COMMERCE DEPARTMENT

Evaluation of HF 5199 – Coverage for Maternal Mental Health Programs

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

January 28, 2025

Report Prepared By

This report was prepared by the American Institutes for Research (AIR) at the request of the Minnesota Department of Commerce. AIR created this document for internal use by the Minnesota Department of Commerce pursuant to Contract No. 216732. The document assumes reader familiarity with the proposed mandated health benefits currently under consideration by the Minnesota State Legislature. The document was prepared solely to assist the Minnesota Department of Commerce. No other use of this document or the information or conclusions contained herein is authorized. The period of data collection for any policies and literature analyzed for the proposed mandate ended on December 31, 2024.

Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

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As requested by Minnesota Statute § 3.197: This report cost approximately $7,387.00 to prepare, including staff time, printing and mailing expenses.

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Contents

Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs an evaluation of benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

House File (HF) 5199 is sponsored by Representative Mary Frances Clardy and was introduced in the 93rd Legislature (2023-2024) on April 2, 2024.

If enacted, this bill would require a health issuer to create a "quality" and "cost-effective" maternal mental health program. Programs and included quality measures must be designed to encourage screening, diagnosis, treatment, and referral. This proposed mandate would also expand the list of health care professionals who are covered and included in maternal mental health programs and screenings. A health issuer would be required to give program guidelines and criteria to all health care providers included in a maternal health program. Additionally, health care professionals who provide care to pregnant or postpartum individuals are required to perform maternal mental health screenings, except when providing emergency care.

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), Medicare supplemental policies, and Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare). This would not apply to self-insured employer plans or grandfathered plans.[a]

This bill would amend Minn. Stat. § 62A.0411; 62Q.521; 147.091, subdivision 1; 147A.13, subdivision 1; 256B.69, by adding a subdivision; 256L.12, by adding a subdivision; 148.261, subdivision 1.

Key Terms

For the purpose of this bill and its evaluation:

- "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

[a] The bill language explicitly refers to managed care plans and county-based purchasing plans.

- "Contracted obstetric providers" means a licensed health care professional who is contracted to provide services relating to pregnancy, postpartum care, or postpartum depression under the enrollee's health plan.

Related Health Conditions and Associated Services

There are no specific conditions identified by this proposed mandate. There are many conditions, symptoms, and comorbidities associated with maternal mental health that can occur during pregnancy and/or following pregnancy, which together are referred to as the perinatal period.[1] Hormonal changes, environment, stress, and genetics may play a role in an individual's susceptibility to perinatal mental and behavioral health conditions.[2] Some mental health symptoms and conditions may be the result of untreated conditions prior to pregnancy, and/or unrelated to the pregnancy itself. Conditions and symptoms include, but are not limited to:

- Depression;
- Substance use disorder;
- Anxiety; and
- Psychosis.

A quality and cost-effective maternal mental health program implemented by an insurance plan may include a broad range of treatments and services. While specific services such as mental health screenings occurring at prenatal or postpartum health care visits and patient education are explicitly indicated in the mandate, additional services may include:[2,3]

- Medication;
- Substance use counseling; and
- Psychotherapy (e.g., cognitive behavioral therapy).

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from four commercial health issuers, two health care providers, two health care organizations, three advocacy organizations, and one individual.

Five respondents indicated support for this proposed mandate in how it will address Minnesotans' access to care and maternal mental health outcomes. Several respondents provided sources related to the potential impact of the proposed policy and to support claims provided in their response (See Appendix B). Statements of support highlighted the following key aspects of the proposed coverage:

Access to Care

- **Maternal Mental Health Outcomes.** Respondents stated that perinatal health disorders are associated with infant and maternal mortality rates, low infant birth weights, and other long-term consequences. These respondents stated that ensuring access to mental health care before, during, and after pregnancy will significantly improve health outcomes for mothers and children.

- **Current Gaps in Screening**. One respondent highlighted the proposed mandate's importance in bridging the gap between women experiencing perinatal mental health issues and mental health providers. They supported the structured approach to screening during pregnancy and postpartum, providing referrals, and ensuring follow-up care.

- **Provider Capacity.** Respondents reported that there is a sufficient number of maternal mental health providers, but also stressed that patient awareness and adequate provider compensation are needed to ensure that mental health screening occurs.

- **Care Options**. One respondent supported the mandate because it ensured access to mental health services but noted its omission of non-pharmaceutical approaches, such as acupuncture, which provides holistic care without pharmaceutical risks.

Cost Implications

- **Premium Increases versus Long-Term Savings:** While one respondent acknowledged potential premium increases, they argued the potential for long-term savings resulting from addressing untreated perinatal mental health issues, which would outweigh upfront costs.

    - They also cited California's Assembly Bill 2193 (passed in 2018), which mandates maternal mental health screenings during pregnancy or postpartum and requires insurers to create programs for quality and cost-effective outcomes. The estimated increase on premiums was about $1.54 per pregnant woman.

    - Another source provided by a respondent indicated that the untreated cost of perinatal mood and anxiety disorders resulted in an average of $31,800 per mother-child pair nationally in 2017.

Comparison to Existing Policies

- **Other States:** Respondents indicated that seven states (Arkansas, California, Florida, Illinois, Louisiana, Oklahoma, and West Virginia) mandate maternal mental health screening and reimbursement policies.

- **Minnesota's Current Position:** A respondent noted that Minnesota received a D- on the Policy Center for Maternal Mental Health's report card in 2024. The proposed mandate aims to elevate Minnesota's standards to meet national benchmarks.

Some respondents noted additional considerations, neither for nor against the proposed mandate. These include:

Data Sharing and Program Development

- One respondent recommended conducting further research to better understand providers' data-sharing needs with health issuers, particularly for reporting completed screenings, facilitating referrals, and ensuring effective data sharing. They also suggested that these developments should be managed directly by providers and health issuers.
- Two respondents suggested that the proposed mandate would benefit from greater specificity, particularly in defining the program to help health issuers estimate costs more accurately, as well as clarifying the terminology in the bill text that refers to "quality" and "cost-effectiveness" so that health plans can align these requirements with existing practices and identify necessary adjustments.

Workforce Considerations

- Respondents recommended including a plan to address the increased demand for mental health providers.
- Two respondents suggested that doulas should assist health care providers with screenings and receive adequate reimbursement, emphasizing that this approach could improve care quality and better support marginalized communities.

Administrative Costs and Compliance Concerns

- Some respondents noted that, regardless of whether a health issuer already covers maternal mental health services, implementing a program aligned with the proposed requirements would lead to added administrative costs.
- A respondent requested that health issuers be allowed sufficient time to scale up, develop the necessary program, and achieve compliance if the mandate is implemented (e.g., law does not take effect until two years after it is passed).

General Comments

- One respondent highlighted Minnesota's implementation of Minn. Stat. § 62M.07, effective January 1, 2026, which prohibits prior authorization for certain medical conditions, including outpatient mental health or substance use disorder treatment, antineoplastic cancer treatment per National Comprehensive Cancer Network® guidelines (excluding medications), preventive services, pediatric hospice care, neonatal abstinence program treatment by pediatric pain or palliative care specialists, and chronic condition treatment. The respondent suggested that many of this year's proposed benefit mandates fall under this new statute and expressed concerns that removing prior authorization could increase health care costs and negatively affect health outcomes for Minnesotans.
- Another respondent noted that all of the proposed health benefit mandates have the potential to broadly improve health outcomes for Minnesotans by enhancing their quality of life, supporting individuals, families, and caregivers, and increasing workforce participation, while also benefiting the broader health care system.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB's health plan administrators expect that this proposed mandate will not have a fiscal impact on SEGIP as maternity, mental health, and related prescriptions are covered with cost-sharing based on service or drug tier. However, if benefit design or coverage changes are required, then there may be a fiscal impact not included in the analysis (see State Fiscal Impact section).
- Commercial health issuers indicated that while they already cover maternal mental health screenings and services, the lack of clarity around the proposed mandate requirements made it difficult to fully quantify the financial impact. If enacted, respondents indicated that the proposed mandate could lead to an estimated cost increase of less than $0.70 per member per month.

Stakeholders' results may or may not reflect generalizable estimates for the mandate, depending on the methodology, data sources, and assumptions used for analysis.

Evaluation Limitations

The evaluation of the potential public health and economic impacts for this mandate was limited by several factors. First, an actuarial analysis was not feasible for this mandate. Health plans may create a "quality" and "cost-effective" maternal mental health program using a variety of services, provider types, and cost structures, each of which would have a different actuarial cost. Given the various combinations of services and providers that could be included in the maternal mental health program and potential utilization of those services, a claims analysis using the Minnesota All Payer Claims Database could not be conducted. Additionally, while there is literature to describe the need for maternal mental health services and its relationship with health outcomes in the perinatal and postpartum periods, published studies do not evaluate the specific requirements of the mandate. Some considerations for the proposed mandate were broadly covered in the literature review for the evaluation of last year's Senate Bill for the coverage for prenatal, maternity, and postnatal care. However, the literature within the evaluation did not specifically address the impact of maternal mental health programs developed by health plans, or the impact of the expanded provider list or training required by the mandate.

State Fiscal Impact

The potential state fiscal impact of this proposed mandate includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the potential impact to Minnesota Health Care Programs.

- The proposed mandate is estimated to have no fiscal impact on SEGIP.
- There are no estimated defrayal costs associated with this proposed mandate.
- The proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), and may have a cost.

Fiscal Impact Estimate for SEGIP

There is no estimated cost for SEGIP, as the required program would be created by MMB's Health Plan Administrators for all members with no cost to the Advantage Plan. MMB currently covers maternity care, mental health services—including outpatient and inpatient professional services for behavioral health disorders—and mental health prescription drugs, with cost-sharing varying by the place of service or drug tier. MMB assumes this mandate does not require changes to the Advantage Plan benefit design or coverage, including coverage for doulas, and therefore does not estimate any fiscal impact to the state plan. However, if benefit design or coverage changes are required from the proposed mandate, including coverage for doulas, then there may be a fiscal impact that is not included in the current analysis.

Patient Protection and Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, this bill would not constitute an additional benefit mandate requiring defrayal, as it does not relate to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's benchmark plan. Minnesota's benchmark plan includes coverage for prenatal care, maternity and newborn care, and postpartum services, as well as mental and behavioral health services.

Fiscal Impact of State Public Programs

As written, this proposed mandate would apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare) when the services are being delivered by a managed care organization; however, it does not explicitly apply to fee-for-service Medical Assistance. Minnesota Health Care Programs cover behavioral and mental health services during prenatal and postpartum periods (12 months after pregnancy ends). Costs may be incurred if the proposed mandate requires additional administrative costs or services not currently included in this coverage.[4] However, a fiscal estimate has not yet been completed on this proposed mandate.

Appendix A. Bill Text

Section 1. Minnesota Statutes 2022, section 62A.0411, is amended to read:

62A.0411 MATERNITY CARE.

Subdivision 1. **Definitions.**

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

(b) "Contracting obstetric provider" means a licensed health care professional who is contracted to provide services relating to pregnancy, postpartum care, or postpartum depression under the enrollee's health plan.

(c) "Enrollee" means a natural person covered by a health plan and includes an insured, policyholder, subscriber, contract holder, member, covered person, or certificate holder.

(d) "Health plan" means a health plan as defined in section 62Q.01, subdivision 3, and a county-based purchasing plan.

(e) "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4, and a county that elects to purchase medical assistance undersection 256B.692.

(f) "Maternal mental health" means a mental health condition that occurs during pregnancy or during the postpartum period and includes but is not limited to postpartum depression.

Subd. 2. **Maternity coverage required.**

(a) Every health plan ~~as defined in section 62Q.01, subdivision 3~~, that provides maternity benefits must, consistent with other coinsurance, co-payment, deductible, and related contract terms, provide coverage of a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn. The health plan shall not provide any compensation or other nonmedical remuneration to encourage a mother and newborn to leave inpatient care before the duration minimums specified in this section.

(b) The health plan must also provide coverage for postdelivery care to a mother and her newborn if the duration of inpatient care is less than the minimums provided in this section.

(c) Postdelivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her child.

Subd. 3. **Maternal mental health program required.**

(a) By July 1, 2025, every health plan company that provides maternity benefits must develop a maternal mental health program designed to promote quality and cost-effective outcomes.

(b) The maternal mental health program must be developed consistent with sound clinical principles and processes and must include quality measures to encourage screening, diagnosis, treatment, and referral.

(c) The maternal mental health program must be designed to improve screening, treatment, and referral to maternal mental health services; include coverage for doulas; incentivize training opportunities for contracting obstetric providers; and educate enrollees about the program.

(d) The health plan company must provide the maternal mental health program guidelines and criteria to relevant medical providers, including all contracting obstetric providers.

Sec. 2. Minnesota Statutes 2022, section 62Q.521, is amended to read:

62Q.521 POSTNATAL CARE.

(a) For purposes of this section, "comprehensive postnatal visit" means a visit with a health care provider that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

(b) A health plan must provide coverage for the following:

(1) a comprehensive postnatal visit with a health care provider not more than three weeks from the date of delivery.

(2) any postnatal visits recommended by a health care provider between three and 11 weeks from the date of delivery.

(3) a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery.

(c) The requirements of this section are separate from and cannot be met by a visit made pursuant to section 62A.0411, subdivision 2.

Sec. 3. **[145.909] MATERNAL MENTAL HEALTH SCREENINGS.**

Subdivision 1. **Definitions.**

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

(b) "Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes but is not limited to postpartum depression.

(c) "Health care professional" means any of the following individuals acting within the individual's scope of practice:

(1) physician or surgeon licensed under chapter 147.

(2) registered naturopathic doctor registered under chapter 147E.

(3) nurse practitioner or nurse-midwife licensed under chapter 148.

(4) physician assistant licensed under chapter 147A.

(5) traditional midwife licensed under chapter 147D.

Subd. 2. **Maternal mental health screening required.**

(a) A health care professional who provides prenatal or postpartum care for a patient must ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions.

(b) This section does not apply to a health care professional when providing emergency care.

(c) This section does not preclude any licensed or certified provider acting within the provider's scope of practice from screening for maternal mental health conditions.

Sec. 4. Minnesota Statutes 2022, section 147.091, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may refuse to grant a license, may refuse to grant registration to perform interstate telehealth services, or may impose disciplinary action as described in section 147.141 against any physician. The following conduct is prohibited and is grounds for disciplinary action:

(a) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements.

(b) Obtaining a license by fraud or cheating or attempting to subvert the licensingexamination process. Conduct which subverts or attempts to subvert the licensing examination process includes, but is not limited to:

(1) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination.

(2) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials.

(3) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(c) Conviction, during the previous five years, of a felony reasonably related to the practice of medicine or osteopathic medicine. Conviction as used in this subdivision shall include a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon.

(d) Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the

person's license have been brought in another state or jurisdiction or having been refused a license by any other state or jurisdiction.

(e) Advertising, which is false or misleading, which violates any rule of the board, or which claims without substantiation the positive cure of any disease, or professionalsuperiority to or greater skill than that possessed by another physician.

(f) Violating a rule promulgated by the board or an order of the board, a state, or federallaw which relates to the practice of medicine, or in part regulates the practice of medicine including without limitation sections 604.201, 609.344, and 609.345, or a state or federal narcotics or controlled substance law.

(g) Engaging in any unethical or improper conduct, including but not limited to:

(1) conduct likely to deceive or defraud the public.

(2) conduct likely to harm the public.

(3) conduct that demonstrates a willful or careless disregard for the health, welfare, or safety of a patient.

(4) medical practice that is professionally incompetent.

(5) conduct that may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established.

(h) Failure to provide proper supervision, including but not limited to supervision of a:

(1) licensed or unlicensed health care provider.

(2) physician under any agreement with the board.

(i) Aiding or abetting an unlicensed person in the practice of medicine, except that it is not a violation of this paragraph for a physician to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of that person's license or registration or delegated authority.

(j) Adjudication by a court of competent jurisdiction, within or outside this state, as:

(1) mentally incompetent.

(2) mentally ill.

(3) developmentally disabled.

(4) a chemically dependent person.

(5) a person dangerous to the public.

(6) a sexually dangerous person.

(7) a person who has a sexual psychopathic personality. Such adjudication shall automatically

suspend a license for the duration of the adjudication unless the board orders otherwise.

(k) Conduct that departs from or fails to conform to the minimal standards of acceptable and prevailing medical practice in which case proof of actual injury need not be established.

(l) Inability to practice medicine with reasonable skill and safety to patients by reason of the following, including but not limited to:

(1) illness

(2) intoxication

(3) use of drugs, narcotics, chemicals, or any other type of substance

(4) mental condition

(5) physical condition

(6) diminished cognitive ability

(7) loss of motor skills

(8) deterioration through the aging process.

(m) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(n) Failure by a doctor of osteopathic medicine to identify the school of healing in theprofessional use of the doctor's name by one of the following terms: osteopathic physician and surgeon, doctor of osteopathic medicine, or D.O.

(o) Improper management of medical records, including failure to maintain adequatemedical records, to comply with a patient's request made pursuant to sections 144.291 to144.298 or to furnish a medical record or report required by law.

(p) Fee splitting, including without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices.

(2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the services provided and the responsibility assumed by each professional, and the physician has disclosed the terms of the division.

(3) referring a patient to any health care provider as defined in sections 144.291 to144.298 in which the referring physician has a "financial or economic interest," as defined in section 144.6521, subdivision 3, unless the physician has disclosed the physician’s financial or economic interest in accordance with section 144.6521.

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's

own profit interest.The physician must make the disclosures required in this clause in advance and in writing to the patient and must include in the disclosure a statement that the patient is free to choose a different health care provider. This clause does not apply to the distribution of revenues from a partnership, group practice, nonprofit corporation, or professional corporation to its partners, shareholders, members, or employees if the revenues consist only of fees for services performed by the physician or under a physician's direct supervision, or to the division or distribution of prepaid or capitated health care premiums, or fee-for-service withhold amounts paid under contracts established under other state law.

(q) Engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws.

(r) Becoming addicted or habituated to a drug or intoxicant.

(s) Inappropriate prescribing of or failure to properly prescribe a drug or device, including prescribing a drug or device for other than medically accepted therapeutic or experimental or investigative purposes authorized by a state or federal agency.

(t) Engaging in conduct with a patient which is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient.

(u) Failure to make reports as required by section 147.111 or to cooperate with aninvestigation of the board as required by section 147.131.

(v) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(w) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(1) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2.

(2) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4.

(3) a copy of the record of a judgment assessing damages under section 609.215,subdivision 5.

(4) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1or 2.

(x) Practice of a board-regulated profession under lapsed or nonrenewed credentials.

(y) Failure to repay a state or federally secured student loan in accordance with theprovisions of the loan.

(z) Providing interstate telehealth services other than according to section 147.032.

(aa) Failure to meet all maternal mental health screening requirements under section145.909.

Sec. 5. Minnesota Statutes 2022, section 147A.13, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may refuse to grant licensure or may impose disciplinary action as described in this subdivision against any physician assistant. The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for licensure contained in this chapter or rules of the board. The burden of proof shall be upon the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or cheating, or attempting to subvert the examinationprocess. Conduct which subverts or attempts to subvert the examination process includes,but is not limited to:

(i) conduct which violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination;

(ii) conduct which violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; and

(iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) conviction, during the previous five years, of a felony reasonably related to the practice of physician assistant. Conviction as used in this subdivision includes a conviction of an offense which if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered;

(4) revocation, suspension, restriction, limitation, or other disciplinary action against the person's physician assistant credentials in another state or jurisdiction, failure to report to the board that charges regarding the person's credentials have been brought in anotherstate or jurisdiction, or having been refused licensure by any other state or jurisdiction;

(5) advertising which is false or misleading, violates any rule of the board, or claims without substantiation the positive cure of any disease or professional superiority to orgreater skill than that possessed by another physician assistant;

(6) violating a rule adopted by the board or an order of the board, a state, or federal lawwhich relates to the practice of a physician assistant, or in part regulates the practice of aphysician assistant, including without limitation sections 604.201, 609.344, and 609.345,or a state or federal narcotics or controlled substance law;

(7) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm thepublic, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or practice which is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(8) engaging in the practice of medicine beyond what is allowed under this chapter, oraiding or abetting an unlicensed person in the practice of medicine;

(9) adjudication as mentally incompetent, mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to the public, a sexually dangerousperson, or a person who has a sexual psychopathic personality by a court of competentjurisdiction, within or without this state. Such adjudication shall automatically suspend alicense for its duration unless the board orders otherwise;

(10) engaging in unprofessional conduct. Unprofessional conduct includes any departurefrom or the failure to conform to the minimal standards of acceptable and prevailing practice in which proceeding actual injury to a patient need not be established;

(11) inability to practice with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals, or any other type of material, or as a resultof any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(12) revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(13) any identification of a physician assistant by the title "Physician" in a patient caresetting or in a communication directed to the general public;

(14) improper management of medical records, including failure to maintain adequatemedical records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a medical record or report required by law;

(15) engaging in abusive or fraudulent billing practices, including violations of thefederal Medicare and Medicaid laws or state medical assistance laws;

(16) becoming addicted or habituated to a drug or intoxicant;

(17) prescribing a drug or device for other than medically accepted therapeutic, experimental, or investigative purposes authorized by a state or federal agency or referring a patient to any health care provider as defined in sections 144.291 to 144.298 for services or tests not medically indicated at the time of referral;

(18) engaging in conduct with a patient which is sexual or may reasonably be interpretedby the patient as sexual, or in any verbal behavior which is seductive or sexually demeaning to a patient;

(19) failure to make reports as required by section 147A.14 or to cooperate with an investigation of the board as required by section 147A.15, subdivision 3;

(20) knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo;

(21) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunctionissued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.The board shall investigate any complaint of a violation of section 609.215, subdivision 1or 2; ~~or~~

(22) failure to maintain the proof of review document as required undersection 147A.09,subdivision 3, or to provide a copy of the document upon request of the board~~.~~; or

(23) failure to meet all maternal mental health screening requirements under section 145.909.

Sec. 6. Minnesota Statutes 2023 Supplement, section 148.261, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license and registration of any person to practice advanced practice, professional, or practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee or applicant as described in section 148.262. The following are grounds for disciplinary action:

(1) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in sections 148.171 to 148.285 or rules of the board. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements.

(2) Employing fraud or deceit in procuring or attempting to procure a permit, license, or registration certificate to practice advanced practice, professional, or practical nursing or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to:

(i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination;

(ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or

(iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(3) Conviction of a felony or gross misdemeanor reasonably related to the practice of professional, advanced practice registered, or practical nursing. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered.

(4) Revocation, suspension, limitation, conditioning, or other disciplinary action againstthe person's professional or practical nursing license or advanced practice registered nursing credential, in another state, territory, or country; failure to report to the board that charges regarding the person's nursing license or other credential are pending in another state, territory, or country; or having been refused a license or other credential by another state, territory, or country.

(5) Failure to or inability to perform professional or practical nursing as defined in section 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a registered nurse to supervise or a licensed practical nurse to monitor adequately the performance of acts by any person working at the nurse's direction.

(6) Engaging in unprofessional conduct, including, but not limited to, a departure from or failure to conform to board rules of professional or practical nursing practice that interpret the statutory definition of professional or practical nursing as well as provide criteria for violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and prevailing professional or practical nursing practice, or any nursing practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause.

(7) Failure of an advanced practice registered nurse to practice with reasonable skill and safety or departure from or failure to conform to standards of acceptable and prevailing advanced practice registered nursing.

(8) Delegating or accepting the delegation of a nursing function or a prescribed healthcare function when the delegation or acceptance could reasonably be expected to result in unsafe or ineffective patient care.

(9) Actual or potential inability to practice nursing with reasonable skill and safety topatients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical condition.

(10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or without this state.

(11) Engaging in any unethical conduct, including, but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard forthe health, welfare, or safety of a patient. Actual injury need not be established under thisclause.

(12) Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient.

(13) Obtaining money, property, or services from a patient, other than reasonable fees for services provided to the patient, through the use of undue influence, harassment, duress, deception, or fraud.

(14) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(15) Engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws.

(16) Improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law.

(17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of advanced practice, professional, or practical nursing.

(18) Violating a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of advanced practice, professional, or practical nursing, or a state or federal narcotics or controlled substance law.

(19) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i)a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

(21) Practicing outside the scope of practice authorized by section 148.171, subdivision 5, 10, 11, 13, 14, 15, or 21.

(22) Making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148.263, or failing to cooperate with an investigation of the board as required by section 148.265.

(23) Engaging in false, fraudulent, deceptive, or misleading advertising.

(24) Failure to inform the board of the person's certification or recertification status as a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner, or certified clinical nurse specialist.

(25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse practitioner practice, or registered nurse anesthetist practice without a license and currentcertification or recertification by a national nurse certification organization acceptable tothe board.

(26) Failing to report employment to the board as required by section 148.211, subdivision 2a, or knowingly aiding, assisting, advising, or allowing a person to fail to report as required by section 148.211, subdivision 2a.

(27) Failure to meet all maternal mental health screening requirements under section 145.909.

Sec. 7. Minnesota Statutes 2022, section 256B.69, is amended by adding a subdivision to read:

Subd. 38. **Maternal mental health program required.** Managed care plans and county-based purchasing plans subject to this section must include the maternal mental health program required under section 62A.0411.

Sec. 8. Minnesota Statutes 2022, section 256L.12, is amended by adding a subdivision to read:

Subd. 12**. Maternal mental health program required**. Managed care plans and county-based purchasing plans subject to this section must include the maternal mental health program required under section 62A.0411.

Appendix B. Resources Provided by Public Comments

The following citations were provided by RFI respondents related to the potential impact of the proposed health benefit mandate. These sources are provided independent of Commerce's evaluation and have not been assessed for quality and/or relevancy to the proposed health benefit mandate.

1. Bobo WV, Wollan P, Lewis G, et al. Depressive symptoms and access to mental health care in women screened for postpartum depression who lose health insurance coverage after delivery: findings from the Translating Research Into Practice for Postpartum Depression (TRIPPD) effectiveness study. *Mayo Clinic Proc.* 2014;89(9):1220-1228. doi:10.1016/j.mayocp.2014.05.011

2. Herman C. Pregnant women struggling with suicidal thoughts may not be identified during screening, new study finds. Illinois Public Media. August 7, 2019. Accessed November 22, 2024. https://will.illinois.edu/news/story/pregnant-women-struggling-with-suicidal-thoughts-may-not-be-identified-during-screening-new-study-finds

3. California Health Benefits Review Program. Key Findings for 2017–2018 California State Legislature: Analysis of California Assembly Bill 2193 Maternal Mental Health. Published online April 17, 2018. https://www.chbrp.org/sites/default/files/bill-documents/AB2193/ab2193-KeyFindings.pdf

4. Luca DL, Margiotta C, Staatz C, Garlow E, Christensen A, Zivin K. Financial toll of untreated perinatal mood and anxiety disorders among 2017 births in the United States. *Am J Public Health*. 2020;110(6):888-896. doi:10.2105/AJPH.2020.305619

5. Massachusetts General Hospital Center for Women's Mental Health. New Study Estimates the Astonishing Cost of Neglected Perinatal Mood and Anxiety Disorders in US Mothers. May 13, 2020. Accessed November 19, 2024. https://womensmentalhealth.org/posts/cost-pmads/

6. Burkhard J, Mendoza M. A comprehensive look at state maternal mental health screening and reimbursement legislation, table 2.0 state screening requirements. Policy Center for Maternal Mental Health. February 2, 2024. Accessed November 19, 2024. https://policycentermmh.org/a-comprehensive-look-at-state-maternal-mental-health-screening-and-reimbursement-legislation/

7. Policy Center for Maternal Mental Health. 2024 Maternal Mental Health State Report Cards. Policy Center for Maternal Mental Health. May 14, 2024. Accessed November 19, 2024. https://policycentermmh.org/2024-maternal-mental-health-state-report-cards/

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1. Summary of perinatal mental health conditions. American Colleges of Obstetricians and Gynecologists. Accessed November 25, 2024. https://www.acog.org/programs/perinatal-mental-health/summary-of-perinatal-mental-health-conditions

2. Health Resources and Services Administration, Maternal and Child Health Bureau. Maternal mental health. Accessed November 25, 2024. https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline/maternal-mental-health

3. Screening and diagnosis of mental health conditions during pregnancy and postpartum: ACOG clinical practice guideline no. 4. *Obstet Gynecol*. 2023;141(6):1232-1261. doi:10.1097/AOG.0000000000005200

4. Minnesota Department of Human Services. Health Care Coverage for Pregnant People. Published online July 1, 2022. https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/pregnant-people.jsp