

**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	7593a	Comm report: To pass as amended and re-refer to Health and Human Services

1.1 A bill for an act

1.2 relating to health; making changes to provisions covering prescription drug prior

1.3 authorizations, transactions with group purchasers, prescription drug price

1.4 transparency, health maintenance organizations, network design, coverage for

1.5 immunizations, and obsolete language; amending Minnesota Statutes 2024, sections

1.6 62D.02, subdivision 7, by adding a subdivision; 62D.08, subdivisions 5, 6; 62D.09,

1.7 subdivisions 1, 5; 62D.124, subdivision 6; 62J.17, subdivision 6a; 62J.2930,

1.8 subdivision 1; 62J.497, subdivision 5; 62J.536, subdivision 2a; 62K.02, subdivision

1.9 2; 62K.03, subdivision 6; 62K.075; 62K.105; 62K.14; 62M.07, subdivision 2;

1.10 62Q.46, subdivision 1; 144.293, subdivision 7; Minnesota Statutes 2025

1.11 Supplement, sections 3.732, subdivision 1; 62J.84, subdivisions 2, 3, 10, 11, 12,

1.12 13, 14; 62K.10, subdivision 2; repealing Minnesota Statutes 2024, sections 13D.08,

1.13 subdivision 4; 62D.08, subdivision 7; 62D.181; 62J.06; 62J.156; 62J.2930,

1.14 subdivision 4; 62J.57.

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

1.16 **ARTICLE 1**

1.17 **HEALTH INSURANCE**

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

1.19 Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a)

1.20 The commissioner of health, in consultation with the Minnesota e-Health Advisory

1.21 Committee and the Minnesota Administrative Uniformity Committee, shall, by February

1.22 15, 2010, identify an outline on how best to standardize drug prior authorization request

1.23 transactions between providers and group purchasers with the goal of maximizing

1.24 administrative simplification and efficiency in preparation for electronic transmissions.

1.25 (b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall

1.26 develop the standard companion guide by which providers and group purchasers will

1.27 exchange standard drug authorization requests using electronic data interchange standards,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.27 (1) a new drug application approved under United States Code, title 21, section 355(c),  
 3.28 except for a generic drug as defined under Code of Federal Regulations, title 42, section  
 3.29 447.502; or

3.30 (2) a biologics license application approved under United States Code, title 42, section  
 3.31 262(a)(c).

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

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

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

4.4 (2) an authorized generic as defined under Code of Federal Regulations, title 42, section  
4.5 447.502; or

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

4.8 (f) "Manufacturer" means:

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

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

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

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

4.19 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision  
4.20 8.

4.21 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title  
4.22 42, section 1395w-3a(c)(6)(B).

4.23 (k) "30-day supply" means the total daily dosage units of a prescription drug  
4.24 recommended by the prescribing label approved by the FDA for 30 days. If the  
4.25 FDA-approved prescribing label includes more than one recommended daily dosage, the  
4.26 30-day supply is based on the maximum recommended daily dosage on the FDA-approved  
4.27 prescribing label.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.11 (i) the national drug code;

6.12 (ii) the product name;

6.13 (iii) the dosage form;

6.14 (iv) the strength; and

6.15 (v) the package size;

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

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

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

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

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

6.24 (i) to manufacture the prescription drug;

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

6.26 (iii) to distribute the prescription drug;

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

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

6.29 (9) the total rebate payable amount accrued for the prescription drug during the previous  
6.30 12-month period;

7.1 (10) the manufacturer's net profit attributable to the prescription drug during the previous  
7.2 12-month period;

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

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

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

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

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

7.16 (16) if the prescription drug was acquired by the manufacturer during the previous  
7.17 12-month period, all of the following information:

7.18 (i) price at acquisition;

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

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

7.21 (iv) date of acquisition; and

7.22 (v) acquisition price.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.26 (2) which the manufacturer manufactures or repackages;

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

8.28 (4) for which the manufacturer has not submitted data under subdivision 3 during the  
8.29 120-day period prior to the date of the notification to report.

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

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

9.5 (i) the national drug code;

9.6 (ii) the product name;

9.7 (iii) the dosage form;

9.8 (iv) the strength; and

9.9 (v) the package size;

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

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

9.12 (ii) the introduced to market date; or

9.13 (iii) the acquisition date;

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

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

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

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

9.21 (i) to manufacture the prescription drug;

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

9.23 (iii) to distribute the prescription drug;

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

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

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

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

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

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

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

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

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

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

10.20 (i) the price at acquisition;

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

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

10.23 (iv) the date of acquisition; and

10.24 (v) the acquisition price.

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

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

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

- 11.1 (1) included in a notification to report issued to the pharmacy by the department under  
11.2 subdivision 10; and
- 11.3 (2) that the pharmacy dispensed in Minnesota or mailed to a Minnesota address.
- 11.4 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the  
11.5 commissioner no later than 60 days after the date of the notification to report, in the form  
11.6 and manner prescribed by the commissioner, the following information, if applicable:
- 11.7 (1) a description of the drug with the following listed separately:
- 11.8 (i) the national drug code;
- 11.9 (ii) the product name;
- 11.10 (iii) the dosage form;
- 11.11 (iv) the strength; and
- 11.12 (v) the package size;
- 11.13 (2) the number of pricing units of the drug acquired during the reporting period specified  
11.14 in the notification to report;
- 11.15 (3) the total spent before rebates by the pharmacy to acquire the drug during the reporting  
11.16 period specified in the notification to report;
- 11.17 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the  
11.18 reporting period specified in the notification to report;
- 11.19 (5) the number of pricing units of the drug dispensed by the pharmacy during the reporting  
11.20 period specified in the notification to report;
- 11.21 (6) the total payment receivable by the pharmacy for dispensing the drug including  
11.22 ingredient cost, dispensing fee, and administrative fees during the reporting period specified  
11.23 in the notification to report;
- 11.24 (7) the total rebate payable amount accrued by the pharmacy for the drug during the  
11.25 reporting period specified in the notification to report; and
- 11.26 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed  
11.27 where no claim was submitted to a health care service plan or health insurer during the  
11.28 reporting period specified in the notification to report.
- 11.29 (c) The pharmacy may submit any documentation necessary to support the information  
11.30 reported under this subdivision.

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

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

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

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

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

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

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

12.19 (i) the national drug code;

12.20 (ii) the product name;

12.21 (iii) the dosage form;

12.22 (iv) the strength; and

12.23 (v) the package size;

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

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

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

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

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

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

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

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

13.13 and

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

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

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

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

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

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

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

- 14.1 (1) a description of the drug with the following listed separately:
- 14.2 (i) the national drug code;
- 14.3 (ii) the product name;
- 14.4 (iii) the dosage form;
- 14.5 (iv) the strength; and
- 14.6 (v) the package size;
- 14.7 (2) the number of units of the drug product acquired by the wholesale drug distributor
- 14.8 during the reporting period specified in the notification to report;
- 14.9 (3) the total spent before rebates by the wholesale drug distributor to acquire the drug
- 14.10 product during the reporting period specified in the notification to report;
- 14.11 (4) the total rebate receivable amount accrued by the wholesale drug distributor for the
- 14.12 drug product during the reporting period specified in the notification to report;
- 14.13 (5) the number of units of the drug product sold by the wholesale drug distributor during
- 14.14 the reporting period specified in the notification to report;
- 14.15 (6) the gross revenue from sales in the United States generated by the wholesale drug
- 14.16 distributor for the drug product during the reporting period specified in the notification to
- 14.17 report; and
- 14.18 (7) the total rebate payable amount accrued by the wholesale drug distributor for the
- 14.19 drug product during the reporting period specified in the notification to report;
- 14.20 (8) the name of any entity, including but not limited to a group purchasing organization
- 14.21 that the wholesaler contracts with or owns, in part or in full, that negotiates rebates for the
- 14.22 drug product during the reporting period specified in the notification to report;
- 14.23 (9) the total receivable amount accrued from all organizations reported under clause (8)
- 14.24 for the drug product during the reporting period specified in the notification to report; and
- 14.25 (10) of the amount reported under clause (9), the percentage that is accrued and payable
- 14.26 to other entities for the drug product during the reporting period specified in the notification
- 14.27 to report.
- 14.28 (c) The wholesale drug distributor may submit any documentation necessary to support
- 14.29 the information reported under this subdivision.

15.1

**ARTICLE 2**

15.2

**HMO REGULATION**

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

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

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

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

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

15.17 Subd. 5. **Changes in participating entities; penalty.** Any cancellation or discontinuance  
15.18 of any contract or agreement listed in section 62D.03, subdivision 4, clause (e), or listed  
15.19 subsequently in accordance with this subdivision, shall be reported to the commissioner  
15.20 120 days before the effective date. When the health maintenance organization terminates a  
15.21 provider participating entity for cause, death, disability, or loss of license, the health  
15.22 maintenance organization must notify the commissioner within ten working days of the  
15.23 date the health maintenance organization sends out or receives the notice of cancellation,  
15.24 discontinuance, or termination. Any health maintenance organization which fails to notify  
15.25 the commissioner within the time periods prescribed in this subdivision shall be subject to  
15.26 the levy of a fine up to \$200 per contract for each day the notice is past due, accruing up to  
15.27 the date the organization notifies the commissioner of the cancellation or discontinuance.  
15.28 Any fine levied under this subdivision is subject to the contested case and judicial review  
15.29 provisions of chapter 14. The levy of a fine does not preclude the commissioner from using  
15.30 other penalties described in sections 62D.15 to 62D.17.

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

16.2 Subd. 6. **Quarterly financial statements.** (a) A health maintenance organization shall  
16.3 submit to the commissioner unaudited financial statements of the organization for the first  
16.4 three quarters of the year on forms prescribed by the commissioner. The statements are due  
16.5 30 days after the end of the quarter and shall be maintained as nonpublic data, as defined  
16.6 by section 13.02, subdivision 9. Unaudited financial statements for the fourth quarter shall  
16.7 be submitted at the request of the commissioner.

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

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

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

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

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

16.30 (1) health care services not provided;

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

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

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

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

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

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

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

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

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

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

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

18.10 Sec. 8. **REVISOR INSTRUCTION.**

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

18.14	<u>Column A</u>	<u>Column B</u>
18.15	<u>62Q.075</u>	<u>62D.081</u>

18.16 Sec. 9. **REPEALER.**

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

18.18 **ARTICLE 3**  
 18.19 **HEALTH SERVICES**

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

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

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

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

18.29 (d) This chapter does not apply to short-term coverage as defined in section 62A.65,  
 18.30 subdivision 7, or grandfathered plan coverage as defined in section 62A.011, subdivision  
 18.31 1b.

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

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

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

19.5 **62K.075 PROVIDER NETWORK NOTIFICATIONS.**

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

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

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

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

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

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

19.29 **62K.105 NETWORK ADEQUACY COMPLAINTS.**

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

20.1 subdivision 2,~~3~~, or 4. Using this process, an enrollee may file a complaint with the  
 20.2 commissioner that a health carrier is not in compliance with the requirements of section  
 20.3 62K.10, subdivision 2,~~3~~, or 4. The commissioner of health shall investigate all complaints  
 20.4 received under this section.

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

20.6 **62K.14 LIMITED-SCOPE PEDIATRIC DENTAL PLANS.**

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

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

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

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

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

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

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

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

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

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

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

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

21.24 (5) pediatric hospice services provided by a hospice provider licensed under sections  
21.25 144A.75 to 144A.755; and

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

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

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

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

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

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

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

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

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

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

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

22.33 (6) screenings for human immunodeficiency virus for:

- 23.1 (i) all individuals at least 15 years of age but less than 65 years of age; and
- 23.2 (ii) all other individuals with increased risk of human immunodeficiency virus infection
- 23.3 according to guidance from the Centers for Disease Control;
- 23.4 (7) all preexposure prophylaxis when used for the prevention or treatment of human
- 23.5 immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined
- 23.6 in any guidance by the United States Preventive Services Task Force or the Centers for
- 23.7 Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention
- 23.8 of HIV Infection United States Preventive Services Task Force Recommendation Statement;
- 23.9 and
- 23.10 (8) all postexposure prophylaxis when used for the prevention or treatment of human
- 23.11 immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined
- 23.12 in any guidance by the United States Preventive Services Task Force or the Centers for
- 23.13 Disease Control.
- 23.14 (b) A health plan company must provide coverage for preventive items and services at
- 23.15 a participating provider without imposing cost-sharing requirements, including a deductible,
- 23.16 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that
- 23.17 has a network of providers from excluding coverage or imposing cost-sharing requirements
- 23.18 for preventive items or services that are delivered by an out-of-network provider.
- 23.19 (c) A health plan company is not required to provide coverage for any items or services
- 23.20 specified in any recommendation or guideline described in paragraph (a) if the
- 23.21 recommendation or guideline is no longer included as a preventive item or service as defined
- 23.22 in paragraph (a). Annually, a health plan company must determine whether any additional
- 23.23 items or services must be covered without cost-sharing requirements or whether any items
- 23.24 or services are no longer required to be covered.
- 23.25 (d) Nothing in this section prevents a health plan company from using reasonable medical
- 23.26 management techniques to determine the frequency, method, treatment, or setting for a
- 23.27 preventive item or service to the extent not specified in the recommendation or guideline.
- 23.28 (e) A health plan shall not require prior authorization or step therapy for preexposure
- 23.29 prophylaxis or postexposure prophylaxis, except that: if the United States Food and Drug
- 23.30 Administration has approved one or more therapeutic equivalents of a drug, device, or
- 23.31 product for the prevention of HIV, this paragraph does not require a health plan to cover
- 23.32 all of the therapeutically equivalent versions without prior authorization or step therapy, if
- 23.33 at least one therapeutically equivalent version is covered without prior authorization or step
- 23.34 therapy.

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

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

#### 24.4 ARTICLE 4

#### 24.5 OBSOLETE LANGUAGE AMENDMENTS

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

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

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

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

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

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

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

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

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

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

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

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

25.19 (c) The commissioner shall determine, based upon the information submitted, whether  
25.20 the major spending commitment is appropriate under the criteria provided in subdivision  
25.21 5a, or whether it should be excepted from prospective review under subdivision 7. In making  
25.22 this determination, the commissioner may also consider relevant information from other  
25.23 sources. ~~At the request of the commissioner, the health technology advisory committee shall~~  
25.24 ~~convene an expert review panel made up of persons with knowledge and expertise regarding~~  
25.25 ~~medical equipment, specialized services, health care expenditures, and capital expenditures~~  
25.26 ~~to review applications and make recommendations to the commissioner.~~ The commissioner  
25.27 shall make a decision on the application within 60 days after an application is received.

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

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

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

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

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

26.18 Sec. 5. **REPEALER.**

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

APPENDIX  
Article locations for S4419-2

ARTICLE 1 HEALTH INSURANCE..... Page.Ln 1.16  
ARTICLE 2 HMO REGULATION..... Page.Ln 15.1  
ARTICLE 3 HEALTH SERVICES..... Page.Ln 18.18  
ARTICLE 4 OBSOLETE LANGUAGE AMENDMENTS..... Page.Ln 24.4

**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.