State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 402

01/17/2023 Authored by Bierman, Liebling, Stephenson, Noor, Hanson, J., and others
The bill was read for the first time and referred to the Committee on Commerce Finance and Policy
02/06/2023 Adoption of Report: Amended and re-referred to the Committee on Health Finance and Policy
03/23/2023 Adoption of Report: Amended and re-referred to the Committee on Judiciary Finance and Civil Law
03/27/2023 Adoption of Report: Re-referred to the Committee on State and Local Government Finance and Policy
03/30/2023 Adoption of Report: Re-referred to the Committee on Health Finance and Policy
Pursuant to Joint Rule 2.03, re-referred to the Committee on Rules and Legislative Administration
04/03/2023 Adoption of Report: Re-referred to the Committee on Health Finance and Policy
Joint Rule 2.03 has been waived for any subsequent committee action on this bill
04/26/2023 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to health; establishing requirements for certain health care entity transactions; changing the expiration date on moratorium conversion transactions; requiring a health system to return charitable assets received from the state to the general fund in certain circumstances; requiring a study on the regulation of certain transactions; requiring a report; appropriating money; amending Minnesota Statutes 2022, section 62U.04, subdivision 11; Laws 2017, First Special Session chapter 6, article 5, section 11, as amended; proposing coding for new law in Minnesota Statutes, chapter 309; proposing coding for new law as Minnesota Statutes, chapter 145D.

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

Section 1. Minnesota Statutes 2022, section 62U.04, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(6) to conduct analyses of the impact of health care transactions on health care costs, market consolidation, and quality under section 145D.01, subdivision 6.

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

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

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

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

Sec. 2. **[145D.01] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY TRANSACTIONS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Captive professional entity" means a professional corporation, limited liability company, or other entity formed to render professional services in which a beneficial owner

is a health care provider employed by, controlled by, or subject to the direction of a hospital or hospital system.

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

(d) "Health care entity" means:

(1) a hospital;

(2) a hospital system;

(3) a captive professional entity;

(4) a medical foundation;

(5) a health care provider group practice;

(6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

(7) an entity that owns or exercises substantial control over an entity listed in clauses (1) to (5).

(e) "Health care provider" means a physician licensed under chapter 147, a physician assistant licensed under chapter 147A, or an advanced practice registered nurse as defined in section 148.171, subdivision 3, who provides health care services, including but not limited to medical care, consultation, diagnosis, or treatment.

(f) "Health care provider group practice" means two or more health care providers legally organized in a partnership, professional corporation, limited liability company, medical foundation, nonprofit corporation, faculty practice plan, or other similar entity:

(1) in which each health care provider who is a member of the group provides substantially the full range of services that a health care provider routinely provides, including but not limited to medical care, consultation, diagnosis, and treatment, through the joint use of shared office space, facilities, equipment, or personnel;

(2) for which substantially all services of the health care providers who are group members are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or

(3) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group.

An entity that otherwise meets the definition of health care provider group practice in this paragraph shall be considered a health care provider group practice even if its shareholders, partners, or owners include single health care provider professional corporations, limited

liability companies formed to render professional services, or other entities in which beneficial owners are individual health care providers.

(g) "Hospital" means a health care facility licensed as a hospital under sections 144.50 to 144.56.

(h) "Medical foundation" means a nonprofit legal entity through which physicians or other health care providers perform research or provide medical services.

(i)(1) "Transaction" means a single action, or a series of actions within a five-year period, that constitutes:

(i) a merger or exchange of a health care entity with another entity;

(ii) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity to another entity;

(iii) the granting of a security interest of 40 percent or more of the property and assets of a health care entity to another entity;

(iv) the transfer of 40 percent or more of the shares or other ownership of a health care entity to another entity;

(v) a transfer of control, responsibility for, or governance of a health care entity, including any transfer of membership interests that effectively constitutes such a transfer;

(vi) the creation of a new health care entity; or

(vii) substantial investment of 40 percent or more in a health care entity that results in sharing of revenues without a change in ownership or voting shares.

(2) "Transaction" does not include:

(i) a mortgage or other secured loan for business improvement purposes entered into by a health care entity that does not directly affect delivery of health care or governance of the health care entity;

(ii) a clinical affiliation of health care entities formed solely for the purpose of collaborating on clinical trials or providing graduate medical education;

(iii) the mere offer of employment to, or hiring of, a physician or other individual provider by a health care entity;

(iv) a transaction between entities under common ownership or control, either directly or indirectly through one or more intermediaries; or

(v) a single action or series of actions within a five-year period involving only entities that operate solely as a nursing home licensed under chapter 144A; a boarding care home licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that is not the primary residence of the license holder; a community residential setting as defined in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471 to 144A.483.

Subd. 2. **Notice required.** (a) This subdivision applies to all transactions where:

(1) the health care entity involved in the transaction has average revenue of at least $40,000,000 per year; or

(2) an entity created by the transaction is projected to have average revenue of at least $40,000,000 per year once the entity is operating at full capacity.

(b) A health care entity must provide notice to the attorney general and the commissioner and comply with this subdivision before entering into a transaction. Notice must be provided at least 90 days before the proposed completion date of the transaction.

(c) As part of the notice required under this subdivision, at least 90 days before the proposed completion date of the transaction, a health care entity must affirmatively disclose the following to the attorney general and the commissioner:

(1) the entities involved in the transaction;

(2) the leadership of the entities involved in the transaction, including all directors, board members, and officers;

(3) the services provided by each entity and the attributed revenue for each entity by location;

(4) the primary service area for each location;

(5) the proposed service area for each location;

(6) the current relationships between the entities and the affected health care providers and practices, the locations of affected health care providers and practices, the services provided by affected health care providers and practices, and the proposed relationships between the entities and the affected health care providers and practices;

(7) the terms of the transaction agreement or agreements;

(8) the acquisition price;

(9) markets in which the entities expect postmerger synergies to produce a competitive advantage;

(10) potential areas of expansion, whether in existing markets or new markets;

(11) plans to close facilities, reduce workforce, or reduce or eliminate services;

(12) the experts and consultants used to evaluate the transaction;

(13) the number of full-time equivalent positions at each location before and after the transaction by job category, including administrative and contract positions; and

(14) any other information requested by the attorney general or commissioner.

(d) As part of the notice required under this subdivision, at least 90 days before the proposed completion date of the transaction, a health care entity must affirmatively submit the following to the attorney general and the commissioner:

(1) the current governing documents for all entities involved in the transaction and any amendments to these documents;

(2) the transaction agreement or agreements and all related agreements;

(3) any collateral agreements related to the principal transaction, including leases, management contracts, and service contracts;

(4) all expert or consultant reports or valuations conducted in evaluating the transaction, including any valuation of the assets that are subject to the transaction prepared within three years preceding the anticipated transaction completion date and any reports of financial or economic analysis conducted in anticipation of the transaction;

(5) the results of any projections or modeling of health care utilization or financial impacts related to the transaction, including but not limited to copies of reports by appraisers, accountants, investment bankers, actuaries, and other experts;

(6) for a transaction as defined in subdivision 1, paragraph (i), clause (1), item (i) or (v), a financial and economic analysis and report prepared by an independent expert or consultant on the effects of the transaction;

(7) for a transaction as defined in subdivision 1, paragraph (i), clause (1), item (i) or (v), an impact analysis report prepared by an independent expert or consultant on the effects of the transaction on communities and the workforce, including any changes in availability or accessibility of services;

(8) all documents reflecting the purposes of or restrictions on any related nonprofit entity's charitable assets;

(9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino filing the entities submitted to the Federal Trade Commission in connection with the transaction;

(10) a certification sworn under oath by each board member and chief executive officer for any nonprofit entity involved in the transaction containing the following: an explanation of how the completed transaction is in the public interest, addressing the factors in subdivision 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the transaction for the three years following the transaction's anticipated completion date; and a disclosure of any conflicts of interest;

(11) audited and unaudited financial statements from all entities involved in the transaction and tax filings for all entities involved in the transaction covering the preceding five fiscal years; and

(12) any other information or documents requested by the attorney general or commissioner.

(e) The attorney general may extend the notice and waiting period required under paragraph (b) for an additional 90 days by notifying the health care entity in writing of the extension.

(f) The attorney general may waive all or any part of the notice and waiting period required under paragraph (b).

(g) The attorney general or the commissioner may hold public listening sessions or forums to obtain input on the transaction from providers or community members who may be impacted by the transaction.

(h) The attorney general or the commissioner may bring an action in district court to compel compliance with the notice requirements in this subdivision.

Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction that will:

(1) substantially lessen competition; or

(2) tend to create a monopoly or monopsony.

Subd. 4. **Additional requirements for nonprofit health care entities.** A health care entity that is incorporated under chapter 317A or organized under section 322C.1101, or that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

(1) the transaction complies with chapters 317A and 501B and other applicable laws;

(2) the transaction does not involve or constitute a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets. This clause does not apply to a transaction with a public entity or an organization that is exempt under section 501(c)(3) of the Internal Revenue Code of 1986, or any successor section, where the discount between the fair value of the assets and the transaction price will further the charitable purposes of the nonprofit health care entity;

(4) the value of the public benefit assets to be transferred has not been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the transaction will be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the transaction will not result in a breach of fiduciary duty; and

(7) there are procedures and policies in place to prohibit any officer, director, trustee, or other executive of the nonprofit health care entity from directly or indirectly benefiting from the transaction.

Subd. 5. **Attorney general enforcement and supplemental authority.** (a) The attorney general may bring an action in district court to enjoin or unwind a transaction or seek other equitable relief necessary to protect the public interest if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or if both a health care entity or transaction violates this section and the transaction is contrary to the public interest. Factors informing whether a transaction is contrary to the public interest include but are not limited to whether the transaction:

(1) will harm public health;

(2) will reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members of the affected community from receiving a comparable or better patient experience;

(3) will have a detrimental impact on competing health care options within primary and dispersed service areas;

(4) will have a negative impact on wages paid by, or the number of employees employed by, a health care entity involved in a transaction;

(5) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs;

(6) will have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research;

(7) will have a negative impact on the market for health care services, health insurance services, or skilled health care workers;

(8) will have a negative impact on wages, collective bargaining units, and collective bargaining agreements of existing or future workers employed by a health care entity involved in a transaction;

(9) will increase health care costs for patients; or

(10) will adversely impact provider cost trends and containment of total health care spending.

(b) The attorney general may enforce this section under section 8.31.

(c) Failure of the entities involved in a transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin the transaction or provide other equitable relief, provided the attorney general notified the entities of the inadequacy of the information provided and provided the entities with a reasonable opportunity to remedy the inadequacy.

(d) The commissioner shall provide to the attorney general, upon request, data and research on broader market trends, impacts on prices and outcomes, public health and population health considerations, and health care access, for the attorney general to use when evaluating whether a transaction is contrary to the public interest.

Subd. 6. **Supplemental authority of commissioner.** (a) Notwithstanding any law to the contrary, the commissioner may use data or information submitted under this section, section 62U.04, and sections 144.695 to 144.703 to conduct analyses of the aggregate impact of health care transactions on access to or the cost of health care services, health care market consolidation, and health care quality.

(b) The commissioner shall issue periodic public reports on the number and types of transactions subject to this section and on the aggregate impact of transactions on health care cost, quality, and competition in Minnesota.

Subd. 7. **Classification of data.** (a) Data provided by a health care entity to the attorney general and the commissioner under this section is classified as protected nonpublic data as defined in section 13.02, subdivision 13, in the case of data not on individuals or confidential data on individuals as defined in section 13.02, subdivision 3, in the case of data on individuals. The attorney general or the commissioner may make any data classified as confidential or protected nonpublic under this paragraph accessible to any person, agency, or the public if the attorney general or the commissioner determines that the access will aid the law enforcement process, promote public health or safety, or dispel widespread rumor or unrest.

(b) Any information exchanged between the attorney general and the commissioner according to subdivision 5 is classified as confidential data on individuals as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section 13.02, subdivision 13. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the Department of Health to aid in the investigation and review of the transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (d).

Subd. 8. **Relation to other law.** (a) The powers and authority under this section are in addition to, and do not affect or limit, all other rights, powers, and authority of the attorney general or the commissioner under chapters 8, 309, 317A, 325D, and 501B, or other law.

(b) Nothing in this section shall suspend any obligation imposed under chapters 8, 309, 317A, 325D, and 501B, or other law on the entities involved in a transaction.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date. In determining whether a transaction was completed on or after the effective date, any actions or series of actions necessary to the completion of the transaction must be considered.

Sec. 3. **[309.715] CHARITABLE ASSETS; RETURN TO GENERAL FUND; OWNERSHIP OR CONTROL OF UNIVERSITY OF MINNESOTA HEALTH CARE FACILITIES.**

Subdivision 1. **Return of charitable assets.** If a nonprofit health maintenance organization licensed under chapter 62D, or a health system organized as a charitable organization, sells or transfers control to an out-of-state, nonprofit entity or to any for-profit entity, the health maintenance organization or health system must return to the general fund

an amount equal to the value of any charitable assets the health maintenance organization or health system received from the state.

Subd. 2. **University of Minnesota health care facilities; ownership or control.** The importance of the University of Minnesota health care facilities, which are the academic health care facilities licensed by the commissioner of health as M Health Fairview University, or any successor name, to the state of Minnesota shall be recognized based on their status as publicly supported academic health care facilities; their relationship with the University of Minnesota Medical School, a public entity dedicated to medical education, research, and public service; the status of the University of Minnesota as a constitutionally autonomous state entity; and the university's mission as a land grant institution. The University of Minnesota health care facilities, as charitable assets, must remain dedicated to the university's public health care mission. As such, the University of Minnesota health care facilities shall not be owned or controlled, directly or indirectly, in whole or in part, by a for-profit entity or an out-of-state entity, unless the attorney general determines that ownership or control by a for-profit entity or out-of-state entity is in the public interest. A determination under this subdivision must be made using the procedures and authority in section 145D.01 and in consultation with the commissioner of health and the Board of Regents of the University of Minnesota.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions by a health maintenance organization or health system related to selling or transferring control to an out-of-state nonprofit entity or for-profit entity, and to transactions related to transferring ownership or control of the University of Minnesota health care facilities, that are completed on or after that date.

Sec. 4. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit health service plan corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the

health maintenance organization. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total admitted net assets as of December 31 of the previous year, or $50,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2023~~ 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. **STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER TRANSACTIONS.**

(a) The commissioner of health shall study and develop recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting Minnesota-domiciled nonprofit health maintenance organizations and for-profit health maintenance organizations. The recommendations must at least address:

(1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance organizations;

(2) issues related to public benefit assets held by a nonprofit health maintenance organization, including identifying the portion of the organization's assets that are considered public benefit assets to be protected, establishing a fair and independent process to value the assets, and determining how public benefit assets should be stewarded for the public good;

(3) providing a state agency or executive branch office with authority to review and approve or disapprove a nonprofit health maintenance organization's plan to convert to a for-profit organization; and

(4) establishing a process for the public to learn about and provide input on a nonprofit health maintenance organization's proposed conversion to a for-profit organization.

(b) To fulfill the requirements under this section, the commissioner:

(1) may consult with the commissioners of human services and commerce;

(2) may enter into one or more contracts for professional or technical services;

(3) notwithstanding any law to the contrary, may use data submitted under Minnesota Statutes, sections 62U.04 and 144.695 to 144.703, and other data held by the commissioner for purposes of regulating health maintenance organizations or data already submitted to the commissioner by health carriers; and

(4) may collect from health maintenance organizations and their parent or affiliated companies, financial data and other information, including nonpublic data and trade secret data, that are deemed necessary by the commissioner to conduct the study and develop the recommendations under this section. Health maintenance organizations must provide the commissioner with any information requested by the commissioner under this clause, in the form and manner specified by the commissioner. Any data collected by the commissioner under this clause is classified as confidential data on individuals as defined in Minnesota Statutes, section 13.02, subdivision 3, or protected nonpublic data as defined in Minnesota Statutes, section 13.02, subdivision 13.

(c) No later than October 1, 2023, the commissioner must seek public comments on the regulation of conversion transactions involving nonprofit health maintenance organizations.

(d) The commissioner may use the enforcement authority in Minnesota Statutes, section 62D.17, if a health maintenance organization fails to comply with a request for information under paragraph (b), clause (4).

(e) The commissioner shall submit preliminary findings from this study to the chairs of the legislative committees with jurisdiction over health and human services by January 15, 2024, and shall submit a final report and recommendations to the legislature by June 30, 2024.

Sec. 6. **APPROPRIATIONS.**

$..... in fiscal year 2024 and $..... in fiscal year 2025 are appropriated from the general fund to the commissioner of health for purposes of Minnesota Statutes, section 145D.01.