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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 2202

02/27/2023 Authored by Reyer
The bill was read for the first time and referred to the Committee on Health Finance and Policy

1.1 A bill for an act
1.2 relating to health; establishing the Health Care Affordability Board and Health
1.3 Care Affordability Advisory Council; requiring monitoring of and recommendations
1.4 related to health care market trends; establishing the health care spending growth
1.5 target program; requiring reports; providing for civil penalties; requiring certain
1.6 transfers of funds; amending Minnesota Statutes 2022, section 62U.04, subdivision
1.7 11; proposing coding for new law in Minnesota Statutes, chapter 62J.

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

1.9 Section 1. 62J.86 DEFINITIONS.

1.10 Subdivision 1. Definitions. For the purposes of sections 62J.86 to 62J.92, the following
1.11 terms have the meanings given.

1.12 Subd. 2. Advisory council. "Advisory council" means the Health Care Affordability
1.13 Advisory Council established under section 62J.88.

1.14 Subd. 3. Board. "Board" means the Health Care Affordability Board established under
1.15 section 62J.87.

1.16 Sec. 2. 62J.87 HEALTH CARE AFFORDABILITY BOARD.

1.17 Subdivision 1. Establishment. The Legislative Coordinating Commission shall establish
1.18 the Health Care Affordability Board, which shall be governed as a board under section
1.19 15.012, paragraph (a), to protect consumers, state and local governments, health plan
1.20 companies, providers, and other health care system stakeholders from unaffordable health
1.21 care costs. The board must be operational by January 1, 2024.

1.22 Subd. 2. Membership. (a) The Health Care Affordability Board consists of 13 members,
1.23 appointed as follows:

- 2.1 (1) five members appointed by the governor;
- 2.2 (2) two members appointed by the majority leader of the senate;
- 2.3 (3) two members appointed by the minority leader of the senate;
- 2.4 (4) two members appointed by the speaker of the house; and
- 2.5 (5) two members appointed by the minority leader of the house of representatives.
- 2.6 (b) All appointed members must have knowledge and demonstrated expertise in one or
- 2.7 more of the following areas: health care finance, health economics, health care management
- 2.8 or administration at a senior level, health care consumer advocacy, representing the health
- 2.9 care workforce as a leader in a labor organization, purchasing health care insurance as a
- 2.10 health benefits administrator, delivery of primary care, health plan company administration,
- 2.11 public or population health, and addressing health disparities and structural inequities.
- 2.12 (c) A member may not participate in board proceedings involving an organization,
- 2.13 activity, or transaction in which the member has either a direct or indirect financial interest,
- 2.14 other than as an individual consumer of health services.
- 2.15 (d) The Legislative Coordinating Commission shall coordinate appointments under this
- 2.16 subdivision to ensure that board members are appointed by August 1, 2023, and that board
- 2.17 members as a whole meet all of the criteria related to the knowledge and expertise specified
- 2.18 in paragraph (b).
- 2.19 Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall
- 2.20 not serve more than three consecutive terms.
- 2.21 (b) A board member may resign at any time by giving written notice to the board.
- 2.22 Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from
- 2.23 the members appointed by the governor.
- 2.24 (b) The board shall elect a chair to replace the acting chair at the first meeting of the
- 2.25 board by a majority of the members. The chair shall serve for two years.
- 2.26 (c) The board shall elect a vice-chair and other officers from its membership as it deems
- 2.27 necessary.
- 2.28 Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time
- 2.29 executive director and other staff, who shall serve in the unclassified service. The executive
- 2.30 director must have significant knowledge and expertise in health economics and demonstrated
- 2.31 experience in health policy.

3.1 (b) The attorney general shall provide legal services to the board.

3.2 (c) The Health Economics Division within the Department of Health shall provide  
3.3 technical assistance to the board in analyzing health care trends and costs and in setting  
3.4 health care spending growth targets.

3.5 (d) The board may employ or contract for professional and technical assistance, including  
3.6 actuarial assistance, as the board deems necessary to perform the board's duties.

3.7 Subd. 6. Access to information. (a) The board may request that a state agency provide  
3.8 the board with any publicly available information in a usable format as requested by the  
3.9 board, at no cost to the board.

3.10 (b) The board may request from a state agency unique or custom data sets, and the agency  
3.11 may charge the board for providing the data at the same rate the agency would charge any  
3.12 other public or private entity.

3.13 (c) Any information provided to the board by a state agency must be de-identified. For  
3.14 purposes of this subdivision, "de-identification" means the process used to prevent the  
3.15 identity of a person or business from being connected with the information and ensuring  
3.16 all identifiable information has been removed.

3.17 (d) Any data submitted to the board shall retain its original classification under the  
3.18 Minnesota Data Practices Act in chapter 13.

3.19 Subd. 7. Compensation. Board members shall not receive compensation but may receive  
3.20 reimbursement for expenses as authorized under section 15.059, subdivision 3.

3.21 Subd. 8. Meetings. (a) Meetings of the board are subject to chapter 13D. The board shall  
3.22 meet publicly at least quarterly. The board may meet in closed session when reviewing  
3.23 proprietary information as specified in section 62J.71, subdivision 4.

3.24 (b) The board shall announce each public meeting at least two weeks prior to the  
3.25 scheduled date of the meeting. Any materials for the meeting shall be made public at least  
3.26 one week prior to the scheduled date of the meeting.

3.27 (c) At each public meeting, the board shall provide the opportunity for comments from  
3.28 the public, including the opportunity for written comments to be submitted to the board  
3.29 prior to a decision by the board.

3.30 Sec. 3. [62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.

3.31 Subdivision 1. Establishment. The governor shall appoint a Health Care Affordability  
3.32 Advisory Council to provide advice to the board on health care costs and access issues and

4.1 to represent the views of patients and other stakeholders. Members of the advisory council  
4.2 shall be appointed based on their knowledge and demonstrated expertise in one or more of  
4.3 the following areas: health care delivery, ensuring health care access for diverse populations,  
4.4 public and population health, patient perspectives, health care cost trends and drivers, clinical  
4.5 and health services research, innovation in health care delivery, and health care benefits  
4.6 management.

4.7 Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to  
4.8 the board on:

4.9 (1) the identification of economic indicators and other metrics related to the development  
4.10 and setting of health care spending growth targets;

4.11 (2) data sources for measuring health care spending; and

4.12 (3) measurement of the impact of health care spending growth targets on diverse  
4.13 communities and populations, including but not limited to those communities and populations  
4.14 adversely affected by health disparities.

4.15 (b) The council shall report technical recommendations and a summary of its activities  
4.16 to the board at least annually, and shall submit additional reports on its activities and  
4.17 recommendations to the board, as requested by the board or at the discretion of the council.

4.18 Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered  
4.19 terms of two, three, or four years determined by lot by the secretary of state. Following the  
4.20 initial appointments, advisory council members shall serve four-year terms.

4.21 (b) Removal and vacancies of advisory council members shall be governed by section  
4.22 15.059.

4.23 Subd. 4. **Compensation.** Advisory council members may be compensated according to  
4.24 section 15.059.

4.25 Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the  
4.26 advisory council are subject to chapter 13D.

4.27 Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not  
4.28 expire.

4.29 **Sec. 4. [62J.89] DUTIES OF THE BOARD.**

4.30 Subdivision 1. **General.** (a) The board shall monitor the administration and reform of  
4.31 the health care delivery and payment systems in the state. The board shall:

- 5.1 (1) set health care spending growth targets for the state, as specified under section 62J.90;  
 5.2 (2) enhance the transparency of provider organizations;  
 5.3 (3) monitor the adoption and effectiveness of alternative payment methodologies;  
 5.4 (4) foster innovative health care delivery and payment models that lower health care  
 5.5 cost growth while improving the quality of patient care;  
 5.6 (5) monitor and review the impact of changes within the health care marketplace; and  
 5.7 (6) monitor patient access to necessary health care services.

5.8 (b) The board shall establish goals to reduce health care disparities in racial and ethnic  
 5.9 communities and to ensure access to quality care for persons with disabilities or with chronic  
 5.10 or complex health conditions.

5.11 Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care  
 5.12 delivery and payment system in Minnesota to understand emerging trends in the commercial  
 5.13 health insurance market, including large self-insured employers and the state's public health  
 5.14 care programs, in order to identify opportunities for state action to achieve:

- 5.15 (1) improved patient experience of care, including quality and satisfaction;  
 5.16 (2) improved health of all populations, including a reduction in health disparities; and  
 5.17 (3) a reduction in the growth of health care costs.

5.18 Subd. 3. **Recommendations for reform.** The board shall make recommendations for  
 5.19 legislative policy, market, or any other reforms to:

- 5.20 (1) lower the rate of growth in commercial health care costs and public health care  
 5.21 program spending in the state;  
 5.22 (2) positively impact the state's rankings in the areas listed in this subdivision and  
 5.23 subdivision 2; and  
 5.24 (3) improve the quality and value of care for all Minnesotans, and for specific populations  
 5.25 adversely affected by health inequities.

5.26 Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient  
 5.27 Protection, to be operational by January 1, 2025. The office shall assist consumers with  
 5.28 issues related to access and quality of health care, and advise the legislature on ways to  
 5.29 reduce consumer health care spending and improve consumer experiences by reducing  
 5.30 complexity for consumers.

6.1 Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

6.2 Subdivision 1. Establishment and administration. The board shall establish and  
6.3 administer the health care spending growth target program to limit health care spending  
6.4 growth in the state, and shall report regularly to the legislature and the public on progress  
6.5 toward these targets.

6.6 Subd. 2. Methodology. (a) The board shall develop a methodology to establish annual  
6.7 health care spending growth targets and the economic indicators to be used in establishing  
6.8 the initial and subsequent target levels.

6.9 (b) The health care spending growth target must:

6.10 (1) use a clear and operational definition of total state health care spending;

6.11 (2) promote a predictable and sustainable rate of growth for total health care spending  
6.12 as measured by an established economic indicator, such as the rate of increase of the state's  
6.13 economy or of the personal income of residents of this state, or a combination;

6.14 (3) define the health care markets and the entities to which the targets apply;

6.15 (4) take into consideration the potential for variability in targets across public and private  
6.16 payers;

6.17 (5) account for the health status of patients; and

6.18 (6) incorporate specific benchmarks related to health equity.

6.19 (c) In developing, implementing, and evaluating the growth target program, the board  
6.20 shall:

6.21 (1) consider the incorporation of quality of care and primary care spending goals;

6.22 (2) ensure that the program does not place a disproportionate burden on communities  
6.23 most impacted by health disparities, the providers who primarily serve communities most  
6.24 impacted by health disparities, or individuals who reside in rural areas or have high health  
6.25 care needs;

6.26 (3) explicitly consider payment models that help ensure financial sustainability of rural  
6.27 health care delivery systems and the ability to provide population health;

6.28 (4) allow setting growth targets that encourage an individual health care entity to serve  
6.29 populations with greater health care risks by incorporating:

6.30 (i) a risk factor adjustment reflecting the health status of the entity's patient mix; and

7.1 (ii) an equity adjustment accounting for the social determinants of health and other  
7.2 factors related to health equity for the entity's patient mix;

7.3 (5) ensure that growth targets:

7.4 (i) do not constrain the Minnesota health care workforce, including the need to provide  
7.5 competitive wages and benefits;

7.6 (ii) do not limit the use of collective bargaining or place a floor or ceiling on health care  
7.7 workforce compensation; and

7.8 (iii) promote workforce stability and maintain high-quality health care jobs; and

7.9 (6) consult with the advisory council and other stakeholders.

7.10 Subd. 3. **Data.** The board shall identify data to be used for tracking performance in  
7.11 meeting the growth target and identify methods of data collection necessary for efficient  
7.12 implementation by the board. In identifying data and methods, the board shall:

7.13 (1) consider the availability, timeliness, quality, and usefulness of existing data, including  
7.14 the data collected under section 62U.04;

7.15 (2) assess the need for additional investments in data collection, data validation, or data  
7.16 analysis capacity to support the board in performing its duties; and

7.17 (3) minimize the reporting burden to the extent possible.

7.18 Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2024, and  
7.19 by June 15 of each succeeding calendar year through June 15, 2028, shall establish annual  
7.20 health care spending growth targets for the next calendar year consistent with the  
7.21 requirements of this section. The board shall set annual health care spending growth targets  
7.22 for the five-year period from January 1, 2025, through December 31, 2029.

7.23 (b) The board shall periodically review all components of the health care spending  
7.24 growth target program methodology, economic indicators, and other factors. The board may  
7.25 revise the annual spending growth targets after a public hearing, as appropriate. If the board  
7.26 revises a spending growth target, the board must provide public notice at least 60 days  
7.27 before the start of the calendar year to which the revised growth target will apply.

7.28 (c) The board, based on an analysis of drivers of health care spending and evidence from  
7.29 public testimony, shall evaluate strategies and new policies, including the establishment of  
7.30 accountability mechanisms, that are able to contribute to meeting growth targets and limiting  
7.31 health care spending growth without increasing disparities in access to health care.

8.1 Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present  
8.2 findings from spending growth target monitoring. The board shall also regularly hold public  
8.3 hearings to take testimony from stakeholders on health care spending growth, setting and  
8.4 revising health care spending growth targets, the impact of spending growth and growth  
8.5 targets on health care access and quality, and as needed to perform the duties assigned under  
8.6 section 62J.89, subdivisions 1, 2, and 3.

8.7 Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

8.8 Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that  
8.9 have been identified by the board as exceeding the spending growth target for any given  
8.10 year.

8.11 (b) For purposes of this section, "health care entity" shall be defined by the board during  
8.12 the development of the health care spending growth methodology. When developing this  
8.13 methodology, the board shall consider a definition of health care entity that includes clinics,  
8.14 hospitals, ambulatory surgical centers, physician organizations, accountable care  
8.15 organizations, integrated provider and plan systems, and other entities defined by the board,  
8.16 provided that physician organizations with a patient panel of 15,000 or fewer, or which  
8.17 represent providers who collectively receive less than \$25,000,000 in annual net patient  
8.18 service revenue from health plan companies and other payers, shall be exempt.

8.19 Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement  
8.20 procedures to assist health care entities to improve efficiency and reduce cost growth by  
8.21 requiring some or all health care entities provided notice under subdivision 1 to file and  
8.22 implement a performance improvement plan. The board shall provide written notice of this  
8.23 requirement to health care entities.

8.24 (b) Within 45 days of receiving a notice of the requirement to file a performance  
8.25 improvement plan, a health care entity shall:

8.26 (1) file a performance improvement plan with the board; or

8.27 (2) file an application with the board to waive the requirement to file a performance  
8.28 improvement plan or extend the timeline for filing a performance improvement plan.

8.29 (c) The health care entity may file any documentation or supporting evidence with the  
8.30 board to support the health care entity's application to waive or extend the timeline to file  
8.31 a performance improvement plan. The board shall require the health care entity to submit  
8.32 any other relevant information it deems necessary in considering the waiver or extension  
8.33 application, provided that this information shall be made public at the discretion of the

9.1 board. The board may waive or delay the requirement for a health care entity to file a  
9.2 performance improvement plan in response to a waiver or extension request in light of all  
9.3 information received from the health care entity, based on a consideration of the following  
9.4 factors:

9.5 (1) the costs, price, and utilization trends of the health care entity over time, and any  
9.6 demonstrated improvement in reducing per capita medical expenses adjusted by health  
9.7 status;

9.8 (2) any ongoing strategies or investments that the health care entity is implementing to  
9.9 improve future long-term efficiency and reduce cost growth;

9.10 (3) whether the factors that led to increased costs for the health care entity can reasonably  
9.11 be considered to be unanticipated and outside of the control of the entity. These factors may  
9.12 include but shall not be limited to age and other health status adjusted factors and other cost  
9.13 inputs such as pharmaceutical expenses and medical device expenses;

9.14 (4) the overall financial condition of the health care entity; and

9.15 (5) any other factors the board considers relevant. If the board declines to waive or  
9.16 extend the requirement for the health care entity to file a performance improvement plan,  
9.17 the board shall provide written notice to the health care entity that its application for a waiver  
9.18 or extension was denied and the health care entity shall file a performance improvement  
9.19 plan.

9.20 (d) A health care entity shall file a performance improvement plan with the board:

9.21 (1) within 45 days of receipt of an initial notice;

9.22 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt  
9.23 of a notice that such waiver or extension has been denied; or

9.24 (3) if the health care entity is granted an extension, on the date given on the extension.

9.25 The performance improvement plan shall identify the causes of the entity's cost growth and  
9.26 shall include but not be limited to specific strategies, adjustments, and action steps the entity  
9.27 proposes to implement to improve cost performance. The proposed performance improvement  
9.28 plan shall include specific identifiable and measurable expected outcomes and a timetable  
9.29 for implementation. The timetable for a performance improvement plan must not exceed  
9.30 18 months.

9.31 (e) The board shall approve any performance improvement plan that it determines is  
9.32 reasonably likely to address the underlying cause of the entity's cost growth and has a

10.1 reasonable expectation for successful implementation. If the board determines that the  
10.2 performance improvement plan is unacceptable or incomplete, the board may provide  
10.3 consultation on the criteria that have not been met and may allow an additional time period  
10.4 of up to 30 calendar days for resubmission. Upon approval of the proposed performance  
10.5 improvement plan, the board shall notify the health care entity to begin immediate  
10.6 implementation of the performance improvement plan. Public notice shall be provided by  
10.7 the board on its website, identifying that the health care entity is implementing a performance  
10.8 improvement plan. All health care entities implementing an approved performance  
10.9 improvement plan shall be subject to additional reporting requirements and compliance  
10.10 monitoring, as determined by the board. The board shall provide assistance to the health  
10.11 care entity in the successful implementation of the performance improvement plan.

10.12 (f) All health care entities shall in good faith work to implement the performance  
10.13 improvement plan. At any point during the implementation of the performance improvement  
10.14 plan, the health care entity may file amendments to the performance improvement plan,  
10.15 subject to approval of the board. At the conclusion of the timetable established in the  
10.16 performance improvement plan, the health care entity shall report to the board regarding  
10.17 the outcome of the performance improvement plan. If the board determines the performance  
10.18 improvement plan was not implemented successfully, the board shall:

10.19 (1) extend the implementation timetable of the existing performance improvement plan;

10.20 (2) approve amendments to the performance improvement plan as proposed by the health  
10.21 care entity;

10.22 (3) require the health care entity to submit a new performance improvement plan; or

10.23 (4) waive or delay the requirement to file any additional performance improvement  
10.24 plans.

10.25 Upon the successful completion of the performance improvement plan, the board shall  
10.26 remove the identity of the health care entity from the board's website. The board may assist  
10.27 health care entities with implementing the performance improvement plans or otherwise  
10.28 ensure compliance with this subdivision.

10.29 (g) If the board determines that a health care entity has:

10.30 (1) willfully neglected to file a performance improvement plan with the board within  
10.31 45 days as required;

10.32 (2) failed to file an acceptable performance improvement plan in good faith with the  
10.33 board;

11.1 (3) failed to implement the performance improvement plan in good faith; or  
 11.2 (4) knowingly failed to provide information required by this subdivision to the board or  
 11.3 knowingly provided false information, the board may assess a civil penalty to the health  
 11.4 care entity of not more than \$500,000. The board shall only impose a civil penalty as a last  
 11.5 resort.

11.6 **Sec. 7. [62J.92] REPORTING REQUIREMENTS.**

11.7 Subdivision 1. **General requirement.** (a) The board shall present the reports required  
 11.8 by this section to the chairs and ranking members of the legislative committees with primary  
 11.9 jurisdiction over health care finance and policy. The board shall also make these reports  
 11.10 available to the public on the board's website.

11.11 (b) The board may contract with a third-party vendor for technical assistance in preparing  
 11.12 the reports.

11.13 Subd. 2. **Progress reports.** The board shall submit written progress updates about the  
 11.14 development and implementation of the health care spending growth target program by  
 11.15 February 15, 2025, and February 15, 2026. The updates must include reporting on board  
 11.16 membership and activities, program design decisions, planned timelines for implementation  
 11.17 of the program, and the progress of implementation. The reports must include the  
 11.18 methodological details underlying program design decisions.

11.19 Subd. 3. **Health care spending trends.** By December 15, 2025, and every December  
 11.20 15 thereafter, the board shall submit a report on health care spending trends and the health  
 11.21 care spending growth target program that includes:

11.22 (1) spending growth in aggregate and for entities subject to health care spending growth  
 11.23 targets relative to established target levels;

11.24 (2) findings from analyses of drivers of health care spending growth;

11.25 (3) estimates of the impact of health care spending growth on Minnesota residents,  
 11.26 including for communities most impacted by health disparities, related to their access to  
 11.27 insurance and care, value of health care, and the ability to pursue other spending priorities;

11.28 (4) the potential and observed impact of the health care growth targets on the financial  
 11.29 viability of the rural delivery system;

11.30 (5) changes under consideration for revising the methodology to monitor or set growth  
 11.31 targets;

12.1 (6) recommendations for initiatives to assist health care entities in meeting health care  
 12.2 spending growth targets, including broader and more transparent adoption of value-based  
 12.3 payment arrangements; and

12.4 (7) the number of health care entities whose spending growth exceeded growth targets,  
 12.5 information on performance improvement plans and the extent to which the plans were  
 12.6 completed, and any civil penalties imposed on health care entities related to noncompliance  
 12.7 with performance improvement plans and related requirements.

12.8 Sec. 8. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

12.9 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision  
 12.10 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's  
 12.11 designee shall only use the data submitted under subdivisions 4 and 5 for the following  
 12.12 purposes:

12.13 (1) to evaluate the performance of the health care home program as authorized under  
 12.14 section 62U.03, subdivision 7;

12.15 (2) to study, in collaboration with the reducing avoidable readmissions effectively  
 12.16 (RARE) campaign, hospital readmission trends and rates;

12.17 (3) to analyze variations in health care costs, quality, utilization, and illness burden based  
 12.18 on geographical areas or populations;

12.19 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments  
 12.20 of Health and Human Services, including the analysis of health care cost, quality, and  
 12.21 utilization baseline and trend information for targeted populations and communities; ~~and~~

12.22 (5) to compile one or more public use files of summary data or tables that must:

12.23 (i) be available to the public for no or minimal cost by March 1, 2016, and available by  
 12.24 web-based electronic data download by June 30, 2019;

12.25 (ii) not identify individual patients, payers, or providers;

12.26 (iii) be updated by the commissioner, at least annually, with the most current data  
 12.27 available;

12.28 (iv) contain clear and conspicuous explanations of the characteristics of the data, such  
 12.29 as the dates of the data contained in the files, the absence of costs of care for uninsured  
 12.30 patients or nonresidents, and other disclaimers that provide appropriate context; and

13.1 (v) not lead to the collection of additional data elements beyond what is authorized under  
 13.2 this section as of June 30, 2015; and

13.3 (6) to provide technical assistance to the Health Care Affordability Board to implement  
 13.4 sections 62J.86 to 62J.92.

13.5 (b) The commissioner may publish the results of the authorized uses identified in  
 13.6 paragraph (a) so long as the data released publicly do not contain information or descriptions  
 13.7 in which the identity of individual hospitals, clinics, or other providers may be discerned.

13.8 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from  
 13.9 using the data collected under subdivision 4 to complete the state-based risk adjustment  
 13.10 system assessment due to the legislature on October 1, 2015.

13.11 (d) The commissioner or the commissioner's designee may use the data submitted under  
 13.12 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,  
 13.13 2023.

13.14 (e) The commissioner shall consult with the all-payer claims database work group  
 13.15 established under subdivision 12 regarding the technical considerations necessary to create  
 13.16 the public use files of summary data described in paragraph (a), clause (5).

13.17 **Sec. 9. RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

13.18 (a) The commissioners of human services, health, and commerce and the MNsure board  
 13.19 shall submit to the health care affordability board and the chairs and ranking minority  
 13.20 members of the legislative committees with primary jurisdiction over health and human  
 13.21 services finance and policy and commerce by January 15, 2024, a report on the organization  
 13.22 and duties of the Office of Patient Protection, to be established under Minnesota Statutes,  
 13.23 section 62J.89, subdivision 4. The report must include recommendations on how the office  
 13.24 shall:

13.25 (1) coordinate or consolidate within the office existing state agency patient protection  
 13.26 activities, including but not limited to the activities of ombudsman offices and the MNsure  
 13.27 board;

13.28 (2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for  
 13.29 utilization review organizations;

13.30 (3) work with private sector and state agency consumer assistance programs to assist  
 13.31 consumers with questions or concerns relating to public programs and private insurance  
 13.32 coverage;

14.1 (4) establish and implement procedures to assist consumers aggrieved by restrictions on  
 14.2 patient choice, denials of services, and reductions in quality of care resulting from any final  
 14.3 action by a payer or provider; and

14.4 (5) make health plan company quality of care and patient satisfaction information and  
 14.5 other information collected by the office readily accessible to consumers on the board's  
 14.6 website.

14.7 (b) The commissioners and the MNsure board shall consult with stakeholders as they  
 14.8 develop the recommendations. The stakeholders consulted must include but are not limited  
 14.9 to organizations and individuals representing: underserved communities; persons with  
 14.10 disabilities; low-income Minnesotans; senior citizens; and public and private sector health  
 14.11 plan enrollees, including persons who purchase coverage through MNsure, health plan  
 14.12 companies, and public and private sector purchasers of health coverage.

14.13 (c) The commissioners and the MNsure board may contract with a third party to develop  
 14.14 the report and recommendations.

14.15 Sec. 10. **TRANSFER OF FUNDS.**

14.16 Subdivision 1. **Health Care Affordability Board.** \$..... in fiscal year 2024 and \$.....  
 14.17 in fiscal year 2025 are transferred from the appropriation to extend the Minnesota premium  
 14.18 security plan under Minnesota Statutes, section 62E.23, to the Health Care Affordability  
 14.19 Board to implement this act.

14.20 Subd. 2. **Commissioner of health.** \$..... in fiscal year 2024 and \$..... in fiscal year  
 14.21 2025 are transferred from the appropriation to extend the Minnesota premium security plan  
 14.22 under Minnesota Statutes, section 62E.23, to the commissioner of health to fund activities  
 14.23 of the Health Economics Division necessary to implement this act.