ARTICLE 13

HEALTH COVERAGE

Section 1. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 1a. **Loss ratio standards.** (a) Health plans issued on the individual market must return to enrollees in the form of aggregate benefits not including anticipated refunds or credits, at least 80 percent of the aggregate amount of premiums earned.

(b) Health plans issued on the small employer market, as defined in section 62L.02, subdivision 27, must return to enrollees in the form of aggregate benefits not including anticipated refunds or credits, at least 82 percent of the aggregate amount of premiums earned.

(c) Health plans issued to large groups, meaning groups with 51 or more covered persons, must return to enrollees in the form of aggregate benefits not including anticipated refunds or credits, at least 85 percent of the aggregate amount of premiums earned.

(d) Short-term health plans, as defined in section 62A.65, subdivision 7, must return to enrollees in the form of aggregate benefits not to include anticipated refunds or credits, at least 80 percent of the aggregate amount of premiums earned.

(e) Health plans that are issued by a health maintenance organization or nonprofit health service plan corporation shall have loss ratios calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided on a service rather than reimbursement basis and earned premiums for the period and according to accepted actuarial principles and practices.

(f) A health carrier must submit to the commissioner a report, in a form and manner determined by the commissioner, evidencing compliance with this section. Information in the report must be aggregated and separated by individual, small employer, short-term, and large group market. The form must be submitted to the commissioner by June 1 of the year following the last calendar year during which the health carrier offered individual, small employer, or large group health plans.

(g) The commissioner shall review reports for actuarial reasonableness, soundness, and compliance with this section. If the report does not meet these requirements, the commissioner shall notify the health carrier in writing of the deficiency. The health carrier shall have 30 days from the date of the commissioner's notice to file an amended report that complies with this section. If the health carrier fails to file an amended report, the commissioner shall order the health carrier to issue a rebate calculated pursuant to subdivision 2a.

(h) A health plan that does not comply with the loss ratio requirements of this section is an unfair or deceptive act or practice in the business of insurance and is subject to the penalties in sections 72A.17 to 72A.32.

(i) The commissioners of commerce and health shall each annually issue a public report listing, by health carrier, the actual loss ratios experienced in the individual, small employer, short-term, and large group markets in this state by the health carriers that the commissioners respectively regulate. The commissioners shall coordinate release of these reports so as to release them as a joint report or as separate reports issued the same day. The report or reports shall be released no later than September 1 for loss ratios experienced for the preceding calendar year. Health carriers shall provide to the commissioners any information requested by the commissioners for purposes of this paragraph.

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

Sec. 2. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 2a. **Rebate.** (a) A health carrier must issue a rebate to each enrollee if the health carrier's loss ratio does not meet or exceed the minimum required by subdivision 1a.

(b) The rebate must be in the amount of the aggregate amount of premiums earned, multiplied by the difference between the loss ratio the health carrier had for the prior calendar year and the loss ratio required under subdivision 1a.

(c) A health carrier must issue the rebate under paragraph (b) by August 1 of the year following the prior calendar year during which individual, small employer, short-term, or large group health plans were offered.

(d) The rebate must be paid in the form of a lump-sum check or lump-sum reimbursement to persons who are no longer enrolled in the health plan. The rebate may be paid either as a lump-sum check, a lump-sum reimbursement, or a direct deduction to the current plan year's premiums for current enrollees.

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

Sec. 3. Minnesota Statutes 2018, section 62A.021, is amended by adding a subdivision to read:

Subd. 3a. **Prohibiting subtractions from loss ratio calculations.** (a) A health carrier, when demonstrating compliance with the requirements of this section, shall subtract from incurred claims or incurred health expenses: (1) all reinsurance payments applied for or received under section 62E.23; and (2) all reimbursement payments made by the commissioner under sections 62A.25, subdivision 2, 62A.28, subdivision 2, 62A.3096, and 62A.3097.

(b) The commissioner, in reviewing this information, shall verify that health carriers have complied with the requirements of this subdivision.

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

Sec. 4. Minnesota Statutes 2018, section 62A.25, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

(b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to reconstructive breast surgery: (1) following mastectomies; or (2) if the patient has been diagnosed with ectodermal dysplasia and has congenitally absent breast tissue or nipples. ~~In these cases, Coverage for reconstructive surgery must be provided if the mastectomy is medically necessary as determined by the attending physician.~~

(c) Reconstructive surgery benefits include all stages of reconstruction ~~of the breast on which the mastectomy has been performed~~, including surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages ~~of a mastectomy~~, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not:

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.

(d) The commissioner of commerce shall reimburse health carriers for coverage of ectodermal dysplasias under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical

assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, issued, or sold on or after that date.

Sec. 5. Minnesota Statutes 2018, section 62A.28, subdivision 2, is amended to read:

Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata or ectodermal dysplasias.

(b) The coverage required by this section is subject to the co-payment, coinsurance, deductible, and other enrollee cost-sharing requirements that apply to similar types of items under the policy, plan, certificate, or contract and may be limited to one prosthesis per benefit year.

(c) The commissioner of commerce shall reimburse health carriers for coverage of ectodermal dysplasias under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, issued, or sold on or after that date.

Sec. 6. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

ARTICLE 12:

Section 1. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

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(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 7. [62A.3096] COVERAGE FOR ECTODERMAL DYSPLASIAS.

Subdivision 1. **Definition.** For purposes of this chapter, "ectodermal dysplasias" means a genetic disorder involving the absence or deficiency of tissues and structures derived from the embryonic ectoderm.

Subd. 2. **Coverage.** A health plan must provide coverage for the treatment of ectodermal dysplasias.

Subd. 3. **Dental coverage.** (a) A health plan must provide coverage for dental treatments related to ectodermal dysplasias. Covered dental treatments must include but are not limited to bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

(b) If a dental treatment is eligible for coverage under a dental insurance plan or other health plan, the coverage under this subdivision is secondary.

Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

Senate Language UEH2414-1

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans issued, sold, or renewed on or after that date.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, issued, or sold on or after that date.

Sec. 8. [62A.3097] PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS) TREATMENT; COVERAGE.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Pediatric acute-onset neuropsychiatric syndrome" means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that are not otherwise explained by another known neurologic or medical disorder.

(c) "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

Subd. 2. **Scope of coverage.** This section applies to all health plans that provide coverage to Minnesota residents.

Subd. 3. **Required coverage.** Every health plan included in subdivision 2 must provide coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments that must be covered under this section must be recommended by the insured's licensed health care professional and include but are not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Subd. 4. **Reimbursement.** The commissioner of commerce shall reimburse health carriers for coverage under this section. Reimbursement is available only for coverage that would not have been provided by the health carrier without the requirements of this section. Reimbursement from the commissioner shall be at the medical assistance rate. Health care providers are prohibited from billing an enrollee for any amount in excess of the medical assistance rate. A provider is permitted to bill an enrollee for the applicable co-payment, deductible, or coinsurance.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62A.65, subdivision 2, is amended to read:

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Sec. 9. Minnesota Statutes 2018, section 62A.65, subdivision 7, is amended to read:

Subd. 7. **Short-term coverage.** (a) For purposes of this section, "short-term coverage" means an individual health plan that:

(1) is issued to provide coverage for a period of ~~185~~ 90 days or less, except that the health plan may permit coverage to continue until the end of a period of hospitalization for a condition for which the covered person was hospitalized on the day that coverage would otherwise have ended;

(2) is nonrenewable, provided that the health carrier may provide coverage for one or more subsequent periods that satisfy clause (1), if the total of the periods of coverage do not exceed a total of ~~365~~ 185 days out of any 555-day period, plus any additional days covered as a result of hospitalization on the day that a period of coverage would otherwise have ended;

(3) does not cover any preexisting conditions, including ones that originated during a previous identical policy or contract with the same health carrier where coverage was continuous between the previous and the current policy or contract; and

(4) is available with an immediate effective date without underwriting upon receipt of a completed application indicating eligibility under the health carrier's eligibility requirements, provided that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(b) Short-term coverage is not subject to subdivisions 2 and 5. Short-term coverage may exclude as a preexisting condition any injury, illness, or condition for which the covered person had medical treatment, symptoms, or any manifestations before the effective date of the coverage, but dependent children born or placed for adoption during the policy period must not be subject to this provision.

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Subd. 2. **Preexisting condition protection; guaranteed issue and renewal.** (a) No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the health plan provides that the plan is guaranteed issued and is guaranteed renewable at a premium rate that does not take into account the claims experience or any change in the health status of any covered person that occurred after the initial issuance of the health plan to the person. The premium rate upon renewal must also otherwise comply with this section. A health carrier must not refuse to renew an individual health plan, except for nonpayment of premiums, fraud, ~~or~~ misrepresentation, or as otherwise provided in paragraph (b).

(b) A health carrier may close product offerings that cover less than 50 individuals in total, provided that the carrier offers to each covered individual, on a guaranteed issue basis, the option to purchase another individual health plan currently being offered by the health carrier.

(c) Notwithstanding subdivision 3, and section 62A.021, a health carrier may combine short-term coverage with its most commonly sold individual qualified plan, as defined in section 62E.02, other than short-term coverage, for purposes of complying with the loss ratio requirement.

(d) The ~~365-day~~ 185-day coverage limitation provided in paragraph (a) applies to the total number of days of short-term coverage that covers a person, regardless of the number of policies, contracts, or health carriers that provide the coverage. A written application for short-term coverage must ask the applicant whether the applicant has been covered by short-term coverage by any health carrier within the 555 days immediately preceding the effective date of the coverage being applied for. Short-term coverage issued in violation of the ~~365-day~~ 185-day limitation is valid until the end of its term and does not lose its status as short-term coverage, in spite of the violation. A health carrier that knowingly issues short-term coverage in violation of the ~~365-day~~ 185-day limitation is subject to the administrative penalties otherwise available to the commissioner of commerce or the commissioner of health, as appropriate.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to short-term coverage offered, issued, or renewed on or after that date.

Sec. 10. [62C.045] APPLICATION OF OTHER LAWS.

Chapter 317B and Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by this act, apply to service plan corporations operating under this chapter.

Sec. 11. Minnesota Statutes 2018, section 62D.02, subdivision 4, is amended to read:

Subd. 4. **Health maintenance organization.** "Health maintenance organization" means a ~~foreign or domestic~~ nonprofit corporation organized under chapter 317A, or a local governmental unit as defined in subdivision 11, controlled and operated as provided in sections 62D.01 to 62D.30, which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.

Sec. 12. Minnesota Statutes 2018, section 62D.03, subdivision 1, is amended to read:

Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state to the contrary, any ~~foreign or domestic~~ nonprofit corporation organized to do so or a local governmental unit may apply to the commissioner of health for a certificate of authority to establish and operate a health maintenance organization in compliance with sections 62D.01 to 62D.30. No person shall establish or operate a health maintenance organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization or health maintenance contract unless the organization has a certificate of authority under sections 62D.01 to 62D.30.

Sec. 13. [62D.046] APPLICATION OF OTHER LAW.

Chapter 317B applies to nonprofit health maintenance organizations operating under this chapter.

Sec. 14. Minnesota Statutes 2018, section 62D.05, subdivision 1, is amended to read:

Subdivision 1. **Authority granted.** Any nonprofit corporation or local governmental unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30, operate as a health maintenance organization.

Sec. 15. Minnesota Statutes 2018, section 62D.06, subdivision 1, is amended to read:

Subdivision 1. **Governing body composition; enrollee advisory body.** The governing body of any health maintenance organization which is a nonprofit corporation may include enrollees, providers, or other individuals; provided, however, that after a health maintenance organization which is a nonprofit corporation has been authorized under sections 62D.01 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of enrollees and members elected by the enrollees and members from among the enrollees and members. For purposes of this section, "member" means a consumer who receives health care services through a self-insured contract that is administered by the health maintenance organization or its related third-party administrator. The number of members elected to the governing body shall not exceed the number of enrollees elected to the governing body. An enrollee or member elected to the governing board may not be a person:

(1) whose occupation involves, or before retirement involved, the administration of health activities or the provision of health services;

(2) who is or was employed by a health care facility as a licensed health professional; or

(3) who has or had a direct substantial financial or managerial interest in the rendering of a health service, other than the payment of a reasonable expense reimbursement or compensation as a member of the board of a health maintenance organization.

After a health maintenance organization which is a local governmental unit has been authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall be established. The enrollees who make up this advisory body shall be elected by the enrollees from among the enrollees.

Sec. 16. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to read:

Subd. 8a. **Net earnings.** All net earnings of a nonprofit health maintenance organization must be devoted to the nonprofit purposes of the health maintenance organization in providing comprehensive health care. A nonprofit health maintenance organization must not provide for the payment, whether directly or indirectly, of any part of its net earnings to any person for a purpose other than providing comprehensive health care, except that the health

maintenance organization may make payments to providers or other persons based on the efficient provision of services or as incentives to provide quality care. The commissioner of health shall, pursuant to this chapter, revoke the certificate of authority of any nonprofit health maintenance organization in violation of this subdivision.

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

Sec. 3. Minnesota Statutes 2018, section 62D.12, is amended by adding a subdivision to read:

Subd. 20. **Dividends, distributions, or transfers.** (a) A for-profit health maintenance organization may pay dividends or make distributions or transfers, including to a legal entity that is an affiliate of the health maintenance organization or that is a subsidiary corporation of a local unit of government organized under chapter 383B, in accordance with section 60D.20, subdivision 2, except that the commissioner referenced in section 60D.20, subdivision 2, shall be the commissioner of health.

(b) If a nonprofit health maintenance organization plans on distributing or transferring an amount, including to a legal entity that is an affiliate of the health maintenance organization or that is a subsidiary corporation of a local unit of government organized under chapter 383B, that together with other distributions or transfers made within the preceding 12 months exceeds the greater of: (1) ten percent of the health maintenance organization's net worth on December 31 of the preceding year; or (2) the health maintenance organization's net income, not including realized capital gains, for the 12-month period ending on December 31 of the preceding year, but does not include pro rata distributions of any class of the health maintenance organization's own securities, the health maintenance organization must meet the requirements of paragraph (c).

(c) Prior to making a distribution or transfer identified in paragraph (b), a nonprofit health maintenance organization must notify the commissioner of the planned distribution or transfer. Upon receipt of notification, the commissioner shall review the distribution or transfer to determine whether the distribution or transfer is reasonable in relation to the health maintenance organization's outstanding liabilities and the quality of the health maintenance organization's earnings and the extent to which the reported earnings include items such as surplus relief reinsurance transactions and reserve restrengthening, and in consideration of the factors described in section 60D.20, subdivision 4. No distribution or transfer shall be made by the health maintenance organization until: (1) 30 days after the commissioner has received notice and has not within this time period disapproved the distribution or transfer; or (2) the commissioner has approved the distribution or transfer within the 30-day period.

(d) For purposes of this subdivision, "affiliate" means an entity that controls, is controlled by, or is under common control with the health maintenance organization including a

Sec. 17. Minnesota Statutes 2018, section 62D.124, subdivision 1, is amended to read:

Subdivision 1. **Emergency care; primary care; mental health services; general hospital services.** (a) Within the health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services. The health maintenance organization must designate which method is used.

(b) Emergency care must be available to enrollees 24 hours a day, 7 days a week. Appointment wait times for primary care services must not exceed 45 calendar days from the date of the enrollee's request for routine and preventive care and 48 hours for urgent care. Appointment wait times for mental health services and substance use disorder treatment services must not exceed 15 calendar days from the date of the enrollee's request for routine care and 24 hours for urgent care.

Sec. 18. Minnesota Statutes 2018, section 62D.124, subdivision 2, is amended to read:

Subd. 2. **Other health services.** (a) Within a health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 1. The health maintenance organization must designate which method is used.

(b) Appointment wait times for nonurgent specialty care must not exceed 60 calendar days from the date of the enrollee's request.

(c) Appointment wait time for dental, optometry, laboratory, and x-ray services must not exceed 45 calendar days from the date of the enrollee's request for regular appointments and 48 hours for urgent care. For purposes of this paragraph, regular appointments for dental care means preventive care and initial appointments for restorative care.

Sec. 19. Minnesota Statutes 2018, section 62D.124, subdivision 3, is amended to read:

Subd. 3. ~~**Exception** **Waiver.** The commissioner shall grant an exception to the requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the health maintenance organization can demonstrate with specific data that the requirement of subdivision 1 or 2 is not feasible in a particular service area or part of a service area.~~ (a) A health maintenance organization may apply to the commissioner of health for a waiver of the requirements in subdivision 1 or 2 if it is unable to meet those requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied

nonprofit hospital that is within the same integrated health care system as the health maintenance organization.

(e) The commissioner of health shall enforce this subdivision.

by an application fee of $1,000 per county per year, for each application to waive the requirements in subdivision 1 or 2 for one or more provider types in that county, and must:

(1) demonstrate with specific data that the requirements of subdivision 1 or 2 are not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) Using the guidelines and standards established under section 62K.10, subdivision 5, paragraph (b), the commissioner shall review each waiver request and shall approve a waiver only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for implementing these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health maintenance organization demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health maintenance organization is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) A waiver shall automatically expire after three years. Upon or prior to expiration of a waiver, a health maintenance organization unable to meet the requirements in subdivision 1 or 2 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the organization took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the organization for the most recent three-year period, the commissioner shall also examine the steps the organization took during that three-year period to address network inadequacy, and shall only approve a subsequent waiver application if it satisfies the requirements in paragraph (b), demonstrates that the organization took the steps it proposed to address network inadequacy, and explains why the organization continues to be unable to satisfy the requirements in subdivision 1 or 2.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 20. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 6. **Complaints alleging violation of network adequacy requirements; investigation.** Enrollees of a health maintenance organization may file a complaint with the commissioner that the health maintenance organization is not in compliance with the requirements of subdivision 1 or 2, using the process established under section 62K.105, subdivision 1. The commissioner shall investigate all complaints received under this

subdivision and may use the program established under section 62K.105, subdivision 2, to investigate complaints.

Sec. 21. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 7. **Provider network notifications.** A health maintenance organization must provide on the organization's website the provider network for each product offered by the organization, and must update the organization's website at least once a month with any changes to the organization's provider network, including provider changes from in-network status to out-of-network status. A health maintenance organization must also provide on the organization's website, for each product offered by the organization, a list of the current waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

Sec. 22. Minnesota Statutes 2018, section 62D.17, subdivision 1, is amended to read:

Subdivision 1. **Administrative penalty.** The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to $25,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.30 shall be considered a separate violation. The commissioner shall impose an administrative penalty of at least $100 per day that a provider network in a county violates section 62D.124, subdivision 1 or 2, and may take other enforcement action authorized in law but shall not also impose an administrative penalty under section 62K.105, subdivision 3, for a violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of enrollees affected by the violation;

(2) the effect of the violation on enrollees' health and access to health services;

(3) if only one enrollee is affected, the effect of the violation on that enrollee's health;

(4) whether the violation is an isolated incident or part of a pattern of violations; and

(5) the economic benefits derived by the health maintenance organization or a participating provider by virtue of the violation.

Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have 15 days within which to file a written request for an administrative hearing and review of the commissioner of health's determination. Such administrative hearing shall be subject to judicial review pursuant to chapter 14. If an administrative penalty is levied, the commissioner must divide 50 percent of the amount among any enrollees affected by the violation, unless the commissioner certifies in writing that the division and

distribution to enrollees would be too administratively complex or that the number of enrollees affected by the penalty would result in a distribution of less than $50 per enrollee.

Sec. 23. Minnesota Statutes 2018, section 62D.19, is amended to read:

62D.19 UNREASONABLE EXPENSES.

No health maintenance organization shall incur or pay for any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The commissioner of health shall implement and enforce this section by rules adopted under this section.

In an effort to achieve the stated purposes of sections 62D.01 to 62D.30, in order to safeguard the underlying nonprofit status of nonprofit health maintenance organizations, and to ensure that the payment of health maintenance organization money to major participating entities results in a corresponding benefit to the health maintenance organization and its enrollees, when determining whether an organization has incurred an unreasonable expense in relation to a major participating entity, due consideration shall be given to, in addition to any other appropriate factors, whether the officers and trustees of the health maintenance organization have acted with good faith and in the best interests of the health maintenance organization in entering into, and performing under, a contract under which the health maintenance organization has incurred an expense. The commissioner has standing to sue, on behalf of a health maintenance organization, officers or trustees of the health maintenance organization who have breached their fiduciary duty in entering into and performing such contracts.

Sec. 24. Minnesota Statutes 2018, section 62D.30, subdivision 8, is amended to read:

Subd. 8. **Rural demonstration project.** (a) The commissioner may permit demonstration projects to allow health maintenance organizations to extend coverage to a health improvement and purchasing coalition located in rural Minnesota, comprised of the health maintenance organization and members from a geographic area. For purposes of this subdivision, rural is defined as greater Minnesota excluding the seven-county metropolitan area of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. The coalition must be designed in such a way that members will:

(1) become better informed about health care trends and cost increases;

(2) be actively engaged in the design of health benefit options that will meet the needs of their community;

(3) pool their insurance risk;

(4) purchase these products from the health maintenance organization involved in the demonstration project; and

(5) actively participate in health improvement decisions for their community.

(b) The commissioner must consider the following when approving applications for rural demonstration projects:

(1) the extent of consumer involvement in development of the project;

(2) the degree to which the project is likely to reduce the number of uninsured or to maintain existing coverage; and

(3) a plan to evaluate and report to the commissioner and legislature as prescribed by paragraph (e).

(c) For purposes of this subdivision, the commissioner must waive compliance with the following statutes and rules: the cost-sharing restrictions under section 62D.095, subdivisions 2, 3, and 4, and Minnesota Rules, part 4685.0801, subparts 1 to 7; for a period of at least two years, participation in government programs under section 62D.04, subdivision 5, in the counties of the demonstration project if that compliance would have been required solely due to participation in the demonstration project and shall continue to waive this requirement beyond two years if the enrollment in the demonstration project is less than 10,000 enrollees; small employer marketing under section 62L.05, subdivisions 1 to 3; and small employer geographic premium variations under section 62L.08, subdivision 4. The commissioner shall approve enrollee cost-sharing features desired by the coalition that appropriately share costs between employers, individuals, and the health maintenance organization.

(d) The health maintenance organization may make the starting date of the project contingent upon a minimum number of enrollees as cited in the application, provide for an initial term of contract with the purchasers of a minimum of three years, and impose a reasonable penalty for employers who withdraw early from the project. For purposes of this subdivision, loss ratios are to be determined as if the policies issued under this section are considered individual or small employer policies pursuant to section 62A.021, subdivision ~~1, paragraph (f)~~ 1a. The health maintenance organization may consider businesses of one to be a small employer under section 62L.02, subdivision 26. The health maintenance organization may limit enrollment and establish enrollment criteria for businesses of one. Health improvement and purchasing coalitions under this subdivision are not associations under section 62L.045, subdivision 1, paragraph (a).

(e) The health improvement and purchasing coalition must report to the commissioner and legislature annually on the progress of the demonstration project and, to the extent possible, any significant findings in the criteria listed in clauses (1), (2), and (3) for the final report. The coalition must submit a final report five years from the starting date of the project. The final report must detail significant findings from the project and must include, to the extent available, but should not be limited to, information on the following:

(1) the extent to which the project had an impact on the number of uninsured in the project area;

(2) the effect on health coverage premiums for groups in the project's geographic area, including those purchasing health coverage outside the health improvement and purchasing coalition; and

(3) the degree to which health care consumers were involved in the development and implementation of the demonstration project.

(f) The commissioner must limit the number of demonstration projects under this subdivision to five projects.

(g) Approval of the application for the demonstration project is deemed to be in compliance with section 62E.06, subdivisions 1, paragraph (a), 2, and 3.

(h) Subdivisions 2 to 7 apply to demonstration projects under this subdivision. Waivers permitted under subdivision 1 do not apply to demonstration projects under this subdivision.

(i) If a demonstration project under this subdivision works in conjunction with a purchasing alliance formed under chapter 62T, that chapter will apply to the purchasing alliance except to the extent that chapter 62T is inconsistent with this subdivision.

Sec. 25. Minnesota Statutes 2018, section 62E.02, subdivision 3, is amended to read:

Subd. 3. **Health maintenance organization.** "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in chapter 62D.

Sec. 26. Minnesota Statutes 2018, section 62E.23, subdivision 4, is amended to read:

Subd. 4. **Calculation of reinsurance payments.** (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

(c) In calculating claims costs incurred for an individual enrollee's covered benefits for a benefit year and eligible to be reimbursed by the commissioner of commerce, an eligible health carrier shall not include claims costs for coverage of ectodermal dysplasias or

PANDAS or PANS under section 62A.25, subdivision 2; 62A.28, subdivision 2; 62A.3096; or 62A.3097.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to claims costs incurred on or after that date.

Sec. 4. Minnesota Statutes 2018, section 62K.07, is amended to read:

62K.07 INFORMATION DISCLOSURES.

Subdivision 1. **In general.** (a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:

(1) claims payment policies and practices;

(2) periodic financial disclosures;

(3) data on enrollment;

(4) data on disenrollment;

(5) data on the number of claims that are denied;

(6) data on rating practices;

(7) information on cost-sharing and payments with respect to out-of-network coverage; and

(8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.

(b) A health carrier offering an individual or small group health plan must comply with all information disclosure requirements of all applicable state and federal law, including the Affordable Care Act.

(c) Except for qualified health plans sold on MNsure, information reported under paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02, subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be reported by MNsure for qualified health plans sold through MNsure.

Subd. 2. **Prescription drug costs.** (a) Each health carrier that offers a prescription drug benefit in its individual health plans or small group health plans shall include in the applicable rate filing required under section 62A.02 the following information about covered prescription drugs:

(1) the 25 most frequently prescribed drugs in the previous plan year;

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Sec. 27. Minnesota Statutes 2018, section 62K.075, is amended to read:

62K.075 PROVIDER NETWORK NOTIFICATIONS.

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

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

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(2) the 25 most costly prescription drugs as a portion of the individual health plan's or small group health plan's total annual expenditures in the previous plan year;

(3) the 25 prescription drugs that have caused the greatest increase in total individual health plan or small group health plan spending in the previous plan year;

(4) the projected impact of the cost of prescription drugs on premium rates;

(5) if any health plan offered by the health carrier requires enrollees to pay cost-sharing on any covered prescription drugs including deductibles, co-payments, or coinsurance in an amount that is greater than the amount the enrollee's health plan would pay for the drug absent the applicable enrollee cost-sharing and after accounting for any rebate amount; and

(6) if the health carrier prohibits third-party payments including manufacturer drug discounts or coupons that cover all or a portion of an enrollee's cost-sharing requirements including deductibles, co-payments, or coinsurance from applying toward the enrollee's cost-sharing obligations under the enrollee's health plan.

(b) The commissioner of commerce, in consultation with the commissioner of health, shall release a summary of the information reported in paragraph (a) at the same time as the information required under section 62A.02, subdivision 2, paragraph (c).

Subd. 3. **Enforcement.** ~~(d)~~ The commissioner of commerce shall enforce this section.

EFFECTIVE DATE. This section is effective for individual health plans and small group health plans offered, issued, sold, or renewed on or after January 1, 2021.

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

Sec. 28. Minnesota Statutes 2018, section 62K.10, subdivision 2, is amended to read:

Subd. 2. **Emergency care; primary care; mental health services; general hospital services.** (a) The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services.

(b) Emergency care must be available to enrollees 24 hours a day, 7 days a week. A provider network must comply with the access standards for appointment wait times specified in section 62D.124, subdivision 1, paragraph (b), for primary care services, mental health services, and substance use disorder treatment services.

Sec. 29. Minnesota Statutes 2018, section 62K.10, subdivision 3, is amended to read:

Subd. 3. **Other health services.** (a) The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

(b) A provider network must comply with the access standards for appointment wait times specified in section 62D.124, subdivision 2, paragraph (b), for nonurgent specialty care.

(c) A provider network must comply with the access standards for appointment wait times specified in section 62D.124, subdivision 2, paragraph (c), for dental, optometry, laboratory, and x-ray services.

Sec. 30. Minnesota Statutes 2018, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall ensure that a provider network is sufficient to satisfy the access standards for emergency care and appointment wait times in subdivisions 2 and 3 and shall also consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

Sec. 31. Minnesota Statutes 2018, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) A health carrier ~~or preferred provider organization~~ may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $1,000 for each application to waive the requirements in subdivision 2 or 3 for one or more provider types per county, and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area; and

(2) include specific information as to the steps that were and will be taken to address the network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) The commissioner shall establish guidelines for evaluating waiver applications, standards governing approval or denial of a waiver application, and standards for steps that health carriers must take to address the network inadequacy and allow the health carrier to meet network adequacy requirements within a reasonable time period. The commissioner shall review each waiver application using these guidelines and standards and shall approve a waiver application only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for taking these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health carrier demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health carrier is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) The waiver shall automatically expire after ~~four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.~~ one year. Upon or prior to expiration of a waiver, a health

carrier unable to meet the requirements in subdivision 2 or 3 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the carrier took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the carrier for the most recent one-year period, the commissioner shall also examine the steps the carrier took during that one-year period to address network inadequacy, and shall only approve a subsequent waiver application that satisfies the requirements in paragraph (b), demonstrates that the carrier took the steps it proposed to address network inadequacy, and explains why the carrier continues to be unable to satisfy the requirements in subdivision 2 or 3.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 32. [62K.105] NETWORK ADEQUACY COMPLAINTS AND INVESTIGATIONS.

Subdivision 1. **Complaints.** The commissioner shall establish a clear, easily accessible process for accepting complaints from enrollees regarding health carrier compliance with section 62K.10, subdivision 2, 3, or 4. Using this process, an enrollee may file a complaint with the commissioner that a health carrier is not in compliance with the requirements of section 62K.10, subdivision 2, 3, or 4. The commissioner shall investigate all complaints received under this subdivision.

Subd. 2. **Commissioner investigations of provider networks.** The commissioner shall establish a program to examine health carrier compliance with the requirements in section 62K.10, subdivisions 2, 3, and 4. Under this program, department employees or contractors shall seek to make appointments with a range of provider types in a carrier's designated provider network to determine whether covered services are available to enrollees within the required appointment times, and shall examine whether the carrier's network complies with the maximum distance or travel time requirements for specific provider types. The commissioner shall develop a schedule to ensure that all health carriers are periodically examined under this program, and shall also use this program to investigate enrollee complaints filed under subdivision 1.

Subd. 3. **Administrative penalties.** The commissioner shall impose on a health carrier an administrative penalty of at least $100 per day that a provider network violates section 62K.10, subdivision 2, 3, or 4, in a county. The commissioner may also take other enforcement actions authorized in law for a violation, except that if the commissioner imposes an administrative penalty under this subdivision, the commissioner shall not also impose an administrative penalty under section 62D.17, subdivision 1. The commissioner shall use the factors in section 62D.17, subdivision 1, to determine the amount of the administrative penalty, and the procedures in section 62D.17, subdivision 1, apply to administrative penalties imposed under this subdivision.

Sec. 33. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to read:

Sec. 5. Minnesota Statutes 2018, section 62Q.01, is amended by adding a subdivision to read:

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Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include but are not limited to:

(1) medical management standards limiting or excluding benefits based on (i) medical necessity or medical appropriateness, or (ii) whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the health plan;

(9) in- and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

Sec. 34. [62Q.1841] PROHIBITION ON USE OF STEP THERAPY FOR METASTATIC CANCER.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

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Subd. 6b. **Nonquantitative treatment limitations or NQTLs.** "Nonquantitative treatment limitations" or "NQTLs" means processes, strategies, or evidentiary standards, or other factors that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include but are not limited to:

(1) medical management standards limiting or excluding benefits based on (i) medical necessity or medical appropriateness, or (ii) whether the treatment is experimental or investigative;

(2) formulary design for prescription drugs;

(3) health plans with multiple network tiers;

(4) criteria and parameters for provider inclusion in provider networks, including credentialing standards and reimbursement rates;

(5) health plan methods for determining usual, customary, and reasonable charges;

(6) fail-first or step therapy protocols;

(7) exclusions based on failure to complete a course of treatment;

(8) restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the health plan;

(9) in- and out-of-network geographic limitations;

(10) standards for providing access to out-of-network providers;

(11) limitations on inpatient services for situations where the enrollee is a threat to self or others;

(12) exclusions for court-ordered and involuntary holds;

(13) experimental treatment limitations;

(14) service coding;

(15) exclusions for services provided by clinical social workers; and

(16) provider reimbursement rates, including rates of reimbursement for mental health and substance use disorder services in primary care.

(b) "Health plan" has the meaning given in section 62Q.01, subdivision 3. Health plan includes health coverage provided by a county-based purchasing plan participating in a public program under chapter 256B or 256L or an integrated health partnership under section 256B.0755.

(c) "Stage four advanced metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the body.

(d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that provides coverage for the treatment of stage four advanced metastatic cancer or associated conditions must not limit or exclude coverage for a drug approved by the United States Food and Drug Administration that is on the health plan's prescription drug formulary by mandating that an enrollee with stage four advanced metastatic cancer or associated conditions follow a step therapy protocol if the use of the approved drug is consistent with:

(1) a United States Food and Drug Administration-approved indication; and

(2) a clinical practice guideline published by the National Comprehensive Care Network.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 35. Minnesota Statutes 2018, section 62Q.47, is amended to read:
62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the plan as written

Sec. 6. Minnesota Statutes 2018, section 62Q.47, is amended to read:
62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health

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and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner, in consultation with advocates, providers, and health plan companies, may require information from health plan companies to confirm that mental health parity is being implemented. Information required may include comparisons between mental health and substance use disorder treatment against other health care conditions for other issues, including wait times, prior authorizations, provider credentialing and reimbursement, drug formularies, use of out-of-network providers, out-of-pocket costs, medical necessity, network adequacy, claim denials, adoption of coverage for new treatments, in-home services, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the care provider's professional license, if the care is consistent with the provider's scope of practice and the health plan's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits are considered primary care visits for the purposes of applying any patient cost-sharing requirements imposed by the health plan. Beginning June 1, 2021, and each year thereafter, the commissioner of commerce, in consultation with the commissioner of health, must issue an updated report to the legislature. The report must:

(1) describe how the commissioners review health plan compliance with United States Code, title 42, section 18031(j), and any federal regulations or guidance relating to compliance and oversight;

(2) describe how the commissioners review compliance with this section and section 62Q.53;

(3) identify enforcement actions taken during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law and summarize the results of such market conduct examinations. The summary must include:

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plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

~~(d)~~ (e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the

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(i) the number of formal enforcement actions taken;

(ii) the benefit classifications examined in each enforcement action;

(iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations; and

(iv) a description of how individually identifiable information will be excluded from the reports, consistent with state and federal privacy protections;

(4) detail any corrective actions the commissioners have taken to ensure health plan compliance with this section and section 62Q.53, and United States Code, title 42, section 18031(j);

(5) detail the approach taken by the commissioners relating to informing the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law; and

(6) be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites.

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subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section and section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

Sec. 7. [62Q.48] COST-SHARING IN PRESCRIPTION INSULIN DRUGS.

Subdivision 1. **Scope of coverage.** This section applies to all health plans issued or renewed to a Minnesota resident.

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

(b) "Cost-sharing" means a deductible payment, co-payment, or coinsurance amount imposed on an enrollee for a covered prescription drug in accordance with the terms and conditions of the enrollee's health plan.

(c) "Legend drug" has the same meaning as in section 151.01, subdivision 17.

(d) "Prescription insulin drug" means a legend drug that contains insulin and is used to treat diabetes.

(e) "Net price" means the health plan company's cost for a prescription insulin drug, including any rebates or discounts received by or accrued directly or indirectly to the health plan company from a drug manufacturer or pharmacy benefit manager.

Subd. 3. **Cost-sharing limits.** (a) A health plan that imposes a cost-sharing requirement on the coverage of a prescription insulin drug shall limit the total amount of cost-sharing that an enrollee is required to pay at point of sale, including deductible payments and the

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Sec. 36. [62Q.521] COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closely held for-profit entity" means an entity that:

(1) is not a nonprofit entity;

(2) has more than 50 percent of the value of its ownership interest owned directly or indirectly by five or fewer individuals, or has an ownership structure that is substantially similar; and

(3) has no publicly traded ownership interest, having any class of common equity securities required to be registered under United States Code, title 15, section 781.

For purposes of this paragraph:

(i) ownership interests owned by a corporation, partnership, estate, or trust are considered owned proportionately by that entity's shareholders, partners, or beneficiaries;

(ii) ownership interests owned by a nonprofit entity are considered owned by a single owner;

(iii) ownership interests owned by an individual are considered owned, directly or indirectly, by or for the individual's family. For purposes of this item, "family" means brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

(iv) if an individual or entity holds an option to purchase an ownership interest, the individual or entity is considered to be the owner of those ownership interests.

(c) "Contraceptive method" means a drug, device, or other product approved by the Food and Drug Administration to prevent unintended pregnancy.

(d) "Contraceptive service" means consultation, examination, procedures, and medical services related to the prevention of unintended pregnancy. This includes but is not limited to voluntary sterilization procedures, patient education, counseling on contraceptives, and

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cost-sharing amounts charged once the deductible is met at an amount that does not exceed the net price of the prescription insulin drug.

(b) Nothing in this section shall prevent a health plan company from imposing a cost-sharing requirement that is less than the amount specified in paragraph (a).

EFFECTIVE DATE. This section is effective for health plans issued or renewed on or after January 1, 2020.

FOR SECTION 8, SEE ARTICLE 10 SIDE BY SIDE.FOR SECTION 9, SEE ARTICLE 19 SIDE BY SIDE.

follow-up services related to contraceptive methods or services, management of side effects, counseling for continued adherence, and device insertion or removal.

(e) "Eligible organization" means an organization that opposes providing coverage for some or all contraceptive methods or services on account of religious objections and that is:

(1) organized as a nonprofit entity and holds itself as a religious organization; or

(2) organized and operates as a closely held for-profit entity, and the organization's highest governing body has adopted, under the organization's applicable rules of governance and consistent with state law, a resolution or similar action establishing that it objects to covering some or all contraceptive methods or services on account of the owners' sincerely held religious beliefs.

(f) "Medical necessity" includes but is not limited to considerations such as severity of side effects, difference in permanence and reversibility of a contraceptive method or service, and ability to adhere to the appropriate use of the contraceptive method or service, as determined by the attending provider.

(g) "Religious employer" means an organization that is organized and operates as a nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(h) "Therapeutic equivalent version" means a drug, device, or product that can be expected to have the same clinical effect and safety profile when administered to a patient under the conditions specified in the labeling, and that:

(1) is approved as safe and effective;

(2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (ii) meeting compendial or other applicable standards of strength, quality, purity, and identity;

(3) is bioequivalent in that:

(i) the drug, device, or product does not present a known or potential bioequivalence problem and meet an acceptable in vitro standard; or

(ii) if the drug, device, or product does present a known or potential bioequivalence problem, it is shown to meet an appropriate bioequivalence standard;

(4) is adequately labeled; and

(5) is manufactured in compliance with current manufacturing practice regulations.

Subd. 2. **Required coverage; cost sharing prohibited.** (a) A health plan must provide coverage for contraceptive methods and services.

(b) A health plan company must not impose cost-sharing requirements, including co-pays, deductibles, or co-insurance, for contraceptive methods or services.

(c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in conjunction with a health savings account must include cost-sharing for contraceptive methods and services at the minimum level necessary to preserve the enrollee's ability to make tax exempt contributions and withdrawals from the health savings account, as provided by section 223 of the Internal Revenue Code of 1986, as amended.

(d) A health plan company must not impose any referral requirements, restrictions, or delays for contraceptive methods or services.

(e) A health plan must include at least one of each type of Food and Drug Administration approved contraceptive method in its formulary. If more than one therapeutic equivalent version of a contraceptive method is approved, a health plan must include at least one therapeutic equivalent version in its formulary, but is not required to include all therapeutic equivalent versions.

(f) For each health plan, a health plan company must list the contraceptive methods and services that are covered without cost-sharing in a manner that is easily accessible to enrollees, health care providers, and representatives of health care providers. The list for each health plan must be promptly updated to reflect changes to the coverage.

(g) If an enrollee's attending provider recommends a particular contraceptive method or service based on a determination of medical necessity for that enrollee, the health plan must cover that contraceptive method or service without cost-sharing. The health plan company issuing the health plan must defer to the attending provider's determination that the particular contraceptive method or service is medically necessary for the enrollee.

Subd. 3. **Religious employers; exempt** (a) A religious employer is not required to cover contraceptive methods or services if the employer has religious objections to the coverage. A religious employer that chooses to not provide coverage for contraceptive methods and services must notify employees as part of the hiring process and total employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(b) If the religious employer provides coverage for some contraceptive methods or services, the notice must provide a list of the contraceptive methods or services the employer refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptive methods and services if the eligible organization provides notice to any health plan company the eligible organization contracts with that it is an eligible

organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptive methods or services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include the name of the eligible organization, a statement that it objects to coverage for some or all of contraceptive methods or services, including a list of the contraceptive methods or services the eligible organization objects to, if applicable, and the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (b) to prospective employees as part of the hiring process and total employees at least 30 days before:

(1) an employee enrolls in the health plan; or

(2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must:

(1) expressly exclude coverage for some or all contraceptive methods or services from the health plan; and

(2) provide separate payments for any contraceptive methods or services required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or methods on the eligible organization, health plan, or enrollee.

(f) On January 1, 2021, and every year thereafter a health plan company must notify the commissioner, in a manner to be determined by the commissioner, regarding the number of eligible organizations granted an accommodation under this subdivision.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 37. [62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS.

Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521, subdivision 3, all health plans that provide prescription coverage must comply with the requirements of this section.

Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug

Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug that prevents pregnancy when administered after sexual contact.

Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by the health plan at the time of the first dispensing.

(b) The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 38. Minnesota Statutes 2018, section 62Q.81, is amended to read:

62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.

Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering individual and small group health plans must include the essential health benefits package ~~required under section 1302(a) of the Affordable Care Act and~~ as described in this subdivision.

(b) The essential health benefits package means coverage that:

(1) provides essential health benefits as ~~outlined in the Affordable Care Act~~ described in subdivision 4;

(2) limits cost-sharing for such coverage ~~in accordance with the Affordable Care Act,~~ as described in subdivision 2; and

(3) ~~subject to subdivision 3,~~ provides bronze, silver, gold, or platinum level of coverage ~~in accordance with the Affordable Care Act~~ as described in subdivision 3.

Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing includes deductibles, coinsurance, co-payments, or similar charges, and qualified medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986, as amended. It does not include premiums, balance billing from non-network providers, or spending for noncovered services.

(b) Cost-sharing per year for individual health plans is limited to the amount allowed under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased by an amount equal to the product of that amount and the premium adjustment percentage. The premium adjustment percentage is the percentage which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds the average per capita premium for 2017. If the amount of the increase is not a multiple of $50, the increases shall be rounded to the next lowest multiple of $50.

(c) Cost-sharing per year for small group health plans is limited to twice the amount allowed under paragraph (b).

(d) If a health plan company offers health plans in any level of coverage ~~specified under section 1302(d) of the Affordable Care Act,~~ as described in subdivision ~~1, paragraph (b), clause (3)~~ 3, the health plan company shall also offer coverage in that level to individuals who have not attained 21 years of age as of the beginning of a policy year.

Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans.** (a) A health plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(b) A health plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(c) A health plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(d) A health plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(e) A health plan company that does not provide an individual or small group health plan in the bronze, silver, gold, or platinum level of coverage~~, as described in subdivision 1, paragraph (b), clause (3),~~ shall be treated as meeting the requirements of this section ~~1302(d) of the Affordable Care Act~~ with respect to any ~~policy~~ plan year if the health plan company provides a catastrophic plan that meets the following requirements ~~of section 1302(c) of the Affordable Care Act.~~:

(1) the only individuals to enroll in the health plan are those that:

(i) have not attained age 30 before the beginning of the plan year;

(ii) have an inability to access affordable coverage; or

(iii) are experiencing a hardship in reference to their capability to access coverage; and

(2) the health plan provides essential health benefits, except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in the amount equal to the limitation in effect under subdivision 2 and the plan provides coverage for at least three primary care visits.

Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential health benefits" ~~has the meaning given under section 1302(b) of the Affordable Care Act and includes~~ means:

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

(6) mental health and substance use disorder services, including behavioral health treatment;

(7) pediatric services, including oral and vision care;

(8) prescription drugs;

(9) preventive and wellness services and chronic disease management;

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the ~~EHB benchmark plan, as defined under the Affordable Care Act~~ health plan described in paragraph (c).

(b) Emergency services must be provided without imposing any prior authorization requirement or limitation on coverage, where the provider of services does not have a contractual relationship with the health plan for the providing of services, that is more restrictive than the requirements or limitations that apply to emergency services received from providers who have a contractual relationship with the health plan. If services are provided out-of-network the cost-sharing is the same that would apply if services were provided in-network.

(c) The scope of essential health benefits under paragraph (a) must be equal to the scope of benefits provided under a typical employer plan.

(d) The essential health benefits must:

(1) reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category;

(2) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(3) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups; and

(4) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of

life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section 1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric dental benefits.

Sec. 39. Minnesota Statutes 2018, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner or as provided in paragraph (g).

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes

of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Medical assistance coverage for a prescription contraceptive must provide a 12-month supply for any prescription contraceptive, regardless of whether the enrollee was covered by medical assistance or the health plan at the time of the first dispensing. The prescribing health care provider must determine the appropriate number of months to prescribe the prescription contraceptives for, up to 12 months.

For purposes of this paragraph, "prescription contraceptive" means any drug or device that requires a prescription and is approved by the Food and Drug Administration to prevent pregnancy. Prescription contraceptive does not include an emergency contraceptive drug approved to prevent pregnancy when administered after sexual contact. For purposes of this paragraph, "health plan" has the meaning provided in section 62Q.01, subdivision 3.

EFFECTIVE DATE. This section applies to medical assistance and MinnesotaCare coverage effective January 1, 2021.

Sec. 40. Minnesota Statutes 2018, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for

which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.

(e) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates

"dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

(f) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

(g) Any step therapy protocol requirements established by the commissioner must comply with section 62Q.1841.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 41. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).** Medical assistance covers treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). Coverage shall be developed in collaboration with the Health Services Policy Committee established under subdivision 3c.

Sec. 42. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Ectodermal dysplasias.** Medical assistance covers the following services for the treatment of ectodermal dysplasias:

(1) scalp hair prosthesis;

(2) breast reconstruction surgery; and

(3) dental services, including bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 43. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision to read:

Subd. 6e. **Access standards; appointment wait times.** Managed care and county-based purchasing plans must comply with the access standards for emergency care and appointment

wait times specified in section 62D.124, subdivisions 1, paragraph (b), and 2, paragraphs (b) and (c).

EFFECTIVE DATE. This section is effective for managed care and county-based purchasing contracts entered into on or after January 1, 2020.

Sec. 44. Minnesota Statutes 2018, section 256L.121, subdivision 3, is amended to read:

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; ~~and~~

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care~~.~~; and

(6) complying with the appointment wait time standards specified in section 62D.124, subdivisions 1, paragraph (b), and 2, paragraphs (b) and (c).

EFFECTIVE DATE. This section is effective for managed care, county-based purchasing, and participating entity contracts entered into on or after January 1, 2020.

Sec. 45. Minnesota Statutes 2018, section 317A.811, is amended by adding a subdivision to read:

Subd. 1a. **Nonprofit health care entity; notice and approval required.** In addition to the requirements of subdivision 1, a nonprofit health care entity as defined in section 317B.01, subdivision 12, is subject to the notice and approval requirements for certain transactions under chapter 317B.

Sec. 46. [317B.01] NONPROFIT HEALTH CARE ENTITY CONVERSIONS; DEFINITIONS.

Subdivision 1. **Application.** The definitions in this section apply to this chapter.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of commerce for a nonprofit health care entity that is a nonprofit health service plan corporation operating under chapter 62C, or the commissioner of health for a nonprofit health care entity that is a nonprofit health maintenance organization operating under chapter 62D.

Subd. 3. **Conversion benefit entity.** "Conversion benefit entity" means a foundation, corporation, limited liability company, trust, partnership, or other entity that receives, in connection with a conversion transaction, the value of any public benefit assets, in accordance with section 317B.02, subdivision 7.

Subd. 4. **Conversion transaction or transaction.** "Conversion transaction" or "transaction" means a transaction otherwise permitted by applicable law in which a nonprofit health care entity:

(1) merges, consolidates, converts, or transfers all or a material amount of its assets to any entity except a corporation that is also exempt under United States Code, title 26, section 501(c)(3);

(2) makes a series of separate transfers within a 24-month period that in the aggregate constitute a transfer of all or a material amount of the nonprofit health care entity's assets to any entity except a corporation that is also exempt under United States Code, title 26, section 501(c)(3); or

(3) adds or substitutes one or more members that effectively transfers the control, responsibility for, or governance of the nonprofit health care entity to any entity except a corporation that is also exempt under United States Code, title 26, section 501(c)(3).

Subd. 5. **Corporation.** "Corporation" has the meaning given in section 317A.011, subdivision 6, and also includes a nonprofit limited liability company organized under section 322C.1101.

Subd. 6. **Director.** "Director" has the meaning given in section 317A.011, subdivision 7.

Subd. 7. **Family member.** "Family member" means a spouse, parent, child, spouse of a child, brother, sister, or spouse of a brother or sister.

Subd. 8. **Full and fair value.** "Full and fair value" means the amount that the public benefit assets of the nonprofit health care entity would be worth if the assets were equal to stock in the nonprofit health care entity, if the nonprofit health care entity was a for-profit corporation, and if the nonprofit health care entity had 100 percent of its stock authorized by the corporation and available for purchase without transfer restrictions. The valuation

shall consider market value, investment or earning value, net asset value, goodwill, the amount of donations received, and a control premium, if any.

Subd. 9. **Key employee.** "Key employee" means a person, regardless of title, who:

(1) has responsibilities, power, or influence over an organization similar to those of an officer or director;

(2) manages a discrete segment or activity of the organization that represents ten percent or more of the activities, assets, income, or expenses of the organization, as compared to the organization as a whole; or

(3) has or shares authority to control or determine ten percent or more of the organization's capital expenditures, operating budget, or compensation for employees.

Subd. 10. **Material amount.** "Material amount" means the lesser of ten percent of a nonprofit health care entity's total net admitted assets as of December 31 of the preceding year, or $10,000,000.

Subd. 11. **Member.** "Member" has the meaning given in section 317A.011, subdivision 12.

Subd. 12. **Nonprofit health care entity.** "Nonprofit health care entity" means a nonprofit health service plan corporation operating under chapter 62C, a nonprofit health maintenance organization operating under chapter 62D, a corporation that can effectively exercise control over a nonprofit health service plan corporation or a nonprofit health maintenance organization, or any other entity that is effectively controlled by a corporation operating a nonprofit health service plan corporation or a nonprofit health maintenance organization.

Subd. 13. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision 15.

Subd. 14. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit health care entity's assets, whether tangible or intangible, including but not limited to its goodwill and anticipated future revenue.

Subd. 15. **Related organization.** "Related organization" has the meaning given in section 317A.011, subdivision 18.

Sec. 47. [317B.02] NONPROFIT HEALTH CARE ENTITY CONVERSION TRANSACTIONS; REVIEW, NOTICE, APPROVAL.

Subdivision 1. **Certain conversion transactions prohibited.** A nonprofit health care entity shall not enter into a conversion transaction if a person who has been an officer, director, or key employee of the nonprofit health care entity or of a related organization, or a family member of such a person:

(1) has received or will receive any type of compensation or other financial benefit, directly or indirectly, in connection with the conversion transaction;

(2) has held or will hold, whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in an entity to which the nonprofit health care entity transfers public benefit assets in connection with the conversion transaction;

(3) has received or will receive any type of compensation or other financial benefit from an entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction;

(4) has held or will hold, whether guaranteed or contingent, an ownership stake, stock, securities, investment, or other financial interest in an entity that has or will have a business relationship with an entity to which the nonprofit health care entity transfers public benefit assets in connection with the conversion transaction; or

(5) has received or will receive any type of compensation or other financial benefit from an entity that has or will have a business relationship with an entity to which the nonprofit health care entity transfers public benefit assets in connection with the conversion transaction.

Subd. 2. **Attorney general notice required.** (a) Before entering into a conversion transaction, a nonprofit health care entity must notify the attorney general according to section 317A.811. In addition to the elements listed in section 317A.811, subdivision 1, the notice required by this subdivision must also include an itemization of the nonprofit health care entity's public benefit assets and the valuation the nonprofit health care entity attributes to those assets; a proposed plan for the distribution of the value of those assets to a conversion benefit entity that meets the requirements of subdivision 4; and other information from the nonprofit health care entity or the proposed conversion benefit entity that the attorney general reasonably considers necessary to review the proposed conversion transaction under subdivision 3.

(b) At the time the nonprofit health care entity provides the attorney general with the notice and other information required under this subdivision, the nonprofit health care entity must also provide a copy of the notice and other information required under this subdivision to the commissioner. If the attorney general requests additional information from a nonprofit health care entity in connection with its review of a proposed conversion transaction, the nonprofit health care entity must also provide a copy of this information to the commissioner, at the time this information is provided to the attorney general.

Subd. 3. **Review elements.** (a) The attorney general may approve, conditionally approve, or disapprove a proposed conversion transaction under this section. In determining whether to approve, conditionally approve, or disapprove a proposed transaction, the attorney general, in consultation with the commissioner, shall consider any factors the attorney general considers relevant in evaluating whether the proposed transaction is in the public interest, including whether:

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

(2) the proposed transaction involves or constitutes a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets;

(4) the value of the public benefit assets to be transferred has been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the proposed 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 proposed transaction will result in a breach of fiduciary duty, as determined by the attorney general, including whether:

(i) conflicts of interest exist related to payments to or benefits conferred upon officers, directors, or key employees of the nonprofit health care entity or a related organization;

(ii) the nonprofit health care entity's directors exercised reasonable care and due diligence in deciding to pursue the transaction, in selecting the entity with which to pursue the transaction, and in negotiating the terms and conditions of the transaction; and

(iii) the nonprofit health care entity's directors considered all reasonably viable alternatives, including any competing offers for its public benefit assets, or alternative transactions;

(7) the transaction will result in financial benefit to a person, including owners, directors, officers, or key employees of the nonprofit health care entity or of the entity to which the nonprofit health care entity proposes to transfer public benefit assets;

(8) the conversion benefit entity meets the requirements in subdivision 4; and

(9) the attorney general and the commissioner have been provided with sufficient information by the nonprofit health care entity to adequately evaluate the proposed transaction and its effects on the public and enrollees, provided the attorney general or commissioner has notified the nonprofit health care entity or the proposed conversion benefit entity if the information provided is insufficient and has provided the nonprofit health care entity or proposed conversion benefit entity with a reasonable opportunity to remedy that insufficiency.

(b) In addition to the elements in paragraph (a), the attorney general shall also consider public comments received under subdivision 5 regarding the proposed conversion transaction and the proposed transaction's likely effect on the availability, accessibility, and affordability of health care services to the public.

(c) In deciding whether to approve, conditionally approve, or disapprove a transaction, the attorney general must consult with the commissioner.

Subd. 4. **Conversion benefit entity requirements.** (a) A conversion benefit entity shall:

(1) be an existing or new, domestic, nonprofit corporation operating under chapter 317A and exempt under United States Code, title 26, section 501(c)(3);

(2) have in place procedures and policies to prohibit conflicts of interest, including but not limited to conflicts of interest relating to any grant-making activities that may benefit:

(i) the directors, officers, or key employees of the conversion benefit entity;

(ii) any entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction; or

(iii) any directors, officers, or key employees of an entity to which the nonprofit health care entity transfers public benefit assets in connection with a conversion transaction;

(3) operate to benefit the health of the people of this state; and

(4) have in place procedures and policies that prohibit:

(i) an officer, director, or key employee of the nonprofit health care entity from serving as an officer, director, or key employee of the conversion benefit entity for the five-year period following the conversion transaction;

(ii) an officer, director, or key employee of the nonprofit health care entity or of the conversion benefit entity from directly or indirectly benefiting from the conversion transaction; and

(iii) elected or appointed public officials from serving as an officer, director, or key employee of the conversion benefit entity.

(b) A conversion benefit entity shall not make grants or payments or otherwise provide financial benefit to an entity to which a nonprofit health care entity transfers public benefit assets as part of a conversion transaction, or to a related organization of the entity to which the nonprofit health care entity transfers public benefit assets as part of a conversion transaction.

(c) No person who has been an officer, director, or key employee of an entity that has received public benefit assets in connection with a conversion transaction may serve as an officer, director, or key employee of the conversion benefit entity.

(d) The attorney general must review and approve the governance structure of a conversion benefit entity before the conversion benefit entity receives the value of public benefit assets from a nonprofit health care entity. In order to be approved by the attorney general under this paragraph, the conversion benefit entity's governance must be broadly based in the community served by the nonprofit health care entity and must be independent of the entity to which the nonprofit health care entity transfers public benefit assets as part of the conversion transaction. As part of the review of the conversion benefit entity's governance, the attorney general shall hold a public hearing. If the attorney general finds

it necessary, a portion of the value of the public benefit assets shall be used to develop a community-based plan for use by the conversion benefit entity.

(e) The attorney general shall establish a community advisory committee for a conversion benefit entity receiving the value of public benefit assets. The members of the community advisory committee must be selected to represent the diversity of the community previously served by the nonprofit health care entity. The community advisory committee shall:

(1) provide a slate of three nominees for each vacancy on the governing board of the conversion benefit entity, from which the remaining board members shall select new members to the board;

(2) provide the governing board with guidance on the health needs of the community previously served by the nonprofit health care entity; and

(3) promote dialogue and information sharing between the conversion benefit entity and the community previously served by the nonprofit health care entity.

Subd. 5. **Hearing; public comment; maintenance of record.** (a) Before issuing a decision under subdivision 6, the attorney general shall hold one or more hearings and solicit public comments regarding the proposed conversion transaction. No later than 45 days after the attorney general receives notice of a proposed conversion transaction, the attorney general shall hold at least one public hearing in the area served by the nonprofit health care entity, and shall hold as many hearings as necessary in various parts of the state to ensure that each community in the nonprofit health care entity's service area has an opportunity to provide comments on the conversion transaction. Any person may appear and speak at the hearing, file written comments, or file exhibits for the hearing. At least 14 days before the hearing, the attorney general shall provide written notice of the hearing through posting on the attorney general's website, publication in one or more newspapers of general circulation, and notice by means of a public listserv or through other means to all persons who request notice from the attorney general of such hearings. A public hearing is not required if the waiting period under subdivision 6 is waived or is shorter than 45 days in duration. The attorney general may also solicit public comments through other means.

(b) The attorney general shall develop and maintain a summary of written and oral public comments made at a hearing and otherwise received by the attorney general, shall record all questions posed during the public hearing or received by the attorney general, and shall require answers from the appropriate parties. The summary materials, questions, and answers shall be maintained on the attorney general's website, and the attorney general must provide a copy of these materials at no cost to any person who requests them.

Subd. 6. **Approval required; period for approval or disapproval; extension.** (a) Notwithstanding the time periods in section 15.99 or 317A.811, a nonprofit health care entity shall not enter into a conversion transaction until:

(1) 150 days after the entity has given written notice to the attorney general, unless the attorney general waives all or a part of the waiting period. The attorney general shall establish

guidelines for when the attorney general may waive all or part of the waiting period, and must provide public notice if the attorney general waives all or part of the waiting period; and

(2) the nonprofit health care entity obtains approval of the transaction from the attorney general, or obtains conditional approval from the attorney general and satisfies the required conditions.

(b) During the waiting period, the attorney general shall decide whether to approve, conditionally approve, or disapprove the conversion transaction and shall notify the nonprofit health care entity in writing of the attorney general's decision. If the transaction is disapproved, the notice must include the reasons for the decision. If the transaction is conditionally approved, the notice must specify the conditions that must be met and the reasons for these conditions. The attorney general may extend the waiting period for an additional 90 days by notifying the nonprofit health care entity of the extension in writing.

(c) The time periods under this subdivision shall be suspended while a request from the attorney general for additional information is outstanding.

Subd. 7. **Transfer of value of assets required.** If a proposed conversion transaction is approved or conditionally approved by the attorney general, the nonprofit health care entity shall transfer the entirety of the full and fair value of its public benefit assets to one or more conversion benefit entities as part of the transaction.

Subd. 8. **Assessment of costs.** (a) The nonprofit health care entity must reimburse the attorney general or a state agency for all reasonable and actual costs incurred by the attorney general or the state agency in reviewing the proposed conversion transaction and in exercising enforcement remedies under this section. Costs incurred may include attorney fees at the rate at which the attorney general bills state agencies; costs for retaining actuarial, valuation, or other experts and consultants; and administrative costs. In order to receive reimbursement under this subdivision, the attorney general or state agency must provide the nonprofit health care entity with a statement of costs incurred.

(b) The nonprofit health care entity must remit the total amount listed on the statement to the attorney general or state agency within 30 days after the statement date, unless the entity disputes some or all of the submitted costs. The nonprofit health care entity may dispute the submitted costs by bringing an action in district court to have the court determine the amount of the reasonable and actual costs that must be remitted.

(c) Money remitted to the attorney general or state agency under this subdivision shall be deposited in the general fund in the state treasury and is appropriated to the attorney general or state agency, as applicable, to reimburse the attorney general or state agency for costs paid or incurred under this section.

Subd. 9. **Challenge to disapproval or conditional approval.** If the attorney general disapproves or conditionally approves a conversion transaction, a nonprofit health care entity may bring an action in district court to challenge the disapproval, or any condition

of a conditional approval, as applicable. To prevail in such an action, the nonprofit health care entity must clearly establish that the disapproval, or each condition being challenged, as applicable, is arbitrary and capricious and unnecessary to protect the public interest.

Subd. 10. **Penalties; remedies.** The attorney general is authorized to bring an action to unwind a conversion transaction entered into in violation of this section and to recover the amount of any financial benefit received or held in violation of subdivision 1. In addition to this recovery, the officers, directors, and key employees of each entity that is a party to, and who materially participated in, the transaction entered into in violation of this section, may be subject to a civil penalty of up to the greater of the entirety of any financial benefit each officer, director, or key employee derived from the transaction or $1,000,000, as determined by the court. The attorney general is authorized to enforce this section under section 8.31.

Subd. 11. **Relation to other law.** (a) This section is in addition to, and does not affect or limit any power, remedy, or responsibility of a health maintenance organization, a service plan corporation, a conversion benefit entity, the attorney general, the commissioner of commerce, or commissioner of health under chapter 62C, 62D, 317A, or 501B, or other law.

(b) Nothing in this section authorizes a nonprofit health care entity to enter into a conversion transaction not otherwise permitted under chapter 317A or 501B or other law.

Sec. 48. Laws 2017, First Special Session chapter 6, article 5, section 11, 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~~;~~; or a direct or indirect parent, subsidiary, or other affiliate of such an entity, may only merge or consolidate with; ~~or~~ convert~~;~~, or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a ~~substantial portion~~ material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total net admitted assets as of December 31 of the preceding year, or $10,000,000.

(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 ~~health~~ service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

Sec. 10. Laws 2017, First Special Session chapter 6, article 5, section 11, 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 nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; or convert, or transfer all or a substantial portion of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A~~;~~ or to a nonprofit hospital within the same integrated health system as the health maintenance organization.

(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 health maintenance organization or a nonprofit ~~health~~ service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

House Language H2414-2

(d) This section expires July 1, ~~2019~~ 2029.

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

Sec. 49. **FINDINGS.**

The Legislature of the state of Minnesota finds and declares that:

(1) nonprofit health care entities hold their assets in trust, and those assets are irrevocably dedicated, as a condition of their tax-exempt status, to the specific charitable purpose set forth in the articles of incorporation of the entities;

(2) the public is the beneficiary of that trust;

(3) nonprofit health care entities have a substantial and beneficial effect on the quality of life of the people of Minnesota;

(4) transfers of assets by nonprofit health care entities to for-profit entities directly affect the charitable uses of those assets and may adversely affect the public as the beneficiary of the charitable assets;

(5) it is in the best interest of the public to ensure that the public interest is fully protected whenever the assets or operations of a nonprofit health care entity are transferred, directly or indirectly, from a charitable trust to a for-profit or mutual benefit entity; and

(6) the attorney general's approval of any transfers of assets or operations by a nonprofit health care entity is necessary to ensure the protection of these trusts.

Sec. 50. **REPORT; DENIALS OF COVERAGE FOR TREATMENT FOR PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTIONS (PANDAS) AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME (PANS).**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Health carrier" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 2.

(c) "Health plan" has the meaning given in Minnesota Statutes, section 62A.011, subdivision 3.

(d) "Pediatric acute-onset neuropsychiatric syndrome" and "pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" have the meanings given in Minnesota Statutes, section 62A.3097, subdivision 1.

Subd. 2. **Report required.** (a) A health carrier that offers a health plan providing coverage to Minnesota residents must report the following to the commissioner of health by October 1, 2019:

Senate Language UEH2414-1

(d) This section expires July 1, ~~2019~~ 2023.

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

(1) the number of times the health carrier has denied coverage for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) or for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS); and

(2) for each denial of coverage, the specific treatment for which coverage was denied.

(b) The commissioner of health must compile the information submitted under this subdivision into a single report and must post that report to the department's website on or before November 1, 2019. The posted report must identify each reporting health carrier and must specify, for each carrier, the number of coverage denials for each specific treatment.

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

Sec. 51. **COVERAGE FOR ECTODERMAL DYSPLASIAS AND PANDAS OR PANS.**

A health plan's coverage as of January 1, 2019, must be used by the health carrier as the basis for determining whether coverage would not have been provided by the health carrier pursuant to Minnesota Statutes, section 62A.25, subdivision 2, paragraph (d); 62A.28, subdivision 2, paragraph (c); 62A.3096, subdivision 4; or 62A.3097, subdivision 4. Treatments and services covered by the health plan as of January 1, 2019, are not eligible for reimbursement by the commissioner of commerce.

Sec. 52. **REVISOR INSTRUCTION.**

The revisor of statutes shall codify Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by this act, in Minnesota Statutes, chapter 62D.

Sec. 53. **REPEALER.**

Minnesota Statutes 2018, section 62A.021, subdivisions 1 and 3, are repealed effective the day following final enactment.