverage.**

(a) A health plan must provide coverage for augmentative and alternative communication systems, including repair and replacement, determined by the enrollee's prescribing physician to be both medically necessary and the most appropriate system to meet the enrollee's communication needs.

(b) A health plan must provide coverage for habilitation services determined by the physician who prescribed the augmentative and alternative communication device to be medically necessary.

(c) A health plan must not subject augmentative and alternative communication systems and associated habilitation services to separate financial requirements that apply only to those benefits.

(d) A health plan must not apply any quantitative limits to habilitation services associated with a prescribed augmentative and alternative communication system when the habilitation services are ordered by the prescribing physician.

Subd. 3. **Prior authorization.**

(a) A health plan may require prior authorization for augmentative and alternative communication systems and associated habilitation services in the same manner and to the same extent as prior authorization is required for any other covered benefit.

(b) When performing a utilization review for a request for coverage of augmentative and alternative communication systems and associated habilitation services, a health plan company must apply the most recent version of evidence-based guidelines recognized by relevant clinical specialists.

(c) A health plan company must render utilization review determinations in a nondiscriminatory manner and must not deny coverage for augmentative and alternative communication systems and associated habilitation services solely on the basis of an enrollee's actual or perceived disability.

Subd. 4. **Reimbursement.**

(a) The commissioner of commerce must reimburse health plan companies for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health plan without the requirements of this section. Augmentative and alternative communication systems and associated habilitation services covered by the health plan as of January 1, 2025, are ineligible for payment under this subdivision by the commissioner of commerce.

(b) Health plan companies must report to the commissioner of commerce quantified costs attributable to the additional benefit under this section in a format developed by the commissioner. A health plan's coverage as of January 1, 2025, must be used by the health plan company as the basis for determining whether coverage would not have been provided by the health plan for purposes of this subdivision.

(c) The commissioner of commerce must evaluate submissions and make payments to health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to health plan companies to defray the cost of providing coverage under this section is appropriated to the commissioner of commerce.

**EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to all health plans offered, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 31, is amended to read:

Subd. 31**. Medical supplies and equipment.**

(a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under ~~subdivision 31a, paragraph (a)~~section 62Q.671. To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or (d), shall be considered durable medical equipment.

(i) Seizure detection devices are covered as durable medical equipment under this subdivision if:

(1) the seizure detection device is medically appropriate based on the recipient's medical condition or status; and

(2) the recipient's health care provider has identified that a seizure detection device would:

(i) likely assist in reducing bodily harm to or death of the recipient as a result of the recipient experiencing a seizure; or

(ii) provide data to the health care provider necessary to appropriately diagnose or treat a health condition of the recipient that causes the seizure activity.

(j) For purposes of paragraph (i), "seizure detection device" means a United States Food and Drug Administration-approved monitoring device and related service or subscription supporting the prescribed use of the device, including technology that provides ongoing patient monitoring and alert services that detect seizure activity and transmit notification of the seizure activity to a caregiver for appropriate medical response or collects data of the seizure activity of the recipient that can be used by a health care provider to diagnose or appropriately treat a health care condition that causes the seizure activity. The medical assistance reimbursement rate for a subscription supporting the prescribed use of a seizure detection device is 60 percent of the rate for monthly remote monitoring under the medical assistance telemonitoring benefit.

**EFFECTIVE DATE.** This section is effective January 1, 2026.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 31a, is amended to read:

Subd. 31a. **Augmentative and alternative communication systems.**

(a) Medical assistance covers augmentative and alternative communication systems ~~consisting of electronic or nonelectronic devices and the related components necessary to enable a person with severe expressive communication limitations to produce or transmit messages or symbols in a manner that compensates for that disability~~ as defined under section 62Q.671.

(b) Augmentative and alternative communication systems must be paid the lower of the:

(1) submitted charge; or

(2)(i) manufacturer's suggested retail price minus 20 percent for providers that are manufacturers of augmentative and alternative communication systems; or

(ii) manufacturer's invoice charge plus 20 percent for providers that are not manufacturers of augmentative and alternative communication systems.

(c) Reimbursement rates established by this purchasing program are not subject to Minnesota Rules, part 9505.0445, item S or T.

**EFFECTIVE DATE.** This section is effective January 1, 2026.

Sec. 4. Minnesota Statutes 2024, section 256B.4914, subdivision 12, is amended to read:

Subd. 12. **Customization of rates for individuals.**

(a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6 to 9. The customization rate with respect to deaf or hard-of-hearing persons shall be $2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf and hard-of-hearing" means either:

(1) the person has a developmental disability and:

(i) an assessment score which indicates a hearing impairment that is severe or that the person has no useful hearing;

(ii) an expressive communications score that indicates the person uses single signs or gestures, uses an augmentative and alternative communication ~~aid~~ system, or does not have functional communication, or the person's expressive communications is unknown; and

(iii) a communication score which indicates the person comprehends signs, gestures, and modeling prompts or does not comprehend verbal, visual, or gestural communication, or that the person's receptive communication score is unknown; or

(2) the person receives long-term care services and has an assessment score that indicates the person hears only very loud sounds, the person has no useful hearing, or a determination cannot be made; and the person receives long-term care services and has an assessment that indicates the person communicates needs with sign language, symbol board, written messages, gestures, or an interpreter; communicates with inappropriate content, makes garbled sounds or displays echolalia, or does not communicate needs.

**EFFECTIVE DATE.** This section is effective January 1, 2026.

## Appendix J – Coverage for Prescription Opioid Alternatives

Section 1. **[62Q.474] TREATMENT AND MANAGEMENT OF PAIN.**

Subdivision 1. **Requirement.**

(a) A health plan must provide coverage for alternatives to the prescription of opioids to treat and manage pain, including but not limited to:

(1) prescribing nonopioid drugs; and

(2) providing nonpharmacologic, nonoperative modalities.

(b) A health plan must provide coverage for a minimum of two alternative prescription drugs

approved by the federal Food and Drug Administration to treat and manage pain that are not Schedule I, II, or III controlled substances.

(c) A health plan must provide coverage for a minimum of three alternative nonpharmacologic, nonoperative modalities to treat and manage pain.

Subd. 2. **Prohibition.**

(a) A health plan is prohibited from providing preferential coverage for and access to opioids.

(b) A health plan is prohibited from establishing utilization controls, including but not limited to prior authorization or step therapy requirements, for clinically appropriate nonopioid prescription drugs approved by the federal Food and Drug Administration to treat and manage pain that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

Subd. 3. **Educational materials.** A health plan company must annually distribute educational materials to in-network health care providers and enrollees regarding access to the pain treatment and management options described in subdivision 1 and must make the educational materials and information publicly available on the health plan company's website.

**EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health plans offered, issued, or renewed on or after that date.

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