SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 4419

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/12/2026	6670	Introduction and first reading Referred to Health and Human Services
03/23/2026	6870a	Comm report: To pass as amended and re-refer to Commerce and Consumer Protection
04/07/2026		Comm report: To pass as amended and re-refer to Health and Human Services

A bill for an act

relating to health; making changes to provisions covering prescription drug prior authorizations, transactions with group purchasers, prescription drug price transparency, health maintenance organizations, network design, coverage for immunizations, and obsolete language; amending Minnesota Statutes 2024, sections 62D.02, subdivision 7, by adding a subdivision; 62D.08, subdivisions 5, 6; 62D.09, subdivisions 1, 5; 62D.124, subdivision 6; 62J.17, subdivision 6a; 62J.2930, subdivision 1; 62J.497, subdivision 5; 62J.536, subdivision 2a; 62K.02, subdivision 2; 62K.03, subdivision 6; 62K.075; 62K.105; 62K.14; 62M.07, subdivision 2; 62Q.46, subdivision 1; 144.293, subdivision 7; Minnesota Statutes 2025 Supplement, sections 3.732, subdivision 1; 62J.84, subdivisions 2, 3, 10, 11, 12, 13, 14; 62K.10, subdivision 2; repealing Minnesota Statutes 2024, sections 13D.08, subdivision 4; 62D.08, subdivision 7; 62D.181; 62J.06; 62J.156; 62J.2930, subdivision 4; 62J.57.

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

ARTICLE 1
HEALTH INSURANCE

Section 1. Minnesota Statutes 2024, section 62J.497, subdivision 5, is amended to read:

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards,

if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, 2016, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

(d) Starting January 1, 2027, providers and group purchasers must exchange prescription drug prior authorization request transactions electronically using the NCPDP SCRIPT Standard.

Sec. 2. Minnesota Statutes 2024, section 62J.536, subdivision 2a, is amended to read:

Subd. 2a. **Group purchasers not covered by HIPAA.** ~~For transactions with~~ Group purchasers defined in section 62J.03, subdivision 6, that are not covered under United States Code, title 42, sections 1320d to 1320d-8, ~~the requirements of this section are modified as follows:~~ are exempt from the requirements of subdivision 1, paragraphs (a) and (b), to accept and transmit the eligibility for a health plan transaction described in Code of Federal Regulations, title 45, part 162, subpart L.

~~(1) The group purchasers may be exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1 if the commissioner of health determines that:~~

~~(i) a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or~~

~~(ii) another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.~~

~~(2) If group purchasers are exempt from one or more of the requirements to exchange claims and eligibility information electronically using the transactions, companion guides, implementation guides, and timelines in subdivision 1, providers shall also be exempt from exchanging those transactions with the group purchaser.~~

~~(3) If the commissioner of health exempts a group purchaser from one or more of the requirements because a transaction is incapable of exchanging data that are currently being exchanged on paper and are necessary to accomplish the purpose of the transaction, the commissioner shall review that exemption annually. If the commissioner determines that the exemption is no longer necessary or appropriate, the commissioner of health shall adopt~~

~~rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph (e). Group purchasers and providers shall have 12 months to implement any rules adopted.~~

~~(4) If the commissioner of health exempts a group purchaser from one or more of the requirements because another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction, the commissioner shall adopt rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the national electronic transaction standard. Group purchasers and providers shall have 12 months to implement any rules adopted.~~

~~(5) The requirement of paper claims attachments shall not indicate that a health care claims or equivalent encounter information transaction described under Code of Federal Regulations, title 45, part 162, subpart K, is incapable of exchanging data that are currently being exchanged on paper provided that the electronic health care claims transaction has a mechanism to link the paper attachments to the electronic claim.~~

Providers exchanging transactions with exempt group purchasers are exempt from the requirements in subdivision 1, paragraphs (a) and (b), to accept and transmit the eligibility for a health plan transaction described in Code of Federal Regulations, title 45, part 162, subpart L.

Sec. 3. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics license application approved under United States Code, title 42, section 262(K)(3).

(c) "Brand name drug" means a drug that is produced or distributed pursuant to:

(1) a new drug application approved under United States Code, title 21, section 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42, section 447.502; or

(2) a biologics license application approved under United States Code, title 42, section 262(a)(c).

(d) "Commissioner" means the commissioner of health.

(e) "Generic drug" means a drug that is marketed or distributed pursuant to:

(1) an abbreviated new drug application approved under United States Code, title 21, section 355(j);

(2) an authorized generic as defined under Code of Federal Regulations, title 42, section 447.502; or

(3) a drug that entered the market the year before 1962 and was not originally marketed under a new drug application.

(f) "Manufacturer" means:

(1) a drug manufacturer licensed under section 151.252.; or

(2) an entity that sets the wholesale acquisition cost for prescription drugs that are distributed in Minnesota.

(g) "New prescription drug" or "new drug" means a prescription drug approved for marketing by the United States Food and Drug Administration (FDA) for which no previous wholesale acquisition cost has been established for comparison.

(h) "Patient assistance program" means a program that a manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

(i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision 8.

(j) "Price" means the wholesale acquisition cost as defined in United States Code, title 42, section 1395w-3a(c)(6)(B).

(k) "30-day supply" means the total daily dosage units of a prescription drug recommended by the prescribing label approved by the FDA for 30 days. If the FDA-approved prescribing label includes more than one recommended daily dosage, the 30-day supply is based on the maximum recommended daily dosage on the FDA-approved prescribing label.

(l) "Course of treatment" means the total dosage of a single prescription for a prescription drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing label includes more than one recommended dosage for a single course of treatment, the course of treatment is the maximum recommended dosage on the FDA-approved prescribing label.

(m) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

(n) "National drug code" means the three-segment code maintained by the federal Food and Drug Administration that includes a labeler code, a product code, and a package code for a drug product and that has been converted to an 11-digit format consisting of five digits in the first segment, four digits in the second segment, and two digits in the third segment. A three-segment code shall be considered converted to an 11-digit format when, as necessary, at least one "0" has been added to the front of each segment containing less than the specified number of digits such that each segment contains the specified number of digits.

(o) "Pharmacy" or "pharmacy provider" means a community/outpatient pharmacy as defined in Minnesota Rules, part 6800.0100, subpart 2, that is also licensed as a pharmacy by the Board of Pharmacy under section 151.19.

(p) "Pharmacy benefit manager" or "PBM" means an entity licensed to act as a pharmacy benefit manager under section 62W.03.

(q) "Pricing unit" means the ~~smallest dispensable amount of a prescription drug product that could be dispensed or administered~~ standard unit of measure, such as milliliter, gram, or each, of a prescription drug product.

(r) "Rebate" means a discount, chargeback, or other price concession that affects the price of a prescription drug product, regardless of whether conferred through regular aggregate payments, on a claim-by-claim basis at the point of sale, as part of retrospective financial reconciliations, including reconciliations that also reflect other contractual arrangements, or by any other method. Rebate does not mean a bona fide service fee as defined in Code of Federal Regulations, title 42, section 447.502.

(s) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefit manager, wholesale drug distributor, or any other entity required to submit data under this section.

(t) "Wholesale drug distributor" or "wholesaler" means an entity that is licensed to act as a wholesale drug distributor under section 151.47.

Sec. 4. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 3, is amended to read:

Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022, a drug manufacturer must submit to the commissioner the information described in paragraph (b) for each prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for brand name drugs where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in the price over the previous 24-month period; and

(2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the price increase goes into effect, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the description and price of the drug and the net increase, expressed as a percentage, with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the year the prescription drug was introduced for sale in the United States;

(5) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

(6) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(7) the number of units of the prescription drug sold during the previous 12-month period;

(8) the total sales revenue for the prescription drug during the previous 12-month period;

(9) the total rebate payable amount accrued for the prescription drug during the previous 12-month period;

(10) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

(11) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the previous 12-month period, if applicable;

(12) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(13) the patent expiration date of the prescription drug if it is under patent;

(14) the name and location of the company that manufactured the drug;

(15) if a brand name prescription drug, the highest ~~price~~ amount paid for a drug product with the same generic drug description or nontrade name, dosage form, strength, and, where available, package size of the prescription drug during the previous calendar year in the ten countries, excluding the United States, that charged the highest single ~~price~~ amount for the prescription drug~~; and~~. Where a package size equivalent is not available, the value provided should represent the amount paid per unit of measure of the drug product multiplied by the total package size in the United States of the prescription drug reported;

(16) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 5. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 10, is amended to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2024, and up to quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the commissioner determines to represent a substantial public interest and for which the commissioner intends to request data under subdivisions 11 to 14, subject to paragraph (c). The commissioner shall base its

inclusion of prescription drugs on any information the commissioner determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the commissioner shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment process.

(b) Not sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via email, reporting entities registered with the department of:

(1) the requirement to report under subdivisions 11 to 14; and

(2) the reporting period for which data must be provided.

(c) The commissioner must not designate more than 500 prescription drugs as having a substantial public interest in any one notice.

(d) Notwithstanding subdivision 16, the commissioner is exempt from chapter 14, including section 14.386, in implementing this subdivision.

Sec. 6. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 11, is amended to read:

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivision 3 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the year the prescription drug was introduced for sale in the United States;

(5) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(6) the direct costs incurred during the reporting period specified in the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(7) the number of units of the prescription drug sold during the reporting period specified in the notification to report;

(8) the total sales revenue for the prescription drug during the reporting period specified in the notification to report;

(9) the total rebate payable amount accrued for the prescription drug during the reporting period specified in the notification to report;

(10) the manufacturer's net profit attributable to the prescription drug during the reporting period specified in the notification to report;

(11) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the reporting period specified in the notification to report, if applicable;

(12) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(13) the patent expiration date of the prescription drug if the prescription drug is under patent;

(14) the name and location of the company that manufactured the drug;

(15) if the prescription drug is a brand name prescription drug, the ten countries other than the United States that paid the highest ~~prices~~ amounts for a drug product with the same generic drug description or nontrade name, dosage form, strength, and, where available, package size of the prescription drug during the previous calendar year and their ~~prices~~ amounts. Where a package size equivalent is not available, the value provided should represent the amount paid per unit of measure of the drug product multiplied by the total package size in the United States of the prescription drug reported; and

(16) if the prescription drug was acquired by the manufacturer within the reporting period specified in the notification to report, all of the following information:

(i) the price at acquisition;

(ii) the price in the calendar year prior to acquisition;

(iii) the name of the company from which the drug was acquired;

(iv) the date of acquisition; and

(v) the acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 7. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 12, is amended to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the pharmacy by the department under subdivision 10; and

(2) that the pharmacy dispensed in Minnesota or mailed to a Minnesota address.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug acquired during the reporting period specified in the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the reporting period specified in the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the reporting period specified in the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug including ingredient cost, dispensing fee, and administrative fees during the reporting period specified in the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the reporting period specified in the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the reporting period specified in the notification to report.

(c) The pharmacy may submit any documentation necessary to support the information reported under this subdivision.

(d) The commissioner may grant extensions, exemptions, or both to compliance with the requirements of paragraphs (a) and (b) by small or independent pharmacies, if compliance with paragraphs (a) and (b) would represent a hardship or undue burden to the pharmacy. The commissioner may establish procedures for small or independent pharmacies to request extensions or exemptions under this paragraph.

Sec. 8. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 13, is amended to read:

Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a PBM must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the PBM by the department under subdivision 10; and

(2) for which the PBM fulfilled pharmacy benefit management duties for Minnesota residents.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of pricing units of the drug product filled during the reporting period specified in the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled during the reporting period specified in the notification to report;

(4) the total reimbursement amount accrued and receivable from payers for pricing units of the drug product filled during the reporting period specified in the notification to report;

(5) the total administrative fee amount accrued and receivable from payers for pricing units of the drug product filled during the reporting period specified in the notification to report;

(6) the total rebate receivable amount accrued by the PBM for the drug product during the reporting period specified in the notification to report; ~~and~~

(7) the total rebate payable amount accrued by the PBM for the drug product during the reporting period specified in the notification to report~~.~~;

(8) the name of any entity, including but not limited to a group purchasing organization, that the PBM contracts with or owns, in part or in full, that negotiates rebates for the drug product during the reporting period specified in the notification to report;

(9) the total amount accrued and receivable from all organizations reported under clause (8) for the drug product during the reporting period specified in the notification to report; and

(10) of the amount reported under clause (9), the percentage that is accrued and payable to health plan companies or other entities for the drug product during the reporting period specified in the notification to report.

(c) The PBM may submit any documentation necessary to support the information reported under this subdivision.

Sec. 9. Minnesota Statutes 2025 Supplement, section 62J.84, subdivision 14, is amended to read:

Subd. 14. **Wholesale drug distributor prescription drug substantial public interest reporting.** (a) Beginning January 1, 2024, a wholesale drug distributor that distributes prescription drugs, for which it is not the manufacturer, to persons or entities, or both, other than a consumer or patient in the state, must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the wholesale drug distributor by the department under subdivision 10; and

(2) that the wholesale drug distributor distributed within or into Minnesota.

(b) For each of the drugs described in paragraph (a), the wholesale drug distributor shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the reporting period specified in the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the reporting period specified in the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the reporting period specified in the notification to report;

(6) the gross revenue from sales in the United States generated by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report; ~~and~~

(7) the total rebate payable amount accrued by the wholesale drug distributor for the drug product during the reporting period specified in the notification to report~~.~~;

(8) the name of any entity, including but not limited to a group purchasing organization that the wholesaler contracts with or owns, in part or in full, that negotiates rebates for the drug product during the reporting period specified in the notification to report;

(9) the total receivable amount accrued from all organizations reported under clause (8) for the drug product during the reporting period specified in the notification to report; and

(10) of the amount reported under clause (9), the percentage that is accrued and payable to other entities for the drug product during the reporting period specified in the notification to report.

(c) The wholesale drug distributor may submit any documentation necessary to support the information reported under this subdivision.

ARTICLE 2
HMO REGULATION

Section 1. Minnesota Statutes 2024, section 62D.02, subdivision 7, is amended to read:

Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health maintenance services" means a set of comprehensive health services which the enrollees might reasonably require to be maintained in good health including as a minimum, but not limited to, emergency care, emergency ground ambulance transportation services, inpatient hospital and physician care, outpatient health services and preventive ~~health~~ items and services.

Sec. 2. Minnesota Statutes 2024, section 62D.02, is amended by adding a subdivision to read:

Subd. 18. **Service area.** "Service area" means the geographic locations in which the health maintenance organization is approved by the commissioner to sell its health maintenance organization products. Geographic locations shall be identified according to recognized political subdivisions such as cities, counties, and townships.

Sec. 3. Minnesota Statutes 2024, section 62D.08, subdivision 5, is amended to read:

Subd. 5. **Changes in participating entities; penalty.** Any cancellation or discontinuance of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed subsequently in accordance with this subdivision, shall be reported to the commissioner 120 days before the effective date. When the health maintenance organization terminates a ~~provider~~ participating entity for cause, death, disability, or loss of license, the health maintenance organization must notify the commissioner within ten working days of the date the health maintenance organization sends out or receives the notice of cancellation, discontinuance, or termination. Any health maintenance organization which fails to notify the commissioner within the time periods prescribed in this subdivision shall be subject to the levy of a fine up to $200 per contract for each day the notice is past due, accruing up to the date the organization notifies the commissioner of the cancellation or discontinuance. Any fine levied under this subdivision is subject to the contested case and judicial review provisions of chapter 14. The levy of a fine does not preclude the commissioner from using other penalties described in sections 62D.15 to 62D.17.

Sec. 4. Minnesota Statutes 2024, section 62D.08, subdivision 6, is amended to read:

Subd. 6. **Quarterly financial statements.** (a) A health maintenance organization shall submit to the commissioner unaudited financial statements of the organization for the first three quarters of the year on forms prescribed by the commissioner. The statements are due 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall be submitted at the request of the commissioner.

(b) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(c) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

Sec. 5. Minnesota Statutes 2024, section 62D.09, subdivision 1, is amended to read:

Subdivision 1. **Marketing requirements.** (a) Any written marketing materials which may be directed toward potential enrollees and which include a detailed description of benefits provided by the health maintenance organization shall include a statement of enrollee information and rights as described in section 62D.07, subdivision 3, clauses (2) and (3). Prior to any oral marketing presentation, the agent marketing the plan must inform the potential enrollees that any complaints concerning the material presented should be directed to the health maintenance organization, the commissioner of health, or, if applicable, the employer.

(b) Detailed marketing materials must affirmatively disclose all exclusions and limitations in the organization's services or kinds of services offered to the contracting party, including but not limited to the following types of exclusions and limitations:

(1) health care services not provided;

(2) health care services requiring co-payments or deductibles paid by enrollees;

(3) the fact that access to health care services does not guarantee access to a particular provider or provider type; and

(4) health care services that are or may be provided only by referral of a physician, advanced practice registered nurse, or physician assistant.

(c) No marketing materials may lead consumers to believe that all health care needs will be covered. All marketing materials must alert consumers to possible uncovered expenses with the following language in bold print: "THIS HEALTH CARE PLAN MAY NOT COVER ALL YOUR HEALTH CARE EXPENSES; READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH EXPENSES ARE COVERED." Immediately following the disclosure required under paragraph (b), clause (3), consumers must be given a telephone number to use to contact the health maintenance organization for specific information about access to provider types.

(d) The disclosures required in paragraphs (b) and (c) are not required on billboards or image, and name identification advertisement.

Sec. 6. Minnesota Statutes 2024, section 62D.09, subdivision 5, is amended to read:

Subd. 5. **Participating providers.** (a) Health maintenance organizations shall ~~provide enrollees with a list of the names and locations of participating providers to whom enrollees have direct access without referral no later than the effective date of enrollment or date the evidence of coverage is issued and upon request~~ publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to enrollees and potential enrollees. Health maintenance organizations need not provide the names of their employed providers.

(b) Upon request, a health maintenance organization shall provide a hard copy of the provider directory to enrollees or potential enrollees.

Sec. 7. Minnesota Statutes 2024, section 62D.124, subdivision 6, is amended to read:

Subd. 6. **Provider network notifications.** (a) A health maintenance organization must provide on the organization's website the provider network for each product offered by the organization, and must update the organization's website at least once a month with any changes to the organization's provider network, including provider changes from in-network status to out-of-network status. A health maintenance organization must also provide on the organization's website, for each product offered by the organization, a list of the current waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health maintenance organization must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a), unless the health maintenance organization notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health maintenance organization is able to verify that the health maintenance organization's website displayed the correct provider network status on the health maintenance organization's website at the time the service was provided.

Sec. 8. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber the section of Minnesota Statutes listed in column A with the number listed in column B. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

Column A	Column B
62Q.075	62D.081

Sec. 9. **REPEALER.**

Minnesota Statutes 2024, sections 62D.08, subdivision 7; and 62D.181, are repealed.

ARTICLE 3
HEALTH SERVICES

Section 1. Minnesota Statutes 2024, section 62K.02, subdivision 2, is amended to read:

Subd. 2. **Scope.** (a) This chapter applies only to health plans offered in the individual market or the small group market, including stand-alone dental plans.

(b) This chapter applies to health carriers with respect to individual health plans and small group health plans, unless otherwise specified.

(c) If a health carrier issues or renews individual or small group health plans in other states, this chapter applies only to health plans issued or renewed in this state to a Minnesota resident, or to cover a resident of the state, or issued or renewed to a small employer that is actively engaged in business in this state, unless otherwise specified.

(d) This chapter does not apply to short-term coverage as defined in section 62A.65, subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision 1b.

Sec. 2. Minnesota Statutes 2024, section 62K.03, subdivision 6, is amended to read:

Subd. 6. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes stand-alone dental plans.

Sec. 3. Minnesota Statutes 2024, section 62K.075, is amended to read:

62K.075 PROVIDER NETWORK NOTIFICATIONS.

(a) A health carrier must provide on the carrier's website the provider network for each product offered by the carrier, and must update the carrier's website at least once a month with any changes to the carrier's provider network, including provider changes from in-network status to out-of-network status. A health carrier must also provide on the carrier's website, for each product offered by the carrier, a list of the current waivers of the requirements in section 62K.10, subdivision 2 ~~or 3~~, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health carrier must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a) unless the health carrier notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health carrier is able to verify that the health carrier's website displayed the correct provider network status on the health carrier's website at the time the service was provided.

(c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required by paragraph (b).

Sec. 4. Minnesota Statutes 2025 Supplement, section 62K.10, subdivision 2, is amended to read:

Subd. 2. **Time and distance standards.** Health carriers must meet the time and distance standards under Code of Federal Regulations, title 45, section 155.1050, for all covered health services, including dental, retail pharmacy, and specialty services.

Sec. 5. Minnesota Statutes 2024, section 62K.105, is amended to read:

62K.105 NETWORK ADEQUACY COMPLAINTS.

The commissioner of health shall establish a clear, easily accessible process for accepting complaints from enrollees regarding health carrier compliance with section 62K.10,

subdivision 2~~, 3,~~ or 4. Using this process, an enrollee may file a complaint with the commissioner that a health carrier is not in compliance with the requirements of section 62K.10, subdivision 2~~, 3,~~ or 4. The commissioner of health shall investigate all complaints received under this section.

Sec. 6. Minnesota Statutes 2024, section 62K.14, is amended to read:

62K.14 LIMITED-SCOPE PEDIATRIC DENTAL PLANS.

(a) Limited-scope pediatric dental plans must be offered to the extent permitted under the Affordable Care Act: (1) on a guaranteed issue and guaranteed renewable basis; (2) with premiums rated on allowable rating factors used for health plans; and (3) without any exclusions or limitations based on preexisting conditions.

(b) Notwithstanding paragraph (a), a health carrier may discontinue a limited scope pediatric dental plan at the end of a plan year if the health carrier provides written notice to enrollees before coverage is to be discontinued that the particular plan is being discontinued and the health carrier offers enrollees other dental plan options that are the same or substantially similar to the dental plan being discontinued in terms of premiums, benefits, cost-sharing requirements, and network adequacy. The written notice to enrollees must be provided at least 105 days before the end of the plan year.

~~(c) Limited-scope pediatric dental plans must ensure primary care dental services are available within 60 miles or 60 minutes' travel time.~~

~~(d)~~ (c) If a stand-alone dental plan as defined under the Affordable Care Act or a limited-scope pediatric dental plan is offered, either separately or in conjunction with a health plan offered to individuals or small employers, the health plan shall not be considered in noncompliance with the requirements of the essential benefit package in the Affordable Care Act because the health plan does not offer coverage of pediatric dental benefits if these benefits are covered through the stand-alone or limited-scope pediatric dental plan, to the extent permitted under the Affordable Care Act.

~~(e)~~ (d) Health carriers offering limited-scope pediatric dental plans must comply with this section and sections 62K.07, 62K.08, 62K.10, 62K.13, and 62K.15.

~~(f)~~ (e) The commissioner of commerce shall enforce paragraphs (a) and (b). Any limited-scope pediatric dental plan that is to be offered to replace a discontinued dental plan under paragraph (b) must be approved by the commissioner of commerce in terms of cost and benefit similarity, and the commissioner of health in terms of network adequacy similarity. ~~The commissioner of health shall enforce paragraph (c).~~

Sec. 7. Minnesota Statutes 2024, section 62M.07, subdivision 2, is amended to read:

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

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

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

(3) antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network, except for treatment which is a medication. Prior authorizations required for medications used for antineoplastic cancer treatment must be processed according to section 62M.05, subdivision 3b, for initial determinations, and according to section 62M.06, subdivision 2, for appeals;

(4) services that currently have a rating of A or B from the United States Preventive Services Task Force, immunizations ~~recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention~~ required to be covered under section 62Q.46, or preventive services and screenings provided to women as described in Code of Federal Regulations, title 45, section 147.130;

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

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

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

Sec. 8. Minnesota Statutes 2024, section 62Q.46, subdivision 1, is amended to read:

Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and services" has the meaning specified in the Affordable Care Act. Preventive items and services includes:

(1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;

(2) immunizations for routine use in children, adolescents, and adults that have in effect at least one of the following:

(i) a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this ~~clause~~ item, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after the recommendation has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if the recommendation is listed on the Immunization Schedules of the Centers for Disease Control and Prevention; or

(ii) a recommendation from at least one of the following organizations: the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Academy of Family Physicians, or the Infectious Disease Society of America. This item does not apply to managed care organizations or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L;

(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(4) with respect to women, additional preventive care and screenings that are not listed with a rating of A or B by the United States Preventive Services Task Force but that are provided for in comprehensive guidelines supported by the Health Resources and Services Administration;

(5) all contraceptive methods established in guidelines published by the United States Food and Drug Administration;

(6) screenings for human immunodeficiency virus for:

(i) all individuals at least 15 years of age but less than 65 years of age; and

(ii) all other individuals with increased risk of human immunodeficiency virus infection according to guidance from the Centers for Disease Control;

(7) all preexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention of HIV Infection United States Preventive Services Task Force Recommendation Statement; and

(8) all postexposure prophylaxis when used for the prevention or treatment of human immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined in any guidance by the United States Preventive Services Task Force or the Centers for Disease Control.

(b) A health plan company must provide coverage for preventive items and services at a participating provider without imposing cost-sharing requirements, including a deductible, coinsurance, or co-payment. Nothing in this section prohibits a health plan company that has a network of providers from excluding coverage or imposing cost-sharing requirements for preventive items or services that are delivered by an out-of-network provider.

(c) A health plan company is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph (a) if the recommendation or guideline is no longer included as a preventive item or service as defined in paragraph (a). Annually, a health plan company must determine whether any additional items or services must be covered without cost-sharing requirements or whether any items or services are no longer required to be covered.

(d) Nothing in this section prevents a health plan company from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent not specified in the recommendation or guideline.

(e) A health plan shall not require prior authorization or step therapy for preexposure prophylaxis or postexposure prophylaxis, except that: if the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of HIV, this paragraph does not require a health plan to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(f) This section does not apply to grandfathered plans.

(g) This section does not apply to plans offered by the Minnesota Comprehensive Health Association.

ARTICLE 4
OBSOLETE LANGUAGE AMENDMENTS

Section 1. Minnesota Statutes 2025 Supplement, section 3.732, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** As used in this section and section 3.736 the terms defined in this section have the meanings given them.

(1) "State" includes each of the departments, boards, agencies, commissions, courts, and officers in the executive, legislative, and judicial branches of the state of Minnesota and includes but is not limited to the Housing Finance Agency, the Minnesota Office of Higher Education, the Health and Education Facilities Authority, ~~the Health Technology Advisory Committee,~~ the Armory Building Commission, the Zoological Board, the Department of Iron Range Resources and Rehabilitation, the Minnesota Historical Society, the State Agricultural Society, the University of Minnesota, the Minnesota State Colleges and Universities, state hospitals, and state penal institutions. It does not include a city, town, county, school district, or other local governmental body corporate and politic.

(2) "Employee of the state" means all present or former officers, members, directors, or employees of the state, members of the Minnesota National Guard, members of a bomb disposal unit approved by the commissioner of public safety and employed by a municipality defined in section 466.01 when engaged in the disposal or neutralization of bombs or other similar hazardous explosives, as defined in section 299C.063, outside the jurisdiction of the municipality but within the state, or persons acting on behalf of the state in an official capacity, temporarily or permanently, with or without compensation. It does not include either an independent contractor except, for purposes of this section and section 3.736 only, a guardian ad litem acting under court appointment, or members of the Minnesota National Guard while engaged in training or duty under United States Code, title 10, or title 32, section 316, 502, 503, 504, or 505, as amended through December 31, 1983. Notwithstanding sections 43A.02 and 611.263, for purposes of this section and section 3.736 only, "employee of the state" includes a district public defender or assistant district public defender in the Second or Fourth Judicial District~~, a member of the Health Technology Advisory Committee,~~

and any officer, agent, or employee of the state of Wisconsin performing work for the state of Minnesota pursuant to a joint state initiative.

(3) "Scope of office or employment" means that the employee was acting on behalf of the state in the performance of duties or tasks lawfully assigned by competent authority.

(4) "Judicial branch" has the meaning given in section 43A.02, subdivision 25.

Sec. 2. Minnesota Statutes 2024, section 62J.17, subdivision 6a, is amended to read:

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7.

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. ~~At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner.~~ The commissioner shall make a decision on the application within 60 days after an application is received.

(d) The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Sec. 3. Minnesota Statutes 2024, section 62J.2930, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The commissioner of health shall establish an information clearinghouse within the Department of Health to facilitate the ability of consumers, employers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the Department of Health on cost containment or other research initiatives, the development of voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of ~~the Health Technology Advisory Committee and other~~ entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Sec. 4. Minnesota Statutes 2024, section 144.293, subdivision 7, is amended to read:

Subd. 7. **Exception to consent.** Subdivision 2 does not apply to the release of health records to the commissioner of health ~~or the Health Data Institute under chapter 62J~~, provided that the commissioner encrypts the patient identifier upon receipt of the data.

Sec. 5. **REPEALER.**

Minnesota Statutes 2024, sections 13D.08, subdivision 4; 62J.06; 62J.156; 62J.2930, subdivision 4; and 62J.57, are repealed.

APPENDIX
Article locations for S4419-2

13D.08 OPEN MEETING LAW CODED ELSEWHERE.

Subd. 4. **Health Technology Advisory Committee.** Certain meetings of the Health Technology Advisory Committee are governed by section 62J.156.

62D.08 ANNUAL REPORT.

Subd. 7. **Consistent administrative expenses and investment income reporting.** (a) Every health maintenance organization must directly allocate administrative expenses to specific lines of business or products when such information is available. Remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. Health maintenance organizations must submit this information, including administrative expenses for dental services, using the reporting template provided by the commissioner of health.

(b) Every health maintenance organization must allocate investment income based on cumulative net income over time by business line or product and must submit this information, including investment income for dental services, using the reporting template provided by the commissioner of health.

62D.181 INSOLVENCY; MCHA ALTERNATIVE COVERAGE.

Subdivision 1. **Definition.** "Association" means the Minnesota Comprehensive Health Association created in section 62E.10.

Subd. 2. **Eligible individuals.** An individual is eligible for alternative coverage under this section if:

(1) the individual had individual health coverage through a health maintenance organization or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization or community integrated service network, and the individual has not obtained alternative coverage; or

(2) the individual had group health coverage through a health maintenance organization or community integrated service network, the coverage is no longer available due to the insolvency of the health maintenance organization or community integrated service network, and the individual has not obtained alternative coverage.

Subd. 3. **Application and issuance.** If a health maintenance organization or community integrated service network will be liquidated, individuals eligible for alternative coverage under subdivision 2 may apply to the association to obtain alternative coverage. Upon receiving an application and evidence that the applicant was enrolled in the health maintenance organization or community integrated service network at the time of an order for liquidation, the association shall issue policies to eligible individuals, without the limitation on preexisting conditions described in section 62E.14, subdivision 3.

Subd. 4. **Coverage.** Alternative coverage issued under this section must be at least a number two qualified plan, as described in section 62E.06, subdivision 2, or for individuals over age 65, a basic Medicare supplement plan, as described in section 62A.316.

Subd. 5. **Premium.** The premium for alternative coverage issued under this section must not exceed 80 percent of the premium for the comparable coverage offered by the association.

Subd. 6. **Duration.** The duration of alternative coverage issued under this section is:

(1) for individuals eligible under subdivision 2, clause (1), 90 days; and

(2) for individuals eligible under subdivision 2, clause (2), 90 days or the length of time remaining in the group contract with the insolvent health maintenance organization or community integrated service network, whichever is greater.

Subd. 7. **Replacement coverage; limitations.** The association is not obligated to offer replacement coverage under this chapter at the end of the periods specified in subdivision 6. Any continuation obligation arising under this chapter or chapter 62A will cease at the end of the periods specified in subdivision 6.

Subd. 8. **Claims expenses exceeding premiums.** Claims expenses resulting from the operation of this section which exceed premiums received shall be borne by contributing members of the association in accordance with section 62E.11, subdivision 5.

Subd. 9. **Coordination of policies.** If an insolvent health maintenance organization or community integrated service network has insolvency insurance coverage at the time of an order for liquidation, the association may coordinate the benefits of the policy issued under this section with those of the insolvency insurance policy available to the enrollees. The premium level for the combined association policy and the insolvency insurance policy may not exceed those described in subdivision 5.

62J.06 IMMUNITY FROM LIABILITY.

No member of the Health Technology Advisory Committee shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

62J.156 CLOSED COMMITTEE HEARINGS.

Notwithstanding chapter 13D, the Health Technology Advisory Committee may meet in closed session to discuss a specific technology or procedure that involves data received that have been classified as nonpublic data, where disclosure of the data would cause harm to the competitive or economic position of the source of the data.

62J.2930 INFORMATION CLEARINGHOUSE.

Subd. 4. **Coordination.** To the extent possible, the commissioner shall coordinate the activities of the clearinghouse with the activities of the Minnesota Health Data Institute.

62J.57 MINNESOTA CENTER FOR HEALTH CARE ELECTRONIC DATA INTERCHANGE.

(a) It is the intention of the legislature to support, to the extent of funds appropriated for that purpose, the creation of the Minnesota Center for Health Care Electronic Data Interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota Center for Health Care Electronic Data Interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

(1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.