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**ARTICLE 2**

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**INSURANCE POLICY**

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**INSURANCE**10.21 Section 1. Minnesota Statutes 2022, section 60A.08, subdivision 15, is amended to read:10.22      Subd. 15. Classification of insurance filings data. (a) All forms, rates, and related  
10.23 information filed with the commissioner under section 61A.02 shall be nonpublic data until  
10.24 the filing becomes effective.10.25      (b) All forms, rates, and related information filed with the commissioner under section  
10.26 62A.02 shall be nonpublic data until the filing becomes effective.10.27      (c) All forms, rates, and related information filed with the commissioner under section  
10.28 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.10.29      (d) All forms, rates, and related information filed with the commissioner under section  
10.30 70A.06 shall be nonpublic data until the filing becomes effective.11.1      (e) All forms, rates, and related information filed with the commissioner under section  
11.2 79.56 shall be nonpublic data until the filing becomes effective.11.3      (f) All forms, rates, and related information filed with the commissioner under section  
11.4 65A.298 are nonpublic data until the filing becomes effective.11.5      (g) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review  
11.6 under section 2794 of the Public Health Services Act and any amendments to, or regulations,  
11.7 or guidance issued under the act that are filed with the commissioner on or after September  
11.8 1, 2011, the commissioner:

11.9      (1) may acknowledge receipt of the information;

11.10      (2) may acknowledge that the corresponding rate filing is pending review;

11.11      (3) must provide public access from the Department of Commerce's website to parts I  
11.12 and II of the Preliminary Justifications of the rate increases subject to review; and11.13      (4) must provide notice to the public on the Department of Commerce's website of the  
11.14 review of the proposed rate, which must include a statement that the public has 30 calendar  
11.15 days to submit written comments to the commissioner on the rate filing subject to review.11.16      (h) Notwithstanding paragraphs (b) and (c), for all proposed premium rates filed  
11.17 with the commissioner for individual health plans, as defined in section 62A.011, subdivision  
11.18 4, and small group health plans, as defined in section 62K.03, subdivision 12, the  
11.19 commissioner must provide public access on the Department of Commerce's website to  
11.20 compiled data of the proposed changes to rates, separated by health plan and geographic  
11.21 rating area, within ten business days after the deadline by which health carriers, as defined  
11.22 in section 62A.011, subdivision 2, must submit proposed rates to the commissioner for  
11.23 approval.

11.24 Sec. 2. **[60A.0812] PROPERTY AND CASUALTY POLICY EXCLUSIONS.**11.25 Subdivision 1. **Short title.** This section may be cited as the "Family Protection Act."11.26 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the  
11.27 meanings given.11.28 (b) "Boat" means a motorized or nonmotorized vessel that floats and is used for personal,  
11.29 noncommercial use on waters in Minnesota.11.30 (c) "Boat insurance policy" means an insurance policy that provides liability coverage  
11.31 for bodily injury resulting from the ownership, maintenance, or use of a boat, although the  
12.1 policy may also provide for property insurance coverage for the boat for noncommercial  
12.2 use.12.3 (d) "Insured" means an insured under a policy specified in subdivision 3, clauses (1) to  
12.4 (4), including the named insured and the following persons not identified by name as an  
12.5 insured while residing in the same household with the named insured:

12.6 (1) a spouse of a named insured;

12.7 (2) a relative of a named insured; or

12.8 (3) a minor in the custody of a named insured, spouse of a named insured, or of a relative  
12.9 residing in the same household with a named insured.12.10 For purposes of this section, a person resides in or is a member of the same household with  
12.11 the named insured if the person's home is usually in the same family unit, even if the person  
12.12 is temporarily living elsewhere.12.13 (e) "Permitted exclusion" means an exclusion of or limitation on liability for damages  
12.14 for bodily injury resulting from fraud, intentional conduct, criminal conduct that intentionally  
12.15 causes an injury, and other exclusions permitted by law, including a permitted exclusion  
12.16 contained in a boat insurance policy issued in this state pursuant to subdivision 6.12.17 (f) "Prohibited exclusion" means an exclusion of or limitation on liability for damages  
12.18 for bodily injury because the injured person is:

12.19 (1) an insured other than a named insured;

12.20 (2) a resident or member of the insured's household; or

12.21 (3) related to the insured by blood or marriage.

12.22 Subd. 3. **Prohibited exclusions.** A prohibited exclusion contained in a plan or policy  
12.23 identified in clauses (1) to (4) is against public policy and is void. The following insurance  
12.24 coverage issued in this state must not contain a prohibited exclusion, unless expressly  
12.25 provided otherwise under this section:

12.26        (1) a plan of reparation security, as defined under section 65B.43;  
12.27        (2) a boat insurance policy;  
12.28        (3) a personal excess liability policy; and  
12.29        (4) a personal umbrella policy.  
12.30        Subd. 4. **Permitted exclusions.** An insurance policy listed in this section may contain  
12.31        a permitted exclusion for bodily injury to an insured.  
13.1        Subd. 5. **Underlying coverage requirement.** An excess or umbrella policy may contain  
13.2        a requirement that coverage for family or household members under an excess or umbrella  
13.3        policy governed by this section is available only to the extent coverage is first available  
13.4        from an underlying policy that provides coverage for damages for bodily injury.  
13.5        Subd. 6. **Election of coverage for boat insurance policies.** (a) An insurer issuing bodily  
13.6        injury liability coverage for a boat insurance policy under this section must notify a person  
13.7        at the time of sale of the person's rights under this section to decline coverage for insureds  
13.8        and be provided an updated quote reflecting the appropriate premium for the coverage  
13.9        provided.  
13.10        (b) Named insureds must affirmatively make an election to decline coverage, in a form  
13.11        approved by the commissioner, after being informed that an updated quote will be provided.  
13.12        (c) An insurer offering an election of coverage under this subdivision must have the  
13.13        disclosure approved by the commissioner. The notice must be in 14-point bold type, in a  
13.14        conspicuous location of the notice document, and contain at least the following:  
13.15        ELECTION TO DECLINE COVERAGE: YOU HAVE THE RIGHT TO DECLINE  
13.16        BODILY INJURY COVERAGE FOR INJURIES TO YOUR FAMILY AND HOUSEHOLD  
13.17        MEMBERS FOR WHICH YOU WOULD OTHERWISE BE ENTITLED TO UNDER  
13.18        MINNESOTA LAW. IF YOU ELECT TO DECLINE THIS COVERAGE, YOU WILL  
13.19        RECEIVE AN UPDATED PREMIUM QUOTE BASED ON THE COVERAGE YOU  
13.20        ARE ELECTING TO PURCHASE. READ YOUR POLICY CAREFULLY TO  
13.21        DETERMINE WHICH FAMILY AND HOUSEHOLD MEMBERS WOULD NOT BE  
13.22        COVERED FOR BODILY INJURY IF YOU ELECT TO DECLINE COVERAGE.  
13.23        Subd. 7. **Excessive rate hearings for boat insurance policies.** Whenever an insurer  
13.24        files a change in a rate for a boat insurance policy that will result in a 15 percent or more  
13.25        increase in a 12-month period over existing rates, the commissioner may hold a hearing to  
13.26        determine if the change is excessive. The hearing must be conducted under chapter 14. The  
13.27        commissioner must give notice of intent to hold a hearing within 60 days of the filing of  
13.28        the change. It shall be the responsibility of the insurer to show the rate is not excessive. The  
13.29        rate is effective unless it is determined as a result of the hearing that the rate is excessive.  
13.30        This subdivision expires January 1, 2029.

10.28 Section 1. Minnesota Statutes 2022, section 60A.14, subdivision 1, is amended to read:

10.29 Subdivision 1. **Fees other than examination fees.** In addition to the fees and charges  
10.30 provided for examinations, the following fees must be paid to the commissioner for deposit  
10.31 in the general fund:

11.1 (a) by township mutual fire insurance companies:

11.2 (1) for filing certificate of incorporation \$25 and amendments thereto, \$10;

11.3 (2) for filing annual statements, \$15;

11.4 (3) for each annual certificate of authority, \$15;

11.5 (4) for filing bylaws \$25 and amendments thereto, \$10;

11.6 (b) by other domestic and foreign companies including fraternals and reciprocal  
11.7 exchanges:

11.8 (1) for filing an application for an initial certification of authority to be admitted to  
11.9 transact business in this state, \$1,500;

11.10 (2) for filing certified copy of certificate of articles of incorporation, \$100;

11.11 (3) for filing annual statement, ~~\$225~~ \$300;

11.12 (4) for filing certified copy of amendment to certificate or articles of incorporation, \$100;

11.13 (5) for filing bylaws, \$75 or amendments thereto, \$75;

11.14 (6) for each company's certificate of authority, ~~\$575~~ \$750, annually;

11.15 (c) the following general fees apply:

11.16 (1) for each certificate, including certified copy of certificate of authority, renewal,  
11.17 valuation of life policies, corporate condition or qualification, \$25;

11.18 (2) for each copy of paper on file in the commissioner's office 50 cents per page, and  
11.19 \$2.50 for certifying the same;

11.20 (3) for license to procure insurance in unadmitted foreign companies, \$575;

13.31 Subd. 8. **No endorsement required.** An endorsement, rider, or contract amendment is  
13.32 not required for this section to be effective.

13.33 **EFFECTIVE DATE.** This section is effective January 1, 2024, for plans of reparation  
13.34 security, as defined under Minnesota Statutes, section 65B.43, a personal excess liability  
14.1 policy, or a personal umbrella policy offered, issued, or renewed on or after that date. This  
14.2 section is effective on May 1, 2024, for a boat insurance policy covering a personal injury  
14.3 sustained while using a boat.

14.4 Sec. 3. Minnesota Statutes 2022, section 60A.14, subdivision 1, is amended to read:

14.5 Subdivision 1. **Fees other than examination fees.** In addition to the fees and charges  
14.6 provided for examinations, the following fees must be paid to the commissioner for deposit  
14.7 in the general fund:

14.8 (a) by township mutual fire insurance companies:

14.9 (1) for filing certificate of incorporation \$25 and amendments thereto, \$10;

14.10 (2) for filing annual statements, \$15;

14.11 (3) for each annual certificate of authority, \$15;

14.12 (4) for filing bylaws \$25 and amendments thereto, \$10;

14.13 (b) by other domestic and foreign companies including fraternals and reciprocal  
14.14 exchanges:

14.15 (1) for filing an application for an initial certification of authority to be admitted to  
14.16 transact business in this state, \$1,500;

14.17 (2) for filing certified copy of certificate of articles of incorporation, \$100;

14.18 (3) for filing annual statement, ~~\$225~~ \$300;

14.19 (4) for filing certified copy of amendment to certificate or articles of incorporation, \$100;

14.20 (5) for filing bylaws, \$75 or amendments thereto, \$75;

14.21 (6) for each company's certificate of authority, ~~\$575~~ \$750, annually;

14.22 (c) the following general fees apply:

14.23 (1) for each certificate, including certified copy of certificate of authority, renewal,  
14.24 valuation of life policies, corporate condition or qualification, \$25;

14.25 (2) for each copy of paper on file in the commissioner's office 50 cents per page, and  
14.26 \$2.50 for certifying the same;

14.27 (3) for license to procure insurance in unadmitted foreign companies, \$575;

11.21 (4) for valuing the policies of life insurance companies, ~~one cent~~ two cents per \$1,000  
 11.22 of insurance so valued, provided that the fee shall not exceed \$13,000 ~~\$26,000~~ per year for  
 11.23 any company. The commissioner may, in lieu of a valuation of the policies of any foreign  
 11.24 life insurance company admitted, or applying for admission, to do business in this state,  
 11.25 accept a certificate of valuation from the company's own actuary or from the commissioner  
 11.26 of insurance of the state or territory in which the company is domiciled;

11.27 (5) for receiving and filing certificates of policies by the company's actuary, or by the  
 11.28 commissioner of insurance of any other state or territory, \$50;

11.29 (6) for each appointment of an agent filed with the commissioner, \$30;

12.1 (7) for filing forms, rates, and compliance certifications under section 60A.315, \$140  
 12.2 per filing, or \$125 per filing when submitted via electronic filing system. Filing fees may  
 12.3 be paid on a quarterly basis in response to an invoice. Billing and payment may be made  
 12.4 electronically;

12.5 (8) for annual renewal of surplus lines insurer license, ~~\$300~~ \$400.

12.6 The commissioner shall adopt rules to define filings that are subject to a fee.

## S2219-2

9.26 Sec. 10. Minnesota Statutes 2022, section 61A.031, is amended to read:

### 61A.031 SUICIDE PROVISIONS.

9.28 (a) The sanity or insanity of a person shall not be a factor in determining whether a  
 9.29 person committed suicide within the terms of an individual or group life insurance policy  
 9.30 regulating the payment of benefits in the event of the insured's suicide. This ~~section~~ paragraph  
 9.31 shall not be construed to alter present law but is intended to clarify present law.

10.1 (b) ~~A life insurance policy or certificate issued or delivered in this state may exclude or~~  
 10.2 ~~restrict liability for any death benefit in the event the insured dies as a result of suicide~~  
 10.3 ~~within one year from the date of the issue of the policy or certificate. Any exclusion or~~  
 10.4 ~~restriction shall be clearly stated in the policy or certificate. Any life insurance policy or~~  
 10.5 ~~certificate which contains any exclusion or restriction under this paragraph shall also provide~~  
 10.6 ~~that in the event any death benefit is denied because the insured dies as a result of suicide~~  
 10.7 ~~within one year from the date of issue of the policy or certificate, the insurer shall refund~~  
 10.8 ~~all premiums paid for coverage providing the denied death benefit on the insured.~~

10.9 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to policies  
 10.10 issued ~~on or after that date.~~

10.11 Sec. 11. Minnesota Statutes 2022, section 61A.60, subdivision 3, is amended to read:

10.12 Subd. 3. **Definitions.** The following definitions must appear on the back of the notice  
 10.13 forms provided in subdivisions 1 and 2:

14.28 (4) for valuing the policies of life insurance companies, ~~one cent~~ two cents per \$1,000  
 14.29 of insurance so valued, provided that the fee shall not exceed \$13,000 ~~\$26,000~~ per year for  
 15.1 any company. The commissioner may, in lieu of a valuation of the policies of any foreign  
 15.2 life insurance company admitted, or applying for admission, to do business in this state,  
 15.3 accept a certificate of valuation from the company's own actuary or from the commissioner  
 15.4 of insurance of the state or territory in which the company is domiciled;

15.5 (5) for receiving and filing certificates of policies by the company's actuary, or by the  
 15.6 commissioner of insurance of any other state or territory, \$50;

15.7 (6) for each appointment of an agent filed with the commissioner, \$30;

15.8 (7) for filing forms, rates, and compliance certifications under section 60A.315, \$140  
 15.9 per filing, or \$125 per filing when submitted via electronic filing system. Filing fees may  
 15.10 be paid on a quarterly basis in response to an invoice. Billing and payment may be made  
 15.11 electronically;

15.12 (8) for annual renewal of surplus lines insurer license, ~~\$300~~ \$400.

15.13 The commissioner shall adopt rules to define filings that are subject to a fee.

15.14 Sec. 4. Minnesota Statutes 2022, section 61A.031, is amended to read:

### 61A.031 SUICIDE PROVISIONS.

15.16 (a) The sanity or insanity of a person shall not be a factor in determining whether a  
 15.17 person committed suicide within the terms of an individual or group life insurance policy  
 15.18 regulating the payment of benefits in the event of the insured's suicide. This ~~section~~ shall  
 15.19 not be construed to alter present law but is intended to clarify present law.

15.20 (b) ~~A life insurance policy or certificate issued or delivered in this state may exclude or~~  
 15.21 ~~restrict liability for any death benefit in the event the insured dies as a result of suicide~~  
 15.22 ~~within one year from the date of the policy or certificate is issued. Any exclusion or restriction~~  
 15.23 ~~shall be clearly stated in the policy or certificate. Any life insurance policy or certificate~~  
 15.24 ~~which contains any exclusion or restriction under this paragraph shall also provide that in~~  
 15.25 ~~the event any death benefit is denied because the insured dies as a result of suicide within~~  
 15.26 ~~one year from the date the policy or certificate is issued, the insurer shall refund all premiums~~  
 15.27 ~~paid for coverage providing the denied death benefit on the insured.~~

15.28 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to policies  
 15.29 issued or after that date.

16.1 Sec. 5. Minnesota Statutes 2022, section 61A.60, subdivision 3, is amended to read:

16.2 Subd. 3. **Definitions.** The following definitions must appear on the back of the notice  
 16.3 forms provided in subdivisions 1 and 2:

10.14

## DEFINITIONS

10.15 PREMIUMS: Premiums are the payments you make in exchange for an insurance policy  
10.16 or annuity contract. They are unlike deposits in a savings or investment program, because  
10.17 if you drop the policy or contract, you might get back less than you paid in.

10.18 CASH SURRENDER VALUE: This is the amount of money you can get in cash if you  
10.19 surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender  
10.20 value is the difference between the cash value printed in the policy and the loan value. Not  
10.21 all policies have cash surrender values.

10.22 LAPSE: A life insurance policy may lapse when you do not pay the premiums within  
10.23 the grace period. If you had a cash surrender value, the insurer might change your policy  
10.24 to as much extended term insurance or paid-up insurance as the cash surrender value will  
10.25 buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the  
10.26 premiums.

10.27 SURRENDER: You surrender a life insurance policy when you either let it lapse or tell  
10.28 the company you want to drop it. Whenever a policy has a cash surrender value, you can  
10.29 get it in cash if you return the policy to the company with a written request. Most insurers  
10.30 will also let you exchange the cash value of the policy for paid-up or extended term insurance.

10.31 CONVERT TO PAID-UP INSURANCE: This means you use your cash surrender value  
10.32 to change your insurance to a paid-up policy with the same insurer. The death benefit  
11.1 generally will be lower than under the old policy, but you will not have to pay any more  
11.2 premiums.

11.3 PLACE ON EXTENDED TERM: This means you use your cash surrender value to  
11.4 change your insurance to term insurance with the same insurer. In this case, the net death  
11.5 benefit will be the same as before. However, you will only be covered for a specified period  
11.6 of time stated in the policy.

11.7 BORROW POLICY LOAN VALUES: If your life insurance policy has a cash surrender  
11.8 value, you can almost always borrow all or part of it from the insurer. Interest will be charged  
11.9 according to the terms of the policy, and if the loan with unpaid interest ever exceeds the  
11.10 cash surrender value, your policy will be surrendered. If you die, the amount of the loan  
11.11 and any unpaid interest due will be subtracted from the death benefits.

11.12 EVIDENCE OF INSURABILITY: This means proof that you are an acceptable risk.  
11.13 You have to meet the insurer's standards regarding age, health, occupation, etc., to be eligible  
11.14 for coverage.

11.15 INCONTESTABLE CLAUSE: This says that after two years, depending on the policy  
11.16 or insurer, the life insurer will not resist a claim because you made a false or incomplete  
11.17 statement when you applied for the policy. For the early years, though, if there are wrong  
11.18 answers on the application and the insurer finds out about them, the insurer can deny a claim  
11.19 as if the policy had never existed.

16.4

## DEFINITIONS

16.5 PREMIUMS: Premiums are the payments you make in exchange for an insurance policy  
16.6 or annuity contract. They are unlike deposits in a savings or investment program, because  
16.7 if you drop the policy or contract, you might get back less than you paid in.

16.8 CASH SURRENDER VALUE: This is the amount of money you can get in cash if you  
16.9 surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender  
16.10 value is the difference between the cash value printed in the policy and the loan value. Not  
16.11 all policies have cash surrender values.

16.12 LAPSE: A life insurance policy may lapse when you do not pay the premiums within  
16.13 the grace period. If you had a cash surrender value, the insurer might change your policy  
16.14 to as much extended term insurance or paid-up insurance as the cash surrender value will  
16.15 buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the  
16.16 premiums.

16.17 SURRENDER: You surrender a life insurance policy when you either let it lapse or tell  
16.18 the company you want to drop it. Whenever a policy has a cash surrender value, you can  
16.19 get it in cash if you return the policy to the company with a written request. Most insurers  
16.20 will also let you exchange the cash value of the policy for paid-up or extended term insurance.

16.21 CONVERT TO PAID-UP INSURANCE: This means you use your cash surrender value  
16.22 to change your insurance to a paid-up policy with the same insurer. The death benefit  
16.23 generally will be lower than under the old policy, but you will not have to pay any more  
16.24 premiums.

16.25 PLACE ON EXTENDED TERM: This means you use your cash surrender value to  
16.26 change your insurance to term insurance with the same insurer. In this case, the net death  
16.27 benefit will be the same as before. However, you will only be covered for a specified period  
16.28 of time stated in the policy.

16.29 BORROW POLICY LOAN VALUES: If your life insurance policy has a cash surrender  
16.30 value, you can almost always borrow all or part of it from the insurer. Interest will be charged  
16.31 according to the terms of the policy, and if the loan with unpaid interest ever exceeds the  
16.32 cash surrender value, your policy will be surrendered. If you die, the amount of the loan  
16.33 and any unpaid interest due will be subtracted from the death benefits.

17.1 EVIDENCE OF INSURABILITY: This means proof that you are an acceptable risk.  
17.2 You have to meet the insurer's standards regarding age, health, occupation, etc., to be eligible  
17.3 for coverage.

17.4 INCONTESTABLE CLAUSE: This says that after two years, depending on the policy  
17.5 or insurer, the life insurer will not resist a claim because you made a false or incomplete  
17.6 statement when you applied for the policy. For the early years, though, if there are wrong  
17.7 answers on the application and the insurer finds out about them, the insurer can deny a claim  
17.8 as if the policy had never existed.

11.20     SUICIDE CLAUSE: This says that if you ~~commit~~ complete suicide after being insured  
11.21 for less than ~~two years~~ one year, depending on the policy and insurer, your beneficiaries  
11.22 will receive only a refund of the premiums that were paid.

11.23     **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to policies  
11.24 issued on or after that date.

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12.7     Sec. 2. Minnesota Statutes 2022, section 62A.152, subdivision 3, is amended to read:

12.8     Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber  
12.9 contracts that provide benefits for mental or nervous disorder treatments in a hospital must  
12.10 provide direct reimbursement for those services ~~at a hospital or psychiatric residential~~  
12.11 ~~treatment facility~~ if performed by a mental health professional qualified according to section  
12.12 245L04, subdivision 2, to the extent that the services and treatment are within the scope of  
12.13 mental health professional licensure.

12.14     This subdivision is intended to provide payment of benefits for mental or nervous disorder  
12.15 treatments performed by a licensed mental health professional in a hospital ~~or psychiatric~~  
12.16 ~~residential treatment facility~~ and is not intended to change or add benefits for those services  
12.17 provided in policies or contracts to which this subdivision applies.

17.9     SUICIDE CLAUSE: This says that if you ~~commit~~ complete suicide after being insured  
17.10 for less than ~~two years~~ one year, depending on the policy and insurer, your beneficiaries  
17.11 will receive only a refund of the premiums that were paid.

17.12     **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to policies  
17.13 issued on or after that date.

17.14     Sec. 6. Minnesota Statutes 2022, section 62A.152, subdivision 3, is amended to read:

17.15     Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber  
17.16 contracts that provide benefits for mental or nervous disorder treatments in a hospital must  
17.17 provide direct reimbursement for those services ~~at a hospital or psychiatric residential~~  
17.18 ~~treatment facility~~ if performed by a mental health professional qualified according to section  
17.19 245L04, subdivision 2, to the extent that the services and treatment are within the scope of  
17.20 mental health professional licensure.

17.21     This subdivision is intended to provide payment of benefits for mental or nervous disorder  
17.22 treatments performed by a licensed mental health professional in a hospital ~~or psychiatric~~  
17.23 ~~residential treatment facility~~ and is not intended to change or add benefits for those services  
17.24 provided in policies or contracts to which this subdivision applies.

17.25     **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
17.26 plans offered, issued, or renewed on or after that date.

17.27     Sec. 7. Minnesota Statutes 2022, section 62A.3099, is amended by adding a subdivision  
17.28 to read:

17.29     Subd. 18b. **Open enrollment period.** "Open enrollment period" means the time period  
17.30 described in Code of Federal Regulations, title 42, section 422.62, paragraph (a), clauses  
17.31 (2) to (4), as amended.

18.1     **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
18.2 offered, issued, or renewed on or after that date.

18.3     Sec. 8. Minnesota Statutes 2022, section 62A.31, subdivision 1, is amended to read:

18.4     Subdivision 1. **Policy requirements.** No individual or group policy, certificate, subscriber  
18.5 contract issued by a health service plan corporation regulated under chapter 62C, or other  
18.6 evidence of accident and health insurance the effect or purpose of which is to supplement  
18.7 Medicare coverage, including to supplement coverage under Medicare Advantage plans  
18.8 established under Medicare Part C, issued or delivered in this state or offered to a resident  
18.9 of this state shall be sold or issued to an individual covered by Medicare unless the  
18.10 requirements in subdivisions 1a to ~~1v~~ 1w are met.

18.11       **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
18.12       offered, issued, or renewed on or after that date.

18.13       Sec. 9. Minnesota Statutes 2022, section 62A.31, subdivision 1f, is amended to read:

18.14       Subd. 1f. **Suspension based on entitlement to medical assistance.** (a) The policy or  
18.15       certificate must provide that benefits and premiums under the policy or certificate shall be  
18.16       suspended for any period that may be provided by federal regulation at the request of the  
18.17       policyholder or certificate holder for the period, not to exceed 24 months, in which the  
18.18       policyholder or certificate holder has applied for and is determined to be entitled to medical  
18.19       assistance under title XIX of the Social Security Act, but only if the policyholder or certificate  
18.20       holder notifies the issuer of the policy or certificate within 90 days after the date the  
18.21       individual becomes entitled to this assistance.

18.22       (b) If suspension occurs and if the policyholder or certificate holder loses entitlement  
18.23       to this medical assistance, the policy or certificate shall be automatically reinstated, effective  
18.24       as of the date of termination of this entitlement, if the policyholder or certificate holder  
18.25       provides notice of loss of the entitlement within 90 days after the date of the loss and pays  
18.26       the premium attributable to the period, effective as of the date of termination of entitlement.

18.27       (c) The policy must provide that upon reinstatement (1) there is no additional waiting  
18.28       period with respect to treatment of preexisting conditions, (2) coverage is provided which  
18.29       is substantially equivalent to coverage in effect before the date of the suspension. If the  
18.30       suspended policy provided coverage for outpatient prescription drugs, reinstatement of the  
18.31       policy for Medicare Part D enrollees must be without coverage for outpatient prescription  
18.32       drugs and must otherwise provide coverage substantially equivalent to the coverage in effect  
18.33       before the date of suspension, and (3) premiums are classified on terms that are at least as  
19.1       favorable to the policyholder or certificate holder as the premium classification terms that  
19.2       would have applied to the policyholder or certificate holder had coverage not been suspended.

19.3       **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
19.4       offered, issued, or renewed on or after that date.

19.5       Sec. 10. Minnesota Statutes 2022, section 62A.31, subdivision 1h, is amended to read:

19.6       Subd. 1h. **Limitations on denials, conditions, and pricing of coverage.** No health  
19.7       carrier issuing Medicare-related coverage in this state may impose preexisting condition  
19.8       limitations or otherwise deny or condition the issuance or effectiveness of any such coverage  
19.9       available for sale in this state, nor may it discriminate in the pricing of such coverage,  
19.10       because of the health status, claims experience, receipt of health care, medical condition,  
19.11       or age of an applicant where an application for such coverage is submitted: (1) prior to or  
19.12       during the six-month period beginning with the first day of the month in which an individual  
19.13       first enrolled for benefits under Medicare Part B; or (2) during the open enrollment period.  
19.14       This subdivision applies to each Medicare-related coverage offered by a health carrier  
19.15       regardless of whether the individual has attained the age of 65 years. If an individual who  
19.16       is enrolled in Medicare Part B due to disability status is involuntarily disenrolled due to loss

19.17 of disability status, the individual is eligible for another six-month enrollment period provided  
19.18 under this subdivision beginning the first day of the month in which the individual later  
19.19 becomes eligible for and enrolls again in Medicare Part B and during the open enrollment  
19.20 period. An individual who is or was previously enrolled in Medicare Part B due to disability  
19.21 status is eligible for another six-month enrollment period under this subdivision beginning  
19.22 the first day of the month in which the individual has attained the age of 65 years and either  
19.23 maintains enrollment in, or enrolls again in, Medicare Part B and during the open enrollment  
19.24 period. If an individual enrolled in Medicare Part B voluntarily disenrolls from Medicare  
19.25 Part B because the individual becomes enrolled under an employee welfare benefit plan,  
19.26 the individual is eligible for another six-month enrollment period, as provided in this  
19.27 subdivision, beginning the first day of the month in which the individual later becomes  
19.28 eligible for and enrolls again in Medicare Part B and during the open enrollment period.

19.29 **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
19.30 offered, issued, or renewed on or after that date.

19.31 Sec. 11. Minnesota Statutes 2022, section 62A.31, subdivision 1p, is amended to read:

19.32 **Subd. 1p. Renewal or continuation provisions.** Medicare supplement policies and  
19.33 certificates shall include a renewal or continuation provision. The language or specifications  
20.1 of the provision shall be consistent with the type of contract issued. The provision shall be  
20.2 appropriately captioned and shall appear on the first page of the policy or certificate, and  
20.3 shall include any reservation by the issuer of the right to change premiums. Except for riders  
20.4 or endorsements by which the issuer effectuates a request made in writing by the insured,  
20.5 exercises a specifically reserved right under a Medicare supplement policy or certificate,  
20.6 or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all  
20.7 riders or endorsements added to a Medicare supplement policy or certificate after the date  
20.8 of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the  
20.9 policy or certificate shall require a signed acceptance by the insured. After the date of policy  
20.10 or certificate issue, a rider or endorsement that increases benefits or coverage with a  
20.11 concomitant increase in premium during the policy or certificate term shall be agreed to in  
20.12 writing and signed by the insured, unless the benefits are required by the minimum standards  
20.13 for Medicare supplement policies or if the increased benefits or coverage is required by  
20.14 law. Where a separate additional premium is charged for benefits provided in connection  
20.15 with riders or endorsements, the premium charge shall be set forth in the policy, declaration  
20.16 page, or certificate. If a Medicare supplement policy or certificate contains limitations with  
20.17 respect to preexisting conditions, the limitations shall appear as a separate paragraph of the  
20.18 policy or certificate and be labeled as "preexisting condition limitations."

20.19 Issuers of accident and sickness policies or certificates that provide hospital or medical  
20.20 expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare  
20.21 shall provide to those applicants a "Guide to Health Insurance for People with Medicare"  
20.22 in the form developed by the Centers for Medicare and Medicaid Services and in a type  
20.23 size no smaller than 12-point type. Delivery of the guide must be made whether or not such  
20.24 policies or certificates are advertised, solicited, or issued as Medicare supplement policies

20.25 or certificates as defined in this section and section 62A.3099. Except in the case of direct  
20.26 response issuers, delivery of the guide must be made to the applicant at the time of  
20.27 application, and acknowledgment of receipt of the guide must be obtained by the issuer.  
20.28 Direct response issuers shall deliver the guide to the applicant upon request, but no later  
20.29 than the time at which the policy is delivered.

20.30 **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
20.31 offered, issued, or renewed on or after that date.

20.32 Sec. 12. Minnesota Statutes 2022, section 62A.31, subdivision 1u, is amended to read:

20.33 Subd. 1u. **Guaranteed issue for eligible persons.** (a)(1) Eligible persons are those  
20.34 individuals described in paragraph (b) who seek to enroll under the policy during the period  
21.1 specified in paragraph (c) and who submit evidence of the date of termination or  
21.2 disenrollment described in paragraph (b), or of the date of Medicare Part D enrollment, with  
21.3 the application for a Medicare supplement policy.

21.4 (2) With respect to eligible persons, an issuer shall not: deny or condition the issuance  
21.5 or effectiveness of a Medicare supplement policy described in paragraph (c) that is offered  
21.6 and is available for issuance to new enrollees by the issuer; discriminate in the pricing of  
21.7 such a Medicare supplement policy because of health status, claims experience, receipt of  
21.8 health care, medical condition, or age; or impose an exclusion of benefits based upon a  
21.9 preexisting condition under such a Medicare supplement policy.

21.10 (b) An eligible person is an individual described in any of the following:

21.11 (1) the individual is enrolled under an employee welfare benefit plan that provides health  
21.12 benefits that supplement the benefits under Medicare; and the plan terminates, or the plan  
21.13 ceases to provide all such supplemental health benefits to the individual;

21.14 (2) the individual is enrolled with a Medicare Advantage organization under a Medicare  
21.15 Advantage plan under Medicare Part C, and any of the following circumstances apply, or  
21.16 the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive  
21.17 Care for the Elderly (PACE) provider under section 1894 of the federal Social Security Act,  
21.18 and there are circumstances similar to those described in this clause that would permit  
21.19 discontinuance of the individual's enrollment with the provider if the individual were enrolled  
21.20 in a Medicare Advantage plan:

21.21 (i) the organization's or plan's certification under Medicare Part C has been terminated  
21.22 or the organization has terminated or otherwise discontinued providing the plan in the area  
21.23 in which the individual resides;

21.24 (ii) the individual is no longer eligible to elect the plan because of a change in the  
21.25 individual's place of residence or other change in circumstances specified by the secretary,  
21.26 but not including termination of the individual's enrollment on the basis described in section  
21.27 1851(g)(3)(B) of the federal Social Security Act, United States Code, title 42, section  
21.28 1395w-21(g)(3)(b) (where the individual has not paid premiums on a timely basis or has

21.29     engaged in disruptive behavior as specified in standards under section 1856 of the federal  
21.30     Social Security Act, United States Code, title 42, section 1395w-26), or the plan is terminated  
21.31     for all individuals within a residence area;

21.32         (iii) the individual demonstrates, in accordance with guidelines established by the  
21.33         Secretary, that:

22.1             (A) the organization offering the plan substantially violated a material provision of the  
22.2             organization's contract in relation to the individual, including the failure to provide an  
22.3             enrollee on a timely basis medically necessary care for which benefits are available under  
22.4             the plan or the failure to provide such covered care in accordance with applicable quality  
22.5             standards; or

22.6             (B) the organization, or agent or other entity acting on the organization's behalf, materially  
22.7             misrepresented the plan's provisions in marketing the plan to the individual; or

22.8             (iv) the individual meets such other exceptional conditions as the secretary may provide;

22.9         (3)(i) the individual is enrolled with:

22.10             (A) an eligible organization under a contract under section 1876 of the federal Social  
22.11             Security Act, United States Code, title 42, section 1395mm (Medicare cost);

22.12             (B) a similar organization operating under demonstration project authority, effective for  
22.13             periods before April 1, 1999;

22.14             (C) an organization under an agreement under section 1833(a)(1)(A) of the federal Social  
22.15             Security Act, United States Code, title 42, section 1395l(a)(1)(A) (health care prepayment  
22.16             plan); or

22.17             (D) an organization under a Medicare Select policy under section 62A.318 or the similar  
22.18             law of another state; and

22.19         (ii) the enrollment ceases under the same circumstances that would permit discontinuance  
22.20         of an individual's election of coverage under clause (2);

22.21         (4) the individual is enrolled under a Medicare supplement policy, and the enrollment  
22.22         ceases because:

22.23             (i)(A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

22.24             (B) of other involuntary termination of coverage or enrollment under the policy;

22.25             (ii) the issuer of the policy substantially violated a material provision of the policy; or

22.26             (iii) the issuer, or an agent or other entity acting on the issuer's behalf, materially  
22.27             misrepresented the policy's provisions in marketing the policy to the individual;

22.28         (5)(i) the individual was enrolled under a Medicare supplement policy and terminates  
22.29         that enrollment and subsequently enrolls, for the first time, with any Medicare Advantage

22.30 organization under a Medicare Advantage plan under Medicare Part C; any eligible  
22.31 organization under a contract under section 1876 of the federal Social Security Act, United  
23.1 States Code, title 42, section 1395mm (Medicare cost); any similar organization operating  
23.2 under demonstration project authority; any PACE provider under section 1894 of the federal  
23.3 Social Security Act, or a Medicare Select policy under section 62A.318 or the similar law  
23.4 of another state; and

23.5 (ii) the subsequent enrollment under item (i) is terminated by the enrollee during any  
23.6 period within the first 12 months of the subsequent enrollment during which the enrollee  
23.7 is permitted to terminate the subsequent enrollment under section 1851(e) of the federal  
23.8 Social Security Act;

23.9 (6) the individual, upon first enrolling for benefits under Medicare Part B, enrolls in a  
23.10 Medicare Advantage plan under Medicare Part C, or with a PACE provider under section  
23.11 1894 of the federal Social Security Act, and disenrolls from the plan by not later than 12  
23.12 months after the effective date of enrollment; or

23.13 (7) the individual enrolls in a Medicare Part D plan during the initial Part D enrollment  
23.14 period, as defined under United States Code, title 42, section 1395ss(v)(6)(D), and, at the  
23.15 time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers  
23.16 outpatient prescription drugs and the individual terminates enrollment in the Medicare  
23.17 supplement policy and submits evidence of enrollment in Medicare Part D along with the  
23.18 application for a policy described in paragraph (e), clause (4); or

23.19 (8) the individual was enrolled in a state public program and is losing coverage due to  
23.20 the unwinding of the Medicaid continuous enrollment conditions, as provided by Code of  
23.21 Federal Regulations, title 45, section 155.420(d)(9) and (d)(1), and Public Law 117-328,  
23.22 section 5131 (2022).

23.23 (c)(1) In the case of an individual described in paragraph (b), clause (1), the guaranteed  
23.24 issue period begins on the later of: (i) the date the individual receives a notice of termination  
23.25 or cessation of all supplemental health benefits or, if a notice is not received, notice that a  
23.26 claim has been denied because of a termination or cessation; or (ii) the date that the applicable  
23.27 coverage terminates or ceases; and ends 63 days after the later of those two dates.

23.28 (2) In the case of an individual described in paragraph (b), clause (2), (3), (5), or (6),  
23.29 whose enrollment is terminated involuntarily, the guaranteed issue period begins on the  
23.30 date that the individual receives a notice of termination and ends 63 days after the date the  
23.31 applicable coverage is terminated.

23.32 (3) In the case of an individual described in paragraph (b), clause (4), item (i), the  
23.33 guaranteed issue period begins on the earlier of: (i) the date that the individual receives a  
23.34 notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar  
24.1 notice if any; and (ii) the date that the applicable coverage is terminated, and ends on the  
24.2 date that is 63 days after the date the coverage is terminated.

24.3        (4) In the case of an individual described in paragraph (b), clause (2), (4), (5), or (6),  
24.4        who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days  
24.5        before the effective date of the disenrollment and ends on the date that is 63 days after the  
24.6        effective date.

24.7        (5) In the case of an individual described in paragraph (b), clause (7), the guaranteed  
24.8        issue period begins on the date the individual receives notice pursuant to section  
24.9        1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the  
24.10        60-day period immediately preceding the initial Part D enrollment period and ends on the  
24.11        date that is 63 days after the effective date of the individual's coverage under Medicare Part  
24.12        D.

24.13        (6) In the case of an individual described in paragraph (b) but not described in this  
24.14        paragraph, the guaranteed issue period begins on the effective date of disenrollment and  
24.15        ends on the date that is 63 days after the effective date.

24.16        (7) For all individuals described in paragraph (b), the open enrollment period is a  
24.17        guaranteed issue period.

24.18        (d)(1) In the case of an individual described in paragraph (b), clause (5), or deemed to  
24.19        be so described, pursuant to this paragraph, whose enrollment with an organization or  
24.20        provider described in paragraph (b), clause (5), item (i), is involuntarily terminated within  
24.21        the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with  
24.22        another such organization or provider, the subsequent enrollment is deemed to be an initial  
24.23        enrollment described in paragraph (b), clause (5).

24.24        (2) In the case of an individual described in paragraph (b), clause (6), or deemed to be  
24.25        so described, pursuant to this paragraph, whose enrollment with a plan or in a program  
24.26        described in paragraph (b), clause (6), is involuntarily terminated within the first 12 months  
24.27        of enrollment, and who, without an intervening enrollment, enrolls in another such plan or  
24.28        program, the subsequent enrollment is deemed to be an initial enrollment described in  
24.29        paragraph (b), clause (6).

24.30        (3) For purposes of paragraph (b), clauses (5) and (6), no enrollment of an individual  
24.31        with an organization or provider described in paragraph (b), clause (5), item (i), or with a  
24.32        plan or in a program described in paragraph (b), clause (6), may be deemed to be an initial  
24.33        enrollment under this paragraph after the two-year period beginning on the date on which  
24.34        the individual first enrolled with the organization, provider, plan, or program.

25.1        (e) The Medicare supplement policy to which eligible persons are entitled under:

25.2        (1) paragraph (b), clauses (1) to (4), is any Medicare supplement policy that has a benefit  
25.3        package consisting of the basic Medicare supplement plan described in section 62A.316,  
25.4        paragraph (a), plus any combination of the three optional riders described in section 62A.316,  
25.5        paragraph (b), clauses (1) to (3), offered by any issuer;

25.6 (2) paragraph (b), clause (5), is the same Medicare supplement policy in which the  
25.7 individual was most recently previously enrolled, if available from the same issuer, or, if  
25.8 not so available, any policy described in clause (1) offered by any issuer, except that after  
25.9 December 31, 2005, if the individual was most recently enrolled in a Medicare supplement  
25.10 policy with an outpatient prescription drug benefit, a Medicare supplement policy to which  
25.11 the individual is entitled under paragraph (b), clause (5), is:

25.12 (i) the policy available from the same issuer but modified to remove outpatient  
25.13 prescription drug coverage; or

25.14 (ii) at the election of the policyholder, a policy described in clause (4), except that the  
25.15 policy may be one that is offered and available for issuance to new enrollees that is offered  
25.16 by any issuer;

25.17 (3) paragraph (b), clause (6), is any Medicare supplement policy offered by any issuer;

25.18 (4) paragraph (b), clause (7), is a Medicare supplement policy that has a benefit package  
25.19 classified as a basic plan under section 62A.316 if the enrollee's existing Medicare  
25.20 supplement policy is a basic plan or, if the enrollee's existing Medicare supplement policy  
25.21 is an extended basic plan under section 62A.315, a basic or extended basic plan at the option  
25.22 of the enrollee, provided that the policy is offered and is available for issuance to new  
25.23 enrollees by the same issuer that issued the individual's Medicare supplement policy with  
25.24 outpatient prescription drug coverage. The issuer must permit the enrollee to retain all  
25.25 optional benefits contained in the enrollee's existing coverage, other than outpatient  
25.26 prescription drugs, subject to the provision that the coverage be offered and available for  
25.27 issuance to new enrollees by the same issuer.

25.28 (f)(1) At the time of an event described in paragraph (b), because of which an individual  
25.29 loses coverage or benefits due to the termination of a contract or agreement, policy, or plan,  
25.30 the organization that terminates the contract or agreement, the issuer terminating the policy,  
25.31 or the administrator of the plan being terminated, respectively, shall notify the individual  
25.32 of the individual's rights under this subdivision, and of the obligations of issuers of Medicare  
25.33 supplement policies under paragraph (a). The notice must be communicated  
25.34 contemporaneously with the notification of termination.

26.1 (2) At the time of an event described in paragraph (b), because of which an individual  
26.2 ceases enrollment under a contract or agreement, policy, or plan, the organization that offers  
26.3 the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer  
26.4 offering the policy, or the administrator of the plan, respectively, shall notify the individual  
26.5 of the individual's rights under this subdivision, and of the obligations of issuers of Medicare  
26.6 supplement policies under paragraph (a). The notice must be communicated within ten  
26.7 working days of the issuer receiving notification of disenrollment.

26.8 (g) Reference in this subdivision to a situation in which, or to a basis upon which, an  
26.9 individual's coverage has been terminated does not provide authority under the laws of this  
26.10 state for the termination in that situation or upon that basis.

26.11 (h) An individual's rights under this subdivision are in addition to, and do not modify  
26.12 or limit, the individual's rights under subdivision 1h.

26.13 **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
26.14 offered, issued, or renewed on or after that date.

26.15 Sec. 13. Minnesota Statutes 2022, section 62A.31, is amended by adding a subdivision to  
26.16 read:

26.17 Subd. 1w. **Open enrollment.** A medicare supplement policy or certificate must not be  
26.18 sold or issued to an eligible individual outside of the time periods described in subdivision  
26.19 1u.

26.20 **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
26.21 offered, issued, or renewed on or after that date.

26.22 Sec. 14. Minnesota Statutes 2022, section 62A.31, subdivision 4, is amended to read:

26.23 Subd. 4. **Prohibited policy provisions.** (a) A Medicare supplement policy or certificate  
26.24 in force in the state shall not contain benefits that duplicate benefits provided by Medicare  
26.25 or contain exclusions on coverage that are more restrictive than those of Medicare.  
26.26 Duplication of benefits is permitted to the extent permitted under subdivision 1s, paragraph  
26.27 (a), for benefits provided by Medicare Part D.

26.28 (b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or  
26.29 reduce coverage or benefits for specifically named or described preexisting diseases or  
26.30 physical conditions, except as permitted under subdivision 1b.

26.31 **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
26.32 offered, issued, or renewed on or after that date.

27.1 Sec. 15. Minnesota Statutes 2022, section 62A.44, subdivision 2, is amended to read:

27.2 Subd. 2. **Questions.** (a) Application forms shall include the following questions designed  
27.3 to elicit information as to whether, as of the date of the application, the applicant has another  
27.4 Medicare supplement or other health insurance policy or certificate in force or whether a  
27.5 Medicare supplement policy or certificate is intended to replace any other accident and  
27.6 sickness policy or certificate presently in force. A supplementary application or other form  
27.7 to be signed by the applicant and agent containing the questions and statements may be  
27.8 used.

27.9 (1) You do not need more than one Medicare supplement policy or certificate.

27.10 (2) If you purchase this policy, you may want to evaluate your existing health coverage  
27.11 and decide if you need multiple coverages.

27.12 (3) You may be eligible for benefits under Medicaid and may not need a Medicare  
27.13 supplement policy or certificate.

27.14 (4) The benefits and premiums under your Medicare supplement policy or certificate  
27.15 can be suspended, if requested, during your entitlement to benefits under Medicaid for  
27.16 24 months. You must request this suspension within 90 days of becoming eligible for  
27.17 Medicaid. If you are no longer entitled to Medicaid, your policy or certificate will be  
27.18 reinstated if requested within 90 days of losing Medicaid eligibility.

27.19 (5) Counseling services may be available in Minnesota to provide advice concerning  
27.20 medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs),  
27.21 and Specified Low-Income Medicare Beneficiaries (SLMBs).

27.22 To the best of your knowledge:

27.23 (1) Do you have another Medicare supplement policy or certificate in force?

27.24 (a) If so, with which company?

27.25 (b) If so, do you intend to replace your current Medicare supplement policy with this  
27.26 policy or certificate?

27.27 (2) Do you have any other health insurance policies that provide benefits which this  
27.28 Medicare supplement policy or certificate would duplicate?

27.29 (a) If so, please name the company.

27.30 (b) What kind of policy?

28.1 (3) Are you covered for medical assistance through the state Medicaid program? If so,  
28.2 which of the following programs provides coverage for you?

28.3 (a) Specified Low-Income Medicare Beneficiary (SLMB),

28.4 (b) Qualified Medicare Beneficiary (QMB), or

28.5 (c) full Medicaid Beneficiary?"

28.6 (b) Agents shall list any other health insurance policies they have sold to the applicant.

28.7 (1) List policies sold that are still in force.

28.8 (2) List policies sold in the past five years that are no longer in force.

28.9 (c) In the case of a direct response issuer, a copy of the application or supplemental  
28.10 form, signed by the applicant, and acknowledged by the insurer, shall be returned to the  
28.11 applicant by the insurer on delivery of the policy or certificate.

28.12 (d) Upon determining that a sale will involve replacement of Medicare supplement  
28.13 coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the  
28.14 applicant, before issuance or delivery of the Medicare supplement policy or certificate, a  
28.15 notice regarding replacement of Medicare supplement coverage. One copy of the notice  
28.16 signed by the applicant and the agent, except where the coverage is sold without an agent,  
28.17 shall be provided to the applicant and an additional signed copy shall be retained by the

28.18 issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of  
28.19 the policy or certificate the notice regarding replacement of Medicare supplement coverage.

28.20 (e) The notice required by paragraph (d) for an issuer shall be provided in substantially  
28.21 the following form in no less than 12-point type:

28.22 "NOTICE TO APPLICANT REGARDING REPLACEMENT

28.23 OF MEDICARE SUPPLEMENT INSURANCE

28.24 (Insurance company's name and address)

28.25 SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

28.26 According to (your application) (information you have furnished), you intend to terminate  
28.27 existing Medicare supplement insurance and replace it with a policy or certificate to be  
28.28 issued by (Company Name) Insurance Company. Your new policy or certificate will provide  
28.29 30 days within which you may decide without cost whether you desire to keep the policy  
28.30 or certificate.

29.1 You should review this new coverage carefully. Compare it with all accident and sickness  
29.2 coverage you now have. If, after due consideration, you find that purchase of this Medicare  
29.3 supplement coverage is a wise decision you should terminate your present Medicare  
29.4 supplement policy. You should evaluate the need for other accident and sickness coverage  
29.5 you have that may duplicate this policy.

29.6 STATEMENT TO APPLICANT BY ISSUER, AGENT, (BROKER OR OTHER  
29.7 REPRESENTATIVE): I have reviewed your current medical or health insurance  
29.8 coverage. To the best of my knowledge this Medicare supplement policy will not duplicate  
29.9 your existing Medicare supplement policy because you intend to terminate the existing  
29.10 Medicare supplement policy. The replacement policy or certificate is being purchased  
29.11 for the following reason(s) (check one):

29.12 ..... Additional benefits

29.13 ..... No change in benefits, but lower premiums

29.14 ..... Fewer benefits and lower premiums

29.15 ..... Other (please specify)

29.16 .....

29.17 .....

29.18 .....

29.19 (1) ~~Health conditions which you may presently have (preexisting conditions) may not~~  
29.20 ~~be immediately or fully covered under the new policy or certificate. This could result~~  
29.21 ~~in denial or delay of a claim for benefits under the new policy or certificate, whereas a~~  
29.22 ~~similar claim might have been payable under your present policy or certificate.~~

29.23 (2) ~~State law provides that your replacement policy or certificate may not contain new~~  
29.24 ~~preexisting conditions, waiting periods, elimination periods, or probationary periods.~~  
29.25 ~~The insurer will waive any time periods applicable to preexisting conditions, waiting~~  
29.26 ~~periods, elimination periods, or probationary periods in the new policy (or coverage)~~  
29.27 ~~for similar benefits to the extent the time was spent (depleted) under the original policy~~  
29.28 ~~or certificate.~~

29.29 (3) ~~If you still wish to terminate your present policy or certificate and replace it with~~  
29.30 ~~new coverage, be certain to truthfully and completely answer all questions on the~~  
29.31 ~~application concerning your medical and health history. Failure to include all material~~  
29.32 ~~medical information on an application may provide a basis for the company to deny any~~  
29.33 ~~future claims and to refund your premium as though your policy or certificate had never~~  
29.34 ~~been in force. After the application has been completed and before you sign it, review~~  
30.1 ~~it carefully to be certain that all information has been properly recorded. (If the policy~~  
30.2 ~~or certificate is guaranteed issue, this paragraph need not appear.)~~

30.3 Do not cancel your present policy or certificate until you have received your new policy  
30.4 or certificate and you are sure that you want to keep it.

30.5 .....

30.6 ~~(Signature of Agent, Broker, or Other Representative)\*~~

30.7 .....

30.8 ~~(Typed Name and Address of Issuer, Agent, or Broker)~~

30.9 .....

30.10 ~~(Date)~~

30.11 .....

30.12 ~~(Applicant's Signature)~~

30.13 .....

30.14 ~~(Date)~~

30.15 \*Signature not required for direct response sales."

12.18 Sec. 3. Minnesota Statutes 2022, section 62D.02, is amended by adding a subdivision to  
 12.19 read:

12.20 **Subd. 17. Preventive items and services.** "Preventive items and services" has the  
 12.21 meaning given in section 62Q.46, subdivision 1, paragraph (a).

12.22 Sec. 4. Minnesota Statutes 2022, section 62D.095, subdivision 2, is amended to read:

12.23 **Subd. 2. Co-payments.** A health maintenance contract may impose a co-payment and  
 12.24 coinsurance consistent with the provisions of the Affordable Care Act as defined under  
 12.25 section 62A.011, subdivision 1a, and for items and services that are not preventive items  
 12.26 and services.

12.27 Sec. 5. Minnesota Statutes 2022, section 62D.095, subdivision 3, is amended to read:

12.28 **Subd. 3. Deductibles.** A health maintenance contract may must not impose a deductible  
 12.29 consistent with the provisions of the Affordable Care Act as defined under section 62A.011,  
 12.30 subdivision 1a for preventive items and services.

13.1 Sec. 6. Minnesota Statutes 2022, section 62D.095, subdivision 4, is amended to read:

13.2 **Subd. 4. Annual out-of-pocket maximums.** A health maintenance contract may must  
 13.3 not impose an annual out-of-pocket maximum consistent with the provisions of the  
 13.4 Affordable Care Act as defined under section 62A.011, subdivision 1a for services rendered  
 13.5 that are not listed under section 62D.02, subdivision 17, or for preventive items and services.

13.6 Sec. 7. Minnesota Statutes 2022, section 62D.095, subdivision 5, is amended to read:

13.7 **Subd. 5. Exceptions.** No Co-payments or deductibles may must not be imposed on  
 13.8 preventive health care items and services consistent with the provisions of the Affordable  
 13.9 Care Act as defined under section 62A.011, subdivision 1a.

30.16 (f) Paragraph (e), clauses (1) and (2), of the replacement notice (applicable to preexisting  
 30.17 conditions) may be deleted by an issuer if the replacement does not involve application of  
 30.18 a new preexisting condition limitation.

30.19 **EFFECTIVE DATE.** This section is effective August 1, 2024, and applies to policies  
 30.20 offered, issued, or renewed on or after that date.

30.21 Sec. 16. Minnesota Statutes 2022, section 62D.02, is amended by adding a subdivision to  
 30.22 read:

30.23 **Subd. 17. Preventive items and services.** "Preventive items and services" has the  
 30.24 meaning given in section 62Q.46, subdivision 1, paragraph (a).

30.25 Sec. 17. Minnesota Statutes 2022, section 62D.095, subdivision 2, is amended to read:

30.26 **Subd. 2. Co-payments.** A health maintenance contract may impose a co-payment and  
 30.27 coinsurance consistent with the provisions of the Affordable Care Act as defined under  
 30.28 section 62A.011, subdivision 1a, and for items and services that are not preventive items  
 30.29 and services.

31.1 Sec. 18. Minnesota Statutes 2022, section 62D.095, subdivision 3, is amended to read:

31.2 **Subd. 3. Deductibles.** A health maintenance contract may must not impose a deductible  
 31.3 consistent with the provisions of the Affordable Care Act as defined under section 62A.011,  
 31.4 subdivision 1a for preventive items and services.

31.5 Sec. 19. Minnesota Statutes 2022, section 62D.095, subdivision 5, is amended to read:

31.6 **Subd. 5. Exceptions.** No Co-payments or deductibles may must not be imposed on  
 31.7 preventive health care items and services consistent with the provisions of the Affordable  
 31.8 Care Act as defined under section 62A.011, subdivision 1a.

31.9 Sec. 20. Minnesota Statutes 2022, section 62J.26, subdivision 1, is amended to read:

31.10 **Subdivision 1. Definitions.** (a) For purposes of this section, the following terms have  
 31.11 the meanings given unless the context otherwise requires:

31.12 (1) "commissioner" means the commissioner of commerce;

31.13 (2) "enrollee" has the meaning given in section 62Q.01, subdivision 2b;

31.14 (3) "health plan" means a health plan as defined in section 62A.011, subdivision 3, but  
 31.15 includes coverage listed in clauses (7) and (10) of that definition;

31.16        (4) "mandated health benefit proposal" or "proposal" means a proposal that would  
31.17        statutorily require a health plan company to do the following:  
31.18        (i) provide coverage or increase the amount of coverage for the treatment of a particular  
31.19        disease, condition, or other health care need;  
31.20        (ii) provide coverage or increase the amount of coverage of a particular type of health  
31.21        care treatment or service or of equipment, supplies, or drugs used in connection with a health  
31.22        care treatment or service;  
31.23        (iii) provide coverage for care delivered by a specific type of provider;  
31.24        (iv) require a particular benefit design or impose conditions on cost-sharing for:  
31.25        (A) the treatment of a particular disease, condition, or other health care need;  
31.26        (B) a particular type of health care treatment or service; or  
31.27        (C) the provision of medical equipment, supplies, or a prescription drug used in  
31.28        connection with treating a particular disease, condition, or other health care need; or  
32.1        (v) impose limits or conditions on a contract between a health plan company and a health  
32.2        care provider.  
32.3        (b) "Mandated health benefit proposal" does not include health benefit proposals:  
32.4        (1) amending the scope of practice of a licensed health care professional; or  
32.5        (2) that make state law consistent with federal law.  
32.6        **EFFECTIVE DATE.** This section is effective the day following final enactment.  
32.7        Sec. 21. Minnesota Statutes 2022, section 62J.26, subdivision 2, is amended to read:  
32.8        Subd. 2. **Evaluation process and content.** (a) The commissioner, in consultation with  
32.9        the commissioners of health and management and budget, must evaluate all mandated health  
32.10       benefit proposals as provided under subdivision 3.  
32.11        (b) The purpose of the evaluation is to provide the legislature with a complete and timely  
32.12        analysis of all ramifications of any mandated health benefit proposal. The evaluation must  
32.13        include, in addition to other relevant information, the following to the extent applicable:  
32.14        (1) scientific and medical information on the mandated health benefit proposal, on the  
32.15        potential for harm or benefit to the patient, and on the comparative benefit or harm from  
32.16        alternative forms of treatment, and must include the results of at least one professionally  
32.17        accepted and controlled trial comparing the medical consequences of the proposed therapy,  
32.18        alternative therapy, and no therapy;  
32.19        (2) public health, economic, and fiscal impacts of the mandated health benefit proposal  
32.20        on persons receiving health services in Minnesota, on the relative cost-effectiveness of the  
32.21        proposal, and on the health care system in general;

32.22 (3) the extent to which the treatment, service, equipment, or drug is generally utilized  
32.23 by a significant portion of the population;

32.24 (4) the extent to which insurance coverage for the mandated health benefit proposal is  
32.25 already generally available;

32.26 (5) the extent to which the mandated health benefit proposal, by health plan category,  
32.27 would apply to the benefits offered to the health plan's enrollees;

32.28 (6) the extent to which the mandated health benefit proposal will increase or decrease  
32.29 the cost of the treatment, service, equipment, or drug;

32.30 (7) the extent to which the mandated health benefit proposal may increase enrollee  
32.31 premiums; and

33.1 (8) if the proposal applies to a qualified health plan as defined in section 62A.011,  
33.2 subdivision 7, the cost to the state to defray the cost of the mandated health benefit proposal  
33.3 using commercial market reimbursement rates in accordance with Code of Federal  
33.4 Regulations, title 45, section 155.70.

33.5 (c) The commissioner shall consider actuarial analysis done by health plan companies  
33.6 and any other proponent or opponent of the mandated health benefit proposal in determining  
33.7 the cost of the proposal.

33.8 (d) The commissioner must summarize the nature and quality of available information  
33.9 on these issues, and, if possible, must provide preliminary information to the public. The  
33.10 commissioner may conduct research on these issues or may determine that existing research  
33.11 is sufficient to meet the informational needs of the legislature. The commissioner may seek  
33.12 the assistance and advice of researchers, community leaders, or other persons or organizations  
33.13 with relevant expertise. The commissioner must provide the public with at least 45 days  
33.14 notice when requesting information pursuant to this section. The commissioner must notify  
33.15 the chief authors of a bill when a request for information is issued.

33.16 (e) Information submitted to the commissioner pursuant to this section that meets the  
33.17 definition of trade secret information, as defined in section 13.37, subdivision 1, paragraph  
33.18 (b), is nonpublic data.

33.19 Sec. 22. Minnesota Statutes 2022, section 62J.26, is amended by adding a subdivision to  
33.20 read:

33.21 Subd. 6. Notification. (a) Upon passage of the law containing a mandated health benefit  
33.22 proposal, the commissioner must notify health plan companies of the change to benefits.  
33.23 Health plan companies must report to the commissioner estimated costs attributed to the  
33.24 change in benefits over a ten-year period. A health plan company's calculation of the costs  
33.25 must:

13.10 Sec. 8. **[62J.841] DEFINITIONS.**

13.11 Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following  
 13.12 definitions apply.

13.13 Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price  
 13.14 Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items,  
 13.15 reported by the United States Department of Labor, Bureau of Labor Statistics, or its  
 13.16 successor or, if the index is discontinued, an equivalent index reported by a federal authority  
 13.17 or, if no such index is reported, "Consumer Price Index" means a comparable index chosen  
 13.18 by the Bureau of Labor Statistics.

13.19 Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription  
 13.20 drug for which any exclusive marketing rights granted under the Federal Food, Drug, and  
 13.21 Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law  
 13.22 have expired, including any drug-device combination product for the delivery of a generic  
 13.23 drug.

13.24 Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01,  
 13.25 subdivision 14a, but does not include an entity required solely because the entity repackages  
 13.26 or relabels drugs.

13.27 Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject  
 13.28 to United States Code, title 21, section 353(b)(1).

13.29 Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning  
 13.30 provided in United States Code, title 42, section 1395w-3a.

14.1 Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in  
 14.2 section 151.441, subdivision 14.

14.3 Sec. 9. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

14.4 Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an  
 14.5 excessive price increase, whether directly or through a wholesale distributor, pharmacy, or

33.26 (1) be based on an analysis performed in accordance with generally accepted actuarial  
 33.27 principles and methodologies;

33.28 (2) be conducted by a member of the American Academy of Actuaries; and

33.29 (3) include projected costs for the ten years following the effective date of the change  
 33.30 in benefits.

33.31 (b) The commissioner must annually report to the legislature defrayment amounts paid to  
 33.32 health plan companies pursuant to Code of Federal Regulations, title 45, section 155.70.

34.1 The report must compare the amounts paid to each health plan company to the estimated  
 34.2 amount projected by each health plan company in its report pursuant to paragraph (a).

34.3 Sec. 23. **[62J.841] DEFINITIONS.**

34.4 Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following  
 34.5 definitions apply.

34.6 Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price  
 34.7 Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items,  
 34.8 reported by the United States Department of Labor, Bureau of Labor Statistics, or its  
 34.9 successor or, if the index is discontinued, an equivalent index reported by a federal authority  
 34.10 or, if no such index is reported, "Consumer Price Index" means a comparable index chosen  
 34.11 by the Bureau of Labor Statistics.

34.12 Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription  
 34.13 drug for which any exclusive marketing rights granted under the Federal Food, Drug, and  
 34.14 Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law  
 34.15 have expired, including any drug-device combination product for the delivery of a generic  
 34.16 drug.

34.17 Subd. 4. **Manufacturer.** "Manufacturer" has the meaning given in section 151.01,  
 34.18 subdivision 14a, but does not include an entity that must be licensed solely because the  
 34.19 entity repackages or relabels drugs.

34.20 Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject  
 34.21 to United States Code, title 21, section 353(b)(1).

34.22 Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning  
 34.23 provided in United States Code, title 42, section 1395w-3a.

34.24 Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in  
 34.25 section 151.441, subdivision 14.

34.26 Sec. 24. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

34.27 Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an  
 34.28 excessive price increase, whether directly or through a wholesale distributor, pharmacy, or

14.6 similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or  
 14.7 delivered to any consumer in the state.

14.8 Subd. 2. Excessive price increase. A price increase is excessive for purposes of this  
 14.9 section when:

14.10 (1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

14.11 (i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar  
 14.12 year; or

14.13 (ii) 40 percent of the wholesale acquisition cost over the immediately preceding three  
 14.14 calendar years; and

14.15 (2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds  
 14.16 \$30 for:

14.17 (i) a 30-day supply of the drug; or

14.18 (ii) a course of treatment lasting less than 30 days.

14.19 Subd. 3. Exemption. It is not a violation of this section for a wholesale distributor or  
 14.20 pharmacy to increase the price of a generic or off-patent drug if the price increase is directly  
 14.21 attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy  
 14.22 by the manufacturer of the drug.

14.23 **Sec. 10. [62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

14.24 Any manufacturer that sells, distributes, delivers, or offers for sale any generic or  
 14.25 off-patent drug in the state must maintain a registered agent and office within the state.

14.26 **Sec. 11. [62J.844] ENFORCEMENT.**

14.27 Subdivision 1. Notification. (a) The commissioner of health shall notify the manufacturer  
 14.28 of a generic or off-patent drug, the attorney general, and the Board of Pharmacy of any price  
 14.29 increase that the commissioner believes may violate section 62J.842.

15.1 (b) The commissioner of management and budget and any other state agency that provides  
 15.2 or purchases a pharmacy benefit except the Department of Human Services, and any entity  
 15.3 under contract with a state agency to provide a pharmacy benefit other than an entity under  
 15.4 contract with the Department of Human Services, may notify the manufacturer of a generic  
 15.5 or off-patent drug, the attorney general, and the Board of Pharmacy of any price increase  
 15.6 that the commissioner or entity believes may violate section 62J.842.

15.7 Subd. 2. Submission of drug cost statement and other information by manufacturer;  
 15.8 investigation by attorney general. (a) Within 45 days of receiving a notice under subdivision  
 15.9 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to  
 15.10 the attorney general. The statement must:

34.29 similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or  
 34.30 delivered to any consumer in the state.

35.1 Subd. 2. Excessive price increase. A price increase is excessive for purposes of this  
 35.2 section when:

35.3 (1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

35.4 (i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar  
 35.5 year; or

35.6 (ii) 40 percent of the wholesale acquisition cost over the immediately preceding three  
 35.7 calendar years; and

35.8 (2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds  
 35.9 \$30 for:

35.10 (i) a 30-day supply of the drug; or

35.11 (ii) a course of treatment lasting less than 30 days.

35.12 Subd. 3. Exemption. It is not a violation of this section for a wholesale distributor or  
 35.13 pharmacy to increase the price of a generic or off-patent drug if the price increase is directly  
 35.14 attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy  
 35.15 by the manufacturer of the drug.

35.16 **Sec. 25. [62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

35.17 Any manufacturer that sells, distributes, delivers, or offers for sale any generic or  
 35.18 off-patent drug in the state must maintain a registered agent and office within the state.

35.19 **Sec. 26. [62J.844] ENFORCEMENT.**

35.20 Subdivision 1. Notification. (a) The commissioner of health shall notify the manufacturer  
 35.21 of a generic or off-patent drug and the attorney general of any price increase that the  
 35.22 commissioner believes may violate section 62J.842.

35.23 (b) The commissioner of management and budget and any other state agency that provides  
 35.24 or purchases a pharmacy benefit except the Department of Human Services, and any entity  
 35.25 under contract with a state agency to provide a pharmacy benefit other than an entity under  
 35.26 contract with the Department of Human Services, may notify the manufacturer of a generic  
 35.27 or off-patent drug and the attorney general of any price increase that the commissioner or  
 35.28 entity believes may violate section 62J.842.

35.29 Subd. 2. Submission of drug cost statement and other information by manufacturer;  
 35.30 investigation by attorney general. (a) Within 45 days of receiving a notice under subdivision  
 36.1 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to  
 36.2 the attorney general. The statement must:

15.11       (1) itemize the cost components related to production of the drug;

15.12       (2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

15.15       (3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

15.17       (b) The attorney general may investigate whether a violation of section 62J.842 has occurred, in accordance with section 8.31, subdivision 2.

15.19       Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an order:

15.21       (1) compelling the manufacturer of a generic or off-patent drug to:

15.22       (i) provide the drug cost statement required under subdivision 2, paragraph (a); and

15.23       (ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

15.25       (2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

15.27       (3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

15.29       (4) requiring the manufacturer to repay to all Minnesota consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

16.1       (5) notwithstanding section 16A.151, requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4);

16.6       (6) imposing a civil penalty of up to \$10,000 per day for each violation of section 62J.842;

16.7       (7) providing for the attorney general's recovery of costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and

16.10       (8) providing any other appropriate relief, including any other equitable relief as determined by the court.

16.12       (b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 is considered a separate violation.

36.3       (1) itemize the cost components related to production of the drug;

36.4       (2) identify the circumstances and timing of any increase in materials or manufacturing costs that caused any increase during the preceding calendar year, or preceding three calendar years as applicable, in the price of the drug; and

36.7       (3) provide any other information that the manufacturer believes to be relevant to a determination of whether a violation of section 62J.842 has occurred.

36.9       (b) The attorney general may investigate whether a violation of section 62J.842 has occurred, in accordance with section 8.31, subdivision 2.

36.11       Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an order:

36.13       (1) compelling the manufacturer of a generic or off-patent drug to:

36.14       (i) provide the drug cost statement required under subdivision 2, paragraph (a); and

36.15       (ii) answer interrogatories, produce records or documents, or be examined under oath, as required by the attorney general under subdivision 2, paragraph (b);

36.17       (2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing an order requiring that drug prices be restored to levels that comply with section 62J.842;

36.19       (3) requiring the manufacturer to provide an accounting to the attorney general of all revenues resulting from a violation of section 62J.842;

36.21       (4) requiring the manufacturer to repay to all Minnesota consumers, including any third-party payers, any money acquired as a result of a price increase that violates section 62J.842;

36.24       (5) notwithstanding section 16A.151, requiring that all revenues generated from a violation of section 62J.842 be remitted to the state and deposited into a special fund, to be used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a manufacturer is unable to determine the individual transactions necessary to provide the repayments described in clause (4);

36.29       (6) imposing a civil penalty of up to \$10,000 per day for each violation of section 62J.842;

37.1       (7) providing for the attorney general's recovery of costs and disbursements incurred in bringing an action against a manufacturer found in violation of section 62J.842, including the costs of investigation and reasonable attorney's fees; and

37.4       (8) providing any other appropriate relief, including any other equitable relief as determined by the court.

37.6       (b) For purposes of paragraph (a), clause (6), every individual transaction in violation of section 62J.842 is considered a separate violation.

16.14 Subd. 4. Private right of action. Any action brought pursuant to section 8.31, subdivision  
 16.15 3a, by a person injured by a violation of section 62J.842 is for the benefit of the public.

16.16 **Sec. 12. [62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR  
 16.17 OFF-PATENT DRUGS FOR SALE.**

16.18 Subdivision 1. Prohibition. A manufacturer of a generic or off-patent drug is prohibited  
 16.19 from withdrawing that drug from sale or distribution within this state for the purpose of  
 16.20 avoiding the prohibition on excessive price increases under section 62J.842.

16.21 Subd. 2. Notice to board and attorney general. Any manufacturer that intends to  
 16.22 withdraw a generic or off-patent drug from sale or distribution within the state shall provide  
 16.23 a written notice of withdrawal to the Board of Pharmacy and the attorney general at least  
 16.24 90 days prior to the withdrawal.

16.25 Subd. 3. Financial penalty. The attorney general shall assess a penalty of \$500,000 on  
 16.26 any manufacturer of a generic or off-patent drug that the attorney general determines has  
 16.27 failed to comply with the requirements of this section.

16.28 **Sec. 13. [62J.846] SEVERABILITY.**

16.29 If any provision of sections 62J.841 to 62J.845 or the application thereof to any person  
 16.30 or circumstance is held invalid for any reason in a court of competent jurisdiction, the  
 17.1 invalidity does not affect other provisions or any other application of sections 62J.841 to  
 17.2 62J.845 that can be given effect without the invalid provision or application.

17.3 **Sec. 14. [62J.85] CITATION.**

17.4 Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

17.5 **Sec. 15. [62J.86] DEFINITIONS.**

17.6 Subdivision 1. Definitions. For the purposes of sections 62J.85 to 62J.95, the following  
 17.7 terms have the meanings given.

17.8 Subd. 2. Advisory council. "Advisory council" means the Prescription Drug Affordability  
 17.9 Advisory Council established under section 62J.88.

17.10 Subd. 3. Biologic. "Biologic" means a drug that is produced or distributed in accordance  
 17.11 with a biologics license application approved under Code of Federal Regulations, title 42,  
 17.12 section 447.502.

17.13 Subd. 4. Biosimilar. "Biosimilar" has the meaning provided in section 62J.84, subdivision  
 17.14 2, paragraph (b).

17.15 Subd. 5. Board. "Board" means the Prescription Drug Affordability Board established  
 17.16 under section 62J.87.

37.8 Subd. 4. Private right of action. Any action brought pursuant to section 8.31, subdivision  
 37.9 3a, by a person injured by a violation of section 62J.842 is for the benefit of the public.

37.10 **Sec. 27. [62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR  
 37.11 OFF-PATENT DRUGS FOR SALE.**

37.12 Subdivision 1. Prohibition. A manufacturer of a generic or off-patent drug is prohibited  
 37.13 from withdrawing that drug from sale or distribution within this state for the purpose of  
 37.14 avoiding the prohibition on excessive price increases under section 62J.842.

37.15 Subd. 2. Notice to board and attorney general. Any manufacturer that intends to  
 37.16 withdraw a generic or off-patent drug from sale or distribution within the state shall provide  
 37.17 a written notice of withdrawal to the attorney general at least 90 days prior to the withdrawal.

37.18 Subd. 3. Financial penalty. The attorney general shall assess a penalty of \$500,000 on  
 37.19 any manufacturer of a generic or off-patent drug that the attorney general determines has  
 37.20 failed to comply with the requirements of this section.

37.21 **Sec. 28. [62J.846] SEVERABILITY.**

37.22 If any provision of sections 62J.841 to 62J.845 or the application thereof to any person  
 37.23 or circumstance is held invalid for any reason in a court of competent jurisdiction, the  
 37.24 invalidity does not affect other provisions or any other application of sections 62J.841 to  
 37.25 62J.845 that can be given effect without the invalid provision or application.

37.26 **Sec. 29. [62J.85] CITATION.**

37.27 Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

37.28 **Sec. 30. [62J.86] DEFINITIONS.**

37.29 Subdivision 1. Definitions. For the purposes of sections 62J.85 to 62J.95, the following  
 37.30 terms have the meanings given.

38.1 Subd. 2. Advisory council. "Advisory council" means the Prescription Drug Affordability  
 38.2 Advisory Council established under section 62J.88.

38.3 Subd. 3. Biologic. "Biologic" means a drug that is produced or distributed in accordance  
 38.4 with a biologics license application approved under Code of Federal Regulations, title 42,  
 38.5 section 447.502.

38.6 Subd. 4. Biosimilar. "Biosimilar" has the meaning provided in section 62J.84, subdivision  
 38.7 2, paragraph (b).

38.8 Subd. 5. Board. "Board" means the Prescription Drug Affordability Board established  
 38.9 under section 62J.87.

17.17     Subd. 6. **Brand name drug.** "Brand name drug" means a drug that is produced or  
 17.18     distributed pursuant to:

17.19        (1) a new drug application approved under United States Code, title 21, section 355(c),  
 17.20        except for a generic drug as defined under Code of Federal Regulations, title 42, section  
 17.21        447.502; or

17.22        (2) a biologics license application approved under United States Code, title 45, section  
 17.23        262(a)(c).

17.24     Subd. 7. **Generic drug.** "Generic drug" has the meaning provided in section 62J.84,  
 17.25     subdivision 2, paragraph (e).

17.26     Subd. 8. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03,  
 17.27     subdivision 6, and includes pharmacy benefit managers, as defined in section 62W.02,  
 17.28     subdivision 15.

17.29     Subd. 9. **Manufacturer.** "Manufacturer" means an entity that:

18.1        (1) engages in the manufacture of a prescription drug product or enters into a lease with  
 18.2        another manufacturer to market and distribute a prescription drug product under the entity's  
 18.3        own name; and

18.4        (2) sets or changes the wholesale acquisition cost of the prescription drug product it  
 18.5        manufacturers or markets.

18.6     Subd. 10. **Prescription drug product.** "Prescription drug product" means a brand name  
 18.7     drug, a generic drug, a biologic, or a biosimilar.

18.8     Subd. 11. **Wholesale acquisition cost or WAC.** "Wholesale acquisition cost" or "WAC"  
 18.9     has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

18.10    Sec. 16. **[62J.87] PRESCRIPTION DRUG AFFORDABILITY BOARD.**

18.11    Subdivision 1. **Establishment.** The commissioner of commerce shall establish the  
 18.12    Prescription Drug Affordability Board, which shall be governed as a board under section  
 18.13    15.012, paragraph (a), to protect consumers, state and local governments, health plan  
 18.14    companies, providers, pharmacies, and other health care system stakeholders from  
 18.15    unaffordable costs of certain prescription drugs.

18.16    Subd. 2. **Membership.** (a) The Prescription Drug Affordability Board consists of nine  
 18.17    members appointed as follows:

18.18        (1) seven voting members appointed by the governor;

18.19        (2) one nonvoting member appointed by the majority leader of the senate; and

18.20        (3) one nonvoting member appointed by the speaker of the house.

38.10     Subd. 6. **Brand name drug.** "Brand name drug" means a drug that is produced or  
 38.11     distributed pursuant to:

38.12        (1) a new drug application approved under United States Code, title 21, section 355(c),  
 38.13        except for a generic drug as defined under Code of Federal Regulations, title 42, section  
 38.14        447.502; or

38.15        (2) a biologics license application approved under United States Code, title 45, section  
 38.16        262(a)(c).

38.17     Subd. 7. **Generic drug.** "Generic drug" has the meaning provided in section 62J.84,  
 38.18     subdivision 2, paragraph (e).

38.19     Subd. 8. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03,  
 38.20     subdivision 6, and includes pharmacy benefit managers, as defined in section 62W.02,  
 38.21     subdivision 15.

38.22     Subd. 9. **Manufacturer.** "Manufacturer" means an entity that:

38.23        (1) engages in the manufacture of a prescription drug product or enters into a lease with  
 38.24        another manufacturer to market and distribute a prescription drug product under the entity's  
 38.25        own name; and

38.26        (2) sets or changes the wholesale acquisition cost of the prescription drug product it  
 38.27        manufacturers or markets.

38.28     Subd. 10. **Prescription drug product.** "Prescription drug product" means a brand name  
 38.29     drug, a generic drug, a biologic, or a biosimilar.

38.30     Subd. 11. **Wholesale acquisition cost or WAC.** "Wholesale acquisition cost" or "WAC"  
 38.31     has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

39.1    Sec. 31. **[62J.87] PRESCRIPTION DRUG AFFORDABILITY BOARD.**

39.2    Subdivision 1. **Establishment.** The commissioner of commerce shall establish the  
 39.3    Prescription Drug Affordability Board, which shall be governed as a board under section  
 39.4    15.012, paragraph (a), to protect consumers, state and local governments, health plan  
 39.5    companies, providers, pharmacies, and other health care system stakeholders from  
 39.6    unaffordable costs of certain prescription drugs.

39.7    Subd. 2. **Membership.** (a) The Prescription Drug Affordability Board consists of nine  
 39.8    members appointed as follows:

39.9        (1) seven voting members appointed by the governor;

39.10       (2) one nonvoting member appointed by the majority leader of the senate; and

39.11       (3) one nonvoting member appointed by the speaker of the house.

18.21       (b) All members appointed must have knowledge and demonstrated expertise in  
18.22 pharmaceutical economics and finance or health care economics and finance. A member  
18.23 must not be an employee of, a board member of, or a consultant to a manufacturer or trade  
18.24 association for manufacturers, or a pharmacy benefit manager or trade association for  
18.25 pharmacy benefit managers.

18.26       (c) Initial appointments must be made by January 1, 2024.

18.27       Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms, except that initial  
18.28 appointees shall serve staggered terms of two, three, or four years as determined by lot by  
18.29 the secretary of state. A board member shall serve no more than two consecutive terms.

18.30       (b) A board member may resign at any time by giving written notice to the board.

19.1       Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from  
19.2 the members appointed by the governor.

19.3       (b) The board shall elect a chair to replace the acting chair at the first meeting of the  
19.4 board by a majority of the members. The chair shall serve for one year.

19.5       (c) The board shall elect a vice-chair and other officers from its membership as it deems  
19.6 necessary.

19.7       Subd. 5. **Staff; technical assistance.** (a) The board shall hire an executive director and  
19.8 other staff, who shall serve in the unclassified service. The executive director must have  
19.9 knowledge and demonstrated expertise in pharmacoconomics, pharmacology, health policy,  
19.10 health services research, medicine, or a related field or discipline.

19.11       (b) The commissioner of health shall provide technical assistance to the board. The board  
19.12 may also employ or contract for professional and technical assistance as the board deems  
19.13 necessary to perform the board's duties.

19.14       (c) The attorney general shall provide legal services to the board.

19.15       Subd. 6. **Compensation.** The board members shall not receive compensation but may  
19.16 receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

19.17       Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall  
19.18 meet publicly at least every three months to review prescription drug product information  
19.19 submitted to the board under section 62J.90. If there are no pending submissions, the chair  
19.20 of the board may cancel or postpone the required meeting. The board may meet in closed  
19.21 session when reviewing proprietary information, as determined under the standards developed  
19.22 in accordance with section 62J.91, subdivision 3.

19.23       (b) The board shall announce each public meeting at least three weeks prior to the  
19.24 scheduled date of the meeting. Any materials for the meeting shall be made public at least  
19.25 two weeks prior to the scheduled date of the meeting.

39.12       (b) All members appointed must have knowledge and demonstrated expertise in  
39.13 pharmaceutical economics and finance or health care economics and finance. A member  
39.14 must not be an employee of, a board member of, or a consultant to a manufacturer or trade  
39.15 association for manufacturers, or a pharmacy benefit manager or trade association for  
39.16 pharmacy benefit managers.

39.17       (c) Initial appointments must be made by January 1, 2024.

39.18       Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms, except that initial  
39.19 appointees shall serve staggered terms of two, three, or four years as determined by lot by  
39.20 the secretary of state. A board member shall serve no more than two consecutive terms.

39.21       (b) A board member may resign at any time by giving written notice to the board.

39.22       Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from  
39.23 the members appointed by the governor.

39.24       (b) The board shall elect a chair to replace the acting chair at the first meeting of the  
39.25 board by a majority of the members. The chair shall serve for one year.

39.26       (c) The board shall elect a vice-chair and other officers from its membership as it deems  
39.27 necessary.

39.28       Subd. 5. **Staff; technical assistance.** (a) The board shall hire an executive director and  
39.29 other staff, who shall serve in the unclassified service. The executive director must have  
39.30 knowledge and demonstrated expertise in pharmacoconomics, pharmacology, health policy,  
39.31 health services research, medicine, or a related field or discipline.

40.1       (b) The commissioner of health shall provide technical assistance to the board. The board  
40.2 may also employ or contract for professional and technical assistance as the board deems  
40.3 necessary to perform the board's duties.

40.4       (c) The attorney general shall provide legal services to the board.

40.5       Subd. 6. **Compensation.** The board members shall not receive compensation but may  
40.6 receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

40.7       Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall  
40.8 meet publicly at least every three months to review prescription drug product information  
40.9 submitted to the board under section 62J.90. If there are no pending submissions, the chair  
40.10 of the board may cancel or postpone the required meeting. The board may meet in closed  
40.11 session when reviewing proprietary information, as determined under the standards developed  
40.12 in accordance with section 62J.91, subdivision 3.

40.13       (b) The board shall announce each public meeting at least three weeks prior to the  
40.14 scheduled date of the meeting. Any materials for the meeting shall be made public at least  
40.15 two weeks prior to the scheduled date of the meeting.

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

19.29 **Sec. 17. [62J.88] PRESCRIPTION DRUG AFFORDABILITY ADVISORY  
19.30 COUNCIL.**

19.31 Subdivision 1. **Establishment.** The governor shall appoint a 18-member stakeholder  
19.32 advisory council to provide advice to the board on drug cost issues and to represent  
20.1 stakeholders' views. The governor shall appoint the members of the advisory council based  
20.2 on the members' knowledge and demonstrated expertise in one or more of the following  
20.3 areas: the pharmaceutical business; practice of medicine; patient perspectives; health care  
20.4 cost trends and drivers; clinical and health services research; and the health care marketplace.

20.5 Subd. 2. **Membership.** The council's membership shall consist of the following:

- 20.6 (1) two members representing patients and health care consumers;
- 20.7 (2) two members representing health care providers;
- 20.8 (3) one member representing health plan companies;
- 20.9 (4) two members representing employers, with one member representing large employers  
20.10 and one member representing small employers;
- 20.11 (5) one member representing government employee benefit plans;
- 20.12 (6) one member representing pharmaceutical manufacturers;
- 20.13 (7) one member who is a health services clinical researcher;
- 20.14 (8) one member who is a pharmacologist;
- 20.15 (9) one member representing the commissioner of health with expertise in health  
20.16 economics;
- 20.17 (10) one member representing pharmaceutical wholesalers;
- 20.18 (11) one member representing pharmacy benefit managers;
- 20.19 (12) one member from the Rare Disease Advisory Council;
- 20.20 (13) one member representing generic drug manufacturers;
- 20.21 (14) one member representing pharmaceutical distributors; and
- 20.22 (15) one member who is an oncologist who is not employed by, under contract with, or  
20.23 otherwise affiliated with a hospital.

20.24 Subd. 3. **Terms.** (a) The initial appointments to the advisory council must be made by  
20.25 January 1, 2024. The initial appointed advisory council members shall serve staggered terms

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

40.19 **Sec. 32. [62J.88] PRESCRIPTION DRUG AFFORDABILITY ADVISORY  
40.20 COUNCIL.**

40.21 Subdivision 1. **Establishment.** The governor shall appoint a 18-member stakeholder  
40.22 advisory council to provide advice to the board on drug cost issues and to represent  
40.23 stakeholders' views. The governor shall appoint the members of the advisory council based  
40.24 on the members' knowledge and demonstrated expertise in one or more of the following  
40.25 areas: the pharmaceutical business; practice of medicine; patient perspectives; health care  
40.26 cost trends and drivers; clinical and health services research; and the health care marketplace.

40.27 Subd. 2. **Membership.** The council's membership shall consist of the following:

- 40.28 (1) two members representing patients and health care consumers;
- 40.29 (2) two members representing health care providers;
- 40.30 (3) one member representing health plan companies;
- 40.31 (4) two members representing employers, with one member representing large employers  
40.32 and one member representing small employers;
- 41.1 (5) one member representing government employee benefit plans;
- 41.2 (6) one member representing pharmaceutical manufacturers;
- 41.3 (7) one member who is a health services clinical researcher;
- 41.4 (8) one member who is a pharmacologist;
- 41.5 (9) one member representing the commissioner of health with expertise in health  
41.6 economics;
- 41.7 (10) one member representing pharmaceutical wholesalers;
- 41.8 (11) one member representing pharmacy benefit managers;
- 41.9 (12) one member from the Rare Disease Advisory Council;
- 41.10 (13) one member representing generic drug manufacturers;
- 41.11 (14) one member representing pharmaceutical distributors; and
- 41.12 (15) one member who is an oncologist who is not employed by, under contract with, or  
41.13 otherwise affiliated with a hospital.

41.14 Subd. 3. **Terms.** (a) The initial appointments to the advisory council must be made by  
41.15 January 1, 2024. The initial appointed advisory council members shall serve staggered terms

20.26 of two, three, or four years, determined by lot by the secretary of state. Following the initial  
 20.27 appointments, the advisory council members shall serve four-year terms.

20.28 (b) Removal and vacancies of advisory council members shall be governed by section  
 20.29 15.059.

21.1 **Subd. 4. Compensation.** Advisory council members may be compensated according to  
 21.2 section 15.059, except that those advisory council members designated in subdivision 2,  
 21.3 clauses (10) to (15), must not be compensated.

21.4 **Subd. 5. Meetings.** Meetings of the advisory council are subject to chapter 13D. The  
 21.5 advisory council shall meet publicly at least every three months to advise the board on drug  
 21.6 cost issues related to the prescription drug product information submitted to the board under  
 21.7 section 62J.90.

21.8 **Subd. 6. Exemption.** Notwithstanding section 15.059, the advisory council shall not  
 21.9 expire.

21.10 Sec. 18. **[62J.89] CONFLICTS OF INTEREST.**

21.11 **Subdivision 1. Definition.** For purposes of this section, "conflict of interest" means a  
 21.12 financial or personal association that has the potential to bias or have the appearance of  
 21.13 biasing a person's decisions in matters related to the board, the advisory council, or in the  
 21.14 conduct of the board's or council's activities. A conflict of interest includes any instance in  
 21.15 which a person, a person's immediate family member, including a spouse, parent, child, or  
 21.16 other legal dependent, or an in-law of any of the preceding individuals, has received or  
 21.17 could receive a direct or indirect financial benefit of any amount deriving from the result  
 21.18 or findings of a decision or determination of the board. For purposes of this section, a  
 21.19 financial benefit includes honoraria, fees, stock, the value of the member's, immediate family  
 21.20 member's, or in-law's stock holdings, and any direct financial benefit deriving from the  
 21.21 finding of a review conducted under sections 62J.85 to 62J.95. Ownership of securities is  
 21.22 not a conflict of interest if the securities are: (1) part of a diversified mutual or exchange  
 21.23 traded fund; or (2) in a tax-deferred or tax-exempt retirement account that is administered  
 21.24 by an independent trustee.

21.25 **Subd. 2. General.** (a) Prior to the acceptance of an appointment or employment, or prior  
 21.26 to entering into a contractual agreement, a board or advisory council member, board staff  
 21.27 member, or third-party contractor must disclose to the appointing authority or the board  
 21.28 any conflicts of interest. The information disclosed must include the type, nature, and  
 21.29 magnitude of the interests involved.

21.30 (b) A board member, board staff member, or third-party contractor with a conflict of  
 21.31 interest with regard to any prescription drug product under review must recuse themselves  
 21.32 from any discussion, review, decision, or determination made by the board relating to the  
 21.33 prescription drug product.

41.16 of two, three, or four years, determined by lot by the secretary of state. Following the initial  
 41.17 appointments, the advisory council members shall serve four-year terms.

41.18 (b) Removal and vacancies of advisory council members shall be governed by section  
 41.19 15.059.

41.20 **Subd. 4. Compensation.** Advisory council members may be compensated according to  
 41.21 section 15.059.

41.22 **Subd. 5. Meetings.** Meetings of the advisory council are subject to chapter 13D. The  
 41.23 advisory council shall meet publicly at least every three months to advise the board on drug  
 41.24 cost issues related to the prescription drug product information submitted to the board under  
 41.25 section 62J.90.

41.26 **Subd. 6. Exemption.** Notwithstanding section 15.059, the advisory council shall not  
 41.27 expire.

41.28 Sec. 33. **[62J.89] CONFLICTS OF INTEREST.**

41.29 **Subdivision 1. Definition.** For purposes of this section, "conflict of interest" means a  
 41.30 financial or personal association that has the potential to bias or have the appearance of  
 42.1 biasing a person's decisions in matters related to the board, the advisory council, or in the  
 42.2 conduct of the board's or council's activities. A conflict of interest includes any instance in  
 42.3 which a person, a person's immediate family member, including a spouse, parent, child, or  
 42.4 other legal dependent, or an in-law of any of the preceding individuals, has received or  
 42.5 could receive a direct or indirect financial benefit of any amount deriving from the result  
 42.6 or findings of a decision or determination of the board. For purposes of this section, a  
 42.7 financial benefit includes honoraria, fees, stock, the value of the member's, immediate family  
 42.8 member's, or in-law's stock holdings, and any direct financial benefit deriving from the  
 42.9 finding of a review conducted under sections 62J.85 to 62J.95. Ownership of securities is  
 42.10 not a conflict of interest if the securities are: (1) part of a diversified mutual or exchange  
 42.11 traded fund; or (2) in a tax-deferred or tax-exempt retirement account that is administered  
 42.12 by an independent trustee.

42.13 **Subd. 2. General.** (a) Prior to the acceptance of an appointment or employment, or prior  
 42.14 to entering into a contractual agreement, a board or advisory council member, board staff  
 42.15 member, or third-party contractor must disclose to the appointing authority or the board  
 42.16 any conflicts of interest. The information disclosed must include the type, nature, and  
 42.17 magnitude of the interests involved.

42.18 (b) A board member, board staff member, or third-party contractor with a conflict of  
 42.19 interest with regard to any prescription drug product under review must recuse themselves  
 42.20 from any discussion, review, decision, or determination made by the board relating to the  
 42.21 prescription drug product.

22.1       (c) Any conflict of interest must be disclosed in advance of the first meeting after the  
 22.2 conflict is identified or within five days after the conflict is identified, whichever is earlier.

22.3       Subd. 3. **Prohibitions.** Board members, board staff, or third-party contractors are  
 22.4 prohibited from accepting gifts, bequeaths, or donations of services or property that raise  
 22.5 the specter of a conflict of interest or have the appearance of injecting bias into the activities  
 22.6 of the board.

22.7       Sec. 19. **[62J.90] PRESCRIPTION DRUG PRICE INFORMATION; DECISION**  
 22.8 **TO CONDUCT COST REVIEW.**

22.9       Subdivision 1. **Drug price information from the commissioner of health and other**  
 22.10 **sources.** (a) The commissioner of health shall provide to the board the information reported  
 22.11 to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5.  
 22.12 The commissioner shall provide this information to the board within 30 days of the date the  
 22.13 information is received from drug manufacturers.

22.14       (b) The board may subscribe to one or more prescription drug pricing files, such as  
 22.15 Medispan or FirstDatabank, or as otherwise determined by the board.

22.16       Subd. 2. **Identification of certain prescription drug products.** (a) The board, in  
 22.17 consultation with the advisory council, shall identify selected prescription drug products  
 22.18 that have been on the market for at least seven years, are not designated by the United States  
 22.19 Food and Drug Administration under United States Code, title 21, section 360bb, as a drug  
 22.20 solely for the treatment of a rare disease or condition, and meet the following criteria:

22.21       (1) brand name drugs or biologics for which the WAC increases by \$3,000 during any  
 22.22 12-month period or course of treatment if less than 12 months, after adjusting for changes  
 22.23 in the consumer price index (CPI);

22.24       (2) brand name drugs or biologics with a WAC of \$60,000 or more per calendar year  
 22.25 or per course of treatment;

22.26       (3) biosimilar drugs that have a WAC that is not at least 20 percent lower than the  
 22.27 referenced brand name biologic at the time the biosimilar is introduced; and

22.28       (4) generic drugs for which:

22.29       (i) the price increase, adjusted for inflation using the Consumer Price Index, as defined  
 22.30 in section 62J.841, subdivision 2, exceeds:

22.31       (A) 15 percent of the wholesale acquisition cost over the immediately preceding calendar  
 22.32 year; or

23.1       (B) 40 percent of the wholesale acquisition cost over the immediately preceding three  
 23.2 calendar years; and

42.22       (c) Any conflict of interest must be disclosed in advance of the first meeting after the  
 42.23 conflict is identified or within five days after the conflict is identified, whichever is earlier.

42.24       Subd. 3. **Prohibitions.** Board members, board staff, or third-party contractors are  
 42.25 prohibited from accepting gifts, bequeaths, or donations of services or property that raise  
 42.26 the specter of a conflict of interest or have the appearance of injecting bias into the activities  
 42.27 of the board.

42.28       Sec. 34. **[62J.90] PRESCRIPTION DRUG PRICE INFORMATION; DECISION**  
 42.29 **TO CONDUCT COST REVIEW.**

42.30       Subdivision 1. **Drug price information from the commissioner of health and other**  
 42.31 **sources.** (a) The commissioner of health shall provide to the board the information reported  
 42.32 to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5.  
 42.33 The commissioner shall provide this information to the board within 30 days of the date the  
 42.34 information is received from drug manufacturers.

43.1       (b) The board may subscribe to one or more prescription drug pricing files, such as  
 43.2 Medispan or FirstDatabank, or as otherwise determined by the board.

43.3       Subd. 2. **Identification of certain prescription drug products.** (a) The board, in  
 43.4 consultation with the advisory council, shall identify selected prescription drug products  
 43.5 based on the following criteria:

43.6       (1) brand name drugs or biologics for which the WAC increases by more than 15 percent  
 43.7 or by more than \$3,000 during any 12-month period or course of treatment if less than 12  
 43.8 months, after adjusting for changes in the consumer price index (CPI);

43.9       (2) brand name drugs or biologics with a WAC of \$60,000 or more per calendar year  
 43.10 or per course of treatment;

43.11       (3) biosimilar drugs that have a WAC that is not at least 20 percent lower than the  
 43.12 referenced brand name biologic at the time the biosimilar is introduced; and

43.13       (4) generic drugs for which the WAC:

23.3	<u>(ii) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds</u>	43.14	<u>(i) is \$100 or more, after adjusting for changes in the CPI, for:</u>
23.4	<u>\$30 for:</u>	43.15	<u>(A) a 30-day supply;</u>
23.5	<u>(A) a 30-day supply of the drug; or</u>	43.16	<u>(B) a course of treatment lasting less than 30 days; or</u>
23.6	<u>(B) a course of treatment lasting less than 30 days.</u>	43.17	<u>(C) one unit of the drug, if the labeling approved by the Food and Drug Administration</u>
		43.18	<u>does not recommend a finite dosage; and</u>
23.7	<u>The board is not required to identify all prescription drug products that meet the criteria in this paragraph.</u>	43.19	<u>(ii) increased by 200 percent or more during the immediate preceding 12-month period, as determined by the difference between the resulting WAC and the average WAC reported over the preceding 12 months, after adjusting for changes in the CPI.</u>
23.8		43.22	<u>The board is not required to identify all prescription drug products that meet the criteria in this paragraph.</u>
23.9	<u>(b) The board, in consultation with the advisory council and the commissioner of health, may identify prescription drug products not described in paragraph (a) that may impose costs that create significant affordability challenges for the state health care system or for patients, including but not limited to drugs to address public health emergencies.</u>	43.24	<u>(b) The board, in consultation with the advisory council and the commissioner of health, may identify prescription drug products not described in paragraph (a) that may impose costs that create significant affordability challenges for the state health care system or for patients, including but not limited to drugs to address public health emergencies.</u>
23.10		43.28	<u>(c) The board shall make available to the public the names and related price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary under the standards developed by the board under section 62J.91, subdivision 3, and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.</u>
23.11		44.4	<u>Subd. 3. <b>Determination to proceed with review.</b> (a) The board may initiate a cost review of a prescription drug product identified by the board under this section.</u>
23.12		44.6	<u>(b) The board shall consider requests by the public for the board to proceed with a cost review of any prescription drug product identified under this section.</u>
23.13	<u>(c) The board shall make available to the public the names and related price information of the prescription drug products identified under this subdivision, with the exception of information determined by the board to be proprietary under the standards developed by the board under section 62J.91, subdivision 3, and information provided by the commissioner of health classified as not public data under section 13.02, subdivision 8a, or as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade secret information under the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended.</u>	44.8	<u>(c) If there is no consensus among the members of the board on whether to initiate a cost review of a prescription drug product, any member of the board may request a vote to determine whether to review the cost of the prescription drug product.</u>
23.14		44.11	<u>Sec. 35. <b>[62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.</b></u>
23.15		44.12	<u>Subdivision 1. <b>General.</b> Once a decision by the board has been made to proceed with a cost review of a prescription drug product, the board shall conduct the review and make a determination as to whether appropriate utilization of the prescription drug under review, based on utilization that is consistent with the United States Food and Drug Administration</u>
23.16		44.13	
23.17		44.14	
23.18		44.15	
23.19			
23.20			
23.21	<u>Subd. 3. <b>Determination to proceed with review.</b> (a) The board may initiate a cost review of a prescription drug product identified by the board under this section.</u>		
23.22			
23.23	<u>(b) The board shall consider requests by the public for the board to proceed with a cost review of any prescription drug product identified under this section.</u>		
23.24			
23.25	<u>(c) If there is no consensus among the members of the board on whether to initiate a cost review of a prescription drug product, any member of the board may request a vote to determine whether to review the cost of the prescription drug product.</u>		
23.26			
23.27			
23.28	<u>Sec. 20. <b>[62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.</b></u>		
23.29			
23.30			
23.31			
23.32			

24.1 (FDA) label or standard medical practice, has led or will lead to affordability challenges  
 24.2 for the state health care system or for patients.

24.3 Subd. 2. **Review considerations.** In reviewing the cost of a prescription drug product,  
 24.4 the board may consider the following factors:

24.5 (1) the price at which the prescription drug product has been and will be sold in the state;  
 24.6 (2) manufacturer monetary price concessions, discounts, or rebates, and drug-specific  
 24.7 patient assistance;

24.8 (3) the price of therapeutic alternatives;  
 24.9 (4) the cost to group purchasers based on patient access consistent with the FDA-labeled  
 24.10 indications and standard medical practice;

24.11 (5) measures of patient access, including cost-sharing and other metrics;  
 24.12 (6) the extent to which the attorney general or a court has determined that a price increase  
 24.13 for a generic or off-patent prescription drug product was excessive under sections 62J.842  
 24.14 and 62J.844;

24.15 (7) any information a manufacturer chooses to provide; and  
 24.16 (8) any other factors as determined by the board.

24.17 Subd. 3. **Public data; proprietary information.** (a) Any submission made to the board  
 24.18 related to a drug cost review must be made available to the public with the exception of  
 24.19 information determined by the board to be proprietary and information provided by the  
 24.20 commissioner of health classified as not public data under section 13.02, subdivision 8a, or  
 24.21 as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade  
 24.22 secret information under the Defend Trade Secrets Act of 2016, United States Code, title  
 24.23 18, section 1836, as amended.

24.24 (b) The board shall establish the standards for the information to be considered proprietary  
 24.25 under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened  
 24.26 consideration of proprietary information for submissions for a cost review of a drug that is  
 24.27 not yet approved by the FDA.

24.28 (c) Prior to the board establishing the standards under paragraph (b), the public shall be  
 24.29 provided notice and the opportunity to submit comments.

24.30 (d) The establishment of standards under this subdivision is exempt from the rulemaking  
 24.31 requirements under chapter 14, and section 14.386 does not apply.

25.1 Sec. 21. **[62J.92] DETERMINATIONS; COMPLIANCE; REMEDIES.**

25.2 Subdivision 1. **Upper payment limit.** (a) In the event the board finds that the spending  
 25.3 on a prescription drug product reviewed under section 62J.91 creates an affordability

44.16 (FDA) label or standard medical practice, has led or will lead to affordability challenges  
 44.17 for the state health care system or for patients.

44.18 Subd. 2. **Review considerations.** In reviewing the cost of a prescription drug product,  
 44.19 the board may consider the following factors:

44.20 (1) the price at which the prescription drug product has been and will be sold in the state;  
 44.21 (2) manufacturer monetary price concessions, discounts, or rebates, and drug-specific  
 44.22 patient assistance;

44.23 (3) the price of therapeutic alternatives;  
 44.24 (4) the cost to group purchasers based on patient access consistent with the FDA-labeled  
 44.25 indications and standard medical practice;

44.26 (5) measures of patient access, including cost-sharing and other metrics;  
 44.27 (6) the extent to which the attorney general or a court has determined that a price increase  
 44.28 for a generic or off-patent prescription drug product was excessive under sections 62J.842  
 44.29 and 62J.844;

44.30 (7) any information a manufacturer chooses to provide; and  
 44.31 (8) any other factors as determined by the board.

45.1 Subd. 3. **Public data; proprietary information.** (a) Any submission made to the board  
 45.2 related to a drug cost review must be made available to the public with the exception of  
 45.3 information determined by the board to be proprietary and information provided by the  
 45.4 commissioner of health classified as not public data under section 13.02, subdivision 8a, or  
 45.5 as trade secret information under section 13.37, subdivision 1, paragraph (b), or as trade  
 45.6 secret information under the Defend Trade Secrets Act of 2016, United States Code, title  
 45.7 18, section 1836, as amended.

45.8 (b) The board shall establish the standards for the information to be considered proprietary  
 45.9 under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened  
 45.10 consideration of proprietary information for submissions for a cost review of a drug that is  
 45.11 not yet approved by the FDA.

45.12 (c) Prior to the board establishing the standards under paragraph (b), the public shall be  
 45.13 provided notice and the opportunity to submit comments.

45.14 (d) The establishment of standards under this subdivision is exempt from the rulemaking  
 45.15 requirements under chapter 14, and section 14.386 does not apply.

45.16 Sec. 36. **[62J.92] DETERMINATIONS; COMPLIANCE; REMEDIES.**

45.17 Subdivision 1. **Upper payment limit.** (a) In the event the board finds that the spending  
 45.18 on a prescription drug product reviewed under section 62J.91 creates an affordability

25.4 challenge for the state health care system or for patients, the board shall establish an upper  
 25.5 payment limit after considering:

25.6 (1) extraordinary supply costs, if applicable;

25.7 (2) the range of prices at which the drug is sold in the United States according to one or  
 25.8 more pricing files accessed under section 62J.90, subdivision 1, and the range at which  
 25.9 pharmacies are reimbursed in Canada; and

25.10 (3) any other relevant pricing and administrative cost information for the drug.

25.11 (b) An upper payment limit applies to all purchases of, and payer reimbursements for,  
 25.12 a prescription drug that is dispensed or administered to individuals in the state in person,  
 25.13 by mail, or by other means, and for which an upper payment limit has been established.

25.14 Subd. 2. **Implementation and administration of the upper payment limit.** (a) An  
 25.15 upper payment limit may take effect no sooner than 120 days following the date of its public  
 25.16 release by the board.

25.17 (b) When setting an upper payment limit for a drug subject to the Medicare maximum  
 25.18 fair price under United States Code, title 42, section 1191(c), the board shall set the upper  
 25.19 payment limit at the Medicare maximum fair price.

25.20 (c) Pharmacy dispensing fees must not be counted toward or subject to any upper payment  
 25.21 limit. State-licensed independent pharmacies must not be reimbursed by health carriers and  
 25.22 pharmacy benefit managers at amounts that are less than the upper payment limit.

25.23 (d) Health plan companies and pharmacy benefit managers shall report annually to the  
 25.24 board, in the form and manner specified by the board, on how cost savings resulting from  
 25.25 the establishment of an upper payment limit have been used by the health plan company or  
 25.26 pharmacy benefit manager to benefit enrollees, including but not limited to reducing enrollee  
 25.27 cost-sharing.

25.28 Subd. 3. **Noncompliance.** (a) The board shall, and other persons may, notify the Office  
 25.29 of the Attorney General of a potential failure by an entity subject to an upper payment limit  
 25.30 to comply with that limit.

26.1 (b) If the Office of the Attorney General finds that an entity was noncompliant with the  
 26.2 upper payment limit requirements, the attorney general may pursue remedies consistent  
 26.3 with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.

26.4 (c) An entity who obtains price concessions from a drug manufacturer that result in a  
 26.5 lower net cost to the stakeholder than the upper payment limit established by the board is  
 26.6 not considered noncompliant.

26.7 (d) The Office of the Attorney General may provide guidance to stakeholders concerning  
 26.8 activities that could be considered noncompliant.

45.19 challenge for the state health care system or for patients, the board shall establish an upper  
 45.20 payment limit after considering:

45.21 (1) extraordinary supply costs, if applicable;

45.22 (2) the range of prices at which the drug is sold in the United States according to one or  
 45.23 more pricing files accessed under section 62J.90, subdivision 1, and the range at which  
 45.24 pharmacies are reimbursed in Canada; and

45.25 (3) any other relevant pricing and administrative cost information for the drug.

45.26 (b) An upper payment limit applies to all purchases of, and payer reimbursements for,  
 45.27 a prescription drug that is dispensed or administered to individuals in the state in person,  
 45.28 by mail, or by other means, and for which an upper payment limit has been established.

45.29 Subd. 2. **Implementation and administration of the upper payment limit.** (a) An  
 45.30 upper payment limit may take effect no sooner than 120 days following the date of its public  
 45.31 release by the board.

46.1 (b) When setting an upper payment limit for a drug subject to the Medicare maximum  
 46.2 fair price under United States Code, title 42, section 1191(c), the board shall set the upper  
 46.3 payment limit at the Medicare maximum fair price.

46.4 (c) Pharmacy dispensing fees must not be counted toward or subject to any upper payment  
 46.5 limit. State-licensed independent pharmacies must not be reimbursed by health carriers and  
 46.6 pharmacy benefit managers at amounts that are less than the upper payment limit.

46.7 (d) Health plan companies and pharmacy benefit managers shall report annually to the  
 46.8 board, in the form and manner specified by the board, on how cost savings resulting from  
 46.9 the establishment of an upper payment limit have been used by the health plan company or  
 46.10 pharmacy benefit manager to benefit enrollees, including but not limited to reducing enrollee  
 46.11 cost-sharing.

46.12 Subd. 3. **Noncompliance.** (a) The board shall, and other persons may, notify the Office  
 46.13 of the Attorney General of a potential failure by an entity subject to an upper payment limit  
 46.14 to comply with that limit.

46.15 (b) If the Office of the Attorney General finds that an entity was noncompliant with the  
 46.16 upper payment limit requirements, the attorney general may pursue remedies consistent  
 46.17 with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.

46.18 (c) An entity who obtains price concessions from a drug manufacturer that result in a  
 46.19 lower net cost to the stakeholder than the upper payment limit established by the board is  
 46.20 not considered noncompliant.

46.21 (d) The Office of the Attorney General may provide guidance to stakeholders concerning  
 46.22 activities that could be considered noncompliant.

26.9        Subd. 4. Appeals. (a) Persons affected by a decision of the board may request an appeal  
 26.10      of the board's decision within 30 days of the date of the decision. The board shall hear the  
 26.11      appeal and render a decision within 60 days of the hearing.

26.12      (b) All appeal decisions are subject to judicial review in accordance with chapter 14.

26.13      Sec. 22. **[62J.93] REPORTS.**

26.14      Beginning March 1, 2024, and each March 1 thereafter, the board shall submit a report  
 26.15      to the governor and legislature on general price trends for prescription drug products and  
 26.16      the number of prescription drug products that were subject to the board's cost review and  
 26.17      analysis, including the result of any analysis as well as the number and disposition of appeals  
 26.18      and judicial reviews.

26.19      Sec. 23. **[62J.94] ERISA PLANS AND MEDICARE DRUG PLANS.**

26.20      (a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or  
 26.21      Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare  
 26.22      Part D plans are free to choose to exceed the upper payment limit established by the board  
 26.23      under section 62J.92.

26.24      (b) Providers who dispense and administer drugs in the state must bill all payers no more  
 26.25      than the upper payment limit without regard to whether an ERISA plan or Medicare Part  
 26.26      D plan chooses to reimburse the provider in an amount greater than the upper payment limit  
 26.27      established by the board.

26.28      (c) For purposes of this section, an ERISA plan or group health plan is an employee  
 26.29      welfare benefit plan established by or maintained by an employer or an employee  
 26.30      organization, or both, that provides employer sponsored health coverage to employees and  
 26.31      the employee's dependents and is subject to the Employee Retirement Income Security Act  
 26.32      of 1974 (ERISA).

27.1      Sec. 24. **[62J.95] SEVERABILITY.**

27.2      If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or  
 27.3      circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity  
 27.4      does not affect other provisions or any other application of sections 62J.85 to 62J.94 that  
 27.5      can be given effect without the invalid provision or application.

27.6      Sec. 25. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

27.7      Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient  
 27.8      number and type of providers, including providers that specialize in mental health and  
 27.9      substance use disorder services, to ensure that covered services are available to all enrollees  
 27.10     without unreasonable delay. In determining network adequacy, the commissioner of health  
 27.11     shall consider availability of services, including the following:

46.23      Subd. 4. Appeals. (a) Persons affected by a decision of the board may request an appeal  
 46.24      of the board's decision within 30 days of the date of the decision. The board shall hear the  
 46.25      appeal and render a decision within 60 days of the hearing.

46.26      (b) All appeal decisions are subject to judicial review in accordance with chapter 14.

46.27      Sec. 37. **[62J.93] REPORTS.**

46.28      Beginning March 1, 2024, and each March 1 thereafter, the board shall submit a report  
 46.29      to the governor and legislature on general price trends for prescription drug products and  
 46.30      the number of prescription drug products that were subject to the board's cost review and  
 46.31      analysis, including the result of any analysis as well as the number and disposition of appeals  
 46.32      and judicial reviews.

47.1      Sec. 38. **[62J.94] ERISA PLANS AND MEDICARE DRUG PLANS.**

47.2      (a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or  
 47.3      Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare  
 47.4      Part D plans are free to choose to exceed the upper payment limit established by the board  
 47.5      under section 62J.92.

47.6      (b) Providers who dispense and administer drugs in the state must bill all payers no more  
 47.7      than the upper payment limit without regard to whether an ERISA plan or Medicare Part  
 47.8      D plan chooses to reimburse the provider in an amount greater than the upper payment limit  
 47.9      established by the board.

47.10     (c) For purposes of this section, an ERISA plan or group health plan is an employee  
 47.11     welfare benefit plan established by or maintained by an employer or an employee  
 47.12     organization, or both, that provides employer sponsored health coverage to employees and  
 47.13     the employee's dependents and is subject to the Employee Retirement Income Security Act  
 47.14     of 1974 (ERISA).

47.15     Sec. 39. **[62J.95] SEVERABILITY.**

47.16     If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or  
 47.17     circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity  
 47.18     does not affect other provisions or any other application of sections 62J.85 to 62J.94 that  
 47.19     can be given effect without the invalid provision or application.

47.20     Sec. 40. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

47.21     Subd. 4. **Network adequacy.** (a) Each designated provider network must include a  
 47.22     sufficient number and type of providers, including providers that specialize in mental health  
 47.23     and substance use disorder services, to ensure that covered services are available to all  
 47.24     enrollees without unreasonable delay. In determining network adequacy, the commissioner  
 47.25     of health shall consider availability of services, including the following:

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

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

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

27.18 (4) mental health and substance use disorder treatment providers, including but not  
27.19 limited to psychiatric residential treatment facilities, are available and accessible through  
27.20 the network or contract arrangement;

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

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

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

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

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

48.1 (4) mental health and substance use disorder treatment providers, including but not  
48.2 limited to psychiatric residential treatment facilities, are available and accessible through  
48.3 the network or contract arrangement;

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

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

48.10 (b) The commissioner must determine network sufficiency in a manner that is consistent  
48.11 with the requirements of this section and may establish sufficiency by referencing any  
48.12 reasonable criteria, which may include but is not limited to:

48.13 (1) provider-covered person ratios by specialty;

48.14 (2) primary care professional-covered person ratios;

48.15 (3) geographic accessibility of providers;

48.16 (4) geographic variation and population dispersion;

48.17 (5) waiting times for an appointment with participating providers;

48.18 (6) hours of operation;

48.19 (7) the ability of the network to meet the needs of covered persons, which may include:

48.20 (i) low-income persons;

48.21 (ii) children and adults with serious, chronic, or complex health conditions, physical  
48.22 disabilities, or mental illness; or

48.23 (iii) persons with limited English proficiency and persons from underserved communities;

48.24 (8) other health care service delivery system options, including telemedicine or telehealth,  
48.25 mobile clinics, centers of excellence, and other ways of delivering care; and

48.26        (9) the volume of technological and specialty care services available to serve the needs  
48.27        of covered persons that need technologically advanced or specialty care services.

48.28        **EFFECTIVE DATE.** The amendment to paragraph (a) is effective July 1, 2023.

48.29        Paragraph (b) is effective January 1, 2025, and applies to health plans offered, issued, or  
48.30        renewed on or after that date.

49.1        Sec. 41. Minnesota Statutes 2022, section 62Q.096, is amended to read:

49.2        **62Q.096 CREDENTIALING OF PROVIDERS.**

49.3        (a) If a health plan company has initially credentialed, as providers in its provider network,  
49.4        individual providers employed by or under contract with an entity that:

49.5        (1) is authorized to bill under section 256B.0625, subdivision 5;

49.6        (2) is a mental health clinic certified under section 245I.20;

49.7        (3) is designated an essential community provider under section 62Q.19; and

49.8        (4) is under contract with the health plan company to provide mental health services,  
49.9        the health plan company must continue to credential at least the same number of providers  
49.10        from that entity, as long as those providers meet the health plan company's credentialing  
49.11        standards.

49.12        (b) In order to ensure timely access by patients to mental health services, between July  
49.13        1, 2023, and June 30, 2025, a health plan company must credential and enter into a contract  
49.14        for mental health services with any provider of mental health services that:

49.15        (1) meets the health plan company's credential requirements. For purposes of credentialing  
49.16        under this paragraph, a health plan company may waive credentialing requirements that are  
49.17        not directly related to quality of care in order to ensure patient access to providers from  
49.18        underserved communities or to providers in rural areas;

49.19        (2) seeks to receive a credential from the health plan company;

49.20        (3) agrees to the health plan company's contract terms. The contract shall include payment  
49.21        rates that are usual and customary for the services provided;

49.22        (4) is accepting new patients; and

49.23        (5) is not already under a contract with the health plan company under a separate tax  
49.24        identification number or, if already under a contract with the health plan company, has  
49.25        provided notice to the health plan company of termination of the existing contract.

49.26        (c) A health plan company shall not refuse to credential these providers on the grounds  
49.27        that their provider network has:

27.27 Sec. 26. Minnesota Statutes 2022, section 62Q.19, subdivision 1, is amended to read:

27.28 Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

28.1 (1) a demonstrated ability to integrate applicable supportive and stabilizing services with  
28.2 medical care for uninsured persons and high-risk and special needs populations, underserved,  
28.3 and other special needs populations; and

28.4 (2) a commitment to serve low-income and underserved populations by meeting the  
28.5 following requirements:

28.6 (i) has nonprofit status in accordance with chapter 317A;

28.7 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section  
28.8 501(c)(3);

28.9 (iii) charges for services on a sliding fee schedule based on current poverty income  
28.10 guidelines; and

28.11 (iv) does not restrict access or services because of a client's financial limitation;

28.12 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a  
28.13 hospital district created or reorganized under sections 447.31 to 447.37, an Indian **tribal**  
28.14 government, an Indian health service unit, or a community health board as defined in chapter  
28.15 145A;

28.16 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida,  
28.17 epilepsy, closed head injuries, specialized orthopedic problems, and other disabling  
28.18 conditions;

28.19 (5) a sole community hospital. For these rural hospitals, the essential community provider  
28.20 designation applies to all health services provided, including both inpatient and outpatient  
28.21 services. For purposes of this section, "sole community hospital" means a rural hospital  
28.22 that:

28.23 (i) is eligible to be classified as a sole community hospital according to Code of Federal  
28.24 Regulations, title 42, section 412.92, or is located in a community with a population of less  
28.25 than 5,000 and located more than 25 miles from a like hospital currently providing acute  
28.26 short-term services;

28.27 (ii) has experienced net operating income losses in two of the previous three most recent  
28.28 consecutive hospital fiscal years for which audited financial information is available; and

28.29 (iii) consists of 40 or fewer licensed beds;

49.28 (1) a sufficient number of providers of that type, including but not limited to the provider  
49.29 types identified in paragraph (a); or

49.30 (2) a sufficient number of providers of mental health services in the aggregate.

50.1 Sec. 42. Minnesota Statutes 2022, section 62Q.19, subdivision 1, is amended to read:

50.2 Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

50.4 (1) a demonstrated ability to integrate applicable supportive and stabilizing services with  
50.5 medical care for uninsured persons and high-risk and special needs populations, underserved,  
50.6 and other special needs populations; and

50.7 (2) a commitment to serve low-income and underserved populations by meeting the  
50.8 following requirements:

50.9 (i) has nonprofit status in accordance with chapter 317A;

50.10 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section  
50.11 501(c)(3);

50.12 (iii) charges for services on a sliding fee schedule based on current poverty income  
50.13 guidelines; and

50.14 (iv) does not restrict access or services because of a client's financial limitation;

50.15 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a  
50.16 hospital district created or reorganized under sections 447.31 to 447.37, an Indian **Tribal**  
50.17 government, an Indian health service unit, or a community health board as defined in chapter  
50.18 145A;

50.19 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida,  
50.20 epilepsy, closed head injuries, specialized orthopedic problems, and other disabling  
50.21 conditions;

50.22 (5) a sole community hospital. For these rural hospitals, the essential community provider  
50.23 designation applies to all health services provided, including both inpatient and outpatient  
50.24 services. For purposes of this section, "sole community hospital" means a rural hospital  
50.25 that:

50.26 (i) is eligible to be classified as a sole community hospital according to Code of Federal  
50.27 Regulations, title 42, section 412.92, or is located in a community with a population of less  
50.28 than 5,000 and located more than 25 miles from a like hospital currently providing acute  
50.29 short-term services;

50.30 (ii) has experienced net operating income losses in two of the previous three most recent  
50.31 consecutive hospital fiscal years for which audited financial information is available; and

50.32 (iii) consists of 40 or fewer licensed beds;

28.30 (6) a birth center licensed under section 144.615; ~~or~~

28.31 (7) a hospital and affiliated specialty clinics that predominantly serve patients who are

28.32 under 21 years of age and meet the following criteria:

29.1 (i) provide intensive specialty pediatric services that are routinely provided in fewer

29.2 than five hospitals in the state; and

29.3 (ii) serve children from at least one-half of the counties in the state; or

29.4 (8) a psychiatric residential treatment facility, as defined in section 256B.0625,

29.5 subdivision 45a, paragraph (b), that is certified and licensed by the commissioner of health.

29.6 (b) Prior to designation, the commissioner shall publish the names of all applicants in

29.7 the State Register. The public shall have 30 days from the date of publication to submit

29.8 written comments to the commissioner on the application. No designation shall be made

29.9 by the commissioner until the 30-day period has expired.

29.10 (c) The commissioner may designate an eligible provider as an essential community

29.11 provider for all the services offered by that provider or for specific services designated by

29.12 the commissioner.

29.13 (d) For the purpose of this subdivision, supportive and stabilizing services include at a

29.14 minimum, transportation, child care, cultural, and linguistic services where appropriate.

29.15 Sec. 27. Minnesota Statutes 2022, section 62Q.46, subdivision 1, is amended to read:

29.16 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and

29.17 services" has the meaning specified in the Affordable Care Act. Preventive items and services

29.18 includes:

29.19 (1) evidence-based items or services that have in effect a rating of A or B in the current

29.20 recommendations of the United States Preventive Services Task Force with respect to the

29.21 individual involved;

29.22 (2) immunizations for routine use in children, adolescents, and adults that have in effect

29.23 a recommendation from the Advisory Committee on Immunization Practices of the Centers

29.24 for Disease Control and Prevention with respect to the individual involved. For purposes

29.25 of this clause, a recommendation from the Advisory Committee on Immunization Practices

29.26 of the Centers for Disease Control and Prevention is considered in effect after the

29.27 recommendation has been adopted by the Director of the Centers for Disease Control and

29.28 Prevention, and a recommendation is considered to be for routine use if the recommendation

29.29 is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

51.1 (6) a birth center licensed under section 144.615; ~~or~~

51.2 (7) a hospital and affiliated specialty clinics that predominantly serve patients who are

51.3 under 21 years of age and meet the following criteria:

51.4 (i) provide intensive specialty pediatric services that are routinely provided in fewer

51.5 than five hospitals in the state; and

51.6 (ii) serve children from at least one-half of the counties in the state; or

51.7 (8) a psychiatric residential treatment facility, as defined in section 256B.0625,

51.8 subdivision 45a, paragraph (b), that is certified by the commissioner of health and licensed

51.9 by the commissioner of human services.

51.10 (b) Prior to designation, the commissioner shall publish the names of all applicants in

51.11 the State Register. The public shall have 30 days from the date of publication to submit

51.12 written comments to the commissioner on the application. No designation shall be made

51.13 by the commissioner until the 30-day period has expired.

51.14 (c) The commissioner may designate an eligible provider as an essential community

51.15 provider for all the services offered by that provider or for specific services designated by

51.16 the commissioner.

51.17 (d) For the purpose of this subdivision, supportive and stabilizing services include at a

51.18 minimum, transportation, child care, cultural, and linguistic services where appropriate.

51.19 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health

51.20 plans offered, issued, or renewed on or after that date.

51.21 Sec. 43. Minnesota Statutes 2022, section 62Q.46, subdivision 1, is amended to read:

51.22 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and

51.23 services" has the meaning specified in the Affordable Care Act. Preventive items and services

51.24 includes:

51.25 (1) evidence-based items or services that have in effect a rating of A or B in the current

51.26 recommendations of the United States Preventive Services Task Force with respect to the

51.27 individual involved;

51.28 (2) immunizations for routine use in children, adolescents, and adults that have in effect

51.29 a recommendation from the Advisory Committee on Immunization Practices of the Centers

51.30 for Disease Control and Prevention with respect to the individual involved. For purposes

51.31 of this clause, a recommendation from the Advisory Committee on Immunization Practices

51.32 of the Centers for Disease Control and Prevention is considered in effect after the

52.1 recommendation has been adopted by the Director of the Centers for Disease Control and

52.2 Prevention, and a recommendation is considered to be for routine use if the recommendation

52.3 is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

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

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

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

30.7        (6) screenings for human immunodeficiency virus for:

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

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

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

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

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

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

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

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

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

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

52.13        (6) screenings for human immunodeficiency virus for:

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

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

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

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

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

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

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

31.4       (e) This section does not apply to grandfathered plans.

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

31.6       Sec. 28. Minnesota Statutes 2022, section 62Q.46, subdivision 3, is amended to read:

31.8       Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health plan company from providing coverage for preventive items and services in addition to those specified in the Affordable Care Act under subdivision 1, paragraph (a), or from denying coverage for preventive items and services that are not recommended as preventive items and services specified under the Affordable Care Act subdivision 1, paragraph (a). A health plan company may impose cost-sharing requirements for a treatment not described in the Affordable Care Act under subdivision 1, paragraph (a), even if the treatment results from a preventive item or service described in the Affordable Care Act under subdivision 1, paragraph (a).

31.17      Sec. 29. **[62Q.465] MENTAL HEALTH PARITY AND SUBSTANCE ABUSE ACCOUNTABILITY OFFICE.**

31.19       (a) The Mental Health Parity and Substance Abuse Accountability Office is established within the Department of Commerce to create and execute effective strategies for implementing the requirements under:

31.22       (1) section 62Q.47;

31.23       (2) the federal Mental Health Parity Act of 1996, Public Law 104-204;

31.24       (3) the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, division C, sections 511 and 512;

31.26       (4) the Affordable Care Act, as defined under section 62A.011, subdivision 1a; and

31.27       (5) amendments made to, and federal guidance or regulations issued or adopted under, the acts listed under clauses (2) to (4).

31.29       (b) The office may oversee compliance reviews, conduct and lead stakeholder engagement, review consumer and provider complaints, and serve as a resource for ensuring health plan compliance with mental health and substance abuse requirements.

32.1       Sec. 30. Minnesota Statutes 2022, section 62Q.47, is amended to read:

32.2       **62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.**

32.4       (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.

53.8       (e) This section does not apply to grandfathered plans.

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

53.11      Sec. 44. Minnesota Statutes 2022, section 62Q.46, subdivision 3, is amended to read:

53.12       Subd. 3. **Additional services not prohibited.** Nothing in this section prohibits a health plan company from providing coverage for preventive items and services in addition to those specified in the Affordable Care Act under subdivision 1, paragraph (a), or from denying coverage for preventive items and services that are not recommended as preventive items and services specified under the Affordable Care Act subdivision 1, paragraph (a). A health plan company may impose cost-sharing requirements for a treatment not described in the Affordable Care Act under subdivision 1, paragraph (a), even if the treatment results from a preventive item or service described in the Affordable Care Act under subdivision 1, paragraph (a).

53.21      Sec. 45. **[62Q.465] MENTAL HEALTH PARITY AND SUBSTANCE ABUSE ACCOUNTABILITY OFFICE.**

53.23       (a) The Mental Health Parity and Substance Abuse Accountability Office is established within the Department of Commerce to create and execute effective strategies for implementing the requirements under:

53.26       (1) section 62Q.47;

53.27       (2) the federal Mental Health Parity Act of 1996, Public Law 104-204;

53.28       (3) the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, division C, sections 511 and 512;

53.30       (4) the Affordable Care Act, as defined under section 62A.011, subdivision 1a; and

54.1       (5) amendments made to, and federal guidance or regulations issued or adopted under, the acts listed under clauses (2) to (4).

54.3       (b) The office may oversee compliance reviews, conduct and lead stakeholder engagement, review consumer and provider complaints, and serve as a resource for ensuring health plan compliance with mental health and substance abuse requirements.

54.6       Sec. 46. Minnesota Statutes 2022, section 62Q.47, is amended to read:

54.7       **62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.**

54.9       (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.

32.7 (b) Cost-sharing requirements and benefit or service limitations for outpatient mental  
 32.8 health and outpatient chemical dependency and alcoholism services, except for persons  
 32.9 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to  
 32.10 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more  
 32.11 restrictive than those requirements and limitations for outpatient medical services.

32.12 (c) Cost-sharing requirements and benefit or service limitations for inpatient hospital  
 32.13 mental health services, psychiatric residential treatment facility services, and inpatient  
 32.14 hospital and residential chemical dependency and alcoholism services, except for persons  
 32.15 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to  
 32.16 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more  
 32.17 restrictive than those requirements and limitations for inpatient hospital medical services.

32.18 (d) A health plan company must not impose an NQTL with respect to mental health and  
 32.19 substance use disorders in any classification of benefits unless, under the terms of the health  
 32.20 plan as written and in operation, any processes, strategies, evidentiary standards, or other  
 32.21 factors used in applying the NQTL to mental health and substance use disorders in the  
 32.22 classification are comparable to, and are applied no more stringently than, the processes,  
 32.23 strategies, evidentiary standards, or other factors used in applying the NQTL with respect  
 32.24 to medical and surgical benefits in the same classification.

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

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

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

33.6 (h) All health plan companies offering health plans that provide coverage for alcoholism,  
 33.7 mental health, or chemical dependency benefits shall provide reimbursement for the benefits  
 33.8 delivered through the psychiatric Collaborative Care Model, which must include the following  
 33.9 Current Procedural Terminology or Healthcare Common Procedure Coding System billing  
 33.10 codes:

54.12 (b) Cost-sharing requirements and benefit or service limitations for outpatient mental  
 54.13 health and outpatient chemical dependency and alcoholism services, except for persons  
 54.14 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to  
 54.15 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more  
 54.16 restrictive than those requirements and limitations for outpatient medical services.

54.17 (c) Cost-sharing requirements and benefit or service limitations for inpatient hospital  
 54.18 mental health services, psychiatric residential treatment facility services, and inpatient  
 54.19 hospital and residential chemical dependency and alcoholism services, except for persons  
 54.20 placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to  
 54.21 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more  
 54.22 restrictive than those requirements and limitations for inpatient hospital medical services.

54.23 (d) A health plan company must not impose an NQTL with respect to mental health and  
 54.24 substance use disorders in any classification of benefits unless, under the terms of the health  
 54.25 plan as written and in operation, any processes, strategies, evidentiary standards, or other  
 54.26 factors used in applying the NQTL to mental health and substance use disorders in the  
 54.27 classification are comparable to, and are applied no more stringently than, the processes,  
 54.28 strategies, evidentiary standards, or other factors used in applying the NQTL with respect  
 54.29 to medical and surgical benefits in the same classification.

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

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

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

55.12 (h) All health plan companies offering health plans that provide coverage for alcoholism,  
 55.13 mental health, or chemical dependency benefits shall provide reimbursement for the benefits  
 55.14 delivered through the psychiatric Collaborative Care Model, which must include the following  
 55.15 Current Procedural Terminology or Healthcare Common Procedure Coding System billing  
 55.16 codes:

33.11      (1) 99492;  
33.12      (2) 99493;  
33.13      (3) 99494;  
33.14      (4) G2214; and  
33.15      (5) G0512.

33.16      This paragraph does not apply to: (i) managed care plans or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L; or (ii) health care coverage offered by the state employee group insurance program.

33.20      (i) The commissioner of commerce shall update the list of codes in paragraph (h) if any alterations or additions to the billing codes for the psychiatric Collaborative Care Model are made.

33.23      (j) "Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method described at Federal Register, volume 81, page 80230, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to the following elements:

33.28      (1) care directed by the primary care team;  
33.29      (2) structured care management;  
33.30      (3) regular assessments of clinical status using validated tools; and  
33.31      (4) modification of treatment as appropriate.

34.1      ~~(4)~~(k) 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:

34.5      (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;

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

55.17      (1) 99492;  
55.18      (2) 99493;  
55.19      (3) 99494;  
55.20      (4) G2214; and  
55.21      (5) G0512.

55.22      This paragraph does not apply to managed care plans or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

55.25      (i) The commissioner of commerce shall update the list of codes in paragraph (h) if any alterations or additions to the billing codes for the psychiatric Collaborative Care Model are made.

55.28      (j) "Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method described at Federal Register, volume 81, page 80230, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to the following elements:

56.1      (1) care directed by the primary care team;  
56.2      (2) structured care management;  
56.3      (3) regular assessments of clinical status using validated tools; and  
56.4      (4) modification of treatment as appropriate.

56.5      ~~(4)~~(k) 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:

56.9      (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;

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

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

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

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

34.25 **Sec. 31. [62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED**  
 34.26 **MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

34.27 Subdivision 1. Cost-sharing limits. (a) A health plan must limit the amount of any  
 34.28 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more  
 34.29 than: (1) \$25 per one-month supply for each prescription drug, regardless of the amount or  
 34.30 type of medication required to fill the prescription; and (2) \$50 per month in total for all  
 34.31 related medical supplies. The cost-sharing limit for related medical supplies does not increase  
 34.32 with the number of chronic diseases for which an enrollee is treated. Coverage under this  
 34.33 section shall not be subject to any deductible.

35.1 (b) If application of this section before an enrollee has met the enrollee's plan deductible  
 35.2 results in: (1) health savings account ineligibility under United States Code, title 26, section  
 35.3 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section  
 35.4 18022(e), this section applies to the specific prescription drug or related medical supply  
 35.5 only after the enrollee has met the enrollee's plan deductible.

35.6 Subd. 2. Definitions. (a) For purposes of this section, the following definitions apply.

35.7 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of  
 35.8 epinephrine auto-injectors.

35.9 (c) "Cost-sharing" means co-payments and coinsurance.

35.10 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips,  
 35.11 glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and  
 35.12 other medical supply items necessary to effectively and appropriately treat a chronic disease  
 35.13 or administer a prescription drug prescribed to treat a chronic disease.

35.14 EFFECTIVE DATE. This section is effective January 1, 2024, and applies to health  
 35.15 plans offered, issued, or renewed on or after that date.

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

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

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

56.29 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
 56.30 plans offered, issued, or renewed on or after that date.

57.1 **Sec. 47. [62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED**  
 57.2 **MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.**

57.3 Subdivision 1. Cost-sharing limits. (a) A health plan must limit the amount of any  
 57.4 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more  
 57.5 than: (1) \$25 per one-month supply for each prescription drug, regardless of the amount or  
 57.6 type of medication required to fill the prescription; and (2) \$50 per month in total for all  
 57.7 related medical supplies. The cost-sharing limit for related medical supplies does not increase  
 57.8 with the number of chronic diseases for which an enrollee is treated. Coverage under this  
 57.9 section shall not be subject to any deductible.

57.10 (b) If application of this section before an enrollee has met the enrollee's plan deductible  
 57.11 results in: (1) health savings account ineligibility under United States Code, title 26, section  
 57.12 223; or (2) catastrophic health plan ineligibility under United States Code, title 42, section  
 57.13 18022(e), this section applies to the specific prescription drug or related medical supply  
 57.14 only after the enrollee has met the enrollee's plan deductible.

57.15 Subd. 2. Definitions. (a) For purposes of this section, the following definitions apply.

57.16 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of  
 57.17 epinephrine auto-injectors.

57.18 (c) "Cost-sharing" means co-payments and coinsurance.

57.19 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, test strips,  
 57.20 glucometers, continuous glucose monitors, epinephrine auto-injectors, asthma inhalers, and  
 57.21 other medical supply items necessary to effectively and appropriately treat a chronic disease  
 57.22 or administer a prescription drug prescribed to treat a chronic disease.

57.23 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
 57.24 plans offered, issued, or renewed on or after that date.

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11.25 Sec. 12. Minnesota Statutes 2022, section 62Q.735, subdivision 1, is amended to read:

11.26 Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign  
11.27 a contract, a health plan company shall give to the provider a complete copy of the proposed  
11.28 contract, including:

11.29 (1) all attachments and exhibits;

11.30 (2) operating manuals;

11.31 (3) a general description of the health plan company's health service coding guidelines  
11.32 and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

12.1 (4) all guidelines and treatment parameters incorporated or referenced in the contract.

12.2 (b) The health plan company shall make available to the provider the fee schedule or a  
12.3 method or process that allows the provider to determine the fee schedule for each health  
12.4 care service to be provided under the contract.

12.5 (c) ~~Notwithstanding paragraph (b), a health plan company that is a dental plan organization, as defined in section 62Q.76, shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization. Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.~~

12.11 Sec. 13. Minnesota Statutes 2022, section 62Q.735, subdivision 5, is amended to read:

12.12 Subd. 5. **Fee schedules.** (a) A health plan company shall provide, upon request, any  
12.13 additional fees or fee schedules relevant to the particular provider's practice beyond those  
12.14 provided with the renewal documents for the next contract year to all participating providers,  
12.15 excluding claims paid under the pharmacy benefit. Health plan companies may fulfill the  
12.16 requirements of this section by making the full fee schedules available through a secure  
12.17 web portal for contracted providers.

12.18 (b) ~~A dental organization may satisfy paragraph (a) by complying with section 62Q.735, subdivision 1, paragraph (e).~~

12.20 Sec. 14. Minnesota Statutes 2022, section 62Q.76, is amended by adding a subdivision to  
12.21 read:

12.22 Subd. 9. **Third party.** "Third party" means a person or entity that enters into a contract  
12.23 with a dental organization or with another third party to gain access to the dental care services  
12.24 or contractual discounts under a dental provider contract. Third party does not include an  
12.25 enrollee of a dental organization or an employer or other group for whom the dental  
12.26 organization provides administrative services.

57.25 Sec. 48. Minnesota Statutes 2022, section 62Q.735, subdivision 1, is amended to read:

57.26 Subdivision 1. **Contract disclosure.** (a) Before requiring a health care provider to sign  
57.27 a contract, a health plan company shall give to the provider a complete copy of the proposed  
57.28 contract, including:

57.29 (1) all attachments and exhibits;

57.30 (2) operating manuals;

57.31 (3) a general description of the health plan company's health service coding guidelines  
57.32 and requirement for procedures and diagnoses with modifiers, and multiple procedures; and

58.1 (4) all guidelines and treatment parameters incorporated or referenced in the contract.

58.2 (b) The health plan company shall make available to the provider the fee schedule or a  
58.3 method or process that allows the provider to determine the fee schedule for each health  
58.4 care service to be provided under the contract.

58.5 (c) ~~Notwithstanding paragraph (b), a health plan company that is a dental plan organization, as defined in section 62Q.76, shall disclose information related to the individual contracted provider's expected reimbursement from the dental plan organization. Nothing in this section requires a dental plan organization to disclose the plan's aggregate maximum allowable fee table used to determine other providers' fees. The contracted provider must not release this information in any way that would violate any state or federal antitrust law.~~

58.11 Sec. 49. Minnesota Statutes 2022, section 62Q.735, subdivision 5, is amended to read:

58.12 Subd. 5. **Fee schedules.** (a) A health plan company shall provide, upon request, any  
58.13 additional fees or fee schedules relevant to the particular provider's practice beyond those  
58.14 provided with the renewal documents for the next contract year to all participating providers,  
58.15 excluding claims paid under the pharmacy benefit. Health plan companies may fulfill the  
58.16 requirements of this section by making the full fee schedules available through a secure  
58.17 web portal for contracted providers.

58.18 (b) ~~A dental organization may satisfy paragraph (a) by complying with section 62Q.735, subdivision 1, paragraph (e).~~

58.20 Sec. 50. Minnesota Statutes 2022, section 62Q.76, is amended by adding a subdivision to  
58.21 read:

58.22 Subd. 9. **Third party.** "Third party" means a person or entity that enters into a contract  
58.23 with a dental organization or with another third party to gain access to the dental care services  
58.24 or contractual discounts under a dental provider contract. Third party does not include an  
58.25 enrollee of a dental organization or an employer or other group for whom the dental  
58.26 organization provides administrative services.

12.27 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to dental  
 12.28 plans and dental provider agreements offered, issued, or renewed on or after that date.

13.1 Sec. 15. Minnesota Statutes 2022, section 62Q.78, is amended by adding a subdivision to  
 13.2 read:

13.3 **Subd. 7. Method of payments.** A dental provider contract must include a method of  
 13.4 payment for dental care services in which no fees associated with the method of payment,  
 13.5 including credit card fees and fees related to payment in the form of digital or virtual  
 13.6 currency, are incurred by the dentist or dental clinic. Any fees that may be incurred from a  
 13.7 payment must be disclosed to a dentist prior to entering into or renewing a dental provider  
 13.8 contract. For purposes of this section, fees related to a provider's electronic claims processing  
 13.9 vendor, financial institution, or other vendor used by a provider to facilitate the submission  
 13.10 of claims are excluded.

13.11 Sec. 16. Minnesota Statutes 2022, section 62Q.78, is amended by adding a subdivision to  
 13.12 read:

13.13 **Subd. 8. Network leasing.** (a) A dental organization may grant a third party access to  
 13.14 a dental provider contract or a provider's dental care services or contractual discounts  
 13.15 provided pursuant to a dental provider contract if, at the time the dental provider contract  
 13.16 is entered into or renewed, the dental organization allows a dentist to choose not to participate  
 13.17 in third-party access to the dental provider contract without any penalty to the dentist. The  
 13.18 third-party access provision of the dental provider contract must be clearly identified. A  
 13.19 dental organization must not grant a third party access to the dental provider contract of any  
 13.20 dentist who does not participate in third-party access to the dental provider contract.

13.21 (b) Notwithstanding paragraph (a), if a dental organization exists solely for the purpose  
 13.22 of recruiting dentists for dental provider contracts that establish a network to be leased to  
 13.23 third parties, the dentist waives the right to choose whether to participate in third-party  
 13.24 access.

13.25 (c) A dental organization may grant a third party access to a dental provider contract,  
 13.26 or a dentist's dental care services or contractual discounts under a dental provider contract,  
 13.27 if the following requirements are met:

13.28 (1) the dental organization lists all third parties that may have access to the dental provider  
 13.29 contract on the dental organization's website, which must be updated at least once every 90  
 13.30 days;

13.31 (2) the dental provider contract states that the dental organization may enter into an  
 13.32 agreement with a third party that would allow the third party to obtain the dental  
 13.33 organization's rights and responsibilities as if the third party were the dental organization,  
 14.1 and the dentist chose to participate in third-party access at the time the dental provider  
 14.2 contract was entered into; and

58.27 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to dental  
 58.28 plans and dental provider agreements offered, issued, or renewed on or after that date.

59.1 Sec. 51. Minnesota Statutes 2022, section 62Q.78, is amended by adding a subdivision to  
 59.2 read:

59.3 **Subd. 7. Method of payments.** A dental provider contract must include a method of  
 59.4 payment for dental care services in which no fees associated with the method of payment,  
 59.5 including credit card fees and fees related to payment in the form of digital or virtual  
 59.6 currency, are incurred by the dentist or dental clinic. Any fees that may be incurred from a  
 59.7 payment must be disclosed to a dentist prior to entering into or renewing a dental provider  
 59.8 contract. For purposes of this section, fees related to a provider's electronic claims processing  
 59.9 vendor, financial institution, or other vendor used by a provider to facilitate the submission  
 59.10 of claims are excluded.

59.11 Sec. 52. Minnesota Statutes 2022, section 62Q.78, is amended by adding a subdivision to  
 59.12 read:

59.13 **Subd. 8. Network leasing.** (a) A dental organization may grant a third party access to  
 59.14 a dental provider contract or a provider's dental care services or contractual discounts  
 59.15 provided pursuant to a dental provider contract if, at the time the dental provider contract  
 59.16 is entered into or renewed, the dental organization allows a dentist to choose not to participate  
 59.17 in third-party access to the dental provider contract without any penalty to the dentist. The  
 59.18 third-party access provision of the dental provider contract must be clearly identified. A  
 59.19 dental organization must not grant a third party access to the dental provider contract of any  
 59.20 dentist who does not participate in third-party access to the dental provider contract.

59.21 (b) Notwithstanding paragraph (a), if a dental organization exists solely for the purpose  
 59.22 of recruiting dentists for dental provider contracts that establish a network to be leased to  
 59.23 third parties, the dentist waives the right to choose whether to participate in third-party  
 59.24 access.

59.25 (c) A dental organization may grant a third party access to a dental provider contract,  
 59.26 or a dentist's dental care services or contractual discounts under a dental provider contract,  
 59.27 if the following requirements are met:

59.28 (1) the dental organization lists all third parties that may have access to the dental provider  
 59.29 contract on the dental organization's website, which must be updated at least once every 90  
 59.30 days;

59.31 (2) the dental provider contract states that the dental organization may enter into an  
 59.32 agreement with a third party that would allow the third party to obtain the dental  
 59.33 organization's rights and responsibilities as if the third party were the dental organization,  
 60.1 and the dentist chose to participate in third-party access at the time the dental provider  
 60.2 contract was entered into; and

14.3        (3) the third party accessing the dental provider contract agrees to comply with all  
 14.4        applicable terms of the dental provider contract.

14.5        (d) A dentist is not bound by and is not required to perform dental care services under  
 14.6        a dental provider contract granted to a third party in violation of this section.

14.7        (e) This subdivision does not apply when:

14.8        (1) the dental provider contract is for dental services provided under a public health plan  
 14.9        program, including but not limited to medical assistance, MinnesotaCare, Medicare, or  
 14.10        Medicare Advantage; or

14.11        (2) access to a dental provider contract is granted to a dental organization, an entity  
 14.12        operating in accordance with the same brand licensee program as the dental organization  
 14.13        or other entity, or to an entity that is an affiliate of the dental organization, provided the  
 14.14        entity agrees to substantially similar terms and conditions as the originating dental provider  
 14.15        contract between the dental organization and the dentist or dental clinic. A list of the dental  
 14.16        organization's affiliates must be posted on the dental organization's website.

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35.16        Sec. 32. Minnesota Statutes 2022, section 62Q.81, subdivision 4, is amended to read:

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

35.20        (1) ambulatory patient services;  
 35.21        (2) emergency services;  
 35.22        (3) hospitalization;  
 35.23        (4) laboratory services;  
 35.24        (5) maternity and newborn care;  
 35.25        (6) mental health and substance use disorder services, including behavioral health  
 35.26        treatment;  
 35.27        (7) pediatric services, including oral and vision care;  
 35.28        (8) prescription drugs;  
 35.29        (9) preventive and wellness services and chronic disease management;  
 35.30        (10) rehabilitative and habilitative services and devices; and  
 36.1        (11) additional essential health benefits included in the EHB-benchmark plan, as defined  
 36.2        under the Affordable Care Act, and preventive items and services, as defined under section  
 36.3        62Q.46, subdivision 1, paragraph (a).

60.3        (3) the third party accessing the dental provider contract agrees to comply with all  
 60.4        applicable terms of the dental provider contract.

60.5        (d) A dentist is not bound by and is not required to perform dental care services under  
 60.6        a dental provider contract granted to a third party in violation of this section.

60.7        (e) This subdivision does not apply when:

60.8        (1) the dental provider contract is for dental services provided under a public health plan  
 60.9        program, including but not limited to medical assistance, MinnesotaCare, Medicare, or  
 60.10        Medicare Advantage; or

60.11        (2) access to a dental provider contract is granted to a dental organization, an entity  
 60.12        operating in accordance with the same brand licensee program as the dental organization  
 60.13        or other entity, or to an entity that is an affiliate of the dental organization, provided the  
 60.14        entity agrees to substantially similar terms and conditions as the originating dental provider  
 60.15        contract between the dental organization and the dentist or dental clinic. A list of the dental  
 60.16        organization's affiliates must be posted on the dental organization's website.

60.17        Sec. 53. Minnesota Statutes 2022, section 62Q.81, subdivision 4, is amended to read:

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

60.21        (1) ambulatory patient services;  
 60.22        (2) emergency services;  
 60.23        (3) hospitalization;  
 60.24        (4) laboratory services;  
 60.25        (5) maternity and newborn care;  
 60.26        (6) mental health and substance use disorder services, including behavioral health  
 60.27        treatment;  
 60.28        (7) pediatric services, including oral and vision care;  
 60.29        (8) prescription drugs;  
 60.30        (9) preventive and wellness services and chronic disease management;  
 61.1        (10) rehabilitative and habilitative services and devices; and  
 61.2        (11) additional essential health benefits included in the EHB-benchmark plan, as defined  
 61.3        under the Affordable Care Act, and preventive items and services, as defined under section  
 61.4        62Q.46, subdivision 1, paragraph (a).

36.4 Sec. 33. Minnesota Statutes 2022, section 62Q.81, is amended by adding a subdivision to  
 36.5 read:

36.6 Subd. 7. Standard plans. (a) A health plan company that offers individual health plans  
 36.7 must ensure that no less than one individual health plan at each level of coverage described  
 36.8 in subdivision 1, paragraph (b), clause (3), that the health plan company offers in each  
 36.9 geographic rating area the health plan company serves, conforms to the standard plan  
 36.10 parameters determined by the commissioner under paragraph (e).

36.11 (b) An individual health plan offered under this subdivision must be:

36.12 (1) clearly and appropriately labeled as standard plans to aid the purchaser in the selection

36.13 process;

36.14 (2) marketed as standard plans and in the same manner as other individual health plans  
 36.15 offered by the health plan company; and

36.16 (3) offered for purchase to any individual.

36.17 (c) This subdivision does not apply to catastrophic plans, grandfathered plans, small  
 36.18 group health plans, large group health plans, health savings accounts, qualified high  
 36.19 deductible health benefit plans, limited health benefit plans, or short-term limited-duration  
 36.20 health insurance policies.

36.21 (d) Health plan companies must meet the requirements in this subdivision separately for  
 36.22 plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

36.23 (e) The commissioner of commerce, in consultation with the commissioner of health,  
 36.24 must annually determine standard plan parameters, including but not limited to cost-sharing  
 36.25 structure and covered benefits, that comprise a standard plan in Minnesota.

36.26 (f) Notwithstanding section 62A.65, subdivision 2, a health plan company may  
 36.27 discontinue offering a health plan under this subdivision if, three years after the date the  
 36.28 plan is initially offered, the plan has fewer than 75 enrollees enrolled in the plan. A health  
 36.29 plan company discontinuing a plan under this paragraph must only discontinue the health  
 36.30 plan that has fewer than 75 enrollees and:

37.1 (1) provide notice of the plan's discontinuation in writing, in a form prescribed by the  
 37.2 commissioner, to each individual enrolled in the plan at least 90 calendar days before the  
 37.3 date the coverage is discontinued;

37.4 (2) offer on a guaranteed issue basis to each individual enrolled the option to purchase  
 37.5 an individual health plan currently being offered by the health plan company for individuals  
 37.6 in that geographic rating area. An enrollee who does not select an option must be  
 37.7 automatically enrolled in the individual health plan closest in actuarial value to the enrollee's  
 37.8 current plan; and

61.5 Sec. 54. Minnesota Statutes 2022, section 62Q.81, is amended by adding a subdivision to  
 61.6 read:

61.7 Subd. 7. Standard plans. (a) A health plan company that offers individual health plans  
 61.8 must ensure that no less than one individual health plan at each level of coverage described  
 61.9 in subdivision 1, paragraph (b), clause (3), that the health plan company offers in each  
 61.10 geographic rating area the health plan company serves conforms to the standard plan  
 61.11 parameters determined by the commissioner under paragraph (e).

61.12 (b) An individual health plan offered under this subdivision must be:

61.13 (1) clearly and appropriately labeled as standard plans to aid the purchaser in the selection  
 61.14 process;

61.15 (2) marketed as standard plans and in the same manner as other individual health plans  
 61.16 offered by the health plan company; and

61.17 (3) offered for purchase to any individual.

61.18 (c) This subdivision does not apply to catastrophic plans, grandfathered plans, small  
 61.19 group health plans, large group health plans, health savings accounts, qualified high  
 61.20 deductible health benefit plans, limited health benefit plans, or short-term limited-duration  
 61.21 health insurance policies.

61.22 (d) Health plan companies must meet the requirements in this subdivision separately for  
 61.23 plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

61.24 (e) The commissioner of commerce, in consultation with the commissioner of health,  
 61.25 must annually determine standard plan parameters, including but not limited to cost-sharing  
 61.26 structure and covered benefits, that comprise a standard plan in Minnesota.

61.27 (f) Notwithstanding section 62A.65, subdivision 2, a health plan company may  
 61.28 discontinue offering a health plan under this subdivision if, three years after the date the  
 61.29 plan is initially offered, the plan has fewer than 75 enrollees. A health plan company  
 61.30 discontinuing a health plan under this paragraph may discontinue a health plan that has  
 61.31 fewer than 75 enrollees if it:

62.1 (1) provides notice of the plan's discontinuation in writing, in a form prescribed by the  
 62.2 commissioner, to each enrollee of the plan at least 90 calendar days before the date the  
 62.3 coverage is discontinued;

62.4 (2) offers on a guaranteed issue basis to each enrollee the option to purchase an individual  
 62.5 health plan currently being offered by the health plan company for individuals in that  
 62.6 geographic rating area. An enrollee who does not select an option shall be automatically  
 62.7 enrolled in the individual health plan closest in actuarial value to the enrollee's current plan;  
 62.8 and

37.9       (3) act uniformly without regard to any health status-related factor of enrolled individuals  
 37.10      or dependents of enrolled individuals who may become eligible for coverage.

37.11      **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to individual  
 37.12      health plans offered, issued, or renewed on or after that date.

37.13      Sec. 34. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

37.14      Subdivision 1. **Definition.** (a) For purposes of this section, the following definition  
 37.15      applies.

37.16      (b) "Clinician-administered drug" means an outpatient prescription drug other than a  
 37.17      vaccine that:

37.18      (1) cannot reasonably be self-administered by the enrollee to whom the drug is prescribed  
 37.19      or by an individual assisting the enrollee with self-administration; and

37.20      (2) is typically administered:

37.21      (i) by a health care provider authorized to administer the drug, including when acting  
 37.22      under a physician's delegation and supervision; and

37.23      (ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

37.24      **Subd. 2. Safety and care requirements for clinician-administered drugs.** (a) A  
 37.25      specialty pharmacy that ships a clinician-administered drug to a health care provider or  
 37.26      pharmacy must:

37.27      (1) comply with all federal laws regulating the shipment of drugs, including but not  
 37.28      limited to the U.S. Pharmacopeia General Chapter 800;

37.29      (2) in response to questions from a health care provider or pharmacy, provide access to  
 37.30      a pharmacist or nurse employed by the specialty pharmacy 24 hours a day, 7 days a week;

38.1      (3) allow an enrollee and health care provider to request a refill of a clinician-administered  
 38.2      drug on behalf of an enrollee, in accordance with the pharmacy benefit manager or health  
 38.3      carrier's utilization review procedures; and

38.4      (4) adhere to the track and trace requirements, as defined by the federal Drug Supply  
 38.5      Chain Security Act, United States Code, title 21, section 360eee, et seq., for a  
 38.6      clinician-administered drug that needs to be compounded or manipulated.

38.7      (b) For any clinician-administered drug dispensed by a specialty pharmacy selected by  
 38.8      the pharmacy benefit manager or health carrier, the requesting health care provider or their  
 38.9      designee must provide the requested date, approximate time, and place of delivery of a

62.9      (3) acts uniformly without regard to any health status-related factor of an enrollee or an  
 62.10     enrollee's dependents who may become eligible for coverage.

62.11     **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to individual  
 62.12     health plans offered, issued, or renewed on or after that date.

62.13     Sec. 55. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

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

62.16     (b) "Affiliated pharmacy" means a pharmacy in which a pharmacy benefit manager or  
 62.17     health carrier has an ownership interest either directly or indirectly, or through an affiliate  
 62.18     or subsidiary.

62.19     (c) "Clinician-administered drug" means an outpatient prescription drug, other than a  
 62.20     vaccine, that:

62.21     (1) cannot reasonably be self-administered by the patient to whom the drug is prescribed  
 62.22     or by an individual assisting the patient with self-administration; and

62.23     (2) is typically administered:

62.24     (i) by a health care provider authorized to administer the drug, including when acting  
 62.25     under a physician's delegation and supervision; and

62.26     (ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

62.27     **Subd. 2. Safety and care requirements for clinician-administered drugs.** (a) A  
 62.28     specialty pharmacy that ships a clinician-administered drug to a health care provider or  
 62.29     pharmacy must:

62.30     (1) comply with all federal laws regulating the shipment of drugs, including but not  
 62.31     limited to the United States Pharmacopeia General Chapter 800;

63.1     (2) in response to questions from a health care provider or pharmacy, provide access to  
 63.2     a pharmacist or nurse employed by the specialty pharmacy 24 hours a day, seven days a  
 63.3     week;

63.4     (3) allow an enrollee and health care provider to request a refill of a clinician-administered  
 63.5     drug on behalf of an enrollee, in accordance with the pharmacy benefit manager or health  
 63.6     carrier's utilization review procedures; and

63.7     (4) adhere to the track and trace requirements, as defined in the Drug Supply Chain  
 63.8     Security Act, United States Code, title 21, section 360eee, et seq., for a clinician-administered  
 63.9     drug that needs to be compounded or manipulated.

63.10    (b) For any clinician-administered drug dispensed by a specialty pharmacy selected by  
 63.11    the pharmacy benefit manager or health carrier, the requesting health care provider or their  
 63.12    designee must provide the requested date, approximate time, and place of delivery of a

38.10 clinician-administered drug at least five business days before the date of delivery. The  
 38.11 specialty pharmacy must require a signature upon receipt of the shipment when shipped to  
 38.12 a health care provider.

38.13 (c) A pharmacy benefit manager or health carrier who requires dispensing of a  
 38.14 clinician-administered drug through a specialty pharmacy shall establish and disclose a  
 38.15 process which allows the health care provider or pharmacy to appeal and have exceptions  
 38.16 to the use of a specialty pharmacy when:

38.17 (1) a drug is not delivered as specified in paragraph (b); or  
 38.18 (2) an attending health care provider reasonably believes an enrollee may experience  
 38.19 immediate and irreparable harm without the immediate, onetime use of clinician-administered  
 38.20 drug that a health care provider or pharmacy has in stock.

38.21 (d) A pharmacy benefit manager or health carrier shall not require a specialty pharmacy  
 38.22 to dispense a clinician-administered drug directly to an enrollee with the intention that the  
 38.23 enrollee will transport the clinician-administered drug to a health care provider for  
 38.24 administration.

38.25 (e) A pharmacy benefit manager, health carrier, health care provider, or pharmacist shall  
 38.26 not require and may not deny the use of a home infusion or infusion site external to the  
 38.27 enrollee's provider office or clinic to dispense or administer a clinician-administered drug  
 38.28 when requested by an enrollee and such services are covered by the health plan and are  
 38.29 available and clinically appropriate as determined by the health care provider and delivered  
 38.30 in accordance with state law.

38.31 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health  
 38.32 plans offered, issued, or renewed on or after that date.

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14.17 Sec. 17. **[65A.298] HOMEOWNER'S INSURANCE; FORTIFIED PROGRAM**  
 14.18 **STANDARDS.**

14.19 Subdivision 1. **Definitions.** (a) For purposes of this section the following term has the  
 14.20 meaning given.

14.21 (b) "Insurable property" means a residential property designated as meeting the Fortified  
 14.22 program standards as administered by the Insurance Institute for Business and Home Safety  
 14.23 (IBHS).

63.13 clinician-administered drug at least five business days before the date of delivery. The  
 63.14 specialty pharmacy must require a signature upon receipt of the shipment when shipped to  
 63.15 a health care provider.

63.16 (c) A pharmacy benefit manager or health carrier who requires dispensing of a  
 63.17 clinician-administered drug through a specialty pharmacy shall establish and disclose a  
 63.18 process that allows the health care provider or pharmacy to appeal and have exceptions to  
 63.19 the use of a specialty pharmacy when:

63.20 (1) a drug is not delivered as specified in paragraph (b); or  
 63.21 (2) an attending health care provider reasonably believes an enrollee may experience  
 63.22 immediate and irreparable harm without the immediate, onetime use of a  
 63.23 clinician-administered drug that a health care provider or pharmacy has in stock.

63.24 (d) A pharmacy benefit manager or health carrier shall not require a specialty pharmacy  
 63.25 to dispense a clinician-administered drug directly to an enrollee with the intention that the  
 63.26 enrollee will transport the clinician-administered drug to a health care provider for  
 63.27 administration.

63.28 (e) A pharmacy benefit manager, health carrier, health care provider, or pharmacist shall  
 63.29 not require or may not deny the use of a home infusion or infusion site external to the  
 63.30 enrollee's provider office or clinic to dispense or administer a clinician-administered drug  
 63.31 when requested by an enrollee, and such services are covered by the health plan and are  
 63.32 available and clinically appropriate as determined by the health care provider and delivered  
 63.33 in accordance with state law.

64.1 Subd. 3. **Exclusions.** This section does not apply to managed care plans or county-based  
 64.2 purchasing plans when the plan provides coverage to public health care program enrollees  
 64.3 under chapter 256B or 256L.

64.4 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health  
 64.5 plans offered, issued, or renewed on or after that date.

64.6 Sec. 56. **[65A.298] HOMEOWNER'S INSURANCE; FORTIFIED PROGRAM**  
 64.7 **STANDARDS.**

64.8 Subdivision 1. **Definitions.** (a) For purposes of this section the following term has the  
 64.9 meaning given.

64.10 (b) "Insurable property" means a residential property designated as meeting Fortified  
 64.11 program standards that include a hail supplement as administered by the Insurance Institute  
 64.12 for Business and Home Safety (IBHS).

14.24       **Subd. 2. Fortified new property.** (a) An insurer shall provide a premium discount or  
 14.25        an insurance rate reduction to an owner who builds or locates a new insurable property in  
 14.26        Minnesota.

14.27        (b) An owner of insurable property claiming a premium discount or rate reduction under  
 14.28        this subdivision must submit a certificate issued by IBHS showing proof of compliance  
 14.29        with the Fortified program standards to the insurer prior to receiving the premium discount  
 14.30        or rate reduction.

15.1        **Subd. 3. Fortified existing property.** (a) An insurer shall provide a premium discount  
 15.2        or insurance rate reduction to an owner who retrofits an existing property to meet the  
 15.3        requirements to be an insurable property in Minnesota.

15.4        (b) An owner of insurable property claiming a premium discount or rate reduction under  
 15.5        this subdivision must submit a certificate issued by IBHS showing proof of compliance  
 15.6        with the Fortified program standards to the insurer prior to receiving the premium discount  
 15.7        or rate reduction.

15.8        **Subd. 4. Insurers.** (a) An insurer must submit to the commissioner actuarially justified  
 15.9        rates and a rating plan for a person who builds or locates a new insurable property in  
 15.10       Minnesota.

15.11       (b) An insurer must submit to the commissioner actuarially justified rates and a rating  
 15.12       plan for a person who retrofits an existing property to meet the requirements to be an  
 15.13       insurable property.

15.14       (c) An insurer may offer, in addition to the premium discount and insurance rate  
 15.15       reductions required under subdivisions 2 and 3, more generous mitigation adjustments to  
 15.16       an owner of insurable property.

15.17       (d) Any premium discount, rate reduction, or mitigation adjustment offered by an insurer  
 15.18       under this section applies only to policies that include wind coverage and may be applied  
 15.19       only to the portion of the premium for wind coverage, or for the total premium if the insurer  
 15.20       does not separate the premium for wind coverage in its rate filing.

15.21       (e) A rate and rating plan submitted to the commissioner under this section shall not be  
 15.22       used until the expiration of 60 days after it has been filed unless the commissioner approves  
 15.23       it before that time. In evaluating insurer submissions under this section prior to approval  
 15.24       for use, the commissioner must:

15.25        (I) evaluate evidence of cost savings directly attributed to the Fortified program standards  
 15.26        administered by IBHS; and

15.27        (2) evaluate whether those cost savings are passed along in full to qualified policyholders.

64.13       **Subd. 2. Fortified new property.** (a) An insurer must provide a premium discount or  
 64.14        an insurance rate reduction to an owner who builds or locates a new insurable property in  
 64.15        Minnesota.

64.16        (b) An owner of insurable property claiming a premium discount or rate reduction under  
 64.17        this subdivision must submit and maintain a certificate issued by IBHS showing proof of  
 64.18        compliance with the Fortified program standards to the insurer prior to receiving the premium  
 64.19        discount or rate reduction. At the time of policy renewal an insurer may require evidence  
 64.20        that the issued certificate remains in good standing.

64.21       **Subd. 3. Fortified existing property.** (a) An insurer must provide a premium discount  
 64.22        or insurance rate reduction to an owner who retrofits an existing property to meet the  
 64.23        requirements to be an insurable property in Minnesota.

64.24       (b) An owner of insurable property claiming a premium discount or rate reduction under  
 64.25        this subdivision must submit a certificate issued by IBHS showing proof of compliance  
 64.26        with the Fortified program standards to the insurer prior to receiving the premium discount  
 64.27        or rate reduction.

64.28       **Subd. 4. Insurers.** (a) A participating insurer must submit to the commissioner actuarially  
 64.29        justified rates and a rating plan for a person who builds or locates a new insurable property  
 64.30        in Minnesota.

65.1       (b) A participating insurer must submit to the commissioner actuarially justified rates  
 65.2       and a rating plan for a person who retrofits an existing property to meet the requirements  
 65.3       to be an insurable property.

65.4       (c) A participating insurer may offer, in addition to the premium discount and insurance  
 65.5       rate reductions required under subdivisions 2 and 3, more generous mitigation adjustments  
 65.6       to an owner of insurable property.

65.7       (d) Any premium discount, rate reduction, or mitigation adjustment offered by an insurer  
 65.8       under this section applies only to policies that include wind coverage and may be applied  
 65.9       to: (1) only the portion of the premium for wind coverage; or (2) the total premium, if the  
 65.10       insurer does not separate the premium for wind coverage in the insurer's rate filing.

65.11       (e) A rate and rating plan submitted to the commissioner under this section must not be  
 65.12       used until 60 days after the rate and rating plan has been filed with the commissioner, unless  
 65.13       the commissioner approves the rate and rating plan before that time. A rating plan, rating  
 65.14       classification, and territories applicable to insurance written by a participating insurer and  
 65.15       any related statistics are subject to chapter 70A. When the commissioner is evaluating rate  
 65.16       and rating plans submitted under this section, the commissioner must evaluate:

65.17        (I) evidence of cost savings directly attributable to the Fortified program standards as  
 65.18        administered by IBHS; and

65.19        (ii) whether the cost savings are passed along in full to qualified policyholders.

15.28 (f) Insurers must resubmit rates and rating plans at least every five years following their  
 15.29 initial submissions under this section for review and approval by the commissioner.

15.30 (g) The commissioner shall annually publish the premium savings policyholders  
 15.31 experienced because of the program.

16.1 (h) Participating insurers shall provide to the commissioner any information requested  
 16.2 by the commissioner for the purposes of this paragraph.

16.3 Sec. 18. **[65A.299] STRENGTHEN MINNESOTA HOMES PROGRAM.**

16.4 Subdivision 1. **Short title.** This section may be cited as the "Strengthen Minnesota  
 16.5 Homes Act."

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

16.8 (b) "Insurable property" has the meaning given in section 65A.298, subdivision 3.

16.9 (c) "Program" means the Strengthen Minnesota Homes program established under this  
 16.10 section.

16.11 Subd. 3. **Program established; purpose, permitted activities.** The Strengthen Minnesota  
 16.12 Homes program is established within the Department of Commerce. The purpose of the  
 16.13 program is to provide grants to retrofit insurable property to resist loss due to common  
 16.14 perils, including but not limited to tornadoes or other catastrophic windstorm events.

16.15 Subd. 4. **Strengthen Minnesota homes account; appropriation.** (a) A strengthen  
 16.16 Minnesota homes account is created as a separate account in the special revenue fund of  
 16.17 the state treasury. The account consists of money provided by law and any other money  
 16.18 donated, allotted, transferred, or otherwise provided to the account. Earnings, including  
 16.19 interest, dividends, and any other earnings arising from assets of the account, must be  
 16.20 credited to the account. Money remaining in the account at the end of a fiscal year does not  
 16.21 cancel to the general fund and remains in the account until expended. The commissioner  
 16.22 must manage the account.

16.23 (b) Money in the account is appropriated to the commissioner to pay for (1) grants issued  
 16.24 under the program, and (2) the reasonable costs incurred by the commissioner to administer  
 16.25 the program.

16.26 Subd. 5. **Use of grants.** (a) A grant under this section must be used to retrofit an insurable  
 16.27 property.

16.28 (b) Grant money provided under this section must not be used for maintenance or repairs,  
 16.29 but may be used in conjunction with repairs or reconstruction necessitated by damage from  
 16.30 wind or hail.

65.20 (f) A participating insurer must resubmit a rate and rating plan at least once every five  
 65.21 years following the initial submission under this section.

65.22 (g) The commissioner may annually publish the premium savings that policyholders  
 65.23 experience pursuant to this section.

65.24 (h) An insurer must provide the commissioner with all requested information necessary  
 65.25 for the commissioner to meet the requirements of this subdivision.

65.26 Sec. 57. **[65A.299] STRENGTHEN MINNESOTA HOMES PROGRAM.**

65.27 Subdivision 1. **Short title.** This section may be cited as the "Strengthen Minnesota  
 65.28 Homes Act."

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

65.31 (b) "Insurable property" has the meaning given in section 65A.298, subdivision 1.

66.1 (c) "Program" means the Strengthen Minnesota Homes program established under this  
 66.2 section.

66.3 Subd. 3. **Program established; purpose, permitted activities.** The Strengthen Minnesota  
 66.4 Homes program is established within the Department of Commerce. The purpose of the  
 66.5 program is to provide grants to retrofit insurable property to resist loss due to common  
 66.6 perils, including but not limited to tornadoes or other catastrophic windstorm events.

66.7 Subd. 4. **Strengthen Minnesota homes account; appropriation.** (a) A strengthen  
 66.8 Minnesota homes account is created as a separate account in the special revenue fund of  
 66.9 the state treasury. The account consists of money provided by law and any other money  
 66.10 donated, allotted, transferred, or otherwise provided to the account. Earnings, including  
 66.11 interest, dividends, and any other earnings arising from assets of the account, must be  
 66.12 credited to the account. Money remaining in the account at the end of a fiscal year does not  
 66.13 cancel to the general fund and remains in the account until expended. The commissioner  
 66.14 must manage the account.

66.15 (b) Money in the account is appropriated to the commissioner to pay for (1) grants issued  
 66.16 under the program, and (2) the reasonable costs incurred by the commissioner to administer  
 66.17 the program.

66.18 Subd. 5. **Use of grants.** (a) A grant under this section must be used to retrofit an insurable  
 66.19 property.

66.20 (b) Grant money provided under this section must not be used for maintenance or repairs,  
 66.21 but may be used in conjunction with repairs or reconstruction necessitated by damage from  
 66.22 wind or hail.

17.1       (c) A project funded by a grant under this section must be completed within three months  
17.2       of the date the grant is approved. Failure to complete the project in a timely manner may  
17.3       result in forfeiture of the grant.

17.4       **Subd. 6. Applicant eligibility.** The commissioner must develop (1) administrative  
17.5       procedures to implement this section, and (2) criteria used to determine whether an applicant  
17.6       is eligible for a grant under this section.

17.7       **Subd. 7. Contractor eligibility; conflicts of interest.** (a) To be eligible to work as a  
17.8       contractor on a projected funded by a grant under this section, the contractor must meet all  
17.9       of the following program requirements and must maintain a current copy of all certificates,  
17.10       licenses, and proof of insurance coverage with the program office. The eligible contractor  
17.11       must:

17.12       (1) hold a valid residential building contractor and residential remodeler license issued  
17.13       by the commissioner of labor and industry;  
17.14       (2) not be subject to disciplinary action by the commissioner of labor and industry;  
17.15       (3) hold any other valid state or jurisdictional business license or work permits required  
17.16       by law;  
17.17       (4) possess an in-force general liability policy with \$1,000,000 in liability coverage;  
17.18       (5) possess an in-force workers compensation policy with \$1,000,000 in coverage;  
17.19       (6) possess a certificate of compliance from the commissioner of revenue;  
17.20       (7) successfully complete the Fortified Roof for High Wind and Hail training provided  
17.21       by the IBHS and maintain an active certification or IBHS's successor and provide a certificate  
17.22       of successful completion. The training may be offered as separate courses;  
17.23       (8) agree to the terms and successfully register as a vendor with the commissioner of  
17.24       management and budget and receive direct deposit of payment for mitigation work performed  
17.25       under the program;

17.26       (9) maintain Internet access and keep a valid email address on file with the program and  
17.27       remain active in the commissioner of management and budget's vendor and supplier portal  
17.28       while working on the program;

17.29       (10) maintain an active email address for the communication with the program;  
17.30       (11) successfully complete the program training; and  
18.1       (12) agree to follow program procedures and rules established under this section and by  
18.2       the commissioner.

18.3       (b) An eligible contractor must not have a financial interest, other than payment on  
18.4       behalf of the homeowner, in any project for which the eligible contractor performs work  
18.5       toward a fortified designation under the program. An eligible contractor is prohibited from

66.23       (c) A project funded by a grant under this section must be completed within three months  
66.24       of the date the grant is approved. Failure to complete the project in a timely manner may  
66.25       result in forfeiture of the grant.

66.26       **Subd. 6. Applicant eligibility.** The commissioner must develop (1) administrative  
66.27       procedures to implement this section, and (2) criteria used to determine whether an applicant  
66.28       is eligible for a grant under this section.

66.29       **Subd. 7. Contractor eligibility; conflicts of interest.** (a) To be eligible to work as a  
66.30       contractor on a projected funded by a grant under this section, the contractor must meet all  
66.31       of the following program requirements and must maintain a current copy of all certificates,  
66.32       licenses, and proof of insurance coverage with the program office. The eligible contractor  
66.33       must:

67.1       (1) hold a valid residential building contractor and residential remodeler license issued  
67.2       by the commissioner of labor and industry;  
67.3       (2) not be subject to disciplinary action by the commissioner of labor and industry;  
67.4       (3) hold any other valid state or jurisdictional business license or work permits required  
67.5       by law;  
67.6       (4) possess an in-force general liability policy with \$1,000,000 in liability coverage;  
67.7       (5) possess an in-force workers compensation policy;  
67.8       (6) possess a certificate of compliance from the commissioner of revenue;  
67.9       (7) successfully complete the Fortified Roof for High Wind and Hail training provided  
67.10       by the IBHS and maintain an active certification. The training may be offered as separate  
67.11       courses;  
67.12       (8) agree to the terms and successfully register as a vendor with the commissioner of  
67.13       management and budget and receive direct deposit of payment for mitigation work performed  
67.14       under the program;

67.15       (9) maintain Internet access and keep a valid email address on file with the program and  
67.16       remain active in the commissioner of management and budget's vendor and supplier portal  
67.17       while working on the program;

67.18       (10) maintain an active email address for the communication with the program;  
67.19       (11) successfully complete the program training; and  
67.20       (12) agree to follow program procedures and rules established under this section and by  
67.21       the commissioner.

67.22       (b) An eligible contractor must not have a financial interest, other than payment on  
67.23       behalf of the homeowner, in any project for which the eligible contractor performs work  
67.24       toward a fortified designation under the program. An eligible contractor is prohibited from

18.6 acting as the evaluator for a fortified designation on any project funded by the program. An  
 18.7 eligible contractor must report to the commissioner regarding any potential conflict of  
 18.8 interest before work commences on any job funded by the program.

18.9 Subd. 8. Evaluator eligibility; conflicts of interest. (a) To be eligible to work on the  
 18.10 program as an evaluator, the evaluator must meet all program eligibility requirements and  
 18.11 must submit to the commissioner and maintain a copy of all current certificates and licenses.  
 18.12 The evaluator must:

18.13 (1) be in good standing with IBHS and maintain an active certification as a fortified  
 18.14 home evaluator for hurricane and high wind and hail or a successor certification;

18.15 (2) possess a Minnesota business license and be registered with the secretary of state;  
 18.16 and

18.17 (3) successfully complete the program training.

18.18 (b) Evaluators must not have a financial interest in any project that the evaluator inspects  
 18.19 for designation purposes for the program. An evaluator must not be an eligible contractor  
 18.20 or supplier of any material, product, or system installed in any home that the evaluator  
 18.21 inspects for designation purposes for the program. An evaluator must not be a sales agent  
 18.22 for any home being designated for the program. An evaluator must inform the commissioner  
 18.23 of any potential conflict of interest impacting the evaluator's participation in the program.

18.24 Subd. 9. Grant approval; allocation. (a) The commissioner must review all applications  
 18.25 for completeness and must perform appropriate audits to verify (1) the accuracy of the  
 18.26 information on the application, and (2) that the applicant meets all eligibility rules. All  
 18.27 verified applicants must be placed in the order the application was received. Grants must  
 18.28 be awarded on a first-come, first-served basis, subject to availability of money for the  
 18.29 program.

18.30 (b) When a grant is approved, an approval letter must be sent to the applicant.

18.31 (c) An eligible contractor is prohibited from beginning work until a grant is approved.

18.32 (d) In order to assure equitable distribution of grants in proportion to the income  
 18.33 demographics in counties where the program is made available, grant applications must be  
 19.1 accepted on a first-come, first-served basis. The commissioner may establish pilot projects  
 19.2 as needed to establish a sustainable program distribution system in any geographic area  
 19.3 within Minnesota.

19.4 Subd. 10. Grant award process; release of grant money. (a) After a grant application  
 19.5 is approved, the eligible contractor selected by the homeowner may begin the mitigation  
 19.6 work.

67.25 acting as the evaluator for a fortified designation on any project funded by the program. An  
 67.26 eligible contractor must report to the commissioner regarding any potential conflict of  
 67.27 interest before work commences on any job funded by the program.

67.28 Subd. 8. Evaluator eligibility; conflicts of interest. (a) To be eligible to work on the  
 67.29 program as an evaluator, the evaluator must meet all program eligibility requirements and  
 67.30 must submit to the commissioner and maintain a copy of all current certificates and licenses.  
 67.31 The evaluator must:

68.1 (1) be in good standing with IBHS and maintain an active certification as a fortified  
 68.2 home evaluator for high wind and hail or a successor certification;

68.3 (2) possess a Minnesota business license and be registered with the secretary of state;  
 68.4 and

68.5 (3) successfully complete the program training.

68.6 (b) An evaluator must not have a financial interest in any project that the evaluator  
 68.7 inspects for designation purposes for the program. An evaluator must not be an eligible  
 68.8 contractor or supplier of any material, product, or system installed in any home that the  
 68.9 evaluator inspects for designation purposes for the program. An evaluator must not be a  
 68.10 sales agent for any home being designated for the program. An evaluator must inform the  
 68.11 commissioner of any potential conflict of interest impacting the evaluator's participation in  
 68.12 the program.

68.13 Subd. 9. Grant approval; allocation. (a) The commissioner must review all applications  
 68.14 for completeness and must perform appropriate audits to verify (1) the accuracy of the  
 68.15 information on the application, and (2) that the applicant meets all eligibility rules. All  
 68.16 verified applicants must be placed in the order the application was received. Grants must  
 68.17 be awarded on a first-come, first-served basis, subject to availability of money for the  
 68.18 program.

68.19 (b) When a grant is approved, an approval letter must be sent to the applicant.

68.20 (c) An eligible contractor is prohibited from beginning work until a grant is approved.

68.21 (d) In order to assure equitable distribution of grants in proportion to the income  
 68.22 demographics in counties where the program is made available, grant applications must be  
 68.23 accepted on a first-come, first-served basis. The commissioner may establish pilot projects  
 68.24 as needed to establish a sustainable program distribution system in any geographic area  
 68.25 within Minnesota.

68.26 Subd. 10. Grant award process; release of grant money. (a) After a grant application  
 68.27 is approved, the eligible contractor selected by the homeowner may begin the mitigation  
 68.28 work.

19.7       (b) Once the mitigation work is completed, the eligible contractor must submit a copy  
 19.8       of the signed contract to the commissioner, along with an invoice seeking payment and an  
 19.9       affidavit stating the fortified standards were met by the work.

19.10       (c) The IBHS evaluator must conduct all required evaluations, including a required  
 19.11       interim inspection during construction and the final inspection, and must confirm that the  
 19.12       work was completed according to the mitigation specifications.

19.13       (d) Grant money must be released on behalf of an approved applicant only after a fortified  
 19.14       designation certificate has been issued for the home. The program or another designated  
 19.15       entity must, on behalf of the homeowner, directly pay the eligible contractor that performed  
 19.16       the mitigation work. The program or the program's designated entity must pay the eligible  
 19.17       contractor the costs covered by the grant. The homeowner must pay the eligible contractor  
 19.18       for the remaining cost after receiving an IBHS fortified certificate.

19.19       (e) The program must confirm that the homeowner's insurer provides the appropriate  
 19.20       premium credit.

19.21       (f) The program must conduct random reinspections to detect any fraud and must submit  
 19.22       any irregularities to the attorney general.

19.23       Subd. 11. **Limitations.** (a) This section does not create an entitlement for property  
 19.24       owners or obligate the state of Minnesota to pay for residential property in Minnesota to be  
 19.25       inspected or retrofitted. The program under this section is subject to legislative appropriations,  
 19.26       the receipt of federal grants or money, or the receipt of other sources of grants or money.  
 19.27       The department may obtain grants or other money from the federal government or other  
 19.28       funding sources to support and enhance program activities.

19.29       (b) All mitigation under this section is contingent upon securing all required local permits  
 19.30       and applicable inspections to comply with local building codes and applicable Fortified  
 19.31       program standards. A mitigation project receiving a grant under this section is subject to  
 19.32       random reinspection at a later date.

68.29       (b) Once the mitigation work is completed, the eligible contractor must submit a copy  
 68.30       of the signed contract to the commissioner, along with an invoice seeking payment and an  
 68.31       affidavit stating the fortified standards were met by the work.

69.1       (c) The IBHS evaluator must conduct all required evaluations, including a required  
 69.2       interim inspection during construction and the final inspection, and must confirm that the  
 69.3       work was completed according to the mitigation specifications.

69.4       (d) Grant money must be released on behalf of an approved applicant only after a fortified  
 69.5       designation certificate has been issued for the home. The program or another designated  
 69.6       entity must, on behalf of the homeowner, directly pay the eligible contractor that performed  
 69.7       the mitigation work. The program or the program's designated entity must pay the eligible  
 69.8       contractor the costs covered by the grant. The homeowner must pay the eligible contractor  
 69.9       for the remaining cost after receiving an IBHS fortified certificate.

69.10       (e) The program must confirm that the homeowner's insurer provides the appropriate  
 69.11       premium discount.

69.12       (f) The program must conduct random reinspections to detect any fraud and must submit  
 69.13       any irregularities to the attorney general.

69.14       Subd. 11. **Limitations.** (a) This section does not create an entitlement for property  
 69.15       owners or obligate the state of Minnesota to pay for residential property in Minnesota to be  
 69.16       inspected or retrofitted. The program under this section is subject to legislative appropriations,  
 69.17       the receipt of federal grants or money, or the receipt of other sources of grants or money.  
 69.18       The department may obtain grants or other money from the federal government or other  
 69.19       funding sources to support and enhance program activities.

69.20       (b) All mitigation under this section is contingent upon securing all required local permits  
 69.21       and applicable inspections to comply with local building codes and applicable Fortified  
 69.22       program standards. A mitigation project receiving a grant under this section is subject to  
 69.23       random reinspection at a later date.

69.24       Sec. 58. **[65A.303] HOMEOWNER'S LIABILITY INSURANCE; DOGS.**

69.25       Subdivision 1. **Discrimination prohibited.** An insurer writing homeowner's insurance  
 69.26       for property is prohibited from (1) refusing to issue or renew an insurance policy or contract,  
 69.27       or (2) canceling an insurance policy or contract based solely on the fact that the homeowner  
 69.28       harbors or owns one dog of a specific breed or mixture of breeds.

69.29       Subd. 2. **Exception.** (a) Subdivision 1 does not prohibit an insurer from (1) refusing to  
 69.30       issue or renew an insurance policy or contract, (2) canceling an insurance policy or contract,  
 69.31       or (3) imposing a reasonably increased premium or rate for an insurance policy or contract  
 69.32       based on a dog meeting the criteria of a dangerous dog or potentially dangerous dog under  
 70.1       section 347.50, or based on sound underwriting and actuarial principles that are reasonably  
 70.2       related to actual or anticipated loss experience.

20.1 Sec. 19. Minnesota Statutes 2022, section 65B.49, is amended by adding a subdivision to  
 20.2 read:

20.3 Subd. 10. Time limitations. (a) Unless expressly provided for in this chapter, a plan of  
 20.4 reparation security must conform to the six-year time limitation provided under section  
 20.5 541.05, subdivision 1, clause (1).

20.6 (b) The time limitation for commencing a cause of action relating to underinsured motorist  
 20.7 coverage under subdivision 3a is four years from the date of accrual.

20.8 **EFFECTIVE DATE.** This section is effective on August 1, 2023, and applies to contracts  
 20.9 issued or renewed on or after that date.

S2744-3

39.1 Sec. 35. Minnesota Statutes 2022, section 151.071, subdivision 1, is amended to read:

39.2 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,  
 39.3 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do  
 39.4 one or more of the following:

- 39.5 (1) deny the issuance of a license or registration;
- 39.6 (2) refuse to renew a license or registration;
- 39.7 (3) revoke the license or registration;
- 39.8 (4) suspend the license or registration;

39.9 (5) impose limitations, conditions, or both on the license or registration, including but  
 39.10 not limited to: the limitation of practice to designated settings; the limitation of the scope  
 39.11 of practice within designated settings; the imposition of retraining or rehabilitation  
 39.12 requirements; the requirement of practice under supervision; the requirement of participation  
 39.13 in a diversion program such as that established pursuant to section 214.31 or the conditioning  
 39.14 of continued practice on demonstration of knowledge or skills by appropriate examination  
 39.15 or other review of skill and competence;

39.16 (6) impose a civil penalty not exceeding \$10,000 for each separate violation, except that  
 39.17 a civil penalty not exceeding \$25,000 may be imposed for each separate violation of section  
 39.18 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant

70.3 (b) Subdivision 1 does not prohibit an insurer from (1) refusing to issue or renew an  
 70.4 insurance policy or contract, (2) canceling an insurance policy or contract, or (3) imposing  
 70.5 a reasonably increased premium or rate for an insurance policy or contract if the dog has a  
 70.6 history of causing bodily injury or if the dog owner has a history of owning other animals  
 70.7 who caused bodily injury.

70.8 **EFFECTIVE DATE.** This section is effective April 1, 2024, and applies to insurance  
 70.9 policies and contracts offered, issued, or sold after that date.

70.10 Sec. 59. Minnesota Statutes 2022, section 65B.49, is amended by adding a subdivision to  
 70.11 read:

70.12 Subd. 10. Time limitations. (a) Unless expressly provided for in this chapter, a plan of  
 70.13 reparation security must conform to the six-year time limitation provided under section  
 70.14 541.05, subdivision 1, clause (1).

70.15 (b) The time limitation for commencing a cause of action relating to underinsured motorist  
 70.16 coverage under subdivision 3a is four years from the date of accrual.

70.17 **EFFECTIVE DATE.** This section is effective August 1, 2023, and applies to contracts  
 70.18 issued or renewed on or after that date.

70.19 Sec. 60. Minnesota Statutes 2022, section 151.071, subdivision 1, is amended to read:

70.20 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,  
 70.21 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do  
 70.22 one or more of the following:

- 70.23 (1) deny the issuance of a license or registration;
- 70.24 (2) refuse to renew a license or registration;
- 70.25 (3) revoke the license or registration;
- 70.26 (4) suspend the license or registration;
- 70.27 (5) impose limitations, conditions, or both on the license or registration, including but  
 70.28 not limited to: the limitation of practice to designated settings; the limitation of the scope  
 70.29 of practice within designated settings; the imposition of retraining or rehabilitation  
 70.30 requirements; the requirement of practice under supervision; the requirement of participation  
 70.31 in a diversion program such as that established pursuant to section 214.31 or the conditioning  
 71.1 of continued practice on demonstration of knowledge or skills by appropriate examination  
 71.2 or other review of skill and competence;

71.3 (6) impose a civil penalty not exceeding \$10,000 for each separate violation, except that  
 71.4 a civil penalty not exceeding \$25,000 may be imposed for each separate violation of section  
 71.5 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant

39.19 of any economic advantage gained by reason of the violation, to discourage similar violations  
39.20 by the licensee or registrant or any other licensee or registrant, or to reimburse the board  
39.21 for the cost of the investigation and proceeding, including but not limited to, fees paid for  
39.22 services provided by the Office of Administrative Hearings, legal and investigative services  
39.23 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of  
39.24 records, board members' per diem compensation, board staff time, and travel costs and  
39.25 expenses incurred by board staff and board members; and

39.26 (7) reprimand the licensee or registrant.

39.27 Sec. 36. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

39.28 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is  
39.29 grounds for disciplinary action:

39.30 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or  
39.31 registration contained in this chapter or the rules of the board. The burden of proof is on  
39.32 the applicant to demonstrate such qualifications or satisfaction of such requirements;

40.1 (2) obtaining a license by fraud or by misleading the board in any way during the  
40.2 application process or obtaining a license by cheating, or attempting to subvert the licensing  
40.3 examination process. Conduct that subverts or attempts to subvert the licensing examination  
40.4 process includes, but is not limited to: (i) conduct that violates the security of the examination  
40.5 materials, such as removing examination materials from the examination room or having  
40.6 unauthorized possession of any portion of a future, current, or previously administered  
40.7 licensing examination; (ii) conduct that violates the standard of test administration, such as  
40.8 communicating with another examinee during administration of the examination, copying  
40.9 another examinee's answers, permitting another examinee to copy one's answers, or  
40.10 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an  
40.11 impersonator to take the examination on one's own behalf;

40.12 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist  
40.13 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,  
40.14 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used  
40.15 in this subdivision includes a conviction of an offense that if committed in this state would  
40.16 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding  
40.17 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either  
40.18 withheld or not entered thereon. The board may delay the issuance of a new license or  
40.19 registration if the applicant has been charged with a felony until the matter has been  
40.20 adjudicated;

40.21 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner  
40.22 or applicant is convicted of a felony reasonably related to the operation of the facility. The  
40.23 board may delay the issuance of a new license or registration if the owner or applicant has  
40.24 been charged with a felony until the matter has been adjudicated;

71.6 of any economic advantage gained by reason of the violation, to discourage similar violations  
71.7 by the licensee or registrant or any other licensee or registrant, or to reimburse the board  
71.8 for the cost of the investigation and proceeding, including but not limited to, fees paid for  
71.9 services provided by the Office of Administrative Hearings, legal and investigative services  
71.10 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of  
71.11 records, board members' per diem compensation, board staff time, and travel costs and  
71.12 expenses incurred by board staff and board members; and

71.13 (7) reprimand the licensee or registrant.

71.14 Sec. 61. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

71.15 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is  
71.16 grounds for disciplinary action:

71.17 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or  
71.18 registration contained in this chapter or the rules of the board. The burden of proof is on  
71.19 the applicant to demonstrate such qualifications or satisfaction of such requirements;

71.20 (2) obtaining a license by fraud or by misleading the board in any way during the  
71.21 application process or obtaining a license by cheating, or attempting to subvert the licensing  
71.22 examination process. Conduct that subverts or attempts to subvert the licensing examination  
71.23 process includes, but is not limited to: (i) conduct that violates the security of the examination  
71.24 materials, such as removing examination materials from the examination room or having  
71.25 unauthorized possession of any portion of a future, current, or previously administered  
71.26 licensing examination; (ii) conduct that violates the standard of test administration, such as  
71.27 communicating with another examinee during administration of the examination, copying  
71.28 another examinee's answers, permitting another examinee to copy one's answers, or  
71.29 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an  
71.30 impersonator to take the examination on one's own behalf;

71.31 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist  
71.32 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,  
71.33 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used  
72.1 in this subdivision includes a conviction of an offense that if committed in this state would  
72.2 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding  
72.3 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either  
72.4 withheld or not entered thereon. The board may delay the issuance of a new license or  
72.5 registration if the applicant has been charged with a felony until the matter has been  
72.6 adjudicated;

72.7 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner  
72.8 or applicant is convicted of a felony reasonably related to the operation of the facility. The  
72.9 board may delay the issuance of a new license or registration if the owner or applicant has  
72.10 been charged with a felony until the matter has been adjudicated;

40.25 (5) for a controlled substance researcher, conviction of a felony reasonably related to  
40.26 controlled substances or to the practice of the researcher's profession. The board may delay  
40.27 the issuance of a registration if the applicant has been charged with a felony until the matter  
40.28 has been adjudicated;

40.29 (6) disciplinary action taken by another state or by one of this state's health licensing  
40.30 agencies:

40.31 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a  
40.32 license or registration in another state or jurisdiction, failure to report to the board that  
40.33 charges or allegations regarding the person's license or registration have been brought in  
40.34 another state or jurisdiction, or having been refused a license or registration by any other  
41.1 state or jurisdiction. The board may delay the issuance of a new license or registration if an  
41.2 investigation or disciplinary action is pending in another state or jurisdiction until the  
41.3 investigation or action has been dismissed or otherwise resolved; and

41.4 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a  
41.5 license or registration issued by another of this state's health licensing agencies, failure to  
41.6 report to the board that charges regarding the person's license or registration have been  
41.7 brought by another of this state's health licensing agencies, or having been refused a license  
41.8 or registration by another of this state's health licensing agencies. The board may delay the  
41.9 issuance of a new license or registration if a disciplinary action is pending before another  
41.10 of this state's health licensing agencies until the action has been dismissed or otherwise  
41.11 resolved;

41.12 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of  
41.13 any order of the board, of any of the provisions of this chapter or any rules of the board or  
41.14 violation of any federal, state, or local law or rule reasonably pertaining to the practice of  
41.15 pharmacy;

41.16 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order  
41.17 of the board, of any of the provisions of this chapter or the rules of the board or violation  
41.18 of any federal, state, or local law relating to the operation of the facility;

41.19 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the  
41.20 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of  
41.21 a patient; or pharmacy practice that is professionally incompetent, in that it may create  
41.22 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of  
41.23 actual injury need not be established;

41.24 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it  
41.25 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy  
41.26 technician or pharmacist intern if that person is performing duties allowed by this chapter  
41.27 or the rules of the board;

41.28 (11) for an individual licensed or registered by the board, adjudication as mentally ill  
41.29 or developmentally disabled, or as a chemically dependent person, a person dangerous to

72.11 (5) for a controlled substance researcher, conviction of a felony reasonably related to  
72.12 controlled substances or to the practice of the researcher's profession. The board may delay  
72.13 the issuance of a registration if the applicant has been charged with a felony until the matter  
72.14 has been adjudicated;

72.15 (6) disciplinary action taken by another state or by one of this state's health licensing  
72.16 agencies:

72.17 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a  
72.18 license or registration in another state or jurisdiction, failure to report to the board that  
72.19 charges or allegations regarding the person's license or registration have been brought in  
72.20 another state or jurisdiction, or having been refused a license or registration by any other  
72.21 state or jurisdiction. The board may delay the issuance of a new license or registration if an  
72.22 investigation or disciplinary action is pending in another state or jurisdiction until the  
72.23 investigation or action has been dismissed or otherwise resolved; and

72.24 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a  
72.25 license or registration issued by another of this state's health licensing agencies, failure to  
72.26 report to the board that charges regarding the person's license or registration have been  
72.27 brought by another of this state's health licensing agencies, or having been refused a license  
72.28 or registration by another of this state's health licensing agencies. The board may delay the  
72.29 issuance of a new license or registration if a disciplinary action is pending before another  
72.30 of this state's health licensing agencies until the action has been dismissed or otherwise  
72.31 resolved;

72.32 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of  
72.33 any order of the board, of any of the provisions of this chapter or any rules of the board or  
73.1 violation of any federal, state, or local law or rule reasonably pertaining to the practice of  
73.2 pharmacy;

73.3 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order  
73.4 of the board, of any of the provisions of this chapter or the rules of the board or violation  
73.5 of any federal, state, or local law relating to the operation of the facility;

73.6 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the  
73.7 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of  
73.8 a patient; or pharmacy practice that is professionally incompetent, in that it may create  
73.9 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of  
73.10 actual injury need not be established;

73.11 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it  
73.12 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy  
73.13 technician or pharmacist intern if that person is performing duties allowed by this chapter  
73.14 or the rules of the board;

73.15 (11) for an individual licensed or registered by the board, adjudication as mentally ill  
73.16 or developmentally disabled, or as a chemically dependent person, a person dangerous to

41.30 the public, a sexually dangerous person, or a person who has a sexual psychopathic  
 41.31 personality, by a court of competent jurisdiction, within or without this state. Such  
 41.32 adjudication shall automatically suspend a license for the duration thereof unless the board  
 41.33 orders otherwise;

42.1 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified  
 42.2 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in  
 42.3 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist  
 42.4 intern or performing duties specifically reserved for pharmacists under this chapter or the  
 42.5 rules of the board;

42.6 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on  
 42.7 duty except as allowed by a variance approved by the board;

42.8 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety  
 42.9 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type  
 42.10 of material or as a result of any mental or physical condition, including deterioration through  
 42.11 the aging process or loss of motor skills. In the case of registered pharmacy technicians,  
 42.12 pharmacist interns, or controlled substance researchers, the inability to carry out duties  
 42.13 allowed under this chapter or the rules of the board with reasonable skill and safety to  
 42.14 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type  
 42.15 of material or as a result of any mental or physical condition, including deterioration through  
 42.16 the aging process or loss of motor skills;

42.17 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas  
 42.18 dispenser, or controlled substance researcher, revealing a privileged communication from  
 42.19 or relating to a patient except when otherwise required or permitted by law;

42.20 (16) for a pharmacist or pharmacy, improper management of patient records, including  
 42.21 failure to maintain adequate patient records, to comply with a patient's request made pursuant  
 42.22 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

42.23 (17) fee splitting, including without limitation:

42.24 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,  
 42.25 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

42.26 (ii) referring a patient to any health care provider as defined in sections 144.291 to  
 42.27 144.298 in which the licensee or registrant has a financial or economic interest as defined  
 42.28 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the  
 42.29 licensee's or registrant's financial or economic interest in accordance with section 144.6521;  
 42.30 and

42.31 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner  
 42.32 does not have a significant ownership interest, fills a prescription drug order and the  
 42.33 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price  
 43.1 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy

73.17 the public, a sexually dangerous person, or a person who has a sexual psychopathic  
 73.18 personality, by a court of competent jurisdiction, within or without this state. Such  
 73.19 adjudication shall automatically suspend a license for the duration thereof unless the board  
 73.20 orders otherwise;

73.21 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified  
 73.22 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in  
 73.23 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist  
 73.24 intern or performing duties specifically reserved for pharmacists under this chapter or the  
 73.25 rules of the board;

73.26 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on  
 73.27 duty except as allowed by a variance approved by the board;

73.28 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety  
 73.29 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type  
 73.30 of material or as a result of any mental or physical condition, including deterioration through  
 73.31 the aging process or loss of motor skills. In the case of registered pharmacy technicians,  
 73.32 pharmacist interns, or controlled substance researchers, the inability to carry out duties  
 73.33 allowed under this chapter or the rules of the board with reasonable skill and safety to  
 73.34 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type  
 74.1 of material or as a result of any mental or physical condition, including deterioration through  
 74.2 the aging process or loss of motor skills;

74.3 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas  
 74.4 dispenser, or controlled substance researcher, revealing a privileged communication from  
 74.5 or relating to a patient except when otherwise required or permitted by law;

74.6 (16) for a pharmacist or pharmacy, improper management of patient records, including  
 74.7 failure to maintain adequate patient records, to comply with a patient's request made pursuant  
 74.8 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

74.9 (17) fee splitting, including without limitation:

74.10 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,  
 74.11 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

74.12 (ii) referring a patient to any health care provider as defined in sections 144.291 to  
 74.13 144.298 in which the licensee or registrant has a financial or economic interest as defined  
 74.14 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the  
 74.15 licensee's or registrant's financial or economic interest in accordance with section 144.6521;  
 74.16 and

74.17 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner  
 74.18 does not have a significant ownership interest, fills a prescription drug order and the  
 74.19 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price  
 74.20 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy

43.2 benefit manager, or other person paying for the prescription or, in the case of veterinary  
43.3 patients, the price for the filled prescription that is charged to the client or other person  
43.4 paying for the prescription, except that a veterinarian and a pharmacy may enter into such  
43.5 arrangement provided that the client or other person paying for the prescription is notified,  
43.6 in writing and with each prescription dispensed, about the arrangement, unless such  
43.7 arrangement involves pharmacy services provided for livestock, poultry, and agricultural  
43.8 production systems, in which case client notification would not be required;

43.9 (18) engaging in abusive or fraudulent billing practices, including violations of the  
43.10 federal Medicare and Medicaid laws or state medical assistance laws or rules;

43.11 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted  
43.12 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning  
43.13 to a patient;

43.14 (20) failure to make reports as required by section 151.072 or to cooperate with an  
43.15 investigation of the board as required by section 151.074;

43.16 (21) knowingly providing false or misleading information that is directly related to the  
43.17 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and  
43.18 administration of a placebo;

43.19 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as  
43.20 established by any of the following:

43.21 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation  
43.22 of section 609.215, subdivision 1 or 2;

43.23 (ii) a copy of the record of a judgment of contempt of court for violating an injunction  
43.24 issued under section 609.215, subdivision 4;

43.25 (iii) a copy of the record of a judgment assessing damages under section 609.215,  
43.26 subdivision 5; or

43.27 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.  
43.28 The board must investigate any complaint of a violation of section 609.215, subdivision 1  
43.29 or 2;

43.30 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For  
43.31 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing  
43.32 duties permitted to such individuals by this chapter or the rules of the board under a lapsed  
44.1 or nonrenewed registration. For a facility required to be licensed under this chapter, operation  
44.2 of the facility under a lapsed or nonrenewed license or registration; and

44.3 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge  
44.4 from the health professionals services program for reasons other than the satisfactory  
44.5 completion of the program; and

74.21 benefit manager, or other person paying for the prescription or, in the case of veterinary  
74.22 patients, the price for the filled prescription that is charged to the client or other person  
74.23 paying for the prescription, except that a veterinarian and a pharmacy may enter into such  
74.24 arrangement provided that the client or other person paying for the prescription is notified,  
74.25 in writing and with each prescription dispensed, about the arrangement, unless such  
74.26 arrangement involves pharmacy services provided for livestock, poultry, and agricultural  
74.27 production systems, in which case client notification would not be required;

74.28 (18) engaging in abusive or fraudulent billing practices, including violations of the  
74.29 federal Medicare and Medicaid laws or state medical assistance laws or rules;

74.30 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted  
74.31 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning  
74.32 to a patient;

75.1 (20) failure to make reports as required by section 151.072 or to cooperate with an  
75.2 investigation of the board as required by section 151.074;

75.3 (21) knowingly providing false or misleading information that is directly related to the  
75.4 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and  
75.5 administration of a placebo;

75.6 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as  
75.7 established by any of the following:

75.8 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation  
75.9 of section 609.215, subdivision 1 or 2;

75.10 (ii) a copy of the record of a judgment of contempt of court for violating an injunction  
75.11 issued under section 609.215, subdivision 4;

75.12 (iii) a copy of the record of a judgment assessing damages under section 609.215,  
75.13 subdivision 5; or

75.14 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.  
75.15 The board must investigate any complaint of a violation of section 609.215, subdivision 1  
75.16 or 2;

75.17 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For  
75.18 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing  
75.19 duties permitted to such individuals by this chapter or the rules of the board under a lapsed  
75.20 or nonrenewed registration. For a facility required to be licensed under this chapter, operation  
75.21 of the facility under a lapsed or nonrenewed license or registration; and

75.22 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge  
75.23 from the health professionals services program for reasons other than the satisfactory  
75.24 completion of the program; and

44.6 (25) for a manufacturer, a violation of section 62J.842 or 62J.845.

44.7 Sec. 37. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

44.8 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical  
44.9 assistance benefit plan shall include the following cost-sharing for all recipients, effective  
44.10 for services provided on or after September 1, 2014:

44.11 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this  
44.12 subdivision, a visit means an episode of service which is required because of a recipient's  
44.13 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting  
44.14 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced  
44.15 practice nurse, audiologist, optician, or optometrist;

44.16 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this  
44.17 co-payment shall be increased to \$20 upon federal approval;

44.18 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per  
44.19 prescription for a brand-name multisource drug listed in preferred status on the preferred  
44.20 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No  
44.21 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

44.22 (4) a family deductible equal to \$2.75 per month per family and adjusted annually by  
44.23 the percentage increase in the medical care component of the CPI-U for the period of  
44.24 September to September of the preceding calendar year, rounded to the next higher five-cent  
44.25 increment; and

44.26 (5) total monthly cost-sharing must not exceed five percent of family income. For  
44.27 purposes of this paragraph, family income is the total earned and unearned income of the  
44.28 individual and the individual's spouse, if the spouse is enrolled in medical assistance and  
44.29 also subject to the five percent limit on cost-sharing. This paragraph does not apply to  
44.30 premiums charged to individuals described under section 256B.057, subdivision 9; and

44.31 (6) cost-sharing for prescription drugs and related medical supplies to treat chronic  
44.32 disease must comply with the requirements of section 62Q.481.

45.1 (b) Recipients of medical assistance are responsible for all co-payments and deductibles  
45.2 in this subdivision.

45.3 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process  
45.4 under sections 256B.69 and 256B.692, may allow managed care plans and county-based  
45.5 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value  
45.6 of the family deductible shall not be included in the capitation payment to managed care  
45.7 plans and county-based purchasing plans. Managed care plans and county-based purchasing  
45.8 plans shall certify annually to the commissioner the dollar value of the family deductible.

75.25 (25) for a manufacturer, a violation of section 62J.842 or 62J.845.

75.26 Sec. 62. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

75.27 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical  
75.28 assistance benefit plan shall include the following cost-sharing for all recipients, effective  
75.29 for services provided on or after September 1, 2014:

75.30 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this  
75.31 subdivision, a visit means an episode of service which is required because of a recipient's  
75.32 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting  
76.1 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced  
76.2 practice nurse, audiologist, optician, or optometrist;

76.3 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this  
76.4 co-payment shall be increased to \$20 upon federal approval;

76.5 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per  
76.6 prescription for a brand-name multisource drug listed in preferred status on the preferred  
76.7 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No  
76.8 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

76.9 (4) a family deductible equal to \$2.75 per month per family and adjusted annually by  
76.10 the percentage increase in the medical care component of the CPI-U for the period of  
76.11 September to September of the preceding calendar year, rounded to the next higher five-cent  
76.12 increment; and

76.13 (5) total monthly cost-sharing must not exceed five percent of family income. For  
76.14 purposes of this paragraph, family income is the total earned and unearned income of the  
76.15 individual and the individual's spouse, if the spouse is enrolled in medical assistance and  
76.16 also subject to the five percent limit on cost-sharing. This paragraph does not apply to  
76.17 premiums charged to individuals described under section 256B.057, subdivision 9; and

76.18 (6) cost-sharing for prescription drugs and related medical supplies to treat chronic  
76.19 disease must comply with the requirements of section 62Q.481.

76.20 (b) Recipients of medical assistance are responsible for all co-payments and deductibles  
76.21 in this subdivision.

76.22 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process  
76.23 under sections 256B.69 and 256B.692, may allow managed care plans and county-based  
76.24 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value  
76.25 of the family deductible shall not be included in the capitation payment to managed care  
76.26 plans and county-based purchasing plans. Managed care plans and county-based purchasing  
76.27 plans shall certify annually to the commissioner the dollar value of the family deductible.

45.9 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of the  
45.10 family deductible described under paragraph (a), clause (4), from individuals and allow  
45.11 long-term care and waivered service providers to assume responsibility for payment.

45.12 (e) Notwithstanding paragraph (b), the commissioner, through the contracting process  
45.13 under section 256B.0756 shall allow the pilot program in Hennepin County to waive  
45.14 co-payments. The value of the co-payments shall not be included in the capitation payment  
45.15 amount to the integrated health care delivery networks under the pilot program.

45.16 **EFFECTIVE DATE.** This section is effective January 1, 2024.

76.28 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of the  
76.29 family deductible described under paragraph (a), clause (4), from individuals and allow  
76.30 long-term care and waivered service providers to assume responsibility for payment.

76.31 (e) Notwithstanding paragraph (b), the commissioner, through the contracting process  
76.32 under section 256B.0756 shall allow the pilot program in Hennepin County to waive  
77.1 co-payments. The value of the co-payments shall not be included in the capitation payment  
77.2 amount to the integrated health care delivery networks under the pilot program.

77.3 **EFFECTIVE DATE.** This section is effective January 1, 2024.

77.4 Sec. 63. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

77.5 **Subd. 5a. Managed care contracts.** (a) Managed care contracts under this section and  
77.6 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner  
77.7 may issue separate contracts with requirements specific to services to medical assistance  
77.8 recipients age 65 and older.

77.9 (b) A prepaid health plan providing covered health services for eligible persons pursuant  
77.10 to chapters 256B and 256L is responsible for complying with the terms of its contract with  
77.11 the commissioner. Requirements applicable to managed care programs under chapters 256B  
77.12 and 256L established after the effective date of a contract with the commissioner take effect  
77.13 when the contract is next issued or renewed.

77.14 (c) The commissioner shall withhold five percent of managed care plan payments under  
77.15 this section and county-based purchasing plan payments under section 256B.692 for the  
77.16 prepaid medical assistance program pending completion of performance targets. Each  
77.17 performance target must be quantifiable, objective, measurable, and reasonably attainable,  
77.18 except in the case of a performance target based on a federal or state law or rule. Criteria  
77.19 for assessment of each performance target must be outlined in writing prior to the contract  
77.20 effective date. Clinical or utilization performance targets and their related criteria must  
77.21 consider evidence-based research and reasonable interventions when available or applicable  
77.22 to the populations served, and must be developed with input from external clinical experts  
77.23 and stakeholders, including managed care plans, county-based purchasing plans, and  
77.24 providers. The managed care or county-based purchasing plan must demonstrate, to the  
77.25 commissioner's satisfaction, that the data submitted regarding attainment of the performance  
77.26 target is accurate. The commissioner shall periodically change the administrative measures  
77.27 used as performance targets in order to improve plan performance across a broader range  
77.28 of administrative services. The performance targets must include measurement of plan  
77.29 efforts to contain spending on health care services and administrative activities. The  
77.30 commissioner may adopt plan-specific performance targets that take into account factors  
77.31 affecting only one plan, including characteristics of the plan's enrollee population. The  
77.32 withheld funds must be returned no sooner than July of the following year if performance  
77.33 targets in the contract are achieved. The commissioner may exclude special demonstration  
77.34 projects under subdivision 23.

78.1       (d) The commissioner shall require that managed care plans:

78.2       (1) use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659 and community first services and supports under section 256B.85; and

78.7       (2) by January 30 of each year that follows a rate increase for any aspect of services under section 256B.0659 or 256B.85, inform the commissioner and the chairs and ranking minority members of the legislative committees with jurisdiction over rates determined under section 256B.851 of the amount of the rate increase that is paid to each personal care assistance provider agency with which the plan has a contract; and

78.12       (3) use a six-month timely filing standard and provide an exemption to the timely filing timeliness for the resubmission of claims where there has been a denial, request for more information, or system issue.

78.15       (e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

78.29       The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

79.1       The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withhold that may be returned to the hospitals if the performance target is achieved.

79.7 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall  
79.8 include as part of the performance targets described in paragraph (c) a reduction in the plan's  
79.9 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as  
79.10 determined by the commissioner. To earn the return of the withhold each year, the managed  
79.11 care plan or county-based purchasing plan must achieve a qualifying reduction of no less  
79.12 than five percent of the plan's hospital admission rate for medical assistance and  
79.13 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and  
79.14 28, compared to the previous calendar year until the final performance target is reached.  
79.15 When measuring performance, the commissioner must consider the difference in health risk  
79.16 in a managed care or county-based purchasing plan's membership in the baseline year  
79.17 compared to the measurement year, and work with the managed care or county-based  
79.18 purchasing plan to account for differences that they agree are significant.

79.19 The withheld funds must be returned no sooner than July 1 and no later than July 31 of  
79.20 the following calendar year if the managed care plan or county-based purchasing plan  
79.21 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization  
79.22 rate was achieved. The commissioner shall structure the withhold so that the commissioner  
79.23 returns a portion of the withheld funds in amounts commensurate with achieved reductions  
79.24 in utilization less than the targeted amount.

79.25 The withhold described in this paragraph shall continue until there is a 25 percent  
79.26 reduction in the hospital admission rate compared to the hospital admission rates in calendar  
79.27 year 2011, as determined by the commissioner. The hospital admissions in this performance  
79.28 target do not include the admissions applicable to the subsequent hospital admission  
79.29 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting  
79.30 this performance target and shall accept payment withholds that may be returned to the  
79.31 hospitals if the performance target is achieved.

79.32 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall  
79.33 include as part of the performance targets described in paragraph (c) a reduction in the plan's  
79.34 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous  
79.35 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare  
80.1 enrollees, as determined by the commissioner. To earn the return of the withhold each year,  
80.2 the managed care plan or county-based purchasing plan must achieve a qualifying reduction  
80.3 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,  
80.4 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five  
80.5 percent compared to the previous calendar year until the final performance target is reached.

80.6 The withheld funds must be returned no sooner than July 1 and no later than July 31 of  
80.7 the following calendar year if the managed care plan or county-based purchasing plan  
80.8 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the  
80.9 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold  
80.10 so that the commissioner returns a portion of the withheld funds in amounts commensurate  
80.11 with achieved reductions in utilization less than the targeted amount.

80.12        The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholdings that must be returned to the hospitals if the performance target is achieved.

80.19        (h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

80.25        (i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

80.31        (j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

81.1        (k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

81.4        (l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

81.6        (m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

45.17 Sec. 38. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

45.18 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
45.19 children under the age of 21 and to American Indians as defined in Code of Federal  
45.20 Regulations, title 42, section 600.5.

45.21 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
45.22 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
45.23 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
45.24 services exempt from cost-sharing under state law. The cost-sharing changes described in  
45.25 this paragraph shall not be implemented prior to January 1, 2016.

45.26 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
45.27 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
45.28 title 42, sections 600.510 and 600.520.

45.29 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
45.30 disease must comply with the requirements of section 62Q.481.

45.31 **EFFECTIVE DATE.** This section is effective January 1, 2024.

S2219-2

54.15 Sec. 50. **AUTOMOTIVE SELF-INSURANCE; RULES AMENDMENT; EXPEDITED**  
54.16 **RULEMAKING.**

54.17 Subdivision 1. **Self-insurance working capital condition.** The commissioner of  
54.18 commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item B, subitem (5),  
54.19 to require the commissioner's grant of self-insurance authority to an applicant to be based  
54.20 on the applicant's net working capital in lieu of the applicant's net funds flow.

54.21 Subd. 2. **Commissioner discretion to grant self-insurance authority.** The commissioner  
54.22 of commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item D, to,  
54.23 notwithstanding any other provision of Minnesota Rules, part 2770.6500, permit the  
54.24 commissioner to grant self-insurance authority to an applicant that is not a political  
54.25 subdivision and that has not had positive net income or positive working capital in at least  
54.26 three years of the last five-year period if the applicant's working capital, debt structure,  
54.27 profitability, and overall financial integrity of the applicant and its parent company, if one  
54.28 exists, demonstrate a continuing ability of the applicant to satisfy any financial obligations  
54.29 that have been and might be incurred under the no-fault act.

54.30 Subd. 3. **Working capital.** The commissioner of commerce must define working capital  
54.31 for the purposes of Minnesota Rules, part 2770.6500.

55.1 Subd. 4. **Commissioner discretion to revoke self-insurance authority.** The  
55.2 commissioner of commerce must amend Minnesota Rules, part 2770.7300, to permit, in  
55.3 lieu of require, the commissioner to revoke a self-insurer's authorization to self-insure based

81.17 Sec. 64. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

81.18 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
81.19 children under the age of 21 and to American Indians as defined in Code of Federal  
81.20 Regulations, title 42, section 600.5.

81.21 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered  
81.22 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
81.23 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
81.24 services exempt from cost-sharing under state law. The cost-sharing changes described in  
81.25 this paragraph shall not be implemented prior to January 1, 2016.

81.26 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
81.27 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
81.28 title 42, sections 600.510 and 600.520.

81.29 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
81.30 disease must comply with the requirements of section 62Q.481.

81.31 **EFFECTIVE DATE.** This section is effective January 1, 2024.

82.1 Sec. 65. **AUTOMOTIVE SELF-INSURANCE; RULES AMENDMENT; EXPEDITED**  
82.2 **RULEMAKING.**

82.3 Subdivision 1. **Self-insurance working capital condition.** The commissioner of  
82.4 commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item B, subitem (5),  
82.5 to require the commissioner's grant of self-insurance authority to an applicant to be based  
82.6 on the applicant's net working capital in lieu of the applicant's net funds flow.

82.7 Subd. 2. **Commissioner discretion to grant self-insurance authority.** The commissioner  
82.8 of commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item D, to,  
82.9 notwithstanding any other provision of Minnesota Rules, part 2770.6500, permit the  
82.10 commissioner to grant self-insurance authority to an applicant that is not a political  
82.11 subdivision and that has not had positive net income or positive working capital in at least  
82.12 three years of the last five-year period if the applicant's working capital, debt structure,  
82.13 profitability, and overall financial integrity of the applicant and its parent company, if one  
82.14 exists, demonstrate a continuing ability of the applicant to satisfy any financial obligations  
82.15 that have been and might be incurred under the no-fault act.

82.16 Subd. 3. **Working capital.** The commissioner of commerce must define working capital  
82.17 for the purposes of Minnesota Rules, part 2770.6500.

82.18 Subd. 4. **Commissioner discretion to revoke self-insurance authority.** The  
82.19 commissioner of commerce must amend Minnesota Rules, part 2770.7300, to permit, in  
82.20 lieu of require, the commissioner to revoke a self-insurer's authorization to self-insure based

55.4 on the commissioner's determinations under Minnesota Rules, part 2770.7300, items A and  
 55.5 B.

55.6 **Subd. 5. Expedited rulemaking authorized.** The commissioner of commerce may use  
 55.7 the expedited rulemaking process under Minnesota Statutes, section 14.389, to amend rules  
 55.8 under this section.

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

S2744-3

46.1 **Sec. 39. EVALUATION OF EXISTING STATUTORY HEALTH BENEFIT  
 46.2 MANDATES.**

46.3 (a) The commissioner of commerce must evaluate existing Minnesota statutory provisions  
 46.4 that would constitute a state-required benefit included in Minnesota's EHB-benchmark plan,  
 46.5 as defined in Code of Federal Regulations, title 45, section 156.20, if the statutory provision  
 46.6 was offered as a legislative proposal on the date of enactment of this act.

46.7 (b) The commissioner must conduct the evaluation using the process established under  
 46.8 Minnesota Statutes, section 62J.26, subdivision 2.

46.9 (c) The commissioner may prioritize and determine the order in which statutory provisions  
 46.10 are evaluated under this section, provided that at least one statutory provision is evaluated  
 46.11 each year.

82.21 on the commissioner's determinations under Minnesota Rules, part 2770.7300, items A and  
 82.22 B.

82.23 **Subd. 5. Expedited rulemaking authorized.** The commissioner of commerce may use  
 82.24 the expedited rulemaking process under Minnesota Statutes, section 14.389, to amend rules  
 82.25 under this section.

82.26 **Sec. 66. EVALUATION OF EXISTING STATUTORY HEALTH BENEFIT  
 82.27 MANDATES.**

82.28 **Subdivision 1. Evaluation process and content.** Beginning August 1, 2023, and annually  
 82.29 thereafter for the next five calendar years, the commissioner of commerce shall conduct an  
 82.30 evaluation of the economic cost and health benefits of one state-required benefit included  
 82.31 in Minnesota's EHB-benchmark plan, as defined in Code of Federal Regulations, title 45,  
 82.32 section 156.20. The mandated benefit to be studied each year must be chosen from a list  
 82.33 developed by the chairs of the house of representatives and senate commerce committees,  
 83.1 in consultation with the ranking minority members of the house of representatives and senate  
 83.2 commerce committees. The chairs and ranking minority members of the house of  
 83.3 representatives and senate commerce committees must agree upon and inform the  
 83.4 commissioner of at least one mandate to be reviewed for the period between August 1, 2023,  
 83.5 and August 1, 2024. The commissioner shall consult with the commissioner of health and  
 83.6 clinical and actuarial experts to assist in the evaluation and synthesis of available evidence.  
 83.7 The commissioner may obtain public input as part of the evaluation. At a minimum, the  
 83.8 evaluation must consider the following:

83.9 (1) cost for services;

83.10 (2) the share of Minnesotans' health insurance premiums that are tied to each current  
 83.11 mandated benefit;

83.12 (3) utilization of services;

83.13 (4) contribution to individual and public health;

83.14 (5) extent to which the mandate conforms with existing standards of care in terms of  
 83.15 appropriateness or evidence-based medicine;

83.16 (6) the historical context in which the mandate was enacted, including how the mandate  
 83.17 interacts with other required benefits; and

83.18 (7) other relevant criteria of effectiveness and efficacy as determined by the commissioner  
 83.19 in consultation with the commissioner of health.

46.12

(d) This section expires January 1, 2034.

46.13

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

83.20     Subd. 2. **Report to legislature.** The commissioner must submit a written report on the  
83.21     evaluation to the chairs and ranking minority members of the legislative committees with  
83.22     jurisdiction over health insurance policy and finance no later than 180 days after the  
83.23     commissioner receives notification from a chair, as required under Minnesota Statutes,  
83.24     section 62J.26, subdivision 3.

83.25     Sec. 67. **REPEALER.**

83.26     Minnesota Statutes 2022, section 62A.31, subdivisions 1b and 1i, are repealed.