Senate Language S2744-3

ARTICLE 2

INSURANCE POLICY

House Language UES2744-2

ARTICLE 2

INSURANCE

Section 1. Minnesota Statutes 2022, section 60A.08, subdivision 15, is amended to read:

Subd. 15. **Classification of insurance filings data.** (a) All forms, rates, and related information filed with the commissioner under section 61A.02 shall be nonpublic data until the filing becomes effective.

(b) All forms, rates, and related information filed with the commissioner under section 62A.02 shall be nonpublic data until the filing becomes effective.

(c) All forms, rates, and related information filed with the commissioner under section 62C.14, subdivision 10, shall be nonpublic data until the filing becomes effective.

(d) All forms, rates, and related information filed with the commissioner under section 70A.06 shall be nonpublic data until the filing becomes effective.

(e) All forms, rates, and related information filed with the commissioner under section 79.56 shall be nonpublic data until the filing becomes effective.

(f) All forms, rates, and related information filed with the commissioner under section 65A.298 are nonpublic data until the filing becomes effective.

~~(f)~~ (g) Notwithstanding paragraphs (b) and (c), for all rate increases subject to review under section 2794 of the Public Health Services Act and any amendments to, or regulations, or guidance issued under the act that are filed with the commissioner on or after September 1, 2011, the commissioner:

(1) may acknowledge receipt of the information;

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

(3) must provide public access from the Department of Commerce's website to parts I and II of the Preliminary Justifications of the rate increases subject to review; and

(4) must provide notice to the public on the Department of Commerce's website of the review of the proposed rate, which must include a statement that the public has 30 calendar days to submit written comments to the commissioner on the rate filing subject to review.

~~(g)~~ (h) Notwithstanding paragraphs (b) and (c), for all proposed premium rates filed with the commissioner for individual health plans, as defined in section 62A.011, subdivision 4, and small group health plans, as defined in section 62K.03, subdivision 12, the commissioner must provide public access on the Department of Commerce's website to compiled data of the proposed changes to rates, separated by health plan and geographic rating area, within ten business days after the deadline by which health carriers, as defined in section 62A.011, subdivision 2, must submit proposed rates to the commissioner for approval.

Sec. 2. **[60A.0812] PROPERTY AND CASUALTY POLICY EXCLUSIONS.**

Subdivision 1. **Short title.** This section may be cited as the "Family Protection Act."

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

(b) "Boat" means a motorized or nonmotorized vessel that floats and is used for personal, noncommercial use on waters in Minnesota.

(c) "Boat insurance policy" means an insurance policy that provides liability coverage for bodily injury resulting from the ownership, maintenance, or use of a boat, although the policy may also provide for property insurance coverage for the boat for noncommercial use.

(d) "Insured" means an insured under a policy specified in subdivision 3, clauses (1) to (4), including the named insured and the following persons not identified by name as an insured while residing in the same household with the named insured:

(1) a spouse of a named insured;

(2) a relative of a named insured; or

(3) a minor in the custody of a named insured, spouse of a named insured, or of a relative residing in the same household with a named insured.

For purposes of this section, a person resides in or is a member of the same household with the named insured if the person's home is usually in the same family unit, even if the person is temporarily living elsewhere.

(e) "Permitted exclusion" means an exclusion of or limitation on liability for damages for bodily injury resulting from fraud, intentional conduct, criminal conduct that intentionally causes an injury, and other exclusions permitted by law, including a permitted exclusion contained in a boat insurance policy issued in this state pursuant to subdivision 6.

(f) "Prohibited exclusion" means an exclusion of or limitation on liability for damages for bodily injury because the injured person is:

(1) an insured other than a named insured;

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

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

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

(1) a plan of reparation security, as defined under section 65B.43;

(2) a boat insurance policy;

(3) a personal excess liability policy; and

(4) a personal umbrella policy.

Subd. 4. **Permitted exclusions.** An insurance policy listed in this section may contain a permitted exclusion for bodily injury to an insured.

Subd. 5. **Underlying coverage requirement.** An excess or umbrella policy may contain a requirement that coverage for family or household members under an excess or umbrella policy governed by this section is available only to the extent coverage is first available from an underlying policy that provides coverage for damages for bodily injury.

Subd. 6. **Election of coverage for boat insurance policies.** (a) An insurer issuing bodily injury liability coverage for a boat insurance policy under this section must notify a person at the time of sale of the person's rights under this section to decline coverage for insureds and be provided an updated quote reflecting the appropriate premium for the coverage provided.

(b) Named insureds must affirmatively make an election to decline coverage, in a form approved by the commissioner, after being informed that an updated quote will be provided.

(c) An insurer offering an election of coverage under this subdivision must have the disclosure approved by the commissioner. The notice must be in 14-point bold type, in a conspicuous location of the notice document, and contain at least the following:

ELECTION TO DECLINE COVERAGE: YOU HAVE THE RIGHT TO DECLINE BODILY INJURY COVERAGE FOR INJURIES TO YOUR FAMILY AND HOUSEHOLD MEMBERS FOR WHICH YOU WOULD OTHERWISE BE ENTITLED TO UNDER MINNESOTA LAW. IF YOU ELECT TO DECLINE THIS COVERAGE, YOU WILL RECEIVE AN UPDATED PREMIUM QUOTE BASED ON THE COVERAGE YOU ARE ELECTING TO PURCHASE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FAMILY AND HOUSEHOLD MEMBERS WOULD NOT BE COVERED FOR BODILY INJURY IF YOU ELECT TO DECLINE COVERAGE.

Subd. 7. **Excessive rate hearings for boat insurance policies.** Whenever an insurer files a change in a rate for a boat insurance policy that will result in a 15 percent or more increase in a 12-month period over existing rates, the commissioner may hold a hearing to determine if the change is excessive. The hearing must be conducted under chapter 14. The commissioner must give notice of intent to hold a hearing within 60 days of the filing of the change. It shall be the responsibility of the insurer to show the rate is not excessive. The rate is effective unless it is determined as a result of the hearing that the rate is excessive. This subdivision expires January 1, 2029.

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

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

(a) by township mutual fire insurance companies:

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

(2) for filing annual statements, $15;

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

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

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

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

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

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

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

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

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

(c) the following general fees apply:

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

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

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

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

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

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

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

(a) by township mutual fire insurance companies:

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

(2) for filing annual statements, $15;

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

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

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

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

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

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

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

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

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

(c) the following general fees apply:

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

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

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

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

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

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

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

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

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

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

61A.031 SUICIDE PROVISIONS.

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

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

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

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

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

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

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

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

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

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

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

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

61A.031 SUICIDE PROVISIONS.

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

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

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

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

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

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DEFINITIONS

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

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

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

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

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

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

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

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

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

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DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services at a hospital or psychiatric residential treatment facility if performed by a mental health professional qualified according to section 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

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

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

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

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

Subd. 3. **Provider discrimination prohibited.** All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services at a hospital or psychiatric residential treatment facility if performed by a mental health professional qualified according to section 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To the best of your knowledge:

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

(a) If so, with which company?

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

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

(a) If so, please name the company.

(b) What kind of policy?

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

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

(b) Qualified Medicare Beneficiary (QMB), or

(c) full Medicaid Beneficiary?"

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

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

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

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

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

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

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

"NOTICE TO APPLICANT REGARDING REPLACEMENT

OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

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

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

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

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

..... Additional benefits

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

..... Fewer benefits and lower premiums

..... Other (please specify)

.....

.....

.....

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

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

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

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

.....

(Signature of Agent, Broker, or Other Representative)*

.....

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

.....

(Date)

.....

(Applicant's Signature)

.....

(Date)

*Signature not required for direct response sales."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) "mandated health benefit proposal" or "proposal" means a proposal that would statutorily require a health plan company to do the following:

(i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service;

(iii) provide coverage for care delivered by a specific type of provider;

(iv) require a particular benefit design or impose conditions on cost-sharing for:

(A) the treatment of a particular disease, condition, or other health care need;

(B) a particular type of health care treatment or service; or

(C) the provision of medical equipment, supplies, or a prescription drug used in connection with treating a particular disease, condition, or other health care need; or

(v) impose limits or conditions on a contract between a health plan company and a health care provider.

(b) "Mandated health benefit proposal" does not include health benefit proposals:

(1) amending the scope of practice of a licensed health care professional; or

(2) that make state law consistent with federal law.

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

Sec. 21. Minnesota Statutes 2022, section 62J.26, subdivision 2, is amended to read:

Subd. 2. **Evaluation process and content.** (a) The commissioner, in consultation with the commissioners of health and management and budget, must evaluate all mandated health benefit proposals as provided under subdivision 3.

(b) The purpose of the evaluation is to provide the legislature with a complete and timely analysis of all ramifications of any mandated health benefit proposal. The evaluation must include, in addition to other relevant information, the following to the extent applicable:

(1) scientific and medical information on the mandated health benefit proposal, on the potential for harm or benefit to the patient, and on the comparative benefit or harm from alternative forms of treatment, and must include the results of at least one professionally accepted and controlled trial comparing the medical consequences of the proposed therapy, alternative therapy, and no therapy;

(2) public health, economic, and fiscal impacts of the mandated health benefit proposal on persons receiving health services in Minnesota, on the relative cost-effectiveness of the proposal, and on the health care system in general;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner must annually report to the legislature defrayal amounts paid to health plan companies pursuant to Code of Federal Regulations, title 45, section 155.70. The report must compare the amounts paid to each health plan company to the estimated amount projected by each health plan company in its report pursuant to paragraph (a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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

(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.

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

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

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

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

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

(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;

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

(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;

(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);

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

(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

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

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

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

(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

(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.

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

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

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

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

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

(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;

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

(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;

(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);

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

(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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) seven voting members appointed by the governor;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) seven voting members appointed by the governor;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) two members representing patients and health care consumers;

(2) two members representing health care providers;

(3) one member representing health plan companies;

(4) two members representing employers, with one member representing large employers and one member representing small employers;

(5) one member representing government employee benefit plans;

(6) one member representing pharmaceutical manufacturers;

(7) one member who is a health services clinical researcher;

(8) one member who is a pharmacologist;

(9) one member representing the commissioner of health with expertise in health economics;

(10) one member representing pharmaceutical wholesalers;

(11) one member representing pharmacy benefit managers;

(12) one member from the Rare Disease Advisory Council;

(13) one member representing generic drug manufacturers;

(14) one member representing pharmaceutical distributors; and

(15) one member who is an oncologist who is not employed by, under contract with, or otherwise affiliated with a hospital.

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

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

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

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

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

(1) two members representing patients and health care consumers;

(2) two members representing health care providers;

(3) one member representing health plan companies;

(4) two members representing employers, with one member representing large employers and one member representing small employers;

(5) one member representing government employee benefit plans;

(6) one member representing pharmaceutical manufacturers;

(7) one member who is a health services clinical researcher;

(8) one member who is a pharmacologist;

(9) one member representing the commissioner of health with expertise in health economics;

(10) one member representing pharmaceutical wholesalers;

(11) one member representing pharmacy benefit managers;

(12) one member from the Rare Disease Advisory Council;

(13) one member representing generic drug manufacturers;

(14) one member representing pharmaceutical distributors; and

(15) one member who is an oncologist who is not employed by, under contract with, or otherwise affiliated with a hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) generic drugs for which:

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

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

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

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

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

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

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

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

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

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

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

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

(4) generic drugs for which the WAC:

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(ii) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds $30 for:

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

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

The board is not required to identify all prescription drug products that meet the criteria in this paragraph.

(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.

(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.

Subd. 3. **Determination to proceed with review.** (a) The board may initiate a cost review of a prescription drug product identified by the board under this section.

(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.

(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.

Sec. 20. **[62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.**

Subdivision 1. **General.** 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

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(i) is $100 or more, after adjusting for changes in the CPI, for:

(A) a 30-day supply;

(B) a course of treatment lasting less than 30 days; or

(C) one unit of the drug, if the labeling approved by the Food and Drug Administration does not recommend a finite dosage; and

(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.

The board is not required to identify all prescription drug products that meet the criteria in this paragraph.

(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.

(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.

Subd. 3. **Determination to proceed with review.** (a) The board may initiate a cost review of a prescription drug product identified by the board under this section.

(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.

(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.

Sec. 35. **[62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.**

Subdivision 1. **General.** 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

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

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

(1) the price at which the prescription drug product has been and will be sold in the state;

(2) manufacturer monetary price concessions, discounts, or rebates, and drug-specific patient assistance;

(3) the price of therapeutic alternatives;

(4) the cost to group purchasers based on patient access consistent with the FDA-labeled indications and standard medical practice;

(5) measures of patient access, including cost-sharing and other metrics;

(6) the extent to which the attorney general or a court has determined that a price increase for a generic or off-patent prescription drug product was excessive under sections 62J.842 and 62J.844;

(7) any information a manufacturer chooses to provide; and

(8) any other factors as determined by the board.

Subd. 3. **Public data; proprietary information.** (a) Any submission made to the board related to a drug cost review must be made available to the public with the exception of information determined by the board to be proprietary 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.

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

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

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

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

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

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

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

(1) the price at which the prescription drug product has been and will be sold in the state;

(2) manufacturer monetary price concessions, discounts, or rebates, and drug-specific patient assistance;

(3) the price of therapeutic alternatives;

(4) the cost to group purchasers based on patient access consistent with the FDA-labeled indications and standard medical practice;

(5) measures of patient access, including cost-sharing and other metrics;

(6) the extent to which the attorney general or a court has determined that a price increase for a generic or off-patent prescription drug product was excessive under sections 62J.842 and 62J.844;

(7) any information a manufacturer chooses to provide; and

(8) any other factors as determined by the board.

Subd. 3. **Public data; proprietary information.** (a) Any submission made to the board related to a drug cost review must be made available to the public with the exception of information determined by the board to be proprietary 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.

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

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

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

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

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

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

(1) extraordinary supply costs, if applicable;

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

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

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

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

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

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

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

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

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

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

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

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

(1) extraordinary supply costs, if applicable;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) provider-covered person ratios by specialty;

(2) primary care professional-covered person ratios;

(3) geographic accessibility of providers;

(4) geographic variation and population dispersion;

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

(6) hours of operation;

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

(i) low-income persons;

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

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

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

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

EFFECTIVE DATE. The amendment to paragraph (a) is effective July 1, 2023. Paragraph (b) is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

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

62Q.096 CREDENTIALING OF PROVIDERS.

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

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

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

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

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

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

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

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

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

(4) is accepting new patients; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) consists of 40 or fewer licensed beds;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) consists of 40 or fewer licensed beds;

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

(7) a hospital and affiliated specialty clinics that predominantly serve patients who are under 21 years of age and meet the following criteria:

(i) provide intensive specialty pediatric services that are routinely provided in fewer than five hospitals in the state; and

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

(8) a psychiatric residential treatment facility, as defined in section 256B.0625, subdivision 45a, paragraph (b), that is certified and licensed by the commissioner of health.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

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

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

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

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

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

(7) a hospital and affiliated specialty clinics that predominantly serve patients who are under 21 years of age and meet the following criteria:

(i) provide intensive specialty pediatric services that are routinely provided in fewer than five hospitals in the state; and

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

(8) a psychiatric residential treatment facility, as defined in section 256B.0625, subdivision 45a, paragraph (b), that is certified by the commissioner of health and licensed by the commissioner of human services.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

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

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

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

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

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

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

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

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

(6) screenings for human immunodeficiency virus for:

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

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

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

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

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

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

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

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

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

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

(6) screenings for human immunodeficiency virus for:

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

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

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

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

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

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

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

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

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

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

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).

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

(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:

(1) section 62Q.47;

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

(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;

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

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

(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.

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

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

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

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

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

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

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).

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

(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:

(1) section 62Q.47;

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

(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;

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

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

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

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.

(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.

(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:

(1) care directed by the primary care team;

(2) structured care management;

(3) regular assessments of clinical status using validated tools; and

(4) modification of treatment as appropriate.

~~(h)~~ (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:

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

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

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(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

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.

(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.

(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:

(1) care directed by the primary care team;

(2) structured care management;

(3) regular assessments of clinical status using validated tools; and

(4) modification of treatment as appropriate.

~~(h)~~ (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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) all attachments and exhibits;

(2) operating manuals;

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

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

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

(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.

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

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

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

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

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

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

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

(1) all attachments and exhibits;

(2) operating manuals;

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

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

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

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(3) the third party accessing the dental provider contract agrees to comply with all applicable terms of the dental provider contract.

(d) A dentist is not bound by and is not required to perform dental care services under a dental provider contract granted to a third party in violation of this section.

(e) This subdivision does not apply when:

(1) the dental provider contract is for dental services provided under a public health plan program, including but not limited to medical assistance, MinnesotaCare, Medicare, or Medicare Advantage; or

(2) access to a dental provider contract is granted to a dental organization, an entity operating in accordance with the same brand licensee program as the dental organization or other entity, or to an entity that is an affiliate of the dental organization, provided the entity agrees to substantially similar terms and conditions as the originating dental provider contract between the dental organization and the dentist or dental clinic. A list of the dental organization's affiliates must be posted on the dental organization's website.

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Sec. 32. Minnesota Statutes 2022, section 62Q.81, subdivision 4, is amended to read:

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

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

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

(8) prescription drugs;

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

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the EHB-benchmark plan, as defined under the Affordable Care Act, and preventive items and services, as defined under section 62Q.46, subdivision 1, paragraph (a).

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(3) the third party accessing the dental provider contract agrees to comply with all applicable terms of the dental provider contract.

(d) A dentist is not bound by and is not required to perform dental care services under a dental provider contract granted to a third party in violation of this section.

(e) This subdivision does not apply when:

(1) the dental provider contract is for dental services provided under a public health plan program, including but not limited to medical assistance, MinnesotaCare, Medicare, or Medicare Advantage; or

(2) access to a dental provider contract is granted to a dental organization, an entity operating in accordance with the same brand licensee program as the dental organization or other entity, or to an entity that is an affiliate of the dental organization, provided the entity agrees to substantially similar terms and conditions as the originating dental provider contract between the dental organization and the dentist or dental clinic. A list of the dental organization's affiliates must be posted on the dental organization's website.

Sec. 53. Minnesota Statutes 2022, section 62Q.81, subdivision 4, is amended to read:

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) laboratory services;

(5) maternity and newborn care;

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

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

(8) prescription drugs;

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

(10) rehabilitative and habilitative services and devices; and

(11) additional essential health benefits included in the EHB-benchmark plan, as defined under the Affordable Care Act, and preventive items and services, as defined under section 62Q.46, subdivision 1, paragraph (a).

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Sec. 33. Minnesota Statutes 2022, section 62Q.81, is amended by adding a subdivision to read:

Subd. 7. **Standard plans.** (a) A health plan company that offers individual health plans must ensure that no less than one individual health plan at each level of coverage described in subdivision 1, paragraph (b), clause (3), that the health plan company offers in each geographic rating area the health plan company serves, conforms to the standard plan parameters determined by the commissioner under paragraph (e).

(b) An individual health plan offered under this subdivision must be:

(1) clearly and appropriately labeled as standard plans to aid the purchaser in the selection process;

(2) marketed as standard plans and in the same manner as other individual health plans offered by the health plan company; and

(3) offered for purchase to any individual.

(c) This subdivision does not apply to catastrophic plans, grandfathered plans, small group health plans, large group health plans, health savings accounts, qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(d) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

(e) The commissioner of commerce, in consultation with the commissioner of health, must annually determine standard plan parameters, including but not limited to cost-sharing structure and covered benefits, that comprise a standard plan in Minnesota.

(f) Notwithstanding section 62A.65, subdivision 2, a health plan company may discontinue offering a health plan under this subdivision if, three years after the date the plan is initially offered, the plan has fewer than 75 enrollees enrolled in the plan. A health plan company discontinuing a plan under this paragraph must only discontinue the health plan that has fewer than 75 enrollees and:

(1) provide notice of the plan's discontinuation in writing, in a form prescribed by the commissioner, to each individual enrolled in the plan at least 90 calendar days before the date the coverage is discontinued;

(2) offer on a guaranteed issue basis to each individual enrolled the option to purchase an individual health plan currently being offered by the health plan company for individuals in that geographic rating area. An enrollee who does not select an option must be automatically enrolled in the individual health plan closest in actuarial value to the enrollee's current plan; and

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Sec. 54. Minnesota Statutes 2022, section 62Q.81, is amended by adding a subdivision to read:

Subd. 7. **Standard plans.** (a) A health plan company that offers individual health plans must ensure that no less than one individual health plan at each level of coverage described in subdivision 1, paragraph (b), clause (3), that the health plan company offers in each geographic rating area the health plan company serves conforms to the standard plan parameters determined by the commissioner under paragraph (e).

(b) An individual health plan offered under this subdivision must be:

(1) clearly and appropriately labeled as standard plans to aid the purchaser in the selection process;

(2) marketed as standard plans and in the same manner as other individual health plans offered by the health plan company; and

(3) offered for purchase to any individual.

(c) This subdivision does not apply to catastrophic plans, grandfathered plans, small group health plans, large group health plans, health savings accounts, qualified high deductible health benefit plans, limited health benefit plans, or short-term limited-duration health insurance policies.

(d) Health plan companies must meet the requirements in this subdivision separately for plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

(e) The commissioner of commerce, in consultation with the commissioner of health, must annually determine standard plan parameters, including but not limited to cost-sharing structure and covered benefits, that comprise a standard plan in Minnesota.

(f) Notwithstanding section 62A.65, subdivision 2, a health plan company may discontinue offering a health plan under this subdivision if, three years after the date the plan is initially offered, the plan has fewer than 75 enrollees. A health plan company discontinuing a health plan under this paragraph may discontinue a health plan that has fewer than 75 enrollees if it:

(1) provides notice of the plan's discontinuation in writing, in a form prescribed by the commissioner, to each enrollee of the plan at least 90 calendar days before the date the coverage is discontinued;

(2) offers on a guaranteed issue basis to each enrollee the option to purchase an individual health plan currently being offered by the health plan company for individuals in that geographic rating area. An enrollee who does not select an option shall be automatically enrolled in the individual health plan closest in actuarial value to the enrollee's current plan; and

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(3) act uniformly without regard to any health status-related factor of enrolled individuals or dependents of enrolled individuals who may become eligible for coverage.

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

Sec. 34. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

Subdivision 1. **Definition.** (a) For purposes of this section, the following definition applies.

(b) "Clinician-administered drug" means an outpatient prescription drug other than a vaccine that:

(1) cannot reasonably be self-administered by the enrollee to whom the drug is prescribed or by an individual assisting the enrollee with self-administration; and

(2) is typically administered:

(i) by a health care provider authorized to administer the drug, including when acting under a physician's delegation and supervision; and

(ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

Subd. 2. **Safety and care requirements for clinician-administered drugs.** (a) A specialty pharmacy that ships a clinician-administered drug to a health care provider or pharmacy must:

(1) comply with all federal laws regulating the shipment of drugs, including but not limited to the U.S. Pharmacopeia General Chapter 800;

(2) in response to questions from a health care provider or pharmacy, provide access to a pharmacist or nurse employed by the specialty pharmacy 24 hours a day, 7 days a week;

(3) allow an enrollee and health care provider to request a refill of a clinician-administered drug on behalf of an enrollee, in accordance with the pharmacy benefit manager or health carrier's utilization review procedures; and

(4) adhere to the track and trace requirements, as defined by the federal Drug Supply Chain Security Act, United States Code, title 21, section 360eee, et seq., for a clinician-administered drug that needs to be compounded or manipulated.

(b) For any clinician-administered drug dispensed by a specialty pharmacy selected by the pharmacy benefit manager or health carrier, the requesting health care provider or their designee must provide the requested date, approximate time, and place of delivery of a

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(3) acts uniformly without regard to any health status-related factor of an enrollee or an enrollee's dependents who may become eligible for coverage.

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

Sec. 55. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

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

(b) "Affiliated pharmacy" means a pharmacy in which a pharmacy benefit manager or health carrier has an ownership interest either directly or indirectly, or through an affiliate or subsidiary.

(c) "Clinician-administered drug" means an outpatient prescription drug, other than a vaccine, that:

(1) cannot reasonably be self-administered by the patient to whom the drug is prescribed or by an individual assisting the patient with self-administration; and

(2) is typically administered:

(i) by a health care provider authorized to administer the drug, including when acting under a physician's delegation and supervision; and

(ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

Subd. 2. **Safety and care requirements for clinician-administered drugs.** (a) A specialty pharmacy that ships a clinician-administered drug to a health care provider or pharmacy must:

(1) comply with all federal laws regulating the shipment of drugs, including but not limited to the United States Pharmacopeia General Chapter 800;

(2) in response to questions from a health care provider or pharmacy, provide access to a pharmacist or nurse employed by the specialty pharmacy 24 hours a day, seven days a week;

(3) allow an enrollee and health care provider to request a refill of a clinician-administered drug on behalf of an enrollee, in accordance with the pharmacy benefit manager or health carrier's utilization review procedures; and

(4) adhere to the track and trace requirements, as defined in the Drug Supply Chain Security Act, United States Code, title 21, section 360eee, et seq., for a clinician-administered drug that needs to be compounded or manipulated.

(b) For any clinician-administered drug dispensed by a specialty pharmacy selected by the pharmacy benefit manager or health carrier, the requesting health care provider or their designee must provide the requested date, approximate time, and place of delivery of a

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clinician-administered drug at least five business days before the date of delivery. The specialty pharmacy must require a signature upon receipt of the shipment when shipped to a health care provider.

(c) A pharmacy benefit manager or health carrier who requires dispensing of a clinician-administered drug through a specialty pharmacy shall establish and disclose a process which allows the health care provider or pharmacy to appeal and have exceptions to the use of a specialty pharmacy when:

(1) a drug is not delivered as specified in paragraph (b); or

(2) an attending health care provider reasonably believes an enrollee may experience immediate and irreparable harm without the immediate, onetime use of clinician-administered drug that a health care provider or pharmacy has in stock.

(d) A pharmacy benefit manager or health carrier shall not require a specialty pharmacy to dispense a clinician-administered drug directly to an enrollee with the intention that the enrollee will transport the clinician-administered drug to a health care provider for administration.

(e) A pharmacy benefit manager, health carrier, health care provider, or pharmacist shall not require and may not deny the use of a home infusion or infusion site external to the enrollee's provider office or clinic to dispense or administer a clinician-administered drug when requested by an enrollee and such services are covered by the health plan and are available and clinically appropriate as determined by the health care provider and delivered in accordance with state law.

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

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Sec. 17. **[65A.298] HOMEOWNER'S INSURANCE; FORTIFIED PROGRAM STANDARDS.**

Subdivision 1. **Definitions.** (a) For purposes of this section the following term has the meaning given.

(b) "Insurable property" means a residential property designated as meeting the Fortified program standards as administered by the Insurance Institute for Business and Home Safety (IBHS).

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clinician-administered drug at least five business days before the date of delivery. The specialty pharmacy must require a signature upon receipt of the shipment when shipped to a health care provider.

(c) A pharmacy benefit manager or health carrier who requires dispensing of a clinician-administered drug through a specialty pharmacy shall establish and disclose a process that allows the health care provider or pharmacy to appeal and have exceptions to the use of a specialty pharmacy when:

(1) a drug is not delivered as specified in paragraph (b); or

(2) an attending health care provider reasonably believes an enrollee may experience immediate and irreparable harm without the immediate, onetime use of a clinician-administered drug that a health care provider or pharmacy has in stock.

(d) A pharmacy benefit manager or health carrier shall not require a specialty pharmacy to dispense a clinician-administered drug directly to an enrollee with the intention that the enrollee will transport the clinician-administered drug to a health care provider for administration.

(e) A pharmacy benefit manager, health carrier, health care provider, or pharmacist shall not require or may not deny the use of a home infusion or infusion site external to the enrollee's provider office or clinic to dispense or administer a clinician-administered drug when requested by an enrollee, and such services are covered by the health plan and are available and clinically appropriate as determined by the health care provider and delivered in accordance with state law.

Subd. 3. **Exclusions.** This section 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.

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

Sec. 56. **[65A.298] HOMEOWNER'S INSURANCE; FORTIFIED PROGRAM STANDARDS.**

Subdivision 1. **Definitions.** (a) For purposes of this section the following term has the meaning given.

(b) "Insurable property" means a residential property designated as meeting Fortified program standards that include a hail supplement as administered by the Insurance Institute for Business and Home Safety (IBHS).

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Subd. 2. **Fortified new property.** (a) An insurer shall provide a premium discount or an insurance rate reduction to an owner who builds or locates a new insurable property in Minnesota.

(b) An owner of insurable property claiming a premium discount or rate reduction under this subdivision must submit a certificate issued by IBHS showing proof of compliance with the Fortified program standards to the insurer prior to receiving the premium discount or rate reduction.

Subd. 3. **Fortified existing property.** (a) An insurer shall provide a premium discount or insurance rate reduction to an owner who retrofits an existing property to meet the requirements to be an insurable property in Minnesota.

(b) An owner of insurable property claiming a premium discount or rate reduction under this subdivision must submit a certificate issued by IBHS showing proof of compliance with the Fortified program standards to the insurer prior to receiving the premium discount or rate reduction.

Subd. 4. **Insurers.** (a) An insurer must submit to the commissioner actuarially justified rates and a rating plan for a person who builds or locates a new insurable property in Minnesota.

(b) An insurer must submit to the commissioner actuarially justified rates and a rating plan for a person who retrofits an existing property to meet the requirements to be an insurable property.

(c) An insurer may offer, in addition to the premium discount and insurance rate reductions required under subdivisions 2 and 3, more generous mitigation adjustments to an owner of insurable property.

(d) Any premium discount, rate reduction, or mitigation adjustment offered by an insurer under this section applies only to policies that include wind coverage and may be applied only to the portion of the premium for wind coverage, or for the total premium if the insurer does not separate the premium for wind coverage in its rate filing.

(e) A rate and rating plan submitted to the commissioner under this section shall not be used until the expiration of 60 days after it has been filed unless the commissioner approves it before that time. In evaluating insurer submissions under this section prior to approval for use, the commissioner must:

(1) evaluate evidence of cost savings directly attributed to the Fortified program standards administered by IBHS; and

(2) evaluate whether those cost savings are passed along in full to qualified policyholders.

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Subd. 2. **Fortified new property.** (a) An insurer must provide a premium discount or an insurance rate reduction to an owner who builds or locates a new insurable property in Minnesota.

(b) An owner of insurable property claiming a premium discount or rate reduction under this subdivision must submit and maintain a certificate issued by IBHS showing proof of compliance with the Fortified program standards to the insurer prior to receiving the premium discount or rate reduction. At the time of policy renewal an insurer may require evidence that the issued certificate remains in good standing.

Subd. 3. **Fortified existing property.** (a) An insurer must provide a premium discount or insurance rate reduction to an owner who retrofits an existing property to meet the requirements to be an insurable property in Minnesota.

(b) An owner of insurable property claiming a premium discount or rate reduction under this subdivision must submit a certificate issued by IBHS showing proof of compliance with the Fortified program standards to the insurer prior to receiving the premium discount or rate reduction.

Subd. 4. **Insurers.** (a) A participating insurer must submit to the commissioner actuarially justified rates and a rating plan for a person who builds or locates a new insurable property in Minnesota.

(b) A participating insurer must submit to the commissioner actuarially justified rates and a rating plan for a person who retrofits an existing property to meet the requirements to be an insurable property.

(c) A participating insurer may offer, in addition to the premium discount and insurance rate reductions required under subdivisions 2 and 3, more generous mitigation adjustments to an owner of insurable property.

(d) Any premium discount, rate reduction, or mitigation adjustment offered by an insurer under this section applies only to policies that include wind coverage and may be applied to: (1) only the portion of the premium for wind coverage; or (2) the total premium, if the insurer does not separate the premium for wind coverage in the insurer's rate filing.

(e) A rate and rating plan submitted to the commissioner under this section must not be used until 60 days after the rate and rating plan has been filed with the commissioner, unless the commissioner approves the rate and rating plan before that time. A rating plan, rating classification, and territories applicable to insurance written by a participating insurer and any related statistics are subject to chapter 70A. When the commissioner is evaluating rate and rating plans submitted under this section, the commissioner must evaluate:

(i) evidence of cost savings directly attributable to the Fortified program standards as administered by IBHS; and

(ii) whether the cost savings are passed along in full to qualified policyholders.

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(f) Insurers must resubmit rates and rating plans at least every five years following their initial submissions under this section for review and approval by the commissioner.

(g) The commissioner shall annually publish the premium savings policyholders experienced because of the program.

(h) Participating insurers shall provide to the commissioner any information requested by the commissioner for the purposes of this paragraph.

Sec. 18. **[65A.299] STRENGTHEN MINNESOTA HOMES PROGRAM.**

Subdivision 1. **Short title.** This section may be cited as the "Strengthen Minnesota Homes Act."

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

(b) "Insurable property" has the meaning given in section 65A.298, subdivision 3.

(c) "Program" means the Strengthen Minnesota Homes program established under this section.

Subd. 3. **Program established; purpose, permitted activities.** The Strengthen Minnesota Homes program is established within the Department of Commerce. The purpose of the program is to provide grants to retrofit insurable property to resist loss due to common perils, including but not limited to tornadoes or other catastrophic windstorm events.

Subd. 4. **Strengthen Minnesota homes account; appropriation.** (a) A strengthen Minnesota homes account is created as a separate account in the special revenue fund of the state treasury. The account consists of money provided by law and any other money donated, allotted, transferred, or otherwise provided to the account. Earnings, including interest, dividends, and any other earnings arising from assets of the account, must be credited to the account. Money remaining in the account at the end of a fiscal year does not cancel to the general fund and remains in the account until expended. The commissioner must manage the account.

(b) Money in the account is appropriated to the commissioner to pay for (1) grants issued under the program, and (2) the reasonable costs incurred by the commissioner to administer the program.

Subd. 5. **Use of grants.** (a) A grant under this section must be used to retrofit an insurable property.

(b) Grant money provided under this section must not be used for maintenance or repairs, but may be used in conjunction with repairs or reconstruction necessitated by damage from wind or hail.

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(f) A participating insurer must resubmit a rate and rating plan at least once every five years following the initial submission under this section.

(g) The commissioner may annually publish the premium savings that policyholders experience pursuant to this section.

(h) An insurer must provide the commissioner with all requested information necessary for the commissioner to meet the requirements of this subdivision.

Sec. 57. **[65A.299] STRENGTHEN MINNESOTA HOMES PROGRAM.**

Subdivision 1. **Short title.** This section may be cited as the "Strengthen Minnesota Homes Act."

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

(b) "Insurable property" has the meaning given in section 65A.298, subdivision 1.

(c) "Program" means the Strengthen Minnesota Homes program established under this section.

Subd. 3. **Program established; purpose, permitted activities.** The Strengthen Minnesota Homes program is established within the Department of Commerce. The purpose of the program is to provide grants to retrofit insurable property to resist loss due to common perils, including but not limited to tornadoes or other catastrophic windstorm events.

Subd. 4. **Strengthen Minnesota homes account; appropriation.** (a) A strengthen Minnesota homes account is created as a separate account in the special revenue fund of the state treasury. The account consists of money provided by law and any other money donated, allotted, transferred, or otherwise provided to the account. Earnings, including interest, dividends, and any other earnings arising from assets of the account, must be credited to the account. Money remaining in the account at the end of a fiscal year does not cancel to the general fund and remains in the account until expended. The commissioner must manage the account.

(b) Money in the account is appropriated to the commissioner to pay for (1) grants issued under the program, and (2) the reasonable costs incurred by the commissioner to administer the program.

Subd. 5. **Use of grants.** (a) A grant under this section must be used to retrofit an insurable property.

(b) Grant money provided under this section must not be used for maintenance or repairs, but may be used in conjunction with repairs or reconstruction necessitated by damage from wind or hail.

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(c) A project funded by a grant under this section must be completed within three months of the date the grant is approved. Failure to complete the project in a timely manner may result in forfeiture of the grant.

Subd. 6. **Applicant eligibility.** The commissioner must develop (1) administrative procedures to implement this section, and (2) criteria used to determine whether an applicant is eligible for a grant under this section.

Subd. 7. **Contractor eligibility; conflicts of interest.** (a) To be eligible to work as a contractor on a projected funded by a grant under this section, the contractor must meet all of the following program requirements and must maintain a current copy of all certificates, licenses, and proof of insurance coverage with the program office. The eligible contractor must:

(1) hold a valid residential building contractor and residential remodeler license issued by the commissioner of labor and industry;

(2) not be subject to disciplinary action by the commissioner of labor and industry;

(3) hold any other valid state or jurisdictional business license or work permits required by law;

(4) possess an in-force general liability policy with $1,000,000 in liability coverage;

(5) possess an in-force workers compensation policy with $1,000,000 in coverage;

(6) possess a certificate of compliance from the commissioner of revenue;

(7) successfully complete the Fortified Roof for High Wind and Hail training provided by the IBHS and maintain an active certification or IBHS's successor and provide a certificate of successful completion. The training may be offered as separate courses;

(8) agree to the terms and successfully register as a vendor with the commissioner of management and budget and receive direct deposit of payment for mitigation work performed under the program;

(9) maintain Internet access and keep a valid email address on file with the program and remain active in the commissioner of management and budget's vendor and supplier portal while working on the program;

(10) maintain an active email address for the communication with the program;

(11) successfully complete the program training; and

(12) agree to follow program procedures and rules established under this section and by the commissioner.

(b) An eligible contractor must not have a financial interest, other than payment on behalf of the homeowner, in any project for which the eligible contractor performs work toward a fortified designation under the program. An eligible contractor is prohibited from

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(c) A project funded by a grant under this section must be completed within three months of the date the grant is approved. Failure to complete the project in a timely manner may result in forfeiture of the grant.

Subd. 6. **Applicant eligibility.** The commissioner must develop (1) administrative procedures to implement this section, and (2) criteria used to determine whether an applicant is eligible for a grant under this section.

Subd. 7. **Contractor eligibility; conflicts of interest.** (a) To be eligible to work as a contractor on a projected funded by a grant under this section, the contractor must meet all of the following program requirements and must maintain a current copy of all certificates, licenses, and proof of insurance coverage with the program office. The eligible contractor must:

(1) hold a valid residential building contractor and residential remodeler license issued by the commissioner of labor and industry;

(2) not be subject to disciplinary action by the commissioner of labor and industry;

(3) hold any other valid state or jurisdictional business license or work permits required by law;

(4) possess an in-force general liability policy with $1,000,000 in liability coverage;

(5) possess an in-force workers compensation policy;

(6) possess a certificate of compliance from the commissioner of revenue;

(7) successfully complete the Fortified Roof for High Wind and Hail training provided by the IBHS and maintain an active certification. The training may be offered as separate courses;

(8) agree to the terms and successfully register as a vendor with the commissioner of management and budget and receive direct deposit of payment for mitigation work performed under the program;

(9) maintain Internet access and keep a valid email address on file with the program and remain active in the commissioner of management and budget's vendor and supplier portal while working on the program;

(10) maintain an active email address for the communication with the program;

(11) successfully complete the program training; and

(12) agree to follow program procedures and rules established under this section and by the commissioner.

(b) An eligible contractor must not have a financial interest, other than payment on behalf of the homeowner, in any project for which the eligible contractor performs work toward a fortified designation under the program. An eligible contractor is prohibited from

acting as the evaluator for a fortified designation on any project funded by the program. An eligible contractor must report to the commissioner regarding any potential conflict of interest before work commences on any job funded by the program.

Subd. 8. **Evaluator eligibility; conflicts of interest.** (a) To be eligible to work on the program as an evaluator, the evaluator must meet all program eligibility requirements and must submit to the commissioner and maintain a copy of all current certificates and licenses. The evaluator must:

(1) be in good standing with IBHS and maintain an active certification as a fortified home evaluator for hurricane and high wind and hail or a successor certification;

(2) possess a Minnesota business license and be registered with the secretary of state; and

(3) successfully complete the program training.

(b) Evaluators must not have a financial interest in any project that the evaluator inspects for designation purposes for the program. An evaluator must not be an eligible contractor or supplier of any material, product, or system installed in any home that the evaluator inspects for designation purposes for the program. An evaluator must not be a sales agent for any home being designated for the program. An evaluator must inform the commissioner of any potential conflict of interest impacting the evaluator's participation in the program.

Subd. 9. **Grant approval; allocation.** (a) The commissioner must review all applications for completeness and must perform appropriate audits to verify (1) the accuracy of the information on the application, and (2) that the applicant meets all eligibility rules. All verified applicants must be placed in the order the application was received. Grants must be awarded on a first-come, first-served basis, subject to availability of money for the program.

(b) When a grant is approved, an approval letter must be sent to the applicant.

(c) An eligible contractor is prohibited from beginning work until a grant is approved.

(d) In order to assure equitable distribution of grants in proportion to the income demographics in counties where the program is made available, grant applications must be accepted on a first-come, first-served basis. The commissioner may establish pilot projects as needed to establish a sustainable program distribution system in any geographic area within Minnesota.

Subd. 10. **Grant award process; release of grant money.** (a) After a grant application is approved, the eligible contractor selected by the homeowner may begin the mitigation work.

acting as the evaluator for a fortified designation on any project funded by the program. An eligible contractor must report to the commissioner regarding any potential conflict of interest before work commences on any job funded by the program.

Subd. 8. **Evaluator eligibility; conflicts of interest.** (a) To be eligible to work on the program as an evaluator, the evaluator must meet all program eligibility requirements and must submit to the commissioner and maintain a copy of all current certificates and licenses. The evaluator must:

(1) be in good standing with IBHS and maintain an active certification as a fortified home evaluator for high wind and hail or a successor certification;

(2) possess a Minnesota business license and be registered with the secretary of state; and

(3) successfully complete the program training.

(b) An evaluator must not have a financial interest in any project that the evaluator inspects for designation purposes for the program. An evaluator must not be an eligible contractor or supplier of any material, product, or system installed in any home that the evaluator inspects for designation purposes for the program. An evaluator must not be a sales agent for any home being designated for the program. An evaluator must inform the commissioner of any potential conflict of interest impacting the evaluator's participation in the program.

Subd. 9. **Grant approval; allocation.** (a) The commissioner must review all applications for completeness and must perform appropriate audits to verify (1) the accuracy of the information on the application, and (2) that the applicant meets all eligibility rules. All verified applicants must be placed in the order the application was received. Grants must be awarded on a first-come, first-served basis, subject to availability of money for the program.

(b) When a grant is approved, an approval letter must be sent to the applicant.

(c) An eligible contractor is prohibited from beginning work until a grant is approved.

(d) In order to assure equitable distribution of grants in proportion to the income demographics in counties where the program is made available, grant applications must be accepted on a first-come, first-served basis. The commissioner may establish pilot projects as needed to establish a sustainable program distribution system in any geographic area within Minnesota.

Subd. 10. **Grant award process; release of grant money.** (a) After a grant application is approved, the eligible contractor selected by the homeowner may begin the mitigation work.

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(b) Once the mitigation work is completed, the eligible contractor must submit a copy of the signed contract to the commissioner, along with an invoice seeking payment and an affidavit stating the fortified standards were met by the work.

(c) The IBHS evaluator must conduct all required evaluations, including a required interim inspection during construction and the final inspection, and must confirm that the work was completed according to the mitigation specifications.

(d) Grant money must be released on behalf of an approved applicant only after a fortified designation certificate has been issued for the home. The program or another designated entity must, on behalf of the homeowner, directly pay the eligible contractor that performed the mitigation work. The program or the program's designated entity must pay the eligible contractor the costs covered by the grant. The homeowner must pay the eligible contractor for the remaining cost after receiving an IBHS fortified certificate.

(e) The program must confirm that the homeowner's insurer provides the appropriate premium credit.

(f) The program must conduct random reinspections to detect any fraud and must submit any irregularities to the attorney general.

Subd. 11. **Limitations.** (a) This section does not create an entitlement for property owners or obligate the state of Minnesota to pay for residential property in Minnesota to be inspected or retrofitted. The program under this section is subject to legislative appropriations, the receipt of federal grants or money, or the receipt of other sources of grants or money. The department may obtain grants or other money from the federal government or other funding sources to support and enhance program activities.

(b) All mitigation under this section is contingent upon securing all required local permits and applicable inspections to comply with local building codes and applicable Fortified program standards. A mitigation project receiving a grant under this section is subject to random reinspection at a later date.

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(b) Once the mitigation work is completed, the eligible contractor must submit a copy of the signed contract to the commissioner, along with an invoice seeking payment and an affidavit stating the fortified standards were met by the work.

(c) The IBHS evaluator must conduct all required evaluations, including a required interim inspection during construction and the final inspection, and must confirm that the work was completed according to the mitigation specifications.

(d) Grant money must be released on behalf of an approved applicant only after a fortified designation certificate has been issued for the home. The program or another designated entity must, on behalf of the homeowner, directly pay the eligible contractor that performed the mitigation work. The program or the program's designated entity must pay the eligible contractor the costs covered by the grant. The homeowner must pay the eligible contractor for the remaining cost after receiving an IBHS fortified certificate.

(e) The program must confirm that the homeowner's insurer provides the appropriate premium discount.

(f) The program must conduct random reinspections to detect any fraud and must submit any irregularities to the attorney general.

Subd. 11. **Limitations.** (a) This section does not create an entitlement for property owners or obligate the state of Minnesota to pay for residential property in Minnesota to be inspected or retrofitted. The program under this section is subject to legislative appropriations, the receipt of federal grants or money, or the receipt of other sources of grants or money. The department may obtain grants or other money from the federal government or other funding sources to support and enhance program activities.

(b) All mitigation under this section is contingent upon securing all required local permits and applicable inspections to comply with local building codes and applicable Fortified program standards. A mitigation project receiving a grant under this section is subject to random reinspection at a later date.

Sec. 58. **[65A.303] HOMEOWNER'S LIABILITY INSURANCE; DOGS.**

Subdivision 1. **Discrimination prohibited.** An insurer writing homeowner's insurance for property is prohibited from (1) refusing to issue or renew an insurance policy or contract, or (2) canceling an insurance policy or contract based solely on the fact that the homeowner harbors or owns one dog of a specific breed or mixture of breeds.

Subd. 2. **Exception.** (a) Subdivision 1 does not prohibit an insurer from (1) refusing to issue or renew an insurance policy or contract, (2) canceling an insurance policy or contract, or (3) imposing a reasonably increased premium or rate for an insurance policy or contract based on a dog meeting the criteria of a dangerous dog or potentially dangerous dog under section 347.50, or based on sound underwriting and actuarial principles that are reasonably related to actual or anticipated loss experience.

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Sec. 19. Minnesota Statutes 2022, section 65B.49, is amended by adding a subdivision to read:

Subd. 10. **Time limitations.** (a) Unless expressly provided for in this chapter, a plan of reparation security must conform to the six-year time limitation provided under section 541.05, subdivision 1, clause (1).

(b) The time limitation for commencing a cause of action relating to underinsured motorist coverage under subdivision 3a is four years from the date of accrual.

EFFECTIVE DATE. This section is effective on August 1, 2023, and applies to contracts issued or renewed on or after that date.

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Sec. 35. Minnesota Statutes 2022, section 151.071, subdivision 1, is amended to read:

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice to designated settings; the limitation of the scope of practice within designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, except that a civil penalty not exceeding $25,000 may be imposed for each separate violation of section 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant

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(b) Subdivision 1 does not prohibit an insurer from (1) refusing to issue or renew an insurance policy or contract, (2) canceling an insurance policy or contract, or (3) imposing a reasonably increased premium or rate for an insurance policy or contract if the dog has a history of causing bodily injury or if the dog owner has a history of owning other animals who caused bodily injury.

EFFECTIVE DATE. This section is effective April 1, 2024, and applies to insurance policies and contracts offered, issued, or sold after that date.

Sec. 59. Minnesota Statutes 2022, section 65B.49, is amended by adding a subdivision to read:

Subd. 10. **Time limitations.** (a) Unless expressly provided for in this chapter, a plan of reparation security must conform to the six-year time limitation provided under section 541.05, subdivision 1, clause (1).

(b) The time limitation for commencing a cause of action relating to underinsured motorist coverage under subdivision 3a is four years from the date of accrual.

EFFECTIVE DATE. This section is effective August 1, 2023, and applies to contracts issued or renewed on or after that date.

Sec. 60. Minnesota Statutes 2022, section 151.071, subdivision 1, is amended to read:

Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee, registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do one or more of the following:

(1) deny the issuance of a license or registration;

(2) refuse to renew a license or registration;

(3) revoke the license or registration;

(4) suspend the license or registration;

(5) impose limitations, conditions, or both on the license or registration, including but not limited to: the limitation of practice to designated settings; the limitation of the scope of practice within designated settings; the imposition of retraining or rehabilitation requirements; the requirement of practice under supervision; the requirement of participation in a diversion program such as that established pursuant to section 214.31 or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination or other review of skill and competence;

(6) impose a civil penalty not exceeding $10,000 for each separate violation, except that a civil penalty not exceeding $25,000 may be imposed for each separate violation of section 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant

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of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Sec. 36. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

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of any economic advantage gained by reason of the violation, to discourage similar violations by the licensee or registrant or any other licensee or registrant, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to, fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members; and

(7) reprimand the licensee or registrant.

Sec. 61. Minnesota Statutes 2022, section 151.071, subdivision 2, is amended to read:

Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license or registration contained in this chapter or the rules of the board. The burden of proof is on the applicant to demonstrate such qualifications or satisfaction of such requirements;

(2) obtaining a license by fraud or by misleading the board in any way during the application process or obtaining a license by cheating, or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or (iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf;

(3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration, conviction of a felony reasonably related to the practice of pharmacy. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered thereon. The board may delay the issuance of a new license or registration if the applicant has been charged with a felony until the matter has been adjudicated;

(4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner or applicant is convicted of a felony reasonably related to the operation of the facility. The board may delay the issuance of a new license or registration if the owner or applicant has been charged with a felony until the matter has been adjudicated;

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(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to

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(5) for a controlled substance researcher, conviction of a felony reasonably related to controlled substances or to the practice of the researcher's profession. The board may delay the issuance of a registration if the applicant has been charged with a felony until the matter has been adjudicated;

(6) disciplinary action taken by another state or by one of this state's health licensing agencies:

(i) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration in another state or jurisdiction, failure to report to the board that charges or allegations regarding the person's license or registration have been brought in another state or jurisdiction, or having been refused a license or registration by any other state or jurisdiction. The board may delay the issuance of a new license or registration if an investigation or disciplinary action is pending in another state or jurisdiction until the investigation or action has been dismissed or otherwise resolved; and

(ii) revocation, suspension, restriction, limitation, or other disciplinary action against a license or registration issued by another of this state's health licensing agencies, failure to report to the board that charges regarding the person's license or registration have been brought by another of this state's health licensing agencies, or having been refused a license or registration by another of this state's health licensing agencies. The board may delay the issuance of a new license or registration if a disciplinary action is pending before another of this state's health licensing agencies until the action has been dismissed or otherwise resolved;

(7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of any order of the board, of any of the provisions of this chapter or any rules of the board or violation of any federal, state, or local law or rule reasonably pertaining to the practice of pharmacy;

(8) for a facility, other than a pharmacy, licensed by the board, violations of any order of the board, of any of the provisions of this chapter or the rules of the board or violation of any federal, state, or local law relating to the operation of the facility;

(9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient; or pharmacy practice that is professionally incompetent, in that it may create unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of actual injury need not be established;

(10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy technician or pharmacist intern if that person is performing duties allowed by this chapter or the rules of the board;

(11) for an individual licensed or registered by the board, adjudication as mentally ill or developmentally disabled, or as a chemically dependent person, a person dangerous to

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the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas dispenser, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy

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the public, a sexually dangerous person, or a person who has a sexual psychopathic personality, by a court of competent jurisdiction, within or without this state. Such adjudication shall automatically suspend a license for the duration thereof unless the board orders otherwise;

(12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist intern or performing duties specifically reserved for pharmacists under this chapter or the rules of the board;

(13) for a pharmacy, operation of the pharmacy without a pharmacist present and on duty except as allowed by a variance approved by the board;

(14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. In the case of registered pharmacy technicians, pharmacist interns, or controlled substance researchers, the inability to carry out duties allowed under this chapter or the rules of the board with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills;

(15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas dispenser, or controlled substance researcher, revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law;

(16) for a pharmacist or pharmacy, improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(17) fee splitting, including without limitation:

(i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

(ii) referring a patient to any health care provider as defined in sections 144.291 to 144.298 in which the licensee or registrant has a financial or economic interest as defined in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the licensee's or registrant's financial or economic interest in accordance with section 144.6521; and

(iii) any arrangement through which a pharmacy, in which the prescribing practitioner does not have a significant ownership interest, fills a prescription drug order and the prescribing practitioner is involved in any manner, directly or indirectly, in setting the price for the filled prescription that is charged to the patient, the patient's insurer or pharmacy

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benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board must investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program~~.~~; and

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benefit manager, or other person paying for the prescription or, in the case of veterinary patients, the price for the filled prescription that is charged to the client or other person paying for the prescription, except that a veterinarian and a pharmacy may enter into such an arrangement provided that the client or other person paying for the prescription is notified, in writing and with each prescription dispensed, about the arrangement, unless such arrangement involves pharmacy services provided for livestock, poultry, and agricultural production systems, in which case client notification would not be required;

(18) engaging in abusive or fraudulent billing practices, including violations of the federal Medicare and Medicaid laws or state medical assistance laws or rules;

(19) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(20) failure to make reports as required by section 151.072 or to cooperate with an investigation of the board as required by section 151.074;

(21) knowingly providing false or misleading information that is directly related to the care of a patient unless done for an accepted therapeutic purpose such as the dispensing and administration of a placebo;

(22) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board must investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For a pharmacist intern, pharmacy technician, or controlled substance researcher, performing duties permitted to such individuals by this chapter or the rules of the board under a lapsed or nonrenewed registration. For a facility required to be licensed under this chapter, operation of the facility under a lapsed or nonrenewed license or registration; ~~and~~

(24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge from the health professionals services program for reasons other than the satisfactory completion of the program~~.~~; and

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(25) for a manufacturer, a violation of section 62J.842 or 62J.845.

Sec. 37. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients~~, effective for services provided on or after September 1, 2011~~:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; ~~and~~

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9~~.~~; and

(6) cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

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(25) for a manufacturer, a violation of section 62J.842 or 62J.845.

Sec. 62. Minnesota Statutes 2022, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients~~, effective for services provided on or after September 1, 2011~~:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; ~~and~~

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9~~.~~; and

(6) cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

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(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

EFFECTIVE DATE. This section is effective January 1, 2024.

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(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 63. Minnesota Statutes 2022, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) The commissioner shall withhold five 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 pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) The commissioner shall require that managed care plans:

(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~~

(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

(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.

(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.

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.

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 withholds that may be returned to the hospitals if the performance target is achieved.

(f) 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 plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar 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.

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 this reduction in the hospitalization 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.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) 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 plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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 qualifying reduction in the subsequent hospitalization 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.

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 withholds that must be returned to the hospitals if the performance target is achieved.

(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.

(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.

(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.

(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.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(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.

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Sec. 38. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

EFFECTIVE DATE. This section is effective January 1, 2024.

S2219-2

Sec. 50. **AUTOMOTIVE SELF-INSURANCE; RULES AMENDMENT; EXPEDITED RULEMAKING.**

Subdivision 1. **Self-insurance working capital condition.** The commissioner of commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item B, subitem (5), to require the commissioner's grant of self-insurance authority to an applicant to be based on the applicant's net working capital in lieu of the applicant's net funds flow.

Subd. 2. **Commissioner discretion to grant self-insurance authority.** The commissioner of commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item D, to, notwithstanding any other provision of Minnesota Rules, part 2770.6500, permit the commissioner to grant self-insurance authority to an applicant that is not a political subdivision and that has not had positive net income or positive working capital in at least three years of the last five-year period if the applicant's working capital, debt structure, profitability, and overall financial integrity of the applicant and its parent company, if one exists, demonstrate a continuing ability of the applicant to satisfy any financial obligations that have been and might be incurred under the no-fault act.

Subd. 3. **Working capital.** The commissioner of commerce must define working capital for the purposes of Minnesota Rules, part 2770.6500.

Subd. 4. **Commissioner discretion to revoke self-insurance authority.** The commissioner of commerce must amend Minnesota Rules, part 2770.7300, to permit, in lieu of require, the commissioner to revoke a self-insurer's authorization to self-insure based

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Sec. 64. Minnesota Statutes 2022, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

(d) Cost-sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

EFFECTIVE DATE. This section is effective January 1, 2024.

Sec. 65. **AUTOMOTIVE SELF-INSURANCE; RULES AMENDMENT; EXPEDITED RULEMAKING.**

Subdivision 1. **Self-insurance working capital condition.** The commissioner of commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item B, subitem (5), to require the commissioner's grant of self-insurance authority to an applicant to be based on the applicant's net working capital in lieu of the applicant's net funds flow.

Subd. 2. **Commissioner discretion to grant self-insurance authority.** The commissioner of commerce must amend Minnesota Rules, part 2770.6500, subpart 2, item D, to, notwithstanding any other provision of Minnesota Rules, part 2770.6500, permit the commissioner to grant self-insurance authority to an applicant that is not a political subdivision and that has not had positive net income or positive working capital in at least three years of the last five-year period if the applicant's working capital, debt structure, profitability, and overall financial integrity of the applicant and its parent company, if one exists, demonstrate a continuing ability of the applicant to satisfy any financial obligations that have been and might be incurred under the no-fault act.

Subd. 3. **Working capital.** The commissioner of commerce must define working capital for the purposes of Minnesota Rules, part 2770.6500.

Subd. 4. **Commissioner discretion to revoke self-insurance authority.** The commissioner of commerce must amend Minnesota Rules, part 2770.7300, to permit, in lieu of require, the commissioner to revoke a self-insurer's authorization to self-insure based

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on the commissioner's determinations under Minnesota Rules, part 2770.7300, items A and B.

Subd. 5. **Expedited rulemaking authorized.** The commissioner of commerce may use the expedited rulemaking process under Minnesota Statutes, section 14.389, to amend rules under this section.

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

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Sec. 39. **EVALUATION OF EXISTING STATUTORY HEALTH BENEFIT MANDATES.**

(a) The commissioner of commerce must evaluate existing Minnesota statutory provisions that would constitute a state-required benefit included in Minnesota's EHB-benchmark plan, as defined in Code of Federal Regulations, title 45, section 156.20, if the statutory provision was offered as a legislative proposal on the date of enactment of this act.

(b) The commissioner must conduct the evaluation using the process established under Minnesota Statutes, section 62J.26, subdivision 2.

(c) The commissioner may prioritize and determine the order in which statutory provisions are evaluated under this section, provided that at least one statutory provision is evaluated each year.

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on the commissioner's determinations under Minnesota Rules, part 2770.7300, items A and B.

Subd. 5. **Expedited rulemaking authorized.** The commissioner of commerce may use the expedited rulemaking process under Minnesota Statutes, section 14.389, to amend rules under this section.

Sec. 66. **EVALUATION OF EXISTING STATUTORY HEALTH BENEFIT MANDATES.**

Subdivision 1. **Evaluation process and content.** Beginning August 1, 2023, and annually thereafter for the next five calendar years, the commissioner of commerce shall conduct an evaluation of the economic cost and health benefits of one state-required benefit included in Minnesota's EHB-benchmark plan, as defined in Code of Federal Regulations, title 45, section 156.20. The mandated benefit to be studied each year must be chosen from a list developed by the chairs of the house of representatives and senate commerce committees, in consultation with the ranking minority members of the house of representatives and senate commerce committees. The chairs and ranking minority members of the house of representatives and senate commerce committees must agree upon and inform the commissioner of at least one mandate to be reviewed for the period between August 1, 2023, and August 1, 2024. The commissioner shall consult with the commissioner of health and clinical and actuarial experts to assist in the evaluation and synthesis of available evidence. The commissioner may obtain public input as part of the evaluation. At a minimum, the evaluation must consider the following:

(1) cost for services;

(2) the share of Minnesotans' health insurance premiums that are tied to each current mandated benefit;

(3) utilization of services;

(4) contribution to individual and public health;

(5) extent to which the mandate conforms with existing standards of care in terms of appropriateness or evidence-based medicine;

(6) the historical context in which the mandate was enacted, including how the mandate interacts with other required benefits; and

(7) other relevant criteria of effectiveness and efficacy as determined by the commissioner in consultation with the commissioner of health.

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(d) This section expires January 1, 2034.

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

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Subd. 2. **Report to legislature.** The commissioner must submit a written report on the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance policy and finance no later than 180 days after the commissioner receives notification from a chair, as required under Minnesota Statutes, section 62J.26, subdivision 3.

Sec. 67. **REPEALER.**

Minnesota Statutes 2022, section 62A.31, subdivisions 1b and 1i, are repealed.