DEPARTMENT OF HEALTH

Minnesota HMO Certificate of Coverage Benefits Checklist

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Introduction

HMOs must cover "comprehensive health maintenance services"[1] without limitations or exclusions, except as authorized by statute and rules.[2] HMOs may use utilization management consistent with Minnesota law.[3]

HMOs must maintain a network to provide services that meet geographic requirements[4] and provide a sufficient number and types of providers to meet the projected needs of enrollees.[5]

No lifetime limits, annual limits on specific services, or visit limits are allowed,[6] except as described below.

Individual and small group products must cover all essential health benefits[7] and all benefits included in state benchmark plan.[8]

Insurers on the marketplace must offer child-only coverage.[9] ACA individual and small group regulations contained at 45 CFR 147, 45 CFR 155 and 45 CFR 156

Note on Terminology: In the sections below, *Markets Covered* refers to the categories **Individual**, **Small Group**, and **Large Group**. When all three market segments are included, this will be indicated by the term **"All."**

[1] Minn. Stat. 62D.02, subd. 7; Minn. Rule 4685.0100, subp. 5.; Minn. Rule 4685.0700, subp. 2
[2] Minn. Rule 4685.0700, subp. 3 and 4.
[3] Minn. Stat. 62M
[4] Minn. Stat. 62D.124; Minn. Stat. 62K.10
[5] Minn. Rule 4685.1010
[6] Minn. Rule 4685.0700
[7] 42 U.S. Code § 18022; 45 CFR 147.150; 62Q.81
[8] Information on Essential Health Benefits (EHB) Benchmark Plans | CMS
[9] 45 CFR § 147.150

Major Required Services

Primary Care

Markets Covered: All

HMOs must cover primary care. HMO may use “gate-keeper” models requiring primary care providers to refer specialty services, but most HMOs have moved to “open access” or “PPO” model allowing enrollees to directly access all specialists in the primary care network without a referral from primary care clinic.

HMOs may define what providers are considered “primary care.” However, HMOs must allow open access to certain providers by law, including obstetrics and gynecology and pediatrics. If enrollees are required to designate primary care physicians, this must be clearly stated in coverage documents.

Can designate pediatrician as primary care per ACA.

State Law	Federal Law
EHB state law: 62Q.81, codifies federal coverage requirements for individual and small group markets Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 applies to all HMO products: Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. 4685.0100 Subp. 12a. Primary care physician. "Primary care physician" means a licensed physician, either employed by or under contract with the health maintenance organization, who is in general practice, or who has special education, training, or experience, or who is board-certified or board-eligible and working toward certification in a board approved by the American Board of Medical Specialists or the American Osteopathic Association in family practice, pediatrics, internal medicine, or obstetrics and gynecology. Subp. 12b. Primary care provider. "Primary care provider" means a primary care physician as defined in subpart 12a or a licensed practitioner such as a licensed nurse, optometrist, or chiropractor who, within that practitioner's scope of practice as defined under the relevant state licensing law, provides primary care services. Minn. Stat. 62Q.81 applies to individual and small group plans and requires these plans to cover all essential health benefits designated by federal law. Subdivision 1. Essential health benefits package. (a) Health plan companies offering individual and small group health plans must include the essential health benefits package required under section 1302(a) of the Affordable Care Act and as described in this subdivision.	Primary care fits under ambulatory care as an essential health benefit. It is also clearly called out on the state benchmark plan. For a group plan, an enrollee can designate a pediatrician as primary care provider for a child per 29 CFR § 2590.715-2719A. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A A group plan must allow direct access to obstetric and gynecological care for women enrollees per 29 CFR § 2590.715-2719A. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A A group plan must provide notice in the coverage documents as follows: Notice of right to designate a primary care provider - (i) In general. If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights - (A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated; (B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and (C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. https://www.law.cornell.edu/cfr/text/29/2590.715-2719A

Preventive Care

Markets Covered: All

HMOs must cover all medically necessary preventive care that is accepted, standard of practice and/or required by statute. Must describe covered preventive services with reasonable specificity in COC.

USPTFS A and B services are required to be covered without cost-sharing. If a service is required by law but is not an A or B service, it must be covered, but an HMO can impose cost sharing.

HMO must describe services with reasonable specificity in certificate of coverage and should list basic services. It is acceptable to link to current list of USPSTF A and B services in certificate of coverage.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 "Comprehensive Health Maintenance Services" includes: "Preventive health services," defined as health education, health supervision including evaluation and follow-up, immunization and early disease detection. Minn. Stat. 62A.047—requires coverage for child health supervision services. Minn. Stat. 62Q.46—Preventive Items and Services. Minn. Stat. 62D.095—enrollee cost sharing	Preventive and wellness services and chronic disease management is an EHB See EHB requirements listed above 45 CFR § 147.130 https://www.law.cornell.edu/cfr/text/45/147.130 Must cover all benefits listed as A or B rating by the US Preventive Services Task Force without cost sharing. Search Results | United States Preventive Services Taskforce

Pediatric Services

Markets Covered: All

HMOs must cover all medically necessary pediatric services, including dental, vision and all preventive pediatric health supervision without cost-sharing.

An enrollee may designate a pediatric provider as the primary care provider for a child enrollee.

Per MDH network adequacy requirements, all networks must include at least one pediatric specialty hospital in the in-network tier.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5 D (below); 4685.0700, subp. 2 "Outpatient health services" means **ambulatory care including health supervision, preventive**, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. 62A.047—Children's Health Supervision Services and Prenatal Care services. This statute details definitions and requirements. An HMO must provide coverage for child health supervision services and prenatal care services. The policy, contract, or certificate must specifically exempt reasonable and customary charges for child health supervision services and prenatal care services from a deductible, co-payment, or other coinsurance or dollar limitation requirement.	Pediatric services, including oral and vision care is an essential health benefit. Must cover all A and B services without cost-sharing. Enrollee must be allowed to designate pediatric as primary care. 45 CFR 147.138 (a)(2)

State Law	Federal Law
62Q.57–Designation of Primary Care Provider. This statute makes allowance for a child enrollee to have a pediatric provider designated as their primary care provider.	

Specialty Care

Markets Covered: All

HMOs must cover all medically necessary specialty provider services.

In reviewing HMO networks for network adequacy, MDH verifies that all specialty providers are included in the network. A waiver is granted in certain circumstances such as lack of available providers.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0100, subp. 13b; 4685.0700, subp. 2 62D.124, 62K.10—network adequacy specialty review and requirements.	Ambulatory patient services are an essential health benefit.

Mental Health Services

Markets Covered: All

HMOs must cover all medically necessary mental health treatment, including inpatient, outpatient, adult and child residential, diagnostics and prescription drugs.

Certificates of coverage must include clear statement of benefits, restrictions and limitations and include a statement of mental health parity rights.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2: “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. 62Q.47—State mental health/substance use disorder parity law 62Q.535—Court ordered treatment 62Q.527—Prescription drugs 62D.102—Family therapy for treatment of minors 62D.103—Second opinion 62A.151—Coverage of residential treatment for emotionally disabled children 62Q.53—Mental health medical necessity	Mental health and substance use disorder services, including behavioral health treatment is an essential health benefit. Mental health parity with medical services is required per the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA). This also includes substance use disorder treatment. Subsequent rules were finalized in 2013 and 2024 clarifying, among other things, how parity is defined and determined. A health plan offered by an issuer that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. 45 CFR § 146.136 45 CFR § 147.160 (applies to individual and group plans)

State Law	Federal Law
62Q.01 Subd 6a—Definition of nonquantitative treatment limitations or NQTLs for mental health parity assessment	

Substances Use Disorder Services

Markets Covered: All

HMOs must cover all medically necessary substance use disorder (SUD) services, including inpatient, outpatient, diagnostic, residential and prescription drugs, including medication assisted treatment services (MAT).

Certificate of coverage must include clear statement of benefits, restrictions and limitations and statement of mental health parity rights, which also applies to substance use disorder services.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. 62Q.47—State mental health/substance use disorder parity law 62Q.1055—Assessment criteria for placement in substance use disorder treatment 62Q.135—HMOs must contract with providers who participate in chemical dependency treatment accountability plan established by the commissioner of human services. 62Q.137—HMOs must cover chemical dependency treatment provided to an enrollee by the Department of Corrections while the enrollee is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense. 62Q.472—No limits on screening/testing for opioids.	Mental health and substance use disorder services, including behavioral health treatment is an essential health benefit. Mental health parity with medical services is required per the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA). This also includes substance use disorder treatment. Subsequent rules were finalized in 2013 and 2024 clarifying, among other things, how parity is defined and determined. A health plan offered by an issuer that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. 45 CFR § 146.136 45 CFR § 147.160 (applies to individual and group plans).

Inpatient Hospital

Markets Covered: All

HMOs must cover all medically necessary inpatient treatment. May limit only as described in Rule 4685.0700, subp. 3D(3)

Coverage includes, but is not limited to hospital charges, inpatient physician charges, anesthesia, diagnostic, lab.

If enrollee changes plans while confined to hospital, previous carrier must continue to cover expenses until discharge from hospital even if new carrier plan becomes effective during hospitalization.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2; 4685.0700, subp. 3(D) "In-patient hospital care" means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, X-rays, and laboratory examination, and other usual and customary hospital services. "In-patient physician care" means those health services performed, prescribed or supervised by physicians within a hospital, for registered bed patients therein, which services shall include diagnostic and therapeutic care. Minn. Rule 4685.0700, subp. 3(D) and subp. 4(J) allows for specific coverage limitations and exclusions. Minn. Rule 2755.0400; 2755.0500—Liability of previous carrier when confined to hospital	Inpatient hospital is an essential health benefit.

Outpatient Hospital

Markets Covered: All

HMOs must cover all medically necessary outpatient treatment.

Coverage includes but is not limited to outpatient/ambulatory surgical center services, physician services, anesthesia services, lab and diagnostic services.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Ambulatory patient care is an essential health benefit.

Emergency Services

Markets Covered: All

Emergency services are covered whether received in or out of the network. If emergency services are received outside of the network, coverage is only for emergency and not routine follow up care.

Cost sharing (deductibles, flat fee copays and coinsurance) must be the same for in and out of network.

Must cover all medically necessary emergency care as determined by the reasonably prudent layperson standard. Cost sharing must be same for in and out of network.

Balance billing is not allowed by non-network emergency providers.

Out-of-country care: see Exclusions and Limitations Allowed by Law.

State Law	Federal Law
Minn. Stat. 62Q.55—Emergency services Minn. Stat. 62Q.55, Subd. 2—"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii), of section 1867(e)(1)(A) of the Social Security Act. Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2—"Emergency care" means medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the enrollee in serious jeopardy. Minn. Stat. 62Q.556—prohibits balance billing from a nonparticipating provider or facility providing emergency services. Requires that insurers apply in-network cost sharing for out-of-network emergency services, among other things.	Emergency services are an essential health benefit. The No Suprises Act prohibits balance billing on out-of-network emergency services. Cost sharing must be that of the in-network plan benefits and must go towards the consumer's in-network deductible and maximum out-of-pocket amount, as applicable. Prior authorization cannot be required for emergency care. 29 CFR § 2590.715-2719A—Access to emergency care and cost-sharing 45 CFR 147.138—Requirements for coverage of ER and cost-sharing allowed

Urgent Care

Markets Covered: All

HMOs must cover all medically necessary urgent care.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 16 defines urgently needed care. Minn. Rules 4685.0700, subp. 2 defines minimum services required, which includes all non-excluded outpatient health services.	Ambulatory care, including urgent care, is an essential health benefit.

Prescription Drugs

Markets Covered: All. Note, ACA formulary law only applies to individual and small group. State HMO formulary rule applies to all.

HMOs must cover all medically necessary prescription drugs. May use formulary consistent with state and federal requirements. Must have a formulary exception process consistent with state and federal law.

Drug formulary tiers are allowed. Commonly used: generic, brand, specialty drugs. It is common to require enrollee to pay the difference between generic and brand if brand is dispensed.

If a formulary exception is granted, enrollee pays copay consistent with tier of exception approved drug. If a contraceptive formulary exception is granted, cost-sharing is $0 per ACA requirements.

Under the ACA, must cover FDA-approved tobacco cessation drugs and products, aspirin, folic acid, vitamin D, and fluoride supplements with no cost-sharing as these are considered preventive.

HMOs must cover intractable pain medications on their plan formularies. This should also be addressed in the policy and procedure.

There are cost sharing limits on certain chronic condition drugs per state statute.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Minn. Rules 4685.0700, subpart 3(A)—Formulary requirements 62Q.184—Step therapy exception process 62Q.676—Medication management 62Q.526—Mental health drug coverage 62D.109—Clinical Trials 62A.3095—Prescription eye drops 62A.3075—Oral chemotherapy drugs 62Q.525—Off-label drugs for cancer treatment 62Q.481—Cost-sharing limits on prescription drugs for certain chronic conditions	Prescription drugs are an essential health benefit. 45 CFR 156.122—required coverage, formulary exception process

Lab and Diagnostic

Markets Covered: All

HMOs must cover all medically necessary lab and diagnostic scans. Must apply in-network cost sharing if the sample was taken at an in-network facility, even if it is sent to an out-of-network testing facility.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 “Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment. Minn. Stat. 62Q.556—balance billing is prohibited when a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility, among other things. Cost sharing must be the same as if the lab/testing facility were in-network.	Laboratory services are an essential health benefit.

Maternity and Newborn Care

Markets Covered: All

HMOs must cover all medically necessary prenatal care without cost-sharing. This also includes coverage for one post-natal home health visit.

Must cover inpatient and outpatient maternity and newborn care.

Newborns are covered from date of birth.

Must cover one home health visit if inpatient time is less than in statute.

Must cover breast-feeding support and pumps per ACA requirements.

Must cover surrogate care if the enrollee is the surrogate.

Required coverage of physician recommended transfer of mother/newborn; no cost sharing except for HDHP.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 62A.0411—HMOs must 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. 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. 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. 62A.047—HMOs must provide coverage for child health supervision services and prenatal care services. 62A.042—newborn infants must be covered immediately from the moment of birth.	Maternity and newborn care is an essential health benefit. Individual and small group must cover all USPSTF A and B recommendations, including but not limited to: folic acid supplements for women planning or capable of pregnancy; HIV screening for pregnant women, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation; preeclampsia prevention and screening; breastfeeding intervention (including manual pump) and perinatal depression screening. USPSTF recommendations change regularly; please review the current recommendations. The Newborns' and Mothers' Health Protection Act of 1996 requires a minimum inpatient of 48 hours following a vaginal delivery and 96 hours following a cesarean section.

Contraceptives and Sterilization

Markets Covered: All

HMOs must cover at least one form of contraception in each of all 18 approved FDA approved methods. Includes OTC drugs like emergency contraception with a prescription.

No cost sharing permitted for formulary drugs. Must have exception process for drugs not on formulary, which are also covered without cost-sharing.

Employers with objections to covering contraceptives may apply for an exemption. If an exemption is granted, the HMO must provide contraceptive coverage separately and must notify enrollees of this option for coverage.

Routine ob/gyn, family planning services, and diagnosis of infertility are open access.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 MCS has always interpreted contraceptives as required as part of comprehensive health maintenance services. 62Q.14—Open access for family planning services and infertility diagnosis 62Q.52—Direct access to routine ob/gyn 62Q.522—Coverage of contraceptive methods and services 62Q.679—Describes the exemption process for religiously objecting organizations. Clearly states that health plans must still separately cover the exempted services.	Prescription drugs and preventive and wellness are essential health benefits. Contraceptives are covered in state benchmark plan. Plans and issuers must cover without cost sharing at least one form of contraception in each of the methods (currently 18) that the FDA has identified for women in its current Birth Control Guide. This coverage must also include the clinical services, including patient education and counseling, needed for provision of the contraceptive method. May utilize reasonable medical management methods. Must have a formulary exception process if a provider determines that a non-formulary drug is necessary and must cover the excepted drug without cost-sharing. See the CMS FAQs About Affordable Care Act Implementation Part 26

Residential Treatment – Mental Health

Markets Covered: All

HMOs must cover all medically necessary residential mental health treatment for adults and children.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 HMOs must provide medically necessary inpatient and outpatient mental health services. “In-patient hospital care" means necessary hospital services affording residential treatment to patients. 62A.151—Requires coverage of the treatment of emotionally disabled children in a residential treatment facility. 62Q.47—Requires coverage for mental health and substance use disorder. Specifies that inpatient and residential services are included. Specifies that parity with medical benefits is required.	Residential treatment is not expressly specified as an essential health benefit, but mental health and hospitalization are an essential health benefit so medically necessary residential treatment is required. Mental health parity laws apply. If carrier covers medical residential treatment, it is a violation of mental health parity laws to exclude mental health residential treatment.

Residential Treatment – Substance Use Disorder

Markets Covered: All

HMOs must cover all medically necessary residential substance use disorder treatment for adults and children. May limit providers to those licensed by DHS.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2	HMOs must cover substance use disorder services at parity with medical services for compliance with federal and state mental

State Law	Federal Law
“In-patient hospital care" means necessary hospital services affording residential treatment to patients. 62Q.135—No health plan company shall contract with a chemical dependency treatment program, unless the program participates in the chemical dependency treatment accountability plan established by the commissioner of human services. Minn. Rule 4685.1010, subp. 2(E)—Clarifies requirements of treatment programs, including network adequacy and licensing. 62Q.47—Requires coverage for mental health and substance use disorder. Specifies that inpatient and residential services are included. Specifies that parity with medical benefits is required.	health/substance use disorder parity laws. This requires consistent coverage for residential treatment. Covered in state benchmark plan.

Habilitative Services

Markets Covered: All

HMOs must cover all medically necessary habilitative therapy. This includes physical therapy, occupational therapy, and speech therapy.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5 "Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Rehabilitative and habilitative services and devices are an essential health benefit.

Rehabilitative Services

Markets Covered: All

HMOs must cover all medically necessary rehabilitative therapy. This includes physical therapy, occupational therapy, and speech therapy.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5 "Outpatient health services" means ambulatory care including health supervision, preventive, diagnostic and therapeutic services, including diagnostic radiologic service; therapeutic services for congenital, developmental, or medical conditions that have delayed speech or motor development; treatment of alcohol and other chemical dependency; treatment of mental and emotional conditions; provision of prescription drugs; and other supportive treatment.	Rehabilitative and habilitative services and devices are an essential health benefit.

Other Services Required by Law or Rules

Abortion

Markets Covered: All. Religious exemption allowed on group plans, but the care must be covered separately by the HMO.

State Law	Federal Law
Minn. Stat. 62A.041 subd 3, 62D.02, 62D.20, 62D.22, 62Q.14, 62Q.524 Minn. Rule 256B.0625 Coverage for abortion including pre-abortion and follow-up services required. Must not impose any cost-sharing that is greater than the cost-sharing that applies to similar services covered under the health plan. No other limitations allowed (including prior auth, referral, delay, etc).	45 CFR 156.280 Section 1303(D) of the Affordable Care Act (Exchange must offer at least one product that does not include abortion coverage); On exchange SBCs for individual plans must disclose abortion coverage. The Hyde amendment prohibits coverage of abortion in individual on-exchange products unless carriers follow steps outlined in the 2017 CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf).

Acupuncture

Markets Covered: Large group only.

Large group only must cover a trial of acupuncture for pain management. Coverage is optional for all other markets.

Plans that cover acupuncture services must allow enrollees to use non-physician qualified acupuncture providers.

State Law	Federal Law
No state HMO laws or rules expressly mandate coverage of acupuncture. Regulatory history: MCS received enrollee complaints regarding exclusion of acupuncture. MCS determined based on current medical research at the time that acupuncture is safe and effective for some people and a trial of acupuncture should be covered for chronic pain or when other pain management methods are not tolerated. All HMOs agreed to cover a trial of acupuncture. Because acupuncture is not an EHB and is not covered in the benchmark plan, upon passage of ACA and Chapter 62K, MCS decided, for purposes of market uniformity, not to require this benefit for individual and small group plans. Now it is enforced only for large group plans. 62D.107, 62A.15, subd. 3b—Equal access to acupuncture providers—if acupuncture is covered, must allow enrollees to use non-physician qualified acupuncture providers.	Not an essential health benefit and not covered in benchmark plan.

Amino Acid-Based Elemental Formula

Markets Covered: All

Health plans must provide coverage for amino acid-based formula when medically necessary.

State Law	Federal Law
62Q.531, 256B.0625	Not an essential health benefit, but covered in the MN state benchmark plan.

Autism Therapies

Markets Covered: All, but more stringent requirements for large group plans.

All plans must cover basic autism treatment, but only large group is required to cover intensive therapies.

State Law	Federal Law
62A.3094—Requires large employer plans to cover the diagnosis, evaluation, multidisciplinary assessment, and medically necessary care of children under 18 with autism spectrum disorders.	Not required. However, for plans that cover autism therapies, mental health parity laws apply.

Bariatric Surgery

Markets Covered: Large group only.

HMOs must cover bariatric surgery under their large group plans. Coverage is optional for other markets. HMOs can require enrollees to access services at “referral centers.” These are facilities that provide specialized services and expertise for bariatric surgery. Not required to meet usual geographic access requirements.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 "In-patient hospital care" means necessary hospital services affording residential treatment to patients. Such services shall include room and board, drugs and medicine, dressings, nursing care, X-rays, and laboratory examination, and other usual and customary hospital services.” HMOs routinely excluded bariatric surgery until MCS required coverage years ago based on complaints that this service is medically necessary, standard of care treatment. Because neither ACA nor benchmark plan requires coverage, for purposes of market consistency MCS does not require this benefit for individual or small group HMO products.	Bariatric surgery is not included as an essential health benefit or in the state benchmark plan. Therefore, we do not require coverage for individual and small group plans.

Biomarker Testing

Markets Covered: All

Biomarker testing is mandated in state statute. Nothing prohibits a health plan from imposing utilization management when approving coverage for biomarker testing.

State Law	Federal Law
62Q.473—A health plan must provide coverage for biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility. Utility may be demonstrated by medical and scientific evidence, including but not limited to nationally recognized clinical practices guidelines, consensus statements, labeled indications for a FDA approved or cleared test, and adherence to warnings and precautions.	Not in federal law or benchmark plan.

BRCA Testing

Markets Covered: All

Also see cancer screening, below. Plans must cover BRCA testing for individuals with certain risk factors. Typically, testing coverage will be noted explicitly in the certificate of coverage.

State Law	Federal Law
Minn. Rule 4685.0700—HMOS must cover all medically necessary preventive care	HMOs must cover BRCA testing when medically necessary without cost-sharing, as it is considered preventive. HMOs must cover all USPSTF A and B recommendations for cancer screening. Breast cancer screening, including BRCA testing, when medically necessary is currently a B rating by USPSTF. Medically necessary is defined by USPSTF as part of the screening recommendation.

Cancer Screening

Markets Covered: All

HMOs must cover all standard cancer screening without cost sharing.

State Law	Federal Law
Minn. Rule 4685.0700—HMOs must cover all medically necessary preventive care 62Q.50—Prostate cancer screening 62A.30—Routine cancer screenings, including ovarian, cervical, colorectal and breast cancer screening 62A.154—Denial is not allowed for DES (diethylstilbestrol)-related conditions	See above for BRCA testing specifically. HMOs must cover all USPSTF A and B recommendations for cancer screening as part of preventive care. Preventive care is an EHB.

Cancer Treatment

Markets Covered: All

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 62Q.525—Off-label drugs: HMOs may not exclude coverage of a drug for the treatment of cancer on the ground that the drug has not been approved by the federal Food and Drug Administration for the treatment of cancer if the drug is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature, as defined in subdivision 2. 62Q.526—Must cover qualified clinical trials as defined in statute. 62A.3075—Must cover oral chemotherapy drugs and may not discriminate in cost-sharing between oral chemo and IV chemo drugs. 62Q.1841—Prohibition on use of step therapy for metastatic cancer.	Services considered Essential Health Benefit as defined in US Code 42 USC 18022 must be covered, which would include most components of cancer treatment

Chiropractic Care

Markets Covered: All

HMOs must cover medically necessary services from chiropractors.

State Law	Federal Law
62A.15—Equal access to chiropractic requires HMOs to include chiropractors in their networks.	Covered in the MN benchmark plan.

Clinical Trials

Markets Covered: All

HMOS must cover consumers who participate in approved clinical trials.

State Law	Federal Law
62Q.526—Coverage for participation in approved clinical trials: “A health plan company that offers a health plan to a Minnesota resident may not: (1) deny participation by a qualified individual in an approved clinical trial; (2) deny, limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or (3) discriminate against an individual on the basis of an individual's participation in an approved clinical trial.” 62D.109—Disclosure of coverage to enrollee: “A health maintenance organization must inform an enrollee who is a participant in a clinical trial upon inquiry by the enrollee that coverage shall be provided as required under the enrollee's health maintenance contract or under state or federal rule or statute.”	42 U.S.C.A. § 300gg requires coverage in approved clinical trials. https://www.law.cornell.edu/uscode/text/42/300gg-8

Cleft Lip/Palate

Markets Covered: All

HMOs must cover treatment for cleft lip/palate.

State Law	Federal Law
Minn. Rule 4685.0700—Comprehensive health maintenance services 62A.042, subd. 1(b) and subd. 2(b) specify that cleft lip and cleft palate coverage are required	Covered in the MN benchmark plan.

Dental Care (Adult)

Markets Covered: All, but see limitations below.

Routine and preventive adult dental care are not required, and usually excluded, under health-only plans.

Adult dental coverage is required for treatment of TMD and craniomandibular disorder, or if dental treatment is required due to an underlying medical condition like cancer. See the TMD section for more details.

Plans must also cover anesthesia and hospital charges for dental care provided to a covered person who: (1) is a child under age five; or (2) is severely disabled; or (3) has a medical condition and who requires hospitalization or general anesthesia for dental care treatment.

State Law	Federal Law
4685.0700, subp. 4—Permissible exclusions: routine dental. 62A.043—TMD, craniomandibular disorder 62A.308—Anesthesia and hospitalization for dental procedures related to medical conditions.	None

Dental Care (Pediatric)

Markets Covered: Individual and small group only.

A consumer purchasing an individual or small group plan on MNSure has the option to purchase pediatric dental either embedded in the medical product or as offered in a stand-alone qualified dental plan offered on the exchange. Individual and small group plans offered off the exchange must offer pediatric dental either embedded in the medical product or if not, have enrollee sign off in enrollment application that pediatric dental is an essential health benefit, they understand it is not covered in the plan, and they decline coverage because they have other pediatric dental coverage in place.

As above, plans must also cover anesthesia and hospital charges for dental care provided to a covered person who: (1) is a child under age five; or (2) is severely disabled; or (3) has a medical condition and who requires hospitalization or general anesthesia for dental care treatment.

State Law	Federal Law
62A.308, subd. a—Coverage of anesthesia and hospital charges for dental care for certain populations 62A.308, subd. A—Coverage of general anesthesia and treatment rendered by a dentist for a medical condition covered by the health plan 62K.14—Limited-scope pediatric plans	Pediatric oral care is an essential health benefit. Pediatric dental can be embedded in the medical plan or offered through a stand-alone dental plan. The pediatric dental benchmark is the FEDVIP plan.

Diabetes

Markets Covered: All

Must cover screening as described in USPSTF recommendation.

Must cover all medically necessary treatment, supplies and education.

State statute limits cost-sharing of prescriptions to $25 per month and supplies to $50 per month.

State Law	Federal Law
62A.3093—Coverage for diabetes 62Q.481 cost sharing limits. Also applies to asthma, and allergies requiring the use of epinephrine auto-injectors "Cost-sharing limits. (a) A health plan must limit the amount of any enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease 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."	Not called out as an essential health benefit, but covered in benchmark plan. Many aspects of diabetes care would fit under essential health benefit categories, including ambulatory care and prescription services. Screening coverage is required as a preventive service based on USPSTF recommendation.

Durable Medical Equipment

Markets Covered: All

HMOs must cover medically necessary DME, orthotics and prosthetics, but may limit the brands and models covered to standard equipment medically appropriate for the condition.

Nondurable medical equipment generally is not a required coverage unless specified in statute.

Intermittent catheters must be covered.

Orthotics and prosthetics must be covered. See the section "Orthotic and Prosthetic Devices."

State Law	Federal Law
Minn. Rule 4685.0700, subp. 3(B)—HMOs must cover all medically necessary durable medical equipment, orthotics, prosthetics, and nondurable medical supplies. These benefits	Considered an essential health benefit under "Rehabilitative and habilitative services and devices."

State Law	Federal Law
may have limits, except as required in 62Q.665 and 62Q.6651 (see "Orthotic and Prosthetic devices" section). HMOs must cover only the basic level and are not required to cover the highest level of durable medical equipment. 62Q.66—DME cannot limit to only used in home 62Q.67—Health plans must disclose details about durable medical equipment coverage, including limitations and prior authorization criteria, upon request of an enrollee or prospective enrollee. 62Q.666—Intermittent catheters 62Q.665 and 62Q.6651 are specific to orthotic and prosthetic devices. See that section for details.	Included in state benchmark plan.

Eye Exam (Adult)

Markets Covered: Large group only.

Only large group plans must cover routine adult eye exams. Some small group plans cover as an extra benefit, but this is not required.

State Law	Federal Law
62A.15—Requires plans that cover eye exams to cover equal access to optometrists.	Routine adult eye exams are not an essential health benefit and not a required coverage under the ACA. For purposes of market consistency, we only require coverage in large group, not individual and small group.

Eye Exam and Eyewear (Pediatric)

Markets Covered: All, but there are different requirements for individual and small group.

All HMOs must cover routine pediatric vision screening without cost-sharing. Coverage is required for routine eye exams.

Individual and small group plans must cover pediatric eyewear. Limitations per benchmark plan are allowed. Large group is not required to cover pediatric eyewear.

State Law	Federal Law
4685.0700 subp. 4: allows exclusion of eyewear coverage	Pediatric vision is an essential health benefit under pediatric services. The state benchmark plan includes one routine eye exam and one pair of medically necessary eyeglasses (lenses and frames) per year. Contacts are only covered in medically necessary. The vision benchmark is the FEDVIP vision plan. Includes low vision services

Gender Affirming Care

Markets Covered: All

This is sometimes referred to under the term Gender Dysphoria.

HMOs must cover all medically necessary care. "Medically necessary" is defined in the specific state statute.

Gender reassignment exclusion is not allowed.

Plans may not discriminate in the provision of covered services based on gender identity.

There must be a statement of non-discrimination in certificate of coverage that includes that the HMO does not discriminate based on gender identity.

State Law	Federal Law
62Q.585—Gender-affirming care coverage	OCR nondiscrimination regulations: 45 CFR Part 92: A "covered entity" shall treat individuals consistent with gender identity, except that a covered entity may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth is different. ACA Implementation FAQs pt. 26 (https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf): Whether a sex-specific recommended preventive service that is required to be covered without cost sharing under PHS Act section 2713 and its implementing regulations is medically appropriate for a particular individual is determined by the individual's attending provider.

Genetic Testing

Markets Covered: All

This service usually falls under the "laboratory services" essential health benefit. As such, it is required for all plans and market types when medically necessary.

Plans typically cover genetic testing received in an office or outpatient hospital when test results will directly affect treatment decisions or frequency of screening for a disease, or when results of the test will affect reproductive choices.

For additional genetic testing coverage requirements, see the section on rapid whole genome sequencing.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2—Covered under comprehensive health maintenance services.	Genetic testing is not expressly listed as an essential health benefit, but when medically necessary, it typically falls under the lab services and preventive services essential health benefits.

Hearing Aids

Markets Covered: All

HMOs must cover hearing aids for all individuals for hearing loss that is not correctable by other covered procedures. Some limitations are allowed, see state statute for coverage details.

Most plans also cover cochlear implants when medically necessary.

State Law	Federal Law
62Q.675—Hearing aids Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.	Not an essential health benefit, but it is in the state benchmark plan.

Home Health Care

Markets Covered: All

This is a service that can be limited under HMO rules. It cannot be excluded.

The state benchmark plan allows a limit of no less than 120 days of home health per year, consistent with Medicare requirements.

One postnatal home health care visit must be covered without cost sharing.

Per statute, individuals who are ventilator-dependent must be covered for up to 120 days per year.

State Law	Federal Law
Rule 4685.0700, subp. 3(C)—A health maintenance organization may limit home health care services. 62A.155—Coverage for services provided to ventilator-dependent persons. This includes the 120 hour coverage requirement. 62A.0411—Postnatal home health	Home health care is not expressly listed as an essential health benefit but is covered under outpatient ambulatory care. Home health care is expressly covered in the state benchmark plan up to 120 days per year.

Hospice

Markets Covered: All

HMOs must cover hospice services as an alternative to hospitalization when life expectancy is six months or less and enrollee chooses a plan of care focused on palliative and not curative care.

State Law	Federal Law
Minn. Rule 4685.0700 There are no laws or rules expressly referencing hospice care. However, this falls under provision of comprehensive health maintenance services and is an alternative to hospitalization when life expectancy is six months or less.	Covered in benchmark plan.

Lyme Disease

Markets Covered: All

All plans must cover diagnosis and medically necessary, standard of care treatment of Lyme disease.

State Law	Federal Law
62A.265—Coverage for Lyme disease	Not an essential health benefit, although care would typically be covered under essential health benefits (ambulatory care, hospitalization, laboratory services, and prescription drugs). Included in state benchmark plan.

Mammography

Markets Covered: All

Must be covered per USPSTF recommendations.

3D mammography must be included in coverage.

Additional diagnostics/testing after mammogram, as medically necessary per provider's recommendation, must be covered with no cost-sharing (exception for HDHPs).

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 62A.30, subd. 4 and 5—3D mammography, additional diagnostics/testing, "at risk for breast cancer" criteria.	Mammography is an essential health benefit under preventive services following USPSTF recommendations.

Off-Label Drugs for Cancer Treatment

Markets Covered: All

HMOs must cover off-label drugs for cancer treatment, as medically necessary, per the requirements of 62Q.525.

State Law	Federal Law
62Q.525—Coverage for off-label drug use	This coverage is in the state benchmark plan.

Organ Transplant Services

Markets Covered: All

HMOs must cover all medically necessary non-experimental organ transplant services. They can require enrollees to access services at "referral centers." Geographic access requirements do not apply**.**

HMOs cannot discriminate based on disability when determining transplant access.

State Law	Federal Law
Rule 4685.1010, subp. 1A "Referral centers" means medical facilities that provide specialized medical care such as organ transplants and coronary artery bypass surgery. Examples of criteria the health maintenance organization may use in designating a facility as a referral center are volume of services provided annually and the case mix and severity adjusted mortality and morbidity rates. Referral centers may be located within or outside the health maintenance organization's service area. 62A.082—Nondiscrimination: a covered entity may not, on the basis of a qualified individual's mental or physical disability, discriminate in the provision of access to transplant services. See statute for further detail.	Inpatient hospitalization is an essential health benefit. Covered in state benchmark plan.

Orthognathic Surgery (jaw surgery)

Markets Covered: All

Currently, we only require coverage if orthognathic surgery if medically necessary for treatment of TMJ/TMD.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 62A.043—Required coverage for TMJ	This is excluded in the state benchmark plan, so it may be excluded in individual and small group plans, except for treatment related to TMJ/TMD.

Orthotic and Prosthetic Devices

Markets Covered: All

HMOs must cover medically necessary orthotics and prosthetic devices. Coverage must be at least that provided under federal law for aged and disabled members. Cost sharing must not be more restrictive than medical/surgical benefits. Prior authorization and out-of-network coverage must be the same as any other benefit. There are specific allowances of limitations in the statutes and rules. There are also nondiscrimination requirements specific to orthotics and prosthetics.

State Law	Federal Law
62Q.665—Coverage for orthotic and prosthetic devices Must cover all medically necessary DME, but HMOs are only required to cover the basic level of DME and do not have to cover the highest end options. 62Q.6651—Medical necessity and discrimination standards for coverage or prosthetics or orthotics Minn. Rules 4685.0700, subp. 3 allows limitations to coverage.	DME coverage is not an essential health benefit.

PANS/PANDAS

Markets Covered: All

HMOs must cover treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).

State Law	Federal Law
62A.3097—Coverage for PANS and PANDAS treatments	Not specifically an essential health benefit, although some aspects of care (ambulatory services, hospitalization, prescription drugs) would fit under essential health benefits.

Pharmacist

Markets Covered: All

Like the chiropractic equal access statute, HMOs are required to cover services from a licensed pharmacist if a. they would be covered if they were provided by a physician; and b. they are within the pharmacist's scope of practice.

Coverage and reimbursement for medication therapy management services are unaffected.

State Law	Federal Law
62D.1071—Coverage of licensed pharmacist services	Not in federal law.

Phenylketonuria (PKU)

Markets Covered: All

HMOs must cover special dietary treatment for phenylketonuria when recommended by a physician.

State Law	Federal Law
62A.26—Coverage for phenylketonuria treatment	Covered in benchmark plan.

Port Wine Stain

Markets Covered: All

HMOs must cover elimination or maximum feasible treatment of port-wine stains for any covered person who is a Minnesota resident.

State Law	Federal Law
62A.304—Coverage for port-wine stain elimination	Covered in benchmark plan.

Rapid Whole Genome Sequencing

Markets Covered: All

HMOs must cover for enrollees ages 21 and younger if the statute criteria apply.

State Law	Federal Law
62A.3098—Coverage for Rapid Whole Genome Sequencing is required if the enrollee meets the established medical necessity criteria. See statute for criteria details.	Not in benchmark plan or federal statute.

Rare Disease

Markets Covered: All

HMOs must allow for unrestricted access to providers and facilities, regardless of network participation, when the patient meets specific rare disease criteria listed in statute. In-network cost sharing must apply. Prior authorization and other utilization management techniques are allowed.

State Law	Federal Law
62Q.451—This statute has highly specific criteria for what qualifies a patient for this coverage. It also allows for a 60-day transfer for patients who qualified at the pre-diagnosis stage but are diagnosed with a non-rare disease.	Not an essential health benefit or in the benchmark plan.

Reconstructive Surgery

Markets Covered: All

HMOs must cover medically necessary reconstructive surgery. See statute for details on “medically necessary.”

State Law	Federal Law
62A.25—Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician. The coverage limitations on reconstructive surgery above do not apply to reconstructive breast surgery following mastectomies. The federal The Women’s Health Cancer Rights Act requires coverage.	Covered in benchmark plan. The Women’s Health Cancer Rights Act requires coverage: all stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

Religious Objections

Markets Covered: Small and large group only, as this is employer-based.

An exempt organization is not required to provide coverage under section 62Q.522, 62Q.584, or 62Q.585 if the exempt organization has a religious objection to the coverage. An exempt organization that chooses to not provide coverage pursuant to this paragraph must notify the employees as part of the hiring process and must notify all employees at least 30 days before: an employee enrolls in a health plan; or the effective date of the health plan, whichever occurs first.

If the exempt organization provides partial coverage under any of the above sections, the organization must provide a list of the portion of such coverage they refuse to cover.

State Law	Federal Law
62Q.679 Coverage that can be exempted: 62Q.522—Contraceptive methods and services 62Q.524—Abortion and abortion-related services 62Q.585—Gender-affirming care	45 CFR 147.131 45 CFR 147.132

Scalp Hair Prostheses (Wigs)

Markets Covered: All

HMOs must provide coverage for scalp hair prostheses and equipment and accessories worn for hair loss suffered as a result of any health condition including but not limited to cancer. The HMO may require that the prosthesis be prescribed by a physician.

State Law	Federal Law
62A.28—Must provide coverage for scalp hair prostheses, up to $1000, worn for hair loss suffered as a result of any health condition including but not limited to cancer. May require that it be prescribed by a physician.	Covered in benchmark plan.

Skilled Nursing Facility

Markets Covered: All

Coverage for Skilled Nursing Facility is required for medically necessary care consistent with Medicare coverage criteria. Skilled nursing facilities are not covered for long term care. Can be limited to no fewer than 120 days per year to align with benchmark plan.

Daily skilled care or daily skilled rehabilitation services, including room and board, must be covered up to 120 days per year.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2	Covered in state benchmark plan with a limit of 120 days per year. Rehabilitative and habilitative services are essential health benefits.

Telemedicine

Markets Covered: All

Telemedicine must be covered at parity with in-person coverage.

State Law	Federal Law
62A.673—coverage of services provided through telehealth	Not an essential health benefit or in the state benchmark.

TMJ/TMD Temporomandibular Joint Disorder and Craniomandibular Disorder

Markets Covered: All

HMOs must provide coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder when medically necessary.

Orthodontia and orthognathic surgery that is medically necessary to treat temporomandibular joint disorder and craniomandibular disorder are included.

State Law	Federal Law
62A.043—all HMO plans must provide coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder	Temporomandibular joint disorder and craniomandibular disorder are covered in the state benchmark plan.

Tobacco Cessation Treatment

Markets Covered: All

HMOs must cover tobacco cessation counseling and medication consistent with USPSTF and ACA guidelines.

State Law	Federal Law
Minn. Rules 4685.0100, subp. 5; 4685.0700, subp. 2 Considered preventive care.	Required preventive care under the ACA. FAQs About Affordable Care Act Implementation (Part XIX) (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs19.html) Plans must cover: 1. Screening for tobacco use; and, 2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: (a) Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without

State Law	Federal Law
	prior authorization; and (b) All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Vision Therapy

Markets Covered: Large group only.

Large group plans must cover vision therapy/orthoptic and/or pleoptic training, to establish a home program, for the treatment of strabismus and other disorders of binocular eye movements. Coverage may be limited to 10 training visits and 5 follow-up eye exams per year.

State Law	Federal Law
Coverage requirements based on complaints received by MDH. Limited vision therapy is considered medically necessary and supported by medical literature.	Not required under ACA. Not in benchmark plan.

Exclusions and Limitations Allowed by Law

Appetite Suppressants

Markets Covered: All

Prescription appetite suppressants may be excluded if they are not determined to be safe and effective.

State Law	Federal Law
HMO rules allow HMOs to make determinations of drug formulary selection. Formularies must include all medically necessary drugs. Historically, appetite suppressants were not considered medically necessary.	None.

Cosmetic Services

Markets Covered: All

HMOs are not required to cover cosmetic services.

Required reconstructive services are differentiated from cosmetic services. See the Reconstructive Surgery section for details.

State Law	Federal Law
Minn. Rule 4685.0700, subp. 4B	None.

Custodial Care

Markets Covered: All

HMOs may exclude custodial care.

State Law	Federal Law
Minn. Rule 4685.0700, subp. 4G	None.

Dental Services (Adult)

Markets Covered: All

HMOs may exclude adult dental services unless required for treatment of a covered underlying medical condition. See the Dental Care (Adult) section for details.

Pediatric dental must be offered for individual and small group plans, but can be covered through a separate limited-scope pediatric dental plan.

State Law	Federal Law
Minn. Rule 4685.0700, subp. 4C Minn. Stat. 62K.14—limited-scope pediatric dental plans	Pediatric dental is an essential health benefit; adult dental is not.

Experimental/Unproven Treatment

Markets Covered: All

HMOs may exclude experimental, investigative and unproven treatment.

The certificate of coverage must clearly disclose the standard for exclusion stated in Minnesota Rule 4685.0700, subpart 4F.

There is an exclusion (i.e. coverage requirement) for off-label drugs for cancer treatment.

State Law	Federal Law
Minn. Rule 4685.0700, subpart 4F Minn. Stat. 62Q.73, subdivision 7 (d)—requirements for external review of an adverse determination involving experimental or investigational treatment. Minn. Stat. 62Q.525—off-label drugs for cancer treatment must be covered per statute.	None.

Eyewear (Adult)

Markets Covered: All

HMOs may exclude adult eyewear.

State Law	Federal Law
Minn. Rule 4685.0700, subpart 4E	The ACA requires coverage of pediatric eyewear. Adult eyewear is not required coverage.

Infertility Treatment

Markets Covered: All

Diagnosis of infertility must be covered. However, treatment of infertility is not required except to treat an underlying medical condition such as endometriosis.

State Law	Federal Law
None.	None.

Medical Marijuana

Markets Covered: All

HMOs are not required to cover medical marijuana.

State Law	Federal Law
There is no requirement that health carriers cover therapeutic marijuana, so all HMOs currently exclude. Minn. Stat. 152.22-152.37—THC therapeutic research act	None.

Military

Markets Covered: All

This specifically refers to injuries received while on military duty to extent coverage is available elsewhere.

HMOs may exclude military injuries to extent coverage is available through military coverage.

State Law	Federal Law
Minn. Rule 4685.0700, subpart 4H	None.

Non-Emergency Ambulance

Markets Covered: All

HMOs may exclude nonemergency ambulance services and special transportation services, except as provided by Minnesota Statutes, section 62J.48. HMOs must cover emergency and medically necessary ambulance.

State Law	Federal Law
Minn. Rule 4685.0700, subpart 4D	None. Non-emergency ambulance is specifically excluded from the No Surprises Act.

Out-of-country care

Markets Covered: All

Out-of-country care does not have to be covered and usually will not be in the individual market, even in emergency situations. Some group plans will offer emergency coverage out of the country as an added benefit.

State Law	Federal Law
None.	None.

Sexual Dysfunction and Enhancement Drugs

Markets Covered: All

Drugs for treatment of sexual dysfunction are generally considered not medically necessary and are not required to be covered by HMOs.

State Law	Federal Law
HMO rules allow HMOs to make determinations of drug formulary selection. Formularies must include all medically necessary drugs.	None.

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